The art of Clinical Supervision Program for registered nurses

Kylie P. Russell
The University of Notre Dame, Australia

Follow this and additional works at: https://researchonline.nd.edu.au/theses

Part of the Nursing Commons

COMMONWEALTH OF AUSTRALIA
Copyright Regulations 1969

WARNING
The material in this communication may be subject to copyright under the Act. Any further copying or communication of this material by you may be the subject of copyright protection under the Act.
Do not remove this notice.

Publication Details

This dissertation/thesis is brought to you by ResearchOnline@ND. It has been accepted for inclusion in Theses by an authorized administrator of ResearchOnline@ND. For more information, please contact researchonline@nd.edu.au.
The Art of Clinical Supervision Program
for Registered Nurses

*Its implementation and influence on nursing staffs’ knowledge and attitudes*

Kylie Russell
20103191

A thesis submitted in fulfilment of the requirements for the degree of
Doctor of Philosophy

School of Nursing and Midwifery
The University of Notre Dame, Australia
2013
# Table of Contents

**Table of Contents** ...................................................................................................................... ii

**List of Figures** ............................................................................................................................. viii

**List of Tables** ............................................................................................................................. ix

**List of Graphs** ............................................................................................................................. xiii

**List of Abbreviations** .................................................................................................................. xiv

**Abstract** ....................................................................................................................................... xvi

**Statement of Candidate Contribution** ......................................................................................... xviii

**Acknowledgements** ..................................................................................................................... xx

**Prologue** ...................................................................................................................................... 1

## Chapter 1: Introduction

1.1 Background ............................................................................................................................... 1

1.2 Health Workforce Australia .................................................................................................... 3

1.3 Clinical Supervision .................................................................................................................. 5

1.3.1 Clinical Placement Models .................................................................................................. 6

1.3.1.1 Terminology .................................................................................................................... 6

1.3.1.1.1 Clinical Instructor/Facilitator Model ........................................................................... 7

1.3.1.1.2 Preceptor/Mentor/Supervisor Model ......................................................................... 9

1.3.2 Clinical Supervision Programs .............................................................................................. 11

1.3.2.1 Preceptorship Programs ................................................................................................ 11

1.3.2.2 Mentorship Programs ..................................................................................................... 12

1.3.2.3 Clinical Supervision Programs for Employees ................................................................. 13

1.3.3 Application to Student Clinical Placements ......................................................................... 14

1.4 The Justification ....................................................................................................................... 15

1.5 Research Questions .................................................................................................................. 16

1.6 Operational Definitions ........................................................................................................... 17

1.7 Conclusion ................................................................................................................................ 18

## Chapter 2: Literature Review

2.1 Introduction ............................................................................................................................. 20

2.2 Principles of Clinical Supervision ............................................................................................ 22

2.2.1 Deficits and Requirements .................................................................................................. 22

2.2.2 Supervisor Attitude ............................................................................................................ 26

2.2.3 International and Australian Clinical Supervision Education Programs ......................... 28

2.2.3.1 UK ................................................................................................................................. 28

2.2.3.2 Australian Supervision Programs and Requirements ..................................................... 31

2.2.4 Clinical Supervision in Summary ....................................................................................... 34

2.2.5 Health Workforce Australia—Education Requirements ....................................................... 35

2.3 The Theories of Learning ......................................................................................................... 37

2.3.1 Theories of Adult Learning ................................................................................................. 37

2.3.1.1 Behaviourist Theory ...................................................................................................... 38

2.3.1.1.1 Thorndike, Pavlov and Bandura .................................................................................. 39
Chapter 3: Methodology ........................................................................................................... 51

3.1 Introduction ......................................................................................................................... 51

3.2 Social Sciences .................................................................................................................... 52

3.3 Methodology of the CSP Research Project ........................................................................ 53

3.3.1 Descriptive Study ........................................................................................................... 53

3.3.2 Mixed Method Research ............................................................................................... 54

3.3.2.1 Quantitative ............................................................................................................. 54

3.3.2.2 Qualitative ............................................................................................................... 56

3.3.3 Application of Mixed Methods Research ..................................................................... 57

3.3.4 Triangulation .................................................................................................................. 59

3.3.4.1 Data Triangulation ................................................................................................. 61

3.3.4.2 Investigator Triangulation ....................................................................................... 62

3.3.4.3 Theory Triangulation ............................................................................................. 62

3.3.4.4 Method Triangulation ............................................................................................ 63

3.4 Research Techniques ........................................................................................................ 63

3.4.1 Development of the Program ....................................................................................... 65

3.4.1.1 Program Content and Delivery ............................................................................. 66

3.4.2 Application of HWA’s Publications and Literature ..................................................... 67

3.4.3 Application of the Theories of Learning and Principles of Adult Learning ............. 69

3.4.4 Application of the Theories of Attitude and Attitude Change .................................. 75

3.4.5 Ongoing Learner Support ............................................................................................. 78

3.4.6 Development of the Research Tools ............................................................................. 78

3.4.6.1 Online Reflections About the Experiences of Participants ................................... 82

3.4.6.2 Interview Statements About the Program’s Effect on Participants ....................... 82

3.4.7 Feedback from the Expert Group Regarding the CSP ............................................. 83

3.4.8 Pilot Presentation of Program with Participant Feedback ........................................... 84

3.4.8.1 Pilot Themes ............................................................................................................ 85

3.4.9 Validity and Reliability Testing of the Knowledge Survey Tool by the Expert Group .......................... 86

3.4.9.1 Knowledge Survey ................................................................................................. 87

3.4.10 Modify the Program and/or Tools as a Result of Phase 2 .......................................... 90

3.4.11 Implementation of the Program .................................................................................. 91

3.4.11.1 Population Selection ............................................................................................. 91

3.4.11.2 Participant Selection ............................................................................................ 93

3.4.11.3 Recruitment .......................................................................................................... 94

3.4.11.3.1 Recruitment Process ....................................................................................... 95

3.4.11.3.2 University Recruitment Process ................................................................. 95

3.4.11.3.3 DoH Recruitment Process ............................................................................ 96

3.4.11.4 Program Implementation ...................................................................................... 98

3.4.12 Completion of the Pre-survey and Immediate Post-survey ....................................... 98
3.4.12.1 Maximising Participant Involvement in the Data Collection Phases ........... 99
3.4.13 Online Reflective Feedback.......................................................... 101
3.4.14 Post-program Survey After Eight Weeks....................................... 101
3.4.15 Interviews ................................................................................. 102
3.5 Summary of Research Phases ................................................................ 104
3.6 Ethical Considerations ......................................................................... 104
3.6.1 Ethics Approval ............................................................................. 105
3.6.2 Informed Consent .......................................................................... 105
3.6.3 Benefit and Risk ............................................................................ 106
3.6.4 Privacy and Confidentiality ............................................................. 106
3.6.5 Conflict of Interest ........................................................................ 107
3.6.6 Security of Data ............................................................................. 108
3.7 Chapter Summary .............................................................................. 108

Chapter 4: Quantitative Data Analysis and Findings ..................................... 110
4.1 Introduction ...................................................................................... 110
4.2 Study Population ............................................................................. 111
  4.2.1 Surveys: Knowledge Survey and Stagg’s Attitude Survey ................. 111
4.3 Analysis of Quantitative Data .............................................................. 111
  4.3.1 Participant Demographics .............................................................. 115
    4.3.1.1 Participant Numbers ................................................................ 115
    4.3.1.2 Workplace Characteristics ...................................................... 115
    4.3.1.3 Age and Gender ..................................................................... 118
    4.3.1.4 Speciality of Practice .............................................................. 119
    4.3.1.5 Years of Nursing Experience ................................................. 120
    4.3.1.6 Reason for Attending the Clinical Supervision Program ............ 121
    4.3.1.7 Previous Clinical Supervision Education .................................. 121
    4.3.1.8 Frequency of Providing Clinical Supervision ............................ 123
  4.3.2 Quantitative Data Analysis—Knowledge Survey ............................ 125
    4.3.2.1 Age of Participants ............................................................... 126
    4.3.2.2 Area of Employment .............................................................. 127
    4.3.2.3 Previous Education in Clinical Supervision ............................. 128
    4.3.2.4 Frequency of Providing Clinical Supervision ............................ 130
    4.3.2.5 Years of Nursing Experience .................................................. 130
  4.3.3 Comparison of Results—Knowledge Survey .................................. 131
    4.3.3.1 Participants ............................................................................ 132
    4.3.3.2 Area of Employment .............................................................. 133
    4.3.3.3 Age of Participants ............................................................... 135
    4.3.3.4 Previous Education in Clinical Supervision ............................. 136
    4.3.3.5 Frequency of Providing Clinical Supervision ............................ 139
    4.3.3.6 Years of Nursing Experience .................................................. 140
  4.3.4 Quantitative Data Analysis—Attitude Survey Results ..................... 142
    4.3.4.1 Stagg’s Attitude Survey Analysis by Themes ........................... 143
      4.3.4.1.1 Time ............................................................................... 143
      4.3.4.1.2 Motivation ...................................................................... 145
      4.3.4.1.3 Knowledge .................................................................... 146
      4.3.4.1.4 Professional Issues ......................................................... 148
      4.3.4.1.5 Instructor–Student Relationship ....................................... 150
      4.3.4.1.6 Personal Issues ............................................................... 151
      4.3.4.1.7 Background Comparisons .............................................. 154
    4.3.4.2 Stagg’s (1992) Attitude Survey Analysis by Mean Scores .......... 156
5.1 Introduction ................................................................. 179
5.2 Qualitative Data Collection ........................................ 179
5.3 Qualitative Data Analysis ............................................... 180
  5.3.1 Knowledge Surveys ................................................ 183
    5.3.1.1 Effect on Participants ........................................... 185
      5.3.1.1.1 Improved Self-confidence .................................. 186
      5.3.1.1.2 Renewed Enthusiasm and Attitude ...................... 187
      5.3.1.1.3 Consolidation of Knowledge and Skills ................ 188
      5.3.1.1.4 Current Context of Nursing Education .............. 189
    5.3.1.2 Strategies for Improving Clinical Supervision .......... 190
      5.3.1.2.1 Embracing the Power of Belongingness .............. 190
      5.3.1.2.2 Empathy for Students’ Experiences .................. 192
      5.3.1.2.3 Improving the Student Learning Journey ............. 194
      5.3.1.2.4 Improving Communication ............................... 197
    5.3.1.3 Promoting Staff Knowledge and Culture Change .......... 198
  5.3.2 Online Reflections ................................................ 200
    5.3.2.1 Effect on Participants ........................................... 202
      5.3.2.1.1 Improved Self-confidence .................................. 203
      5.3.2.1.2 Renewed Enthusiasm and Attitude ...................... 204
      5.3.2.1.3 Personal Reward ........................................... 206
    5.3.2.2 Strategies for Improving Clinical Supervision .......... 207
      5.3.2.2.1 Improving the Student Learning Journey ............. 208
      5.3.2.2.2 Improving Communication ............................... 210
      5.3.2.2.3 Embracing the Power of Belongingness .............. 213
    5.3.2.3 Perceived Lack of Staff Support ............................ 215
  5.3.3 Interviews ........................................................... 217
    5.3.3.1 Effect on Participants ........................................... 220
      5.3.3.1.1 Perceptions of Staff Knowledge and Attitudes  ...... 220
      5.3.3.1.2 Current Staff Education .................................. 222
      5.3.3.1.3 Consolidation of Own Knowledge and Attitude ....... 223
      5.3.3.1.4 Current Context of Nursing Education .............. 224
    5.3.3.2 Strategies for Improving Clinical Supervision .......... 226
      5.3.3.2.1 Embracing the Power of Belongingness .............. 226
    5.3.3.3 Improving the Students’ Learning Journey ............... 229
  5.4 Qualitative Findings ............................................... 231
    5.4.1 Extending Oneself and Others ................................. 232
      5.4.1.1 Effect on Staff ............................................... 232
      5.4.1.1.1 Improved Self-confidence, Knowledge and Attitudes 233
      5.4.1.1.2 Improved Understanding of the Current Context of Nursing Education

5.4.1.3 Concerns Regarding Current Staff Knowledge, Attitudes and Education .................................................. 234
5.4.1.2 Strategies for Improving Clinical Supervision ................................................................. 234
5.4.1.2.1 Embracing the Power of Belongingness ................................................................. 234
5.4.1.2.2 Improving Communication ................................................................................. 237
5.4.1.2.3 Improving the Student Learning Journey .......................................................... 238
5.4.1.3 Perceived Lack of Support ......................................................................................... 239
5.5 Qualitative Findings in Summary ..................................................................................... 240
5.6 Program Evaluation .......................................................................................................... 240
5.6.1 Program Content and Presentation .................................................................................. 242
5.6.2 Potential Availability of Program ..................................................................................... 245
5.6.3 Consequences for Recruitment and Retention ............................................................... 246
5.6.4 Application for Graduates and Staff ............................................................................... 248
5.6.5 Taking Back to the Team ............................................................................................... 249
5.7 Chapter Summary ............................................................................................................... 251

Chapter 6: Comparison of Findings ................................................................................................. 252
6.1 Introduction .......................................................................................................................... 252
6.2 Nursing in Australia ............................................................................................................. 252
6.3 Comparison of Qualitative and Quantitative Findings ....................................................... 255
6.4 Comparison of Findings to the Literature ......................................................................... 256
6.4.1 Improved Self-confidence, Knowledge, Attitudes and Enthusiasm ................................. 256
6.4.1.1 Eight-Week Survey Results ....................................................................................... 257
6.4.1.2 Stagg’s (1992) Attitude Survey Findings Across Research Projects .......................... 260
6.4.2 Improved Understanding of Current Context of Nursing Education ............................ 264
6.4.3 Concerns Regarding Current Staff Knowledge, Attitudes and Education .................... 264
6.4.3.1 Role Theory .................................................................................................................. 265
6.4.4 Perceived Lack of Support .............................................................................................. 268
6.4.5 Embracing the Power of Belongingness ......................................................................... 270
6.4.6 Improved Communication .............................................................................................. 274
6.4.7 Students’ Learning Journey ............................................................................................ 275
6.5 Program Evaluation Findings and Implications ................................................................. 277
6.5.1 Principles of Adult Learning ............................................................................................ 278
6.6 Salient Outcomes of This Research .................................................................................... 279
6.6.1 Research Questions .......................................................................................................... 280
6.7 Limitations .......................................................................................................................... 284
6.8 Chapter Summary ............................................................................................................... 284

Chapter 7: Implications and Recommendations of Findings .................................................. 286
7.1 Introduction .......................................................................................................................... 286
7.2 Clinical Implications ........................................................................................................... 287
7.3 Education Implications ....................................................................................................... 288
7.3.1 Considerations ................................................................................................................ 288
7.4 Research Implications ........................................................................................................ 289
7.5 Recommendations ............................................................................................................. 290
7.6 Conclusion ........................................................................................................................... 290

Epilogue ........................................................................................................................................ 292
References ...................................................................................................................................... 293

Appendix 1: Ethics and Research Committee Approval Letters and Approval from the Department of Health .................................................................................................................. 305
Appendix 2: Clinical Supervision Program—Study Day Agenda ............................... 309
Appendix 3: Clinical Supervision Program, Teaching Plan ...................................... 310
Appendix 4: Attitude Survey—Stagg ........................................................................ 324
Appendix 5: Permission from Stagg to Use Survey.................................................. 327
Appendix 6: Pre-program Knowledge Survey ........................................................... 328
Appendix 7: Post-program Knowledge Survey ......................................................... 333
Appendix 8: Online Reflection Feedback Instructions for Research Participants ... 339
Appendix 9: Interview Questions for Research Project Participants ....................... 340
Appendix 10: Information Sheet for Research Expert Group, Validation of Program, Participants .......................................................... 342
Appendix 11: Attachments for Validation Expert Group ......................................... 349
Appendix 12: Clinical Supervision Program Work File ............................................. 350
Appendix 13: Expert Group for Program Validation, Participants’ Details .......... 351
Appendix 14: Pilot Presentation Feedback Form ....................................................... 352
Appendix 15: Pilot Project Participants’ Feedback .................................................... 353
Appendix 16: Request to Participate in Reliability Expert Group ......................... 355
Appendix 17: Expert Group, Reliability of Knowledge Survey, Feedback Form and Feedback .......................................................................................... 356
Appendix 18: Email to Expert Group, Reliability of Knowledge Survey, to Complete Second Survey for Reliability Testing .......................... 357
Appendix 19: Reliability Testing Results, Feedback and Participants’ Details ....... 358
Appendix 20: Marking Tool for Knowledge Surveys ............................................... 362
Appendix 21: Reliability of Knowledge Survey Results ............................................ 365
Appendix 22: Email to Health Care Facilities to Promote the Clinical Supervision Program for Registered Nurses ....................................................... 366
Appendix 23: Program Details/Logistics for Health Care Facilities ....................... 369
Appendix 24: Participants’ Consent for Online Reflections ..................................... 370
Appendix 25: Example of Weekly Email for Online Reflection Participants ............. 371
Appendix 26: Letter of Appreciation for Research Program Participants ............... 372
Appendix 27: Information Sheet for Program Participants ..................................... 373
Appendix 28: Research Program Participants’ Consent .......................................... 375
Appendix 29: Letter Sent to Program Participants with Eight-week Survey and Certificate ......................................................................................... 376
Appendix 30: Conference Presentations of Research Project ................................ 378
Appendix 31: The Art of Clinical Supervision Advertising Poster ........................... 379
List of Figures

Figure 1.1: Clinical facilitator model for clinical practicum ........................................ 8
Figure 1.2: Clinical supervisor model for clinical practicum .......................................... 10
Figure 2.1: Conceptual framework for the development of the CSP ................................. 21
Figure 2.2: Negative and positive influences on students’ perceptions of clinical placements .................................................................................................................................................. 34
Figure 2.3: Kolb’s Experiential Learning Model, adapted with suggested learning strategies (Knowles et al., 2011, p. 197) .................................................................................................................................................... 42
Figure 3.1: Research methodology for the CSP research project ...................................... 52
Figure 3.2: Application of ‘convergent parallel design’ to CSP research project ............... 59
Figure 3.3: Application of ‘triangulation methods’ to the CSP research .......................... 60
Figure 3.4: Phases of the research process ......................................................................... 64
Figure 3.5: Application of HWA’s four key points to the CSP ......................................... 68
Figure 3.6: Theories of learning applied to the CSP ......................................................... 70
Figure 3.7: Theories and principles of learning and attitude applied to the CSP ............. 77
Figure 3.8: Pearson’s correlation coefficient results for the pre-knowledge survey reliability test ..................................................................................................................................................... 89
Figure 3.9: Process of participant recruitment for research program—university .......... 96
Figure 3.10: Process of participant recruitment for research program—DoH ................. 97
Figure 5.1: Concept map of the open-ended survey themes and subthemes .................... 183
Figure 5.2: Concept map of the online reflection themes and subthemes ........................ 201
Figure 5.3: Concept map of the interview themes and subthemes .................................. 218
Figure 5.4: Overall qualitative themes of the CSP research project ................................. 232
Figure 5.5: Effect of belongingness on CSP participants ............................................... 235
Figure 5.6: Strategies for belongingness by CSP participants ........................................ 236
Figure 5.7: Relationship of effective communication skills to clinical supervision ....... 238
Figure 5.8: Influencing factors on improving students’ learning journeys ..................... 239
Figure 6.1: CSP’s study findings ...................................................................................... 256
Figure 7.1: Implications of the findings of the CSP research project .............................. 287
List of Tables

Table 3.1: Pedagogy and andragogy principles of learning, application to CSP, according to the core principles of learning by Knowles et al. (1998) .......... 72
Table 3.2: Application of the theories of persuasion to the CSP ........................................... 76
Table 3.3: Data collection tools ................................................................................................. 79
Table 4.1: Number of completed knowledge and attitude surveys ........................................ 111
Table 4.2: Total number of research participant according to area of employment .......... 116
Table 4.3: Description of participants’ health care facilities ..................................................... 117
Table 4.4: Characteristics of employment sites and attendance numbers for university attendees ........................................................................... 117
Table 4.5: Characteristics of DoH sites with attendance numbers .......................................... 118
Table 4.6: Age and gender ......................................................................................................... 119
Table 4.7: Area of employment and speciality of practice ......................................................... 120
Table 4.8: Years of nursing experience ..................................................................................... 120
Table 4.9: Summary of years of nursing experience ................................................................. 121
Table 4.10: Previous education related to clinical supervision .................................................... 122
Table 4.11: Previous education in clinical supervision cross-tabulated with area of employment ............................................................................ 122
Table 4.12: Frequency of clinical supervision cross-tabulated with area of employment 123
Table 4.13: Pre-program knowledge survey mean score with mode, median and standard deviation ............................................................................ 126
Table 4.14: Pre-program knowledge survey mean scores and standard deviations for age of participants ............................................................................ 127
Table 4.15: Pre-program knowledge survey mean scores for area of employment ........ 128
Table 4.16: Pre-program knowledge survey mean scores and standard deviations for previous education in clinical supervision ............................................................................ 129
Table 4.17: Pre-program knowledge survey mean scores for area of employment cross-tabulated with previous education in clinical supervision ............................................................................ 129
Table 4.18: Pre-program knowledge survey mean scores and standard deviations for frequency of clinical supervision ............................................................................ 130
Table 4.19: Pre-program knowledge survey mean scores and standard deviations for years of nursing experience ................................................................. 131

Table 4.20: Knowledge survey mean scores with standard deviations across the phases of data collection ...................................................................................... 132

Table 4.21: Return rates with mean scores for the knowledge survey at the pre-program and immediate post-program phases for all participants, and eight-week group only (across pre-program, immediate post-program and eight-week surveys), according to area of employment ........................................ 134

Table 4.22: Knowledge survey mean scores for age of participants across the phases of survey completion ...................................................................................... 136

Table 4.23: Knowledge survey mean scores for previous education in clinical supervision across the phases of survey completion ....................................................... 137

Table 4.24: Knowledge survey mean scores according to previous education in clinical supervision cross-tabulated with area of employment, both pre- and post-program attendance .................................................................................................................... 139

Table 4.25: Knowledge survey mean scores for frequency of clinical supervision across the phases of survey completion ................................................................. 140

Table 4.26: Knowledge survey mean scores for years of nursing experience across the phases of survey completion ............................................................................ 141

Table 4.27: Stagg’s (1992) attitude survey theme of ‘time’ across the phases of survey completion ........................................................................................................ 145

Table 4.28: Stagg’s (1992) attitude survey theme of ‘motivation’ across the phases of survey completion .............................................................................................. 146

Table 4.29: Stagg’s (1992) attitude survey theme of ‘knowledge’ across the phases of survey completion .............................................................................................. 148

Table 4.30: Stagg’s (1992) attitude survey theme of ‘professional issues’ across the phases of survey completion .................................................................................. 149

Table 4.31: Stagg’s (1992) attitude survey theme of ‘instructor–student relationship’ across the phases of survey completion .............................................................. 151

Table 4.32: Stagg’s (1992) attitude survey theme of ‘personal issues’ across the phases of survey completion ...................................................................................... 1533

Table 4.33: Stagg’s (1992) attitude survey theme of ‘background comparisons’ across the phases of survey completion ........................................................................ 155
Table 4.34: Study group mean scores with the standard deviation for Stagg’s (1992) attitude survey ................................................................. 157
Table 4.35: Stagg’s (1992) attitude survey mean scores and standards deviations relating to the age of participants across the phases of survey completion...... 159
Table 4.36: Stagg’s (1992) attitude survey mean scores and standard deviation relating to area of employment across the phases of survey completion ...................... 160
Table 4.37: Stagg’s (1992) attitude survey mean scores and standard deviation for previous education in clinical supervision across the phases of survey completion ........................................................................ 161
Table 4.38: Stagg’s (1992) attitude survey mean scores and standard deviation for frequency of clinical supervision across the phases of survey completion ...... 163
Table 4.39: Stagg’s (1992) attitude survey mean scores and standard deviation relating to years of nursing experience across the phases of survey completion .......... 164
Table 4.40: Overall comparison of findings of Stagg’s (1992) attitude survey—score allocation with the CSP ............................................................................. 167
Table 4.41: Overall mean score of Stagg’s (1992) attitude survey divided between low, moderate and high—comparison of finding between Aghamohammadi-Kalkhoran et al. (2010) and the CSP ................................................................. 168
Table 4.42: Comparison of Stagg’s (1992) attitude survey for the theme of ‘time’ for Stagg, AKKA and the CSP ........................................................................ 169
Table 4.43: Comparison of Stagg’s (1992) attitude survey for the theme of ‘motivation’ for Stagg, AKKA and the CSP ..................................................... 170
Table 4.44: Comparison of Stagg’s (1992) attitude survey for the theme of ‘knowledge’ for Stagg, AKKA and the CSP ..................................................... 171
Table 4.45: Comparison of Stagg’s (1992) attitude survey for the theme of ‘professional issues’ for Stagg, AKKA and the CSP ..................................................... 172
Table 4.46: Comparison of Stagg’s (1992) attitude survey for the theme of ‘instructor–student relationship’ for Stagg, AKKA and the CSP ..................................................... 173
Table 4.47: Comparison of Stagg’s (1992) attitude survey for the theme of ‘personal issues’ for Stagg, AKKA and the CSP ..................................................... 174
Table 4.48: Comparison of Stagg’s (1992) attitude survey for the theme of ‘background information’ for Stagg, AKKA and the CSP ..................................................... 175
Table 5.1: Criteria for interviews ........................................................................ 180
Table 6.1: Age of registered nurses in Australia according to the ABS (2001), AHPRA (2013) and the CSP (2012)........................................................................................................................................... 253
List of Graphs

Graph 4.1: Frequency of clinical supervision cross-tabulated with area of employment . 125
Graph 4.2: Pre-program knowledge survey’s mean scores for area of employment ....... 128
Graph 4.3: Knowledge survey mean scores for area of employment across the phases
of survey completion.................................................................................................... 135
Graph 4.4: Knowledge survey mean scores for age of participants across the phases of
survey completion......................................................................................................... 136
Graph 4.5: Knowledge survey mean scores for previous education in clinical
supervision across the phases of survey completion ................................................ 138
Graph 4.6: Knowledge survey mean scores for frequency of clinical supervision across
the phases of survey completion..................................................................................... 140
Graph 4.7: Knowledge survey mean scores for years of nursing experience across the
phases of survey completion ......................................................................................... 141
Graph 4.8: Attitude surveys’ mean scores with standard deviation and range across the
phases of survey completion ......................................................................................... 158
Graph 4.9: Stagg’s (1992) attitude survey mean scores relating to the age of
participants across the phases of survey completion ................................................. 159
Graph 4.10: Stagg’s (1992) attitude survey results relating to area of employment
across the phases of survey completion ....................................................................... 160
Graph 4.11: Stagg’s (1992) attitude survey mean scores for previous education in
clinical supervision across the phases of survey completion ..................................... 162
Graph 4.12: Stagg’s (1992) attitude survey mean scores for frequency of clinical
supervision across the phases of survey completion ................................................. 163
Graph 4.13: Stagg’s (1992) attitude survey mean scores relating to years of nursing
experience across the phases of survey completion ................................................. 164
# List of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
</tr>
<tr>
<td>AHPRA</td>
<td>Australian Health Practitioner Regulation Agency</td>
</tr>
<tr>
<td>AKKA</td>
<td>Aghamohammadi-Kalkhoran et al.</td>
</tr>
<tr>
<td>ANMC</td>
<td>Australian Nursing and Midwifery Council</td>
</tr>
<tr>
<td>CINAHL</td>
<td>Cumulative Index to Nursing and Allied Health Literature</td>
</tr>
<tr>
<td>COAG</td>
<td>Council of Australian Governments</td>
</tr>
<tr>
<td>CPAT</td>
<td>Clinical Placement Assessment Tool</td>
</tr>
<tr>
<td>CSP</td>
<td>Clinical Supervision Program</td>
</tr>
<tr>
<td>CSSP</td>
<td>Clinical Supervisor Support Program</td>
</tr>
<tr>
<td>CSSPDP</td>
<td>Clinical Supervisor Support Program Discussion Paper</td>
</tr>
<tr>
<td>DEST</td>
<td>Department of Education, Science and Training</td>
</tr>
<tr>
<td>DNCSCF</td>
<td>Draft National Clinical Supervision Competency Framework</td>
</tr>
<tr>
<td>DoH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>FHHS</td>
<td>Fremantle Hospital and Health Service</td>
</tr>
<tr>
<td>HREC</td>
<td>Human Research Ethics Committee</td>
</tr>
<tr>
<td>HWA</td>
<td>Health Workforce Australia</td>
</tr>
<tr>
<td>HWS</td>
<td>Health Workforce Series</td>
</tr>
<tr>
<td>IP</td>
<td>immediate post-program survey</td>
</tr>
<tr>
<td>JDF</td>
<td>Job Description Format</td>
</tr>
<tr>
<td>MET</td>
<td>Medical Emergency Team</td>
</tr>
<tr>
<td>NCSSSF</td>
<td>National Clinical Supervision Support Framework</td>
</tr>
<tr>
<td>ND</td>
<td>Notre Dame</td>
</tr>
<tr>
<td>NHMRC</td>
<td>National Health and Medical Research Council</td>
</tr>
<tr>
<td>NMBA</td>
<td>Nursing and Midwifery Board of Australia</td>
</tr>
<tr>
<td>NMC</td>
<td>Nursing and Midwifery Council</td>
</tr>
<tr>
<td>OT</td>
<td>occupational therapist</td>
</tr>
<tr>
<td>PCA</td>
<td>patient care assistant</td>
</tr>
<tr>
<td>RCN</td>
<td>Royal College of Nursing</td>
</tr>
<tr>
<td>RN</td>
<td>registered nurse</td>
</tr>
<tr>
<td>SA</td>
<td>strongly agree</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Definition</td>
</tr>
<tr>
<td>--------------</td>
<td>------------</td>
</tr>
<tr>
<td>SD</td>
<td>strongly disagree</td>
</tr>
<tr>
<td>SDN</td>
<td>staff development nurse</td>
</tr>
<tr>
<td>SOM</td>
<td>sign-off mentor</td>
</tr>
<tr>
<td>SPSS</td>
<td>Statistical Package for Social Sciences</td>
</tr>
<tr>
<td>SWOT</td>
<td>Strength, Weaknesses, Opportunities, Threats</td>
</tr>
<tr>
<td>TAFE</td>
<td>Technical and Further Education</td>
</tr>
<tr>
<td>TEQSA</td>
<td>Tertiary Education Quality and Standards Agency</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>VET</td>
<td>vocational education and training</td>
</tr>
</tbody>
</table>
Abstract

Nursing students’ clinical placements should provide an environment in which they can apply their nursing education in the fast-paced world of health care and develop a framework for practice. Students rely on effective teaching and supportive clinical supervisors to provide a placement in which they are not only encouraged to practice, but also to learn from this practice. This is achieved through welcoming students into the health care team by valuing their input and contributions, and consolidating their clinical practice through activities such as critical thinking and reflection.

The role of the clinical supervisor is therefore complex and often constrained by time because of the need to prioritise patient care. The role is also distant to that of providing clinical care; therefore, staff require specific education and guidance to understand and implement the role’s requirements.

This research aimed to develop, implement and evaluate a new education program for nursing staff. This process was guided by the current literature in relation to the role of the clinical supervisor, the theories and principles of adult learning, and the theories of attitude and attitude change.

The effect of the program was determined using a descriptive methodology involving the collection and analysis of quantitative and qualitative data using a triangulation approach. This involved the use of pre- and post-program attendance (on the day and after eight weeks) knowledge and attitude surveys, online reflective statements for up to eight weeks after attending the program, and individual interviews.

Analysis of the data determined that participants improved both their knowledge and attitude towards students and clinical supervision. Participants viewed the program as a positive strategy for improving their attitude towards students and student clinical supervision, while also being supported with realistic strategies for promoting a welcoming environment conducive to student learning. Participants also articulated their concerns related to perceived organisational barriers to providing effective clinical supervision.
There are multiple implications of this research. The Clinical Supervision Program (CSP) for Registered Nurses is confirmed as a strategy for providing effective education for nurses involved in the role of clinical supervision. The study also articulates the importance of health care facilities and education providers in ensuring ongoing support and recognition of the role, as well as facilitating a workplace that is supportive of student placements.
Statement of Candidate Contribution

Declaration of Authorship

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

To the best of the candidate’s knowledge, the thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

_________________________  ____________________
Kylie Patricia Russell      25.11.2013
In memory of Drew

Thank you for believing in me, guiding me and for always loving me.

‘They shall grow not old, as we that are left grow old;
Age shall not weary them, nor the years condemn.
At the going down of the sun and in the morning
We will remember them’ (Laurence Binyon, 1914)
Acknowledgements

There are so many people I would like to thank who have supported me, but firstly I must mention the generous support of the Western Australian Nurses Memorial Charitable Trust for their financial assistance towards this research.

I would especially like to thank my principal supervisor, Professor Selma Alliex, who first proposed the idea that I undertake this learning journey; I never thought it was possible until she believed in me; and for Dr Heather Gluyus, who confirmed this belief in my ability. Both of you have patiently guided me, supported me, sat through my tears and doubts, and lead me now to this final stage.

To all of my nursing colleagues, you have all, at some time in some way, shaped the nurse that I am today. We have created bonds through shared laughter, tears, successes and losses. These memories remind me of how nurses can change and affect people’s lives. And also to all of the research participants, without you, this journey would simply have not been possible.

For Ann, not only do we share our passion for nursing and education, but we have been there for each other in times of personal heartache. You have and always will be my mentor.

To my mum and dad, who are always there for me, you remind me of who I am and who I want to be. To my beautiful daughter Leisa, without you, the world would simply have no meaning. You are my light, and I feel blessed to share each day with you. For Malcolm, who stands by my side, loving me despite my faults, you have helped when no one else could.
As an educator, I have been involved with the facilitation of preceptorship and clinical supervision training for over 12 years. As a young educator who had recently completed my Masters in Health Science (Education), I presented many of the sessions included in this Clinical Supervision Program (CSP), albeit in a very different manner to my current teaching style. My sessions were individual sessions, heavy in theory, PowerPoint-orientated, and with little, if any, practical application of the material or connection to other topics and sessions of the day. Each time I presented, I received positive feedback from my participants, but I could not help but wonder how their understanding of concepts and theories—such as Kolb’s Learning Model and the principles of pedagogy—really helped them when they had a graduate or student nurse to supervise. I began to question others about their study days and was surprised to find that many hospitals did not provide any education about supervising students; instead, their programs focused on supporting graduates and newly employed nurses.

At the same time that I began this journey of reflection, I transferred into the Undergraduate Coordinator role with a well-respected colleague who was passionate about students and also concerned by the deficits in nursing staff knowledge regarding student clinical supervision. In the previous year, she had been asked by the nursing executive to increase the student numbers within the hospital, and she asked if I would work with her to achieve this goal. We agreed that implementing this increase would require providing intensive support to the ward managers, staff and students. Thus, I began to rethink my approach to preceptorship education, and we rewrote the program offered to nurses at the time. Our new program focused on a team approach, with practical ideas, less theory and the implementation of ideas such as the Team Leader Model and Student Liaison Nurses to facilitate student population growth. Within two years, we had doubled the student intake, with a philosophy that there would be a student for every staff member. With this change in teaching clinical supervision, maintaining a visible presence on the ward to support staff and students, and providing ward areas with strategies to manage the increase in student numbers, we noticed that the most influential factor for staff to accept this increase in student numbers, and for students to have a positive experience, was based on attitude. If
the staff had a positive attitude towards the students and their placement, they accepted more students and the students had a better placement. We confirmed these findings in our research project, ‘The Team Leader Model: An Alternative to Preceptorship’.

After leaving the role and commencing as the Clinical Coordinator at the University of Notre Dame Australia School of Nursing and Midwifery, I soon realised the differences in health care sites in relation to the acceptance of student placements and the attitude towards students and student learning.

I wondered if we could develop the same culture created at one hospital across all health care sites to assist with reducing the shortfall of student placements and improve the learning experiences of students. The outcome of this was the development of the CSP, which encompassed my 12 years of experience in facilitating preceptorship study days and managing undergraduate and graduate placements. Now the time has come to implement the program and determine whether years of supporting a change in attitude in one hospital can be similarly sparked by participants attending just one day.
Chapter 1: Introduction

The first clinical placement timetable for the course was out. She stretched on her tiptoes, eager to see the list on the board. Where would she be placed? Finally, the group moved and she could see her name… YES! A placement in a hospital—just what she had hoped for.

Chapte r one will provide an introduction to the research study. This will include a detailed background of the current clinical supervision models and programs available in Australia and internationally, as well as the role of Health Workforce Australia in reviewing the current Australian context. A justification for the study and the research questions will also be described. The chapter will finish with operational definitions that will be utilised throughout the thesis.

1.1 Background

The introduction of bachelor programs for registered nurses commenced in Australia in the early 1990s. Since then, these courses have educated and assessed students according to the Australian Nursing and Midwifery Council (ANMC) National Competency Standards for the Registered Nurse (Nursing and Midwifery Board of Australia (N MBA), 2006). This has been achieved through a combination of university-based academic studies and a clinical placement program (Department of Education, Science and Training (DEST), 2002).

While on clinical placement, students are supervised by members of the health care facilities’ nursing staff, termed ‘clinical supervisors’ (Health Workforce Australia (HWA), 2010). These nurses provide opportunities for learning and the assessment of students’ performance in the clinical setting. This role of clinical supervision is included within the ‘domains of practice’ of the registered nurse as articulated in the National Competency Standards (N MBA, 2006). These domains articulate the role of the registered nurse and provide a framework for practice that encompasses clinical care, research, management
and education. These domains do not provide detailed descriptions or an outline of the clinical supervisor role or the educational requirements to undertake this.

Student assessment on clinical placement is guided by the ‘Principles for the Assessment of National Competency Standards for Registered and Enrolled Nurses’ (NMBA, 2002). These assessment guidelines provide nursing staff with a valid and reliable framework for determining competency of practice. They are used for both the assessment of students and the performance management of nurses (NMBA, 2002).

As there are no specific education requirements by the NMBA for nursing clinical supervisors, the assistance and education provided to nursing staff in the teaching and assessment role of clinical supervision varies between health care facilities and education providers across Australia (HWA, 2010; Siggins Miller Consultants, 2012).

A review of the literature from Australia and around the world revealed that there are two main support strategies to assist nursing staff: first, the provision of education and training in the role of clinical supervision from a local health care facility perspective; second, the provision of a linked role between the health care facility and the education provider to support both the staff and student during the clinical placement (Andrews & Roberts, 2003; Gleeson, 2008; Hartigan-Rogers, Cobbett, Amirault & Muise-Davis, 2007).

The current education programs provided for nursing staff are generally coordinated by the health care facilities for their own workforce. Programs may be short in-service sessions, online self-directed learning packages or included as a topic within other day programs (Barnett, Cross, Shahwan-Akl & Jacob, 2010; Russell, Hobson & Watts, 2011; Siggins Miller Consultants, 2012). A number of Australian and international universities offer formal post-graduate qualifications related to education in nursing and health sciences (Charleston & Happell, 2004; Smedley, Morey & Race, 2010); however, these courses are often undertaken by senior educators who do not work directly with students in clinical areas.

Feedback from students and nurses in the DEST (2002) National Review of Nursing Education highlighted concerns regarding the effectiveness of clinical placement programs. These findings identified a deficit in the current education and training provided
to nursing staff to enable them to effectively undertake the clinical supervisor role. These concerns included a lack of understanding of the role and confusion regarding the role’s responsibilities and the expectations of universities in relation to teaching and assessing students.

With looming workforce shortages within nursing, medicine and allied health disciplines within Australia, the education of health practitioners has become an issue for further review on the national agenda (HWA, 2013a). This concern is based on the need to increase student numbers and, in the fast-paced workforce environment, for graduates to enter the workforce as skilled professionals who are able to practice (Aston & Molassiotis, 2003; HWA, 2010). As a result, HWA (2013a) was created to review and develop strategies for the management of health practitioner students in Australia.

This research project involved developing a new education program for registered nurses to assist them to consolidate essential knowledge and attitudes to provide effective clinical supervision. The ‘Clinical Supervision Program for Registered Nurses’ (hereafter CSP) was implemented in Western Australia in 2012. It involved registered nurses working in both the public and private health care sectors within the metropolitan and regional areas of the state.

1.2 Health Workforce Australia

HWA was an initiative of the Council of Australian Governments (COAG), and it was established by the Commonwealth, state and territory governments after the 2008 National Partnership Agreement on Hospitals and Health Workforce Reform (HWA, 2013). HWA was created as a strategy to address the challenges of providing the Australian community with a skilled and innovative health workforce (HWA, 2011a).

HWA’s functions include the provision of workforce planning and recruitment, and improving and expanding access to quality clinical placements for health care students (HWA, 2011). Within HWA, the Clinical Supervision Support Program was established to assist with meeting the demands of clinical placements (HWA, 2011a).
Strategies to date include the expansion of the current health service capacity for student placements and the development of a competent health workforce to provide quality clinical placements that promote learning and competence (HWA, 2011a).

The release of the HWA (2010) Clinical Supervisor Support Program (CSSP) Discussion Paper confirmed the concerns outlined in the national and international literature in relation to student clinical placements. This included a lack of preparation of clinical supervisors supporting clinical placements and the ongoing confusion by health care facility staff regarding the role of the clinical supervisor. The report stated that the learning of clinical supervisor skills was separate to professional education requirements to gain entry into a health profession, and the role must therefore be addressed with its own specific education programs (HWA, 2010).

The HWA (2010) paper stated that the existing programs for clinical staff in many instances failed to provide them with the necessary knowledge and skills to effectively supervise students. Thus, it recommended the development of new education programs that had the ability to develop the core themes of good supervision skills for all health professionals involved in the supervision of students. The seven core skills identified for good supervision were: competent clinical skills, teaching and learning skills, effective feedback, communication skills, assessment skills, understanding of remediation processes and interpersonal skills.

The purpose of this research project was to design, implement and evaluate an education program that addressed the core skills of HWA (2010), as well as deficits and requirements identified in domestic and international literature, in order to prepare nursing clinical supervisors for nursing students.

Since the release of HWA’s (2010) CSSP Discussion Paper, HWA has released five publications that have affected the delivery of clinical supervision education in Australia. These publications will be discussed in further detail in Chapters 2 and 3. Prior to reviewing the current literature in relation to clinical supervision and clinical supervision education in Chapter 2, a more detailed definition and description will be presented of clinical supervision in Australia and around the world.
1.3 Clinical Supervision

As a practice-based profession, only through effective supervised clinical practice are student nurses able to learn the essential knowledge, skills and attitudes of the profession (Gleeson, 2008; Smedley et al., 2010). A Clinical placement is where students integrate the theory of their education program into practice (Gidman et al., 2011; Pellatt, 2006). Registered nursing students in Australia must complete a minimum of 800 hours of clinical placement in a variety of health care settings according to the requirements of the Registered Nurse Accreditation Standards (Australian Nursing and Midwifery Accreditation Council (ANMAC), 2012). These placements are designed to promote opportunities for students to consolidate their academic knowledge in a clinical setting. As described by HWA, clinical placements ‘Provide opportunities in a relevant professional setting for the education and training of health sector students’ (HWA, 2011b, p. 4).

Effective clinical supervision provides students with an invaluable opportunity to learn and to apply their university studies (Gidman et al., 2011; Pellatt, 2006). However, the clinical setting is a complex and unfamiliar environment. It highlights how the student’s actions can affect those they are caring for. Student nurses can therefore experience stress and anxiety (Aston & Molassiotis, 2003; Smedley et al., 2010). It is a time where students can feel vulnerable and are strongly affected by the communications and attitudes of those around them. At this crucial time, students require extra support as they are easily affected (Aston & Molassiotis, 2003; Smedley et al., 2010). The attitudes of staff, both positive and negative, can significantly affect students’ learning and career progression (Aston & Molassiotis, 2003; Levett-Jones & Lathlean, 2008; Smedley et al., 2010).

The implementation of effective clinical supervision is therefore vital to assist with good outcomes for students’ learning and career choices (Brammer, 2008; Smedley et al., 2010). Health professionals require appropriate education and support to create a workplace environment that is conducive to learning (Brammer, 2008; Smedley et al., 2010). These education programs should promote the development of professional relationships between students and staff, where students are valued for their input and feel comfortable questioning practice (Levett-Jones & Lathlean, 2009a). This approach should also assist
students as they strive to synthesise classroom theory with the complexity of practice of the registered nurse’s role (Gidman et al., 2011).

In Australia, clinical supervisors and facilitators support nursing students during clinical placement. The level of support and input offered by each of these roles is dependent on the clinical placement model. These roles and models will now be explored further.

1.3.1 Clinical Placement Models

There are various national and international models of student placement. In each model, students are supported and supervised in their placement by health care facility staff and staff from their education providers. The terms used to identify these models and support roles vary, which has added to the confusion of many staff and students (Andrews et al., 2006; Gleeson, 2008).

1.3.1.1 Terminology

For the purpose of this research, the terms identified by HWA have been used. The support and supervisor roles are defined as ‘clinical supervisor’ and ‘clinical facilitator’. HWA refers to a clinical supervisor as an:

Appropriately qualified and recognised professional who guides students’ education and training during clinical placements. The clinical supervisor’s role may encompass education, support and managerial functions. The clinical supervisor is responsible for ensuring safe, appropriate and high quality patient care (HWA, 2011b, p. 4).

The clinical supervisor is therefore a member of the health care facility workforce who is allocated a student nurse to supervise in his or her daily workload. In the literature, this role is also termed a ‘preceptor’, ‘mentor’ and ‘buddy’ (Smedley et al., 2010; Walker et al., 2007).

A clinical facilitator is ‘A role which includes providing support to clinical supervisors and may also involve day to day supervision of learners’ (HWA, 2010, p. 9).
Therefore, clinical facilitators represent education providers. Depending on the model of the clinical placement, different levels of support are provided. This role has also been termed in the literature as ‘link tutor’, ‘practice teacher’ and ‘clinical supervisor’ (Andrews et al., 2006; Andrews & Roberts, 2003; Gleeson, 2008).

The two universal clinical supervision models for university-based nursing education programs are:

1. Clinical Instructor/Clinical Facilitator Model
2. Preceptor/Mentor/Supervisor Model

These two models offer different frameworks for clinical placement design. Both models involve allocating a clinical supervisor to the student; however, the models generally differ in the amount of clinical facilitator support given by the education provider, as well as the types of shifts that students are rostered to attend. These models are explained below.

1.3.1.1.1 Clinical Instructor/Facilitator Model

The clinical facilitation model involves allocating a paid staff member of the education provider to a clinical work area to deliver an overarching level of supervision and support (Brammer, 2008; Smedley et al., 2010; Walker, Cooke & McAllister, 2007). The clinical facilitator may be a staff member of the health care facility funded by the education provider or a person allocated by the education provider. This is usually a decision made between the health care facility and the education provider (HWA, 2010; Smedley et al., 2010). Figure 1.1 outlines the relationship between the clinical facilitator, clinical supervisor and nursing student within this model of supervision.
The clinical facilitator may be allocated to 8–10 nursing students, depending on the health care facility and the education provider’s agreement of students to hours of facilitation ratio (Brammer, 2008; Walker et al., 2007). Students are often allocated to work the same shifts across the week and are only on site when the facilitator is also present. Students are then ‘buddied’ with staff members to work with as their clinical supervisor during shifts (Smedley et al., 2010; Walker et al., 2007). At health care sites, the clinical supervisor role may be referred to as a ‘buddy’, ‘preceptor’, ‘mentor’ or ‘supervisor’ (Smedley et al., 2010; Walker et al., 2007).

For most health care facilities, the role of clinical facilitators is to visit the students each day to observe them undertake procedures/skills, receive feedback from the health care facility’s clinical supervisors and provide one-to-one debrief and reflection time with the students regarding their placement experiences. Clinical facilitators may also present short in-service sessions related to patient care in the area. They are usually responsible for completing students’ assessment documentation with feedback from the health care facility’s staff/supervisors (Smedley et al., 2010; Walker et al., 2007).

**Figure 1.1: Clinical facilitator model for clinical practicum**
1.3.1.1.2 Preceptor/Mentor/Supervisor Model

Students on longer clinical placements, or where full-time clinical facilitators are not provided (due to the remote location of the placement or a small number of students present), are precepted/mentored-supervised (Levett-Jones & Bourgeois, 2007). These terms are often used interchangeably.

The role of clinical facilitators in this model is reduced, as they provide an overarching level of support to students and health care facility staff. Clinical facilitators will often visit clinical areas once per week or be available to health care facilities on request (in particular, for remote placements) to assess the progress of students according to feedback from clinical supervisors (Levett-Jones & Bourgeois, 2007; Russell et al., 2011).

This model allows for greater flexibility with student rosters, as students are able to be rostered on shifts independent of clinical facilitators’ working hours. This placement model is often allocated to students in the final clinical placement of their program, when they are more independent and confident in their practice prior to registration. These placement models have been documented as providing a more positive learning experience for students, as they reduce the reality shock with a more ‘real-world’ experience (Hartigan-Rogers, Cobbett, Amirault & Muise-Davis, 2007, p. 8). The role of clinical facilitators within this model is to provide assistance and support to clinical supervisors and students; however, they are generally not involved in clinical education or day-to-day assessments (Russell et al., 2011).

Figure 1.2 outlines the relationship between the clinical facilitator, clinical supervisor and nursing student within this model of placement.
In both of these models, registered nurses employed by the health care facility are responsible for the clinical supervision of students for each shift. Clinical supervisors are responsible for teaching and for assessing clinical performance (ANMC, 2006; HWA, 2010). Students are allocated to members of staff for each shift of their clinical placement (Russell et al., 2011; Walker et al., 2007). For those in the second model, where students are precepted/mentored/supervised, area nurse managers or staff development nurses/educators often decide whether students are allocated to work with the same clinical supervisors for the entire placement and follow their rosters, or whether they are allocated their own rosters (Russell et al., 2011). Students who are allocated rosters are then allocated to members of staff each day; this is often referred to as ‘team clinical supervision’ and is more frequently a requirement due to workforce demands on the area (Gleeson, 2008; Russell et al., 2011; Smedley, Morey & Race, 2010; Walker et al., 2007).

These workforce demands are often the result of a part-time workforce, which provides little opportunity for students to be placed with the same staff member for the duration of their placement (Russell et al., 2011; Smedley et al., 2010). In addition, given the nature of nursing, for students on clinical placement with full-time clinical facilitators whereby student groups are allocated a set roster in conjunction with their clinical facilitators,
students have little opportunity for continuity of clinical supervisors, as the nursing staff work a variety of shifts across the week (Russell et al., 2011; Walker et al., 2007).

Changing clinical supervisors, often on a daily basis, can add further stress to students’ ability to establish quality relationships with nurses where they feel comfortable to question practice and learn in a fast-paced clinical environment (Russell et al., 2011; Walker et al., 2007). Therefore, in the current workforce climate, it is essential that staff have effective communication skills and abilities to socialise students quickly in order to assist with their learning (Russell et al., 2011; Smedley, Morey & Race, 2010; Walker et al., 2007).

Education provided by health care facilities and education providers differs for staff who partake in the roles of clinical supervisors and facilitators. The literature describes a number of national and international programs for training staff in clinical supervision (Barker et al. 2011; Smedley et al., 2010; Charleston & Happell, 2004).

1.3.2 Clinical Supervision Programs

The HWA (2010) highlighted a lack of national consistency in the training of clinical supervisors across Australia and across all health professions. Within nursing, a review of the literature found that clinical supervision programs to assist nursing staff with the role of clinical supervisor were referred to as preceptorship programs, mentorship programs or clinical supervision programs (Aston & Molassiotis, 2003; Fox, Henderson & Malko-Nyhan, 2006; Gleeson, 2008; Hyrkas & Shoemaker, 2007; Johnson, 2002; McCloughen & O’Brien, 2005; Pellatt, 2006; Smedley et al., 2010).

1.3.2.1 Preceptorship Programs

Preceptorship programs are designed to support students, graduates (first-year enrolled and registered nurses) and new staff in an organisation. Individuals requiring preceptoring are referred to as preceptees. Preceptorship programs aim to provide learning opportunities for students, graduates and new employees in the clinical setting while also socialising and familiarising them with the clinical area (Fox, Henderson & Malko-Nyhan, 2006; Gleeson, 2008). Preceptorship programs are widely based in the United Kingdom (UK), Canada,
Preceptorship is achieved through the promoting of learning opportunities for preceptees in a safe environment that promotes critical thinking, problem-solving, communication skills and competence (Gleeson, 2008; Hyrkas & Shoemaker, 2007). Preceptors are encouraged to promote this through role modelling and being active resource people in order to assist preceptees in their learning experiences (Gleeson, 2008). This provides students with an insight into the roles and practices of registered nurses while being supported and facilitated to apply their theoretical knowledge in a clinical setting (Smedley et al., 2010).

While preceptors are allocated students or new nurses to precept, they are still required to complete their allocated workload. Therefore, their priority is the delivery of patient care while identifying learning opportunities for preceptees. Preceptors are also responsible for providing feedback to preceptees’ line managers or education providers (Gleeson, 2008).

The training provided to staff to undertake preceptorship varies across health care facilities. Programs may be hourly ‘in-service sessions’, full-day study programs or short courses (Gleeson, 2008). Gleeson (2008) and Smedley et al. (2010) suggested that preceptorship programs should be designed to provide preceptors with effective teaching and assessment strategies. This should include the theories and principles of adult learning, identifying student objectives, identifying preceptees’ previous experiences, role modelling, reflection, welcoming into the workplace culture and the use of appropriate questioning skills to enhance critical thinking.

1.3.2.2 Mentorship Programs

In its true sense, mentorship is a lifelong relationship bonded in friendship that is designed to support mentees’ in their career development and progression. Mentors may engage in a number of roles, including role model, teacher, advisor, counsellor and friend (Johnson, 2002; Pellatt, 2006).

Mentorship programs within nursing involve the development of a relationship aimed at enhancing mentees’ professional development in a supportive environment while on
clinical placement (Gleeson, 2008; Panther, 2008). In the mentor–mentee relationship, mentors have a general interest in supporting mentees in their career development and progression (Gleeson, 2008). The relationship is built on a mutual respect and a partnership approach to teaching and learning (Panther, 2008). For students on clinical placement, the style of mentorship adopted can be referred to as secondary mentorship. This shorter period assists mentees through a particular period of professional development (Johnson, 2002).

The qualities of mentors are important to the mentorship relationship. The nursing literature outlines that nursing students’ mentors possess the characteristics of patience, friendliness, approachability, a sense of humour and good interpersonal skills (Gleeson, 2008; Panther, 2008). One of the barriers to effective mentorship is mentors who do not possess these qualities and/or lack an understanding of their importance in students’ development (Panther, 2008).

The use of mentorship programs for the clinical supervision of nursing students is particularly common in the UK (Barker et al., 2011; Gleeson, 2008; McCloughen & O’Brien, 2005; Panther, 2008). Both the Nursing and Midwifery Council (NMC) (2008) and Royal College of Nursing (RCN) (2007) in the UK have adopted this terminology and provide the nursing profession with guidelines and policy statements about its implementation and role. This is discussed in further detail in Chapter 2 as an example of a current international program for staff and student support.

1.3.2.3 Clinical Supervision Programs for Employees

Until the HWA’s (2010) discussion paper, the term ‘clinical supervision’ was a general term used to explain the relationship between staff members and students or employees, termed ‘supervisees’, which aimed to help supervisees to develop high-quality best patient care (Aston & Molassiotis, 2003; Williams & Irvine, 2009). The role of supervision is in addition to the current workload requirements of the registered nurse. Supervisors provide opportunities for learning and reflection to ensure the application of theory and the development of competency (Landmark, Hansen, Bjones & Bohler, 2003). The literature has identified two main applications of the term, which are discussed below (HWA, 2010; Cutcliffe & Hyrkas, 2006; Gordon, 2000; Edwards et al., 2006).
The first of these definitions relates to the role of education providers’ clinical facilitators. Within nursing, the term ‘clinical supervisor’ has often been utilised to explain the role of the now-termed ‘clinical facilitator’ as described within this chapter in relation to education programs for clinical supervisors (HWA, 2010).

The second use of the term identified in the literature relates to its use within nursing as a concept similar to that of mentorship, particularly within the speciality of mental health nursing in Australia and the UK (Cutcliffe & Hyrkas, 2006; Gordon, 2000; Edwards et al., 2006).

This concept of clinical supervision involves the allocation of senior staff members to support junior staff members in their professional development in the workplace. The position is designed to help junior practitioners avoid burnout due to work-related stressors and to promote clinical performance (Edwards et al., 2006). Other claimed benefits include improved staff morale, clinical practice, and reduced patient complaints; however, Gordon (2000) outlined that these claims require further investigation. This is supported by Edwards et al.’s study (2006) in the mental health field, which suggested that staff perceived that the allocation of clinical supervisors helped to reduce the level of ‘burnout’ in the workplace; however, further investigation into its long-term effects is required. Cutcliffe and Hyrkas’ (2006) study, which involved a multidisciplinary approach including registered nurses within mental health, also identified clinical supervision as an opportunity to support nurses and members of allied health through the stressful demands of the profession on the condition that line managers were not supervisors, as this limited the freedom of supervisees to openly discuss their thoughts.

### 1.3.3 Application to Student Clinical Placements

In relation to student supervision, each definition overlaps in its expectations of the relationship between students and registered nurses in the clinical area. Each program requires registered nurses to provide environments that are conducive to learning in order to assist student nurses to achieve their placement objectives and assessment requirements.

Over time, health care facilities have chosen the terminology for their own organisations. HWA (2010) recommended the term ‘clinical supervision’ for nursing and all medical,
dentistry and allied health care professional students in Australia. These recommendations were adopted for this study.

This review of the literature in relation to clinical supervision has demonstrated that although a number of terms are used in relation to the support and supervision of students in the clinical area, they all essentially explain similar concepts. Some differences between the terms are intended, as outlined in the above definitions; however, they are often overlooked in the development of education/training programs. The use of varied terminology is discussed in the literature, with Gleeson (2008) stating that:

Various terminologies have been used in the literature to describe mainly two models of support for student nurses when on clinical practice; mentorship and preceptorship. It would appear that both models are different but on closer examination they are quite similar (p. 379).

1.4 The Justification

Registered nurses require the necessary knowledge, skills and attitudes to provide effective clinical supervision of nursing students on clinical placement. If nurses are not provided with this education, there remains a risk that the next generation of registered nurses entering the workforce will do so without the essential professional attributes to become effective members of the health care team (Brammer, 2008; Gleeson, 2008; Kilcullen, 2007). This can have a detrimental effect on safe and effective health care delivery and patient outcomes (Gleeson, 2008; Kilcullen, 2007).

The current literature paints an alarming picture of student nurses currently not being engaged as active members of the health care team, and not being given the opportunity to practice in an environment that is conducive to learning (Barker et al., 2011; Gleeson, 2008; Smedley et al., 2010). The main risk is the production of skills-based nurses who are unable to think critically about the delivery of patient care (Allan, Smith & Lorentzon, 2008; Brammer, 2008). The secondary risk is the loss of future nurses from the profession before they even begin, or early in their career (Brammer, 2008; HWA, 2013b).

Through HWA, the Australian Government has identified that Australia is at risk not only of a shortage of nurses, but also of nurses that have been provided with ineffective clinical
learning opportunities to meet the demands made of them when entering the workforce (HWA, 2010). This concern is not unique to nursing; it is an issue affecting all health sciences. Without effective clinical placements, students are ill-prepared to meet the domains of practice of their profession (Barker et al., 2011; Brammer, 2008).

One of the current deficits identified with providing students with the opportunity to practice in a safe and productive learning environment is the lack of education and support provided to the nursing staff who supervise students. As stated, ‘research has shown that mentors are often ill prepared…(and) that their preparation varies from place to place, and that in reality most mentors learn on-the-job’ (Andrews et al., 2006, p. 866).

One approach to facing the challenges of the health care team is to equip the current workforce with essential knowledge, skills and attitudes to provide students with effective clinical placements. The implementation of new educational programs and strategies to promote clinical placements and the role of clinical supervisors is a key strategic policy for the future of an effective workforce (HWA, 2013a).

This identified gap in the education of nursing staff in their role of clinical supervisors to nursing students resulted in the development of the following research questions.

1.5 Research Questions

The purpose of this descriptive study is to develop, implement and provide a rich source of data that describes program participants’ knowledge and attitudes towards clinical supervision both before and after attending the CSP. The specific questions of this research study are as follows:

1. What is the pre-program knowledge of nursing participants in relation to the principles of clinical supervision?
2. Is there a change in nursing participants’ knowledge related to the principles of supervision after attending the program?
3. Upon completion of the program, do nursing participants perceive that their knowledge and attitudes towards providing effective student supervision has changed?
4. Do nursing participants perceive a different effect from this program compared to other clinical supervision education? If so, why? If not, why not?
5. Do nursing participants believe that the program assisted them to undertake their role more effectively? If so, why? If not, why not?
6. Do nursing participants perceive that they have changed their attitudes towards nursing students after attending the program?
7. Is there a change in participants’ attitudes towards nursing students after attending the program?

1.6 Operational Definitions

Key terms utilised within this research thesis include:

- Health Workforce Australia (HWA): An initiative of the COAG that was established after the 2008 National Partnership Agreement on Hospitals and Health Workforce Reform by the Commonwealth and state and territory governments (HWA, 2013a). HWA was created as a strategy to address the challenges of providing the Australian community with a skilled and innovative health workforce (HWA, 2011a).

- Clinical Supervision Support Program (CSSP): A program within HWA that aims to expand clinical supervision capacity and the competence of all health professionals’ supervision practice (HWA, 2013a).

- Education provider: A registered higher-education provider (e.g. university) that is responsible for the delivery of education programs that meet the national standards of the Australian Government Tertiary Education Quality and Standards Agency (TEQSA). Education providers in the stream of nursing must ensure that the program is also accredited by the NMBA, whereby graduates are then eligible to apply to the NMBA for nursing registration (ANMAC, 2012).

- Health care facility: An organisation with the key focus of providing and delivering health care to members of society (Levett-Jones & Bourgeois, 2011).

- Student nurse: A student enrolled in an accredited program that meets the requirements for registration with the NMBA as a Registered Nurse (Division 1) or Enrolled Nurse (Division 2) (NMBA, 2013).
Clinical supervision: Involves allocating appropriately qualified professionals to guide students’ learning and practice during clinical placement. Clinical supervisors are role models, educators, assessors, socialisers and advocates for ensuring safe and high-quality best practice patient care (HWA, 2011b).

Clinical facilitation: Clinical facilitators provide support to clinical supervisors and students in health care facilities. Depending on the model of placement, this may involve student teaching, feedback and assessment/evaluation (HWA, 2010).

Preceptorship: A registered nurse employed within a health care facility who provides individual clinical supervision/teaching on a one-on-one basis (Nash, 2007).

Mentorship: A long-term commitment to support a learner through their professional growth and development (Lennox, Skinner & Fouruer, 2008).

1.7 Conclusion

The ability of nursing graduates to meet the domains of practice of the registered nurse (NMBA, 2006) is reliant upon the provision of quality nursing education. This education is dependent on student nurses practicing in health care facilities to link their theory to practice and develop a framework for practice (Gidman et al., 2011; Smedley et al., 2010). The literature has discussed that the success of these clinical placements is partially dependent on the quality of clinical supervision (Smedley et al., 2010). With increasing demands on nursing staff as a result of more nursing students, the role of clinical supervisors is expected to be undertaken by all nurses (HWA, 2010). Nurses require education regarding this role, as well as support from health care facilities and education providers in implementing it successfully (Gidman et al., 2011; Smedley et al., 2010). To date, no standard education requirements have been specified by the NMBA; however, HWA has recommended the development and delivery of education based on its seven core skills (HWA, 2010). The CSP was developed upon these seven core skills and the findings in the literature. This thesis will describe the development of the CSP, its implementation and evaluation from the perspective of the registered nurse attendees.

The thesis comprises seven chapters. Each chapter will provide the reader with an understanding of the research, its findings, implications and conclusions. The aim of
Chapter 1 has been to articulate the background information for this research area and research questions in relation to clinical supervision in Australia and overseas. Chapter 2 discusses the relevant literature associated with this research project in regards to three core areas. The first relates to the literature regarding the current deficits of clinical placements, clinical supervisor training, requirements of clinical supervisors, models of clinical supervision and clinical supervisor training. The second section reviews the theories and principles of adult learning and how they have assisted with the development of the program’s teaching strategies and methods. The third section examines the concepts of attitude, attitude change and the measurement of attitude. Chapter 3 outlines the methodology of the research project, including the role of descriptive studies, the methods of data collection and analysis used in this research, and the implementation of the research project’s phases. Chapter 4 outlines the quantitative data findings and analysis, including a review of the demographics of the research group. Chapter 5 outlines the findings of the qualitative data and compares the findings within the three different sources of qualitative data. In addition, Chapter 5 provides a program evaluation. Chapter 6 provides a comparison of the study’s findings with the literature, as well as a review of the research methodology and the new knowledge gained from this research. Chapter 7 outlines the final implications and recommendations of the project.

***

After 18 months, the day had finally arrived. She was ready for her first clinical placement. She proudly put on her student uniform and carefully pinned on her 18th birthday gift from her grandad: a nurse’s watch engraved with ‘Happy 18th, Love always, Grandad’. This was the day when it all really began.
Chapter 2: Literature Review

She was almost skipping as she walked onto the ward with her group of six students. They were all so excited. They were finally going to nurse; no more manikins or practicing on each other. Instead, real patients, real experiences and a real chance to make a difference to someone’s day. The clinical facilitator guided them towards the nursing station where they would listen to their first shift handover.

2.1 Introduction

The provision of clinical supervision education for registered nurses in Australia evolved to a state where there was no national industry standards or requirements (HWA, 2010). Health care facilities were left to develop and introduce their own education and resource programs. HWA’s (2010) discussion paper on clinical supervision called for a national review and approach to the current education and training provided to all health care professionals.

This research project responds to this call for action by developing and implementing an education program for nursing clinical supervisors to effectively supervise nursing students. The previous chapter presented an introduction to the current context of clinical supervision, as well as the role of HWA in current national policy and strategic development. This chapter will continue to describe the literature relevant to this project from three key areas: the principles of clinical supervision, the theories of learning, and the theories of persuasion and measurement of attitude.

The first section of this review will outline the literature describing the current documented deficits and requirements of the role of clinical supervisors, and it will review previous clinical supervision programs that have been implemented nationally and internationally for university-based nursing students. This chapter will also continue to review the publications by HWA released in 2010–2013 related to clinical supervision requirements in Australia.
In addition, this chapter will describe the principles and theories that supported the development of the CSP, which are essential to the development of adult learning programs. It will also discuss the theories of attitude, attitude change and measurement of attitude as they are related to this research project, including the theories of persuasion (Katz, 1960), which can be applied to the attitudes of nurses towards clinical supervision. This will assist the researcher to develop strategies to assist with changing participants’ poor or negative attitudes towards students and the clinical supervisor role.

The literature sources and their principle relationship to the CSP are outlined in Figure 2.1.

**Figure 2.1: Conceptual framework for the development of the CSP**

The application of this literature to the program will be described in further detail in Chapter 3. The first area to be explored in this literature review will be the ‘Identified Deficits and Requirements of Clinical Supervision’.
2.2 Principles of Clinical Supervision

The literature review in relation to clinical supervision involved searching for articles on the electronic databases of the Cumulative Index to Nursing and Allied Health Literature (CINAHL), PubMed and Science Direct using the key words of ‘nursing clinical supervision’, ‘nursing clinical placement’, ‘preceptorship’ and ‘undergraduate nursing mentorship’, as well as the government directories for national publications from the DEST, HWA and the Australian Health Practitioner Regulation Agency (AHPRA) for the Australian nursing registration requirements. This search was used to identify current education programs and program requirements and deficits in relation to clinical supervision nationally and internationally.

2.2.1 Deficits and Requirements

The role of clinical supervisors is to provide students with the opportunity to develop the knowledge, skills and attitudes of nursing so they can meet the needs of the profession (Gleeson, 2008; Smedley et al., 2010). This helps them to learn from their practice and to function in the fast-paced changing environment of nursing in modern healthcare (Aston & Molassiotis, 2003; Gidman et al., 2011).

Students are at risk of becoming skill-orientated practitioners if the clinical placement lacks the demonstration of problem-solving and reflection (Allan et al., 2008). A recent study by Gidman et al. (2011) determined that student nurses remain skills-focused during clinical placement and risk achieving a narrow perspective of the role and functions of registered nurses. This leaves them unable to think critically about their nursing care and their role in the health care team. As reported by a nursing student (Kleiman, 2009, p. 35):

I think that my nursing care function is being stretched to a level where you cannot see the patient, only the computer screen, and all the red and green lights around him. The sound that beckons is not the scared voice of old Mr John Doe, but the alarm on the machine that quickens my step while I remind myself to check the want ads for nurses wanted.

This has implications for clinical supervisors, who must ensure that students are provided with learning opportunities that promote a holistic approach to nursing care in order to
assist them to develop the complexities and importance of the role (Gidman et al., 2011). Clinical supervisors need to be provided with the necessary abilities to achieve this, not only in their teaching, but also in their assessment of competence (Gidman et al., 2011; NMC, 2008).

The nursing literature outlines a number of barriers to providing effective clinical supervision. One major barrier is the lack of consistency of staff education; this has been documented by health care facilities and education providers and has been highlighted in research from Europe, the UK and Australia. In each of these countries, feelings of unpreparedness for the role of clinical supervision by nurses have been documented (Andrews, Brodie, Andrews, Wong & Thomas, 2005; Barker et al., 2011; Brammer, 2008; Gidman et al., 2011; Gleeson, 2008; Hyrkas & Shoemaker, 2007; Landmark et al., 2003; Pellatt, 2006; Webb & Shakespeare, 2008). A review of these findings was essential to the project in order to understand the current staff deficits in clinical supervision to ensure the development of an appropriate clinical supervision program.

Andrews et al. (2006) determined that many UK nurses did not view themselves as teachers, role models or facilitators of practice when supervising students; rather, they viewed their role in student supervision as assessors of students’ practice. They also noted that there was significant confusion over the terms used to describe the supervision relationship and the role, and they felt a lack of recognition and believed they were given insufficient education and training in the role. From the students’ perspective, the study determined that the effect of the clinical placement could determine their choice of future employment, and, of more concern, if they would like to remain in nursing.

Concerns regarding the assessment role of clinical supervisors were also documented by Webb and Shakespeare (2008). Their study in relation to how nurses make decisions about students’ performance in the UK outlined that students’ competence as assessed by clinical supervisors was often based on the success of the student–nurse relationship rather than the students’ performance. The study suggested that supervisors should attend compulsory education to facilitate their development in the role to ensure the reliable and valid assessment of students’ performance, that a stronger and more positive partnership between supervisors and education providers was essential, and that nurse managers must take a more active role in ensuring a culture of fair and valid assessments in their unit.
Brammer’s (2008) study in Australia determined that there was a lack of understanding of the supervisor role, as well as the implications of poor clinical supervision. Brammer’s findings supported that clinical supervisors have a major role in the development of nursing students, which affected their ability to function when registered. Implications for future practice included the acknowledgement of the formal role of supervisors, an increase in awareness of the influence of the role on student outcomes and formal education for supervisors to ensure a positive influence on the relationship.

Gleeson’s (2008) study focused on the use of different terminology and confusion over the role and requirements of clinical supervisors. This was in response to the changes in nursing education introduced in Ireland and the confusion related to the terminology to support university-based students. Gleeson determined that the success of student clinical placements was dependent upon a positive and supportive relationship between the health care facility and the education provider. Educating staff alone did not guarantee successful clinical placements. Therefore, while nursing staff required initial education to gain the essential knowledge, skills and attitudes, the success of the placement was reliant upon ongoing discussion between stakeholders and them regularly responding to students’ and nursing staffs’ feedback.

These findings were supported by Hyrkas and Shoemaker’s (2007) study in the UK, which determined that while initial education and training for supervisors was vital, an ongoing commitment to them through support strategies was essential. This included not only ongoing education, but also strategies to ensure that nurses felt supported by their organisations. The authors suggested that this could be generated through award systems and support positions within hospitals for staff and students.

Landmark et al.’s (2003) study in Norway determined that the quality of the clinical supervision relationship was influenced by nurses’ self-confidence in their own professional capacity and awareness of the role of clinical supervisors. Participants in the study requested further education in regards to the roles, responsibilities and expectations of education providers and their employers. The study also highlighted that nurses perceived that their motivation towards the role was a major contributor to the success of the student–nurse relationship.
Pellatt’s (2006) study in the UK determined that mentors needed more support in undertaking their role of student supervision and assessment, and that improved education for staff was required in conjunction with increased levels of support by education providers and health care facilities to guarantee the best possible outcomes for staff and students. This was supported by Barker et al. (2011), who noted that despite the introduction of formal student mentorship programs in the UK, nursing staff felt unprepared and required further support than the initial education programs provided. They determined that ongoing communication between health care facilities and education providers was essential for supervisors to feel supported in their role. Nursing staff required ongoing support and guidance, recognition of their role, ongoing education and allocated time for reflection/feedback sessions with their students. In Australia, the former DEST reported that:

The importance of practice settings to the quality of clinical education is often underestimated in the way resources are allocated and expertise developed…the tight supply of clinical places and the competition for these places act as limitations on the development of nursing education. Furthermore, additional resources will have little overall effect if the quality of the experience and the education process during clinical placement does not meet the needs of the students (2002, p. 12).

HWA’s (2010) CSSP Discussion Paper stated that a lack of consistency from education providers of all health professions in outlining definitions of the supervisor role and expectations has compounded these issues. It stated that health care services are confused regarding education providers’ expectations of staff working with students, as well as the learning requirements of students and students’ abilities. It recognised that good clinicians are not always naturally good supervisors and that education to supervise students was essential. The paper concluded that a nationally consistent approach was required regarding the education of supervisors within all health professions.

In conjunction to this state of confusion, due to a lack of consistency of terminology and staffs’ knowledge in relation to the role of clinical supervisors, research has continued to identify the poor attitude of staff towards students and the clinical supervision relationship. The effect of staffs’ attitude on students’ clinical placement has been demonstrated in the literature as another barrier to providing effective clinical placements.
2.2.2 Supervisor Attitude

It is well documented that students on clinical placement internalise the characteristics of the registered nurses around them to assist with their professional development (Felstead, 2013; Freiburger, 2002). This concept of role modelling assists students to incorporate and adopt the functions, values, responsibilities, attitudes and values of importance to the profession (Felstead, 2013; Freiburger, 2002; McKenna & Stockhausen, 2013). Positive role modelling and socialising assists with the internalisation of the nursing culture and the effective practices of the health care team (Allan et al., 2008; Atack, Comacu, Kenny, LaBelle & Miller, 2000; Felstead, 2013; Freiburger, 2002).

In comparison, negative role modelling can lead to a departure from the course or the acceptance of poor behaviours in order to fit in (Levett-Jones & Lathlean, 2008). For many years, the nursing literature has discussed the concept of nurses’ poor attitudes towards nursing students; the phrase ‘nurses eating their young’ has been well documented (Longo, 2007; Meissner, 1986; Sauer, 2012). Meissner (1986) wrote:

> If nurses really want to see nursing achieve profession status, each of us…must re-examine our interactions with novice nurses. We’ve got to stop eating our young. These newly prepared nurses are the profession’s future. If they are not nurtured as they develop, professional extinction beckons (p. 53).

More recent studies have continued to show that despite the discussions of the 1980s, there remains an element of the poor/bullying behaviour within the profession. Sauer (2012) described that student nurses and new junior nurses were most at risk of bullying behaviour, which affects the individual, the workplace and the delivery of patient care.

Longo’s (2007) study, although involving a small cohort of 47 nursing students, highlighted that student nurses continued to experience bullying and violence in the workplace by nurses, with 72% of students agreeing that nurses continue to ‘eat their young’.

Research led by Levett-Jones (2007, 2008, 2009) continued to explore these supervision relationships in the clinical area, as well as their effect on student learning. This research was based on the concept of ‘belongingness’ and includes students’ stories and feelings around the concept of belongingness and its effect on their clinical placement (Levett-
This concept of belongingness relates to the relationship between students and the ward/unit nurses who supervise their practice, and in general the wards’ level of support and attitude towards students (Levett-Jones & Lathlean, 2008). The study highlighted that limitations to student learning in the clinical setting may be due to poor relationships with clinical supervisors (Levett-Jones et al., 2007). The research described the significance of positive clinical placements on students’ ability to learn and achieve competence in the clinical area (Levett-Jones & Lathlean, 2009b). The study described that a negative sense of belongingness at times resulted in students conforming to poor practice to reduce the risk of exclusion from the nursing team. This was noted to leave students with a sense of regret but was seen as ‘the lesser of two evils’ (Levett-Jones & Lathlean, 2009a, p. 348). Levett-Jones and Lathlean (2009b) outlined that for successful student learning, students needed to experience safety and security, followed by belongingness, as the foundations to develop self-concept, learning and eventual competence. The greatest influence on students’ sense of belongingness was the treatment by registered nurses that they were allocated to work with while on clinical placement (Levett-Jones et al., 2009).

These findings are congruent with Vallant and Neville (2006), whose research on student and staff supervision relationships concluded that a positive relationship was essential for student learning. The study highlighted that students often reported feelings of ‘invisibility’ and needing to avoid ‘stepping on toes’, which affected their learning experience (pp. 26–27). Webb and Shakespeare’s study (2008) corroborated these findings, noting that supervisors’ attitudes, allowing nurses to practice while safely supervised, having a positive attitude towards students and the ability to provide effective feedback were all essential. It was also noted that the length of nurses’ experience was not a factor; graduate nurses had the ability to be effective supervisors because of their recent experience and understanding of the students’ journey and assessment requirements.

The literature (Andrews et al., 2005; Brammer, 2008; Landmark et al., 2003; Saarikoski & Leino-Kilpi, 2002) articulates that the self-awareness of clinical supervisors of their role and attitudes towards nursing students and clinical placements is therefore vital to assist with providing quality clinical placements, given that students’ perceptions of clinical placements relate to the attitudes of those around them.
The literature also discusses the effect of unit/area nurse managers on students’ clinical placement experiences. Andrews et al. (2005), Brammer (2008) and Saarikoski and Leino-Kilpi (2002) discussed the influence of unit nurse managers, who play a vital role in welcoming and developing positive staff attitudes towards students by heavily influencing nurses in their areas. A positive attitude towards students and clinical supervision can affect the attitudes of staff. This positive workplace culture is often associated with higher standards of overall ward nursing practice (Saarikoski & Leino-Kilpi, 2002). These findings were also supported by Levett-Jones et al. (2007) in their study on the concept of belongingness. They determined that nurse managers have a positive influence on the unit when role modelling the inclusion of students into the nursing team; this in turn affected students’ sense of belonging in the workplace.

Registered nurses were seen as the most influential factor on the student nurse experience in all of these studies. Given the complex relationship of the supervisor role, all of these studies stated that nurses needed greater support to fulfil the role’s requirements. Brammer (2008) concluded that more emphasis needed to be placed on the role of nurses as supervisors of student practice, as well as the education they required to meet this function. Levett-Jones et al. (2007) suggested that universities should consider how positive experiences could be transcended across health care sites to promote a placement of student belongingness, and that nurses required more education and support in fulfilling this role. Recommendations for clinical supervision practice addressed five elements for student competence (Levett-Jones & Lathlean, 2009b). These strategies related to the allocation of trained mentors, acknowledgement of the role and the effect of clinical leaders in promoting a positive work place culture and attitude towards students.

To further explore the implications of these findings, a review of education programs for nursing staff in the role of clinical supervisor was undertaken from both an Australian and international perspective.

### 2.2.3 International and Australian Clinical Supervision Education Programs

A review of the literature identified a number of journals that discussed the use of mentorship, preceptorship and supervision to support nursing students in their clinical practice. This literature describes a lack of staff support and appropriate education for
nurses. The majority of the literature related to Mentorship Program requirements outlined in the UK and the introduction of two supervisor programs in Australia.

2.2.3.1 UK

In the UK, the NMC and the RCN have attempted to reduce nursing students’ poor clinical placement experiences and reduce the ability of supervisors to fail underperforming students through the provision of mentorship (NMC, 2010; RCN, 2007). Each student is allocated to one staff member for the duration of his or her clinical placement; this staff member is responsible for the placement assessment. However, the student may be allocated to work with other nursing staff during his or her placement (NMC, 2010). Since 2007, the NMC has required that a ‘sign-off mentor’ (SOM) must supervise the student for at least 40% of his or her final placement in the nursing program. These SOMs have participated in an endorsed mentorship education program by the RCN. These staff are then registered with local universities and health care services (NMC, 2010; RCN, 2007).

While on clinical placement, the expectation of the NMC and RCN is that students will spend the majority of their clinical placement with SOMs. Other nursing staff are able to supervise students and provide input into their assessments; however, the final comments and sign-off can only be completed by the endorsed, allocated SOMs (NMC, 2008; RCN, 2007).

To attend SOM training, the NMC requires that registered nurses have completed one year of clinical experience and are deemed clinically competent in the area of practice. Endorsed programs are of at least 10 days’ duration and involve both academic and practice learning with practical application. SOMs thereafter attend an annual refresher program that addresses the following eight domains (NMC standards for mentors, practice teachers and teachers, 2008, p. 13):

1. establishing effective working relationships
2. facilitation of learning
3. assessment and accountability
4. evaluation of learning
5. creating an environment for learning
6. context of practice
7. evidence-based practice
8. leadership.

The domains of SOM programs reflect course content that is similar to many other programs discussed in the literature (Charleston & Happell, 2004; Smedley et al., 2010), and they relate closely to HWA (2010) requirements for clinical supervisor training—the difference being the rigour of the role and stipulated length and depth of detail of the program (NMC, 2008).

This introduction of SOMs in the UK has led to specific education for a core group of nurses (Barker et al., 2011). There does not appear to be any formal program for nurses outside of this cohort.

While the literature in the UK supports a mentorship approach, concerns have been raised about a continued lack of education and understanding of the role of nurses outside of this specialised cohort. Even for those who have attended the program, there is a perceived lack of ongoing support (Barker et al., 2011). It must also be noted that final clinical placements for students in the UK are longer than those in Australia, with most students on placement for 12 weeks, while they may be on placement in Australia for 4–6 weeks, and they may be rotated between sites during this time. The difference in placement length may affect the success of such a program in Australia (Barker et al., 2011; Kilcullen, 2007; Pellatt, 2006; Williams & Irvine, 2009).

While the UK Mentorship Program has demonstrated the importance of mentorship education, it highlights a key concern—that education must be available for all registered nurses who supervise students. This is a key difference in this research study. Education should not be limited to small numbers; instead, it should be made available to all nurses in the workplace. This is particularly evident with the growing number of student placements and the requirement for all clinical staff to supervise students (HWA, 2010). The requirement of nursing staff to supervise students is included in the National Competency Standards of the Registered Nurse, (section) 4.3 ‘Contributes to the professional development of others’, and as indicated in HWA’s reports (NMBa, 2006; HWA, 2010).
A further review of the literature did not identify any other country that provided a national approach to clinical supervision standards and education.

### 2.2.3.2 Australian Supervision Programs and Requirements

Clinical supervision programs in Australia use the terms ‘preceptorship’, ‘mentorship’ and ‘supervision’. The education of nursing staff to fulfil supervisor roles includes a mixture of university post-graduate programs, hospital-based short courses and study day programs (Barnett, Cross, Shahwan-Akl & Jacob, 2010; Russell et al., 2011; Siggins Miller Consultants, 2012). In Western Australia, a scoping study by the Western Australian Country Health Service (WACHS) (2013) determined that a number of health care facilities in Western Australia, both within the metropolitan and regional areas, currently provide no education and training for nursing or allied health staff on supervising students, while others have provided written resources, online information or one-day seminar programs where supervision is included but is not the focus of the day (WACHS, 2013).

A number of articles relating to support programs for nurses have been published under the headings of ‘preceptorship’, ‘clinical supervision’ and ‘mentorship’ (as outlined in Chapter 1) (Andrews et al., 2006; Gleeson, 2008). As a result of this mixed use of terminology, the researcher noted that many of the articles referred to supporting nurses as employees in their graduate programs or while transitioning to a new area of practice rather than in relation to student clinical placements.

Publications involving the supervision of students often discussed the support program available, but not the education provided to support those in the supervisor role. An example of this is Barnett, Cross, Shahwan-Akl and Jacob (2010), who discussed a collaborative model for increasing student placement numbers in a regional hospital in Victoria, including the introduction of an education program for staff; however, no details of the program or its evaluation were discussed.

Literature relating to the education of nursing staff supervising students was therefore limited, as with the international literature. The researcher identified the work of Smedley (2008), Smedley and Penney (2009) and Smedley et al. (2010), who outlined the development, implementation and evaluation of a preceptorship program in partnership
between Avondale College (a higher-education provider in New South Wales) and a local health care site between 2004 and 2007. A second study involving the implementation of a preceptorship program for mental health nurses in Victoria was also identified (Charleston & Happell, 2004).

The Avondale College preceptorship program was developed by designated site representatives based on feedback received by the education provider from its nursing students’ clinical placement evaluations and the literature (Smedley & Penney, 2009). The program was designed to assist registered nurses to develop the necessary knowledge, skills and attitudes for effective clinical supervision (Smedley, 2008). The program was delivered by the education provider over the course of one semester, and participants were accredited in the Master of Nursing program (Smedley et al., 2010). The publication stated that a mixture of face-to-face and self-directed learning was utilised, which incorporated adult learning principles. The program involved a number of written and practical assessments by the education provider and health care facility (Smedley & Penney, 2009).

One hundred and seventeen nurses participated in the course over the four-year study period and 53% completed the research survey. The findings from the surveys, which involved five questions with a scaled response, showed that the participants felt they had an improved knowledge of teaching and learning, supervision skills and a positive attitude towards nursing students, although no attitude survey was used to determine this (Smedley et al., 2010).

These findings were supported by the qualitative data, which asked participants to reflect on their experiences of being in the preceptor program and how it assisted them with gaining the essential knowledge, skills and attitudes of a preceptor. The findings of the research determined that participants perceived that preceptors needed to possess the following skill set: understanding of the principles of adult learning, understanding of learning styles, teaching skills, a positive attitude towards clinical supervision, patience and motivation (Smedley, 2008).

Recommendations from the study outlined that future education programs should focus on communication skills, learning styles, logical thinking, assessment, reflective practice and feedback. It highly recommended that all providers of preceptor education conduct
research to evaluate the effectiveness of the training, and that this research needs to be ongoing as a quality improvement process (Smedley, 2008; Smedley et al., 2010). Of significance to this research was the finding that, in the participants’ perception, an increase in confidence and improved positive attitudes towards the role of clinical supervisor created an improved clinical supervision relationship and placement experience for students (Smedley, 2008; Smedley et al., 2010).

Charleston and Happell (2004) developed and implemented a preceptorship program in Victoria to support registered nurses supervising students during their mental health clinical placement. The program was developed as a strategy to improve the clinical placement experiences of students in mental health as a workforce recruitment strategy during 2002–2003 (Charleston & Happell, 2004).

The program aimed to provide mental health nurses with the knowledge and skills to promote a positive clinical placement experience for students. The program included models of clinical supervision, theories of teaching and learning, the preceptor–preceptee relationship, mental health curriculum issues, competency, learning outcomes and assessment, and organisational change. It was designed to encourage a self-awareness of the preceptors’ role (Charleston & Happell, 2004).

The program delivery included a number of different teaching styles, including lectures, group work, role-play and audio-visual materials. It consisted of either a 12-week workshop, three hours per week or, for rural nurses, an intensive three-day workshop (Charleston & Happell, 2004).

The program evaluation involved two surveys comprising open and closed questions relating to participants’ perceptions of the program and principles of clinical supervision. The findings of the study indicated that participants found the program beneficial, with particular emphasis placed on students’ learning styles and needs, and the need to confirm their workplaces’ commitment to preceptorship (Charleston & Happell, 2004).
### 2.2.4 Clinical Supervision in Summary

Figure 2.2 outlines the findings of the literature review in relation to clinical supervision. These are divided between the positive and negative influences that affect the success of nursing clinical placements.

#### Negative forces:
- Poor attitude towards students
- Poor belonging—students ‘don't rock the boat’
- Poor role models—nurse managers and RNs
- Poor ward/unit nursing practice
- Observational—not encouraged/supported to practice
- Poor communication

#### Positive forces:
- Positive attitude towards students
- Welcoming, belongingness to ward/unit
- Positive role models—nurse managers & RNs
- Best practice nursing care
- Encouraged to practice, ask questions and think critically
- Feedback and reflection

**Figure 2.2: Negative and positive influences on students’ perceptions of clinical placements**

Acknowledging the challenges facing the clinical education of nursing and other health professional students and the future requirements of the health care workforce in Australia, HWA was created in 2008 by the COAG to review the current health workforce issues and provide a national approach to policy and strategy development (HWA, 2013a). HWA conducted a review of the current national situation in relation to the supervision of all health care professional students and published its initial findings in 2010 (HWA, 2010).
2.2.5 Health Workforce Australia—Education Requirements

To provide national continuity regarding clinical supervision education requirements, HWA (2010) acknowledged that supervisors required specific training and development, and that the core skills of the role could be defined in seven core areas (p. 15):

1. clinical skills and knowledge
2. adult teaching and learning skills
3. ability to give and receive feedback
4. communication
5. appraisal and assessment
6. remediation of poorly performing students
7. interpersonal skills.

In April 2011, HWA released the CSSP Directions Paper (HWA, 2011a), which provided five strategy statements that addressed the need for a national approach to the management of student clinical placements and the support of students in clinical placements. This resulted in the National Clinical Supervision Support Framework (NCSSF) (HWA, 2011b) released in the July. It outlined three key focus areas: clarity, quality and culture. Of most relevance to this research was its outline of requirements for education programs for clinical supervisors. It stated that programs should (2011b, p. 6):

- be based on contemporary teaching methods, including role modelling and adult learning principles
- reflect a diversity of experience, including opportunities for interprofessional learning and exposure to non-traditional settings, where appropriate
- provide adequate exposure to the relevant scope of practice for the profession
- incorporate and support valid, reliable student feedback, assessment and reporting tools and processes aligned to the stated learning objectives.

HWA (2012) released, the Draft National Clinical Supervision Competency Framework (DNCSCF) that outlined the competency statements of clinical supervision. Consultations were sought by HWA, including forums around Australia with invitations extended to those within the health care sector and education facilities. The draft outlined competency statements related to four key areas: development of competency, summative assessment
of competence, administration and management of clinical supervision, and facilitation of safety in clinical supervision.

In May 2013, HWA released its final version of this document, renamed the ‘National Supervision Competency Resource’. This document provides a framework for clinical supervisors, education providers and health care facilities for the role and functions of clinical supervisors. This is defined in three broad domains: role of clinical supervision, safety and quality, and organisation. The first area of clinical supervision outlines the clinical supervisors’ role in facilitating learning opportunities for students in clinical practice, while safety and quality ensures that this clinical supervision occurs within a legal and ethical framework to ensure patients’ and students’ safety, and the final domain relates to organisations normalising the role and support for the role into the organisations’ key functions.

Other relevant HWA publications include the ‘National Guidelines for Clinical Placement Agreements’ (HWA, 2013) and literature review ‘Promoting Quality in Clinical Placements’ (Siggins Miller Consultants, 2013). The national guidelines provide standards for the placement agreement between health care facilities and education providers, including the role and responsibilities of each party. This assists with the logistics of student placements and the contract agreements between stakeholders. The literature review outlines the current literature from a national and international perspective regarding the current models of clinical placements and clinical supervision across the health disciplines, and the requirements and current deficits of clinical supervision.

These HWA publications relating to clinical supervision currently provide the groundwork for future policy reform and development in Australia, with an aim to achieve consistency across states and territories.

The literature review in this thesis has outlined the role of clinical supervisors, clinical supervisor programs, documented deficits in current programs and HWA’s publications in relation to the requirements of clinical supervision in Australia. Each of these areas assisted with the development of the CSP. The next section explores the theories and principles of learning in relation to the development of education programs for adult learners.
2.3 The Theories of Learning

The theories of learning were relevant to this research project for the development of the teaching plans and CSP program. These theories guided the researcher in developing the teaching plans for use in the PowerPoint slides, group activities and discussions, as well as a resource file for participants to promote their learning opportunities during the program.

2.3.1 Theories of Adult Learning

The development of learning theory has occurred over the past 200 years. Some have stood the test of time and continue to guide educators today, while others created the foundations that may have changed over time. However, to understand their current meaning, learning their history provides greater depth of understanding and application (Knowles, Holton & Swanson, 2011).

In learning theory, humans are defined as social animals; therefore, the relationships that exist between educators and learners influence the learning experience. The theories of learning guide educators to understand these relationships in order to improve the learning process (Knowles et al., 2011; Wang, 2010).

Different theories view these educator–learner relationships from different perspectives. Educators must take the time to understand the history of learning theory and how they work in practice if they intend to ensure that educational practice is supported by theory (Knowles et al., 2011). By understanding the theory and its perspectives, as well as the relationships that the theory promotes, educators can apply the appropriate theories to their teaching and learning activities to promote positive learning experiences (Knowles et al., 2011; Wang, 2010).

In this section of the thesis, three philosophical approaches to the theory of learning will be explored. These are included under the headings of ‘behaviourism’, ‘cognitivist’ and ‘constructivism’. These learning theories were chosen after the researcher reviewed the literature in relation to theories of learning and determined that these provided the necessary conceptual frameworks to support the researcher in meeting the learning
objectives of the education program and the research questions. The application of these theories will be explored in further detail in the next section and in Chapter 3.

2.3.1.1 Behaviourist Theory

Behaviourist theory states that learning has occurred when a change in behaviour is present. It is not concerned with how the individual learns or the cognitive processes involved; its attention is focused on encouraging a desired outcome through the reinforcement of behaviours by arranging the surrounding environment (Garrison & Archer, 2000; Knowles et al., 2011).

The development of behaviourist theory began with the work of Watson (1913) and Thorndike (1913), who were based in the field of psychology and were concerned with behaviour rather than what occurred in the mind (Knowles et al., 2011). Today, the work of Thorndike (1913), while changed and refined with time, is viewed as the foundation of behaviourist theory. A number of other significant contributions to the theory of behaviourism were also made, including Pavlov’s work with ‘classical conditioning theory’, Guthrie’s ‘continuity of cues with responses’, Skinner’s model of ‘reinforcement’ and Bandura’s theory of ‘social modelling’ (Knowles et al., 2011).

While a number of these theorists’ findings are significant within this field, only the work of Thorndike (1913), Pavlov (1927) and Bandura (1913) will be explored further. These theorists have been included because of their ability to assist the researcher with meeting the learning outcomes of the program. Thorndike is considered to be the first to conduct a systemic investigation into the study of behaviourism, and his findings are the foundation of behaviourism theory (Knowles et al., 2011). Pavlov extended the work of Thorndike (1913) in the area of stimulus and response, which the researcher wanted to use as a teaching strategy within the study day to promote attitude change in conjunction with the strategy of role modelling. Role modelling was the focus of Bandura’s (1913) social modelling theory and therefore was reviewed for further strategy development.
2.3.1.1.1 Thorndike, Pavlov and Bandura

Thorndike (1913) studied the learning behaviour of animals. His theory of learning was based on stimulus and response (S–R). He believed that learning occurred when a specific response was linked to a specific stimulus. Thorndike’s theory was not specific to adult learners, as his studies were mainly based on animals; however, he established the first known evidence of learning (Knowles et al., 2011; Thorndike, 1913). Since Thorndike, a number of theorists have explored this concept of learning, in particular S–R, and they are referred to as the ‘Stimulus Response Theories’ (Knowles et al., 2011).

Pavlov’s (1927) work in the early 1900s added to behaviourism with his concept of ‘classical conditioning’. Pavlov outlined that learners required reinforcement of the stimulus to encourage the learnt behaviour, that the behaviour would become extinct if the reinforcement was removed and that more than one stimulus could be used to evoke the desired response (Knowles et al., 2011).

Bandura’s (1913) work on behaviourism specialised in the field of ‘social modelling’, which involved the learner observing behaviour with attached consequences. If the consequence was deemed desirable, the learner would endeavour to copy this behaviour; if it was deemed undesirable, the learner would attempt to avoid the behaviour (Knowles, 1984). This concept of social modelling is also referred to as ‘role modelling’, which Knowles (1984) stated that ‘every teacher employs...whether consciously or unconsciously’ (p. 94). This concept has a particularly positive influence on educational outcomes when the education is focused on the development of ‘attitudes, beliefs and performance skills’ (Knowles et al., 2011, p. 103). This is of particular importance to the clinical supervision study day, as the program aims to promote positive behaviour and attitudes towards students and student supervision.

Other theorists have continued to study behaviourism and the literature today summarises the behaviourist approach to learning as an observable change in behaviour (Knowles et al., 2011). Behaviourists believe that the environment shapes the learner’s behaviour; therefore, the environment rather than the learner will determine what is learnt. This relates to the S–R concept, in which the teacher provides the environment that prompts the desired behaviour (Knowles et al., 2011). The final shared principle outlines that the learner should
be exposed to the behaviour on more than one occasion with reinforcement, which increases the likelihood that the behaviour will be repeated (Knowles et al., 1998; McKenna, 1995).

The implementation of a behaviourist learning approach requires teachers with the knowledge and ability to provide a learning environment that will shape the desired behaviour and attitude. As stated by Knowles et al. (1998, p. 76), ‘The teacher (is concerned) with structuring the situation so that rewards will operate to strengthen desired responses, (their) role is to cause appropriate S–R bonds to be built up in the learner’s behaviour repertoire’.

A criticism of the behaviourist theory is its simplistic approach, as the external environment moulds the learner and what the learner will learn (Jackson, 2009). The following theories move away from this belief and concentrate on the learner as a person who is central to the learning process.

2.3.1.2 Cognitive Theory

Cognitive theory was developed in the 1960s, when there was a move by psychologists away from behaviourism as they believed that it did not incorporate how humans think (Regehr & Norman, 1996). Cognitive theorists moved the emphasis from the external environment to the internal thoughts and processes of the individual. They believed that learning becomes meaningful when the learner can relate new concepts to those that already exist in the brain (Jackson, 2009).

Cognitive theories of learning are based on the assumption that learning ‘is an internal purposive process concerned with thinking, perception, organisation and insight’ (McKenna, 1995, p. 2). Learning occurs when the individual has insight into the learning and draws from previous experience and/or knowledge to develop new knowledge (Jackson, 2009). Cognitivists believe that ‘in the mind, knowledge resides within sets of organised and interlinked mental schemata which can be activated by experience’ (Yates & Chandler, 1991, p. 136). A schema is ‘a mental construct permitting problem solvers to categorise problems according to solution modes’ (Sweller, 1990, p. 4). The development of schematic networks provides for broad outlines of topics. Keywords are linked to these
so that when the learner is faced with a situation in which there is a relationship, the information is linked to the particular network. In order for this process to occur, the teaching environment must provide for a link to pre-existing knowledge (Regehr & Norman, 1996). Kidd (1973, p. 180) outlined that ‘an effective memory results from improved organisation; and organisation, in turn, is likely to be most productive when there is interest in the content and what is learned is related to what the learner already knows’.

Regehr and Norman (1996) explained that this can be achieved by encouraging students to work through case studies. This requires students to draw on previous knowledge and add to it, therefore applying relevance and meaning to the new knowledge and ensuring it is linked to the appropriate schemata.

Application of the cognitivist theory of learning encourages facilitators to determine the current knowledge and understanding of the participants and the relevance of the learning to the participants so that new information can be presented at the appropriate level of complexity and context (Knowles et al., 2011). Facilitators can achieve this by asking participants at the start of the program to provide a brief background of their understanding, previous education and level of involvement with the topic.

2.3.1.3 Constructivism Theory

Constructivism advocates that learning is context-bound (Jackson, 2009; Knowles et al., 2011). The focus is on the learner making personal meaning of a concrete experience, and new information must relate to existing knowledge (Jackson, 2009; Knowles et al., 2011). An example of this approach is Kolb’s Learning Model, where experience is the fundamental anchor to learning (Jackson, 2009; Knowles et al., 2011; Kolb, 1984).

Kolb (1984) outlined that experiential learning involves learning from experience. Kolb described learning as a continuous cycle where the learner adapts ideas as the result of his or her experiences. As learners, we are engaged in an event that gives us a concrete experience; this provides a point for learning and gives meaning. We can use this experience to form observations and reflect on these to develop a general concept, which is then tested with further experience. This learning results in a change in the individual’s
thought and/or response (see Figure 2.3). The individual has an experience, takes time to reflect on it, forms an opinion about it and then experiments with this in future scenarios (Kolb, 1984).

![Kolb's Experiential Learning Model]

**Figure 2.3: Kolb’s Experiential Learning Model, adapted with suggested learning strategies (Knowles et al., 2011, p. 197)**

Kolb (1984) believed that no one comes into learning without background knowledge; therefore, there may be a bias towards new information. The greatest challenge for educators can be encouraging participants to question this bias and knowledge base and to move beyond this (Kolb, 1984). Therefore, it is important to teach individuals how to seek new information, reflect upon it and relate it to their experiences rather than to hold onto a constant body of information.

Kolb (1984) noted that learning from experience is not limited to the time of the experience. It may be a previous experience, someone else’s experience or a teacher-provided scenario. Applied to the classroom, learning is best achieved through the use of storytelling, sharing experiences and working through role-plays and case studies. These provide an example for participants to apply the knowledge, reflect on the case and gain new knowledge or understanding that can be applied in the future.
Each of these theories of learning can be applied to modern education practice. Together, they provide a framework of how adults learn (Knowles et al., 2011). The ability to incorporate these learning theories into a program requires not only detailed teaching plans for the sessions, but also the skills of facilitators who understand these theories and their importance and relevance, and who can incorporate these into their teaching style in order to promote the course aims (McKenna & Stockhausen, 2013).

In summary, it must be noted that these theories of learning were developed by individuals who themselves were not educators (Knowles et al., 2011). As discussed, these theories were mostly based in the fields of the behavioural sciences. They provided theories of how learning occurs, with some explanation of how to achieve this. In the early twentieth century, educators developed their own theories and principles related to learning, which explored teaching styles and how they affected the learner’s ability to learn.

2.4 The Principles of Adult Learning

Towards the middle of the twentieth century, adult educators developed their own field of theory related to adult learning. The most prominent of these was Knowles’ (1978) principles of adult learning. Unlike the learning theories, Knowles outlined the principles that assist with learning rather than how the learning occurs (Knowles et al., 2011).

Knowles’ (1978) theory of adult learning assisted educators to develop and implement effective teaching and learning. Knowles referred to education as an activity that is designed to facilitate a change in individuals’ or groups’ knowledge, skills or attitudes. Educators are responsible for initiating change by implementing appropriate activities. Learning is described as an activity in which individuals experience change in their knowledge, skills or attitudes (Knowles, 1978).

Knowles’ (1984) revised theory outlined the underlying belief that adults must understand why they need to learn so that a personal value can be placed on the experience in order to maximise the internalisation of the material studied. The learning must relate to one’s own experiences and provide relevance and application so learners can engage with the content (Knowles, 1984).
To understand Knowles’ principles of adult learning, one must first understand the principles of how children learn—the theory of pedagogy (Knowles et al., 2011).

2.4.1 Pedagogy—‘The Art and Science of Teaching Children’

The term ‘pedagogy’ is derived from the Greek word for children and leader. This style of education for children was developed during the seventeenth century, when schooling for children was designed to prepare young boys for priesthood. The purpose of the education was to indoctrinate students’ beliefs and faith in the Catholic Church. This style of learning placed teachers in a position of authority. Teachers determine what, how and when it will be learnt, and if it has been learnt (Knowles et al., 2011).

Knowles (1978) outlined that this style of learning may not meet the inquisitive nature of the human mind as students mature. Learners should then be encouraged to develop self-direction; thus, the style of teaching is adapted to facilitate this personal growth. This style of learning is referred to as andragogy (Knowles, 1978; Knowles et al., 2011).

2.4.2 Andragogy—‘The Art and Science of Teaching Adults’

Andragogy is a style of learning in which the learner is the focus of the experience rather than the teacher. The learner is encouraged to seek out learning, relate learning to life experiences and understand why learning is required and important to them (Knowles, 1984).

Examples of the implementation of the principles of adult learning have been recorded throughout history; however, no formalisation or theory was developed until the twentieth century. History reveals the use of adult learning theory in the accounts of Confucius, Aristotle, Socrates and the Hebrew prophets, to name just a few. These teachers used the principles of storytelling, questioning, the discussion of dilemmas and the defending of statements to evoke enquiry (Knowles et al., 2011). Knowles’ principles state that educators need to determine when to use each of these styles of learning.
2.4.3 Pedagogy Applied with Adult Learners

There are times when adults enter the learning environment with limited knowledge or experience to guide them, or they may have no active interest in the material. The students are therefore dependent on teachers to provide them with the necessary knowledge and skills or external motivation to participate in the learning. At these times, facilitators adopt a pedagogy style of teaching (Knowles et al., 2011).

It is vital in this situation that facilitators monitor learners and assist them to adopt an andragogy style of learning once they have established a core body of knowledge, skills and/or attitudes (Knowles et al., 2011). Therefore, educators who approach adult learning using these principles are able to determine and adapt their teaching styles from the pedagogy approach to andragogy, while pedagogical teachers would remain within the principles of pedagogy (Knowles et al., 2011).

The principles of adult learning developed and refined by Knowles (1978 & 1984) and Knowles et al., (1998 & 2011) provided the researcher with a framework for the development of the CSP, which is described in further detail in Chapter 3. In addition to understanding the theories and principles of learning, the researcher explored the literature in relation to how attitudes are developed, and if and how they can be changed given that the barriers to positive clinical supervision include the poor attitudes of nurses towards nursing students.

2.5 Theory of Persuasion and Measurement of Attitude

For the purpose of this research, ‘attitude’ takes its definition from social psychology. It has been defined as ‘the degree of positive or negative affect associated with some psychological object’ (Thurstone, 1946, p. 39). A psychological object can be ‘any symbol, phrase, slogan, person, institution, ideal, or idea toward which people can differ with respect to positive or negative affect’ (Edwards, 1994, p. 2).
2.5.1 Theories of Persuasion

A number of theories related to attitude change are outlined in the literature. Research within this area was particularly active during World War II due to a large amount of army sponsorship in the US. These initial theories were refined in the 1970s and continue to be the base of current theory. Theories include the Consistency Theory, Learning Theories, Social Judgment Theories and Functional Theories (Katz, 1960; O’Keefe, 2002).

The functional theories of attitude were developed during the 1950s and remain relevant in today’s environment (Katz, 1960; O’Keefe, 2002). Katz (1960), one of the founders of functional theory, stated that individuals need to understand the purpose of their attitude—that is, the function that it serves. These purposes/functions are individualised and personal. Only when they are understood can the attitude be changed (Katz, 1960).

To change an attitude, individuals need to experience a difference between their needs being met by the attitude and the reason for having the attitude (Katz, 1960). Changes in attitude are accomplished when individuals recognise that the purpose of the attitude no longer works or assists them (Katz, 1960).

Katz (1960) highlighted that changing individuals’ attitudes using external forces requires an understanding of the motivational reason for, or function of, the attitude. This allows motivators/educators to develop a persuasive message that will assist individuals to reason with and change their current attitude.

Persuasion is defined as ‘a successful intentional effort at influencing another’s mental state through communication in a circumstance in which the persuadee has some measure of freedom’ (O’Keefe, 2002, p.5).

Maintaining the attitude change is influenced by how individuals are persuaded to adopt the new attitude (O’Keefe, 2002). To facilitate a longer-lasting effect of attitude change, persuaders—in this case, program facilitators—need to encourage participants to actively listen to the message, reflect upon its meaning and implications and how these relate to future practice (Katz, 1960; O’Keefe, 2002). This reflective process promotes the central processing of the information, as described in this chapter in relation to the Theory of
Cognitivism, where information is stored and retrieved for future use and application (Gass & Siter, 2011).

Katz (1960) stated that by provoking individuals to analyse their attitudes, this can change the attitude; however, the success of this approach is usually linked to the charisma and quality of the message to encourage individuals to reflect upon their current attitudes.

One of the objectives of this research is to determine whether a change in nursing participants’ attitudes was achieved after attending the CSP. Given that attitude is the precursor to behaviour (O’Keefe, 2002), changing individuals’ attitudes should affect their supervision behaviour and improve the clinical supervision relationship. To determine whether participants’ attitudes were changed after attending the program, the researcher referred to the literature regarding the measurement of attitude.

2.5.2 Attitude Measurement Tools

The purpose of attitude scales is to determine individuals’ attitudes towards psychological objects. Determining individuals’ attitudes allows only a general classification (Edwards, 1994). It is always based on the ‘degree’ of affect that individuals have with the psychological objects. Therefore, these scales aim to determine whether individuals have a positive, negative or unknown attitude towards the object or a favourable, unfavourable or neutral attitude towards the object (Edwards, 1994, p. 8).

Cutcliffe and Jyrkas (2006) drew attention to the issues of measuring attitude. In particular, the article discussed that participants often give different responses at different times depending on their mood, emotion or moral obligations. However, despite this, Cutcliffe and Jyrkas believed that interesting data and findings could be found that have the ability to extend our understanding and therefore should not be ignored.

A review of the literature sourced an attitude survey developed and implemented by Stagg in 1992 for a nursing master’s thesis that was also used by Aghamohammadi-Kalkhoran Karimollahi and Abdi (2011). The survey used a five-point Likert scale; Likert attitudinal scales measure participants’ attitudes by asking them to agree or disagree with attitudinal
Statements are designed to provoke a response; therefore, any neutral or ambiguous statements are not included (O’Keefe, 2002).

Stagg (1992) designed and validated the survey prior to using it in two hospitals for the research thesis. The results of Stagg’s (1992) study highlighted that nurses’ attitudes towards nursing students was low. There was no significant difference in attitudes in relation to the age, experience or professional preparation of the sample group. Recommendations from Stagg’s study included the use of a larger sample size and a combined quantitative and qualitative approach to facilitate the clarification of questions used in the survey.

Stagg’s attitude survey was utilised again in the study of Iranian nurses’ attitudes towards nursing students by Aghamohammadi-Kalkhoran et al. (2011). Eighty-two nurses were included in the survey from acute medical and surgical wards, with 70 completed forms received. The results showed that most nurses had low to moderate attitudes towards students. Recommendations from the study included education to improve nursing staffs’ attitudes towards, and understanding of, students, and motivating policy-makers to develop solutions to help nurses appreciate the importance of students and to develop a friendly practice environment. No recommendations were made regarding the Stagg’s survey tool (Aghamohammadi-Kalkhoran et al., 2011).

It must be noted that Stagg’s (1992) attitude survey related to staff members’ attitudes towards students, and not specifically student supervision, although this was encompassed within the tool. To provide clarification that a positive attitude towards students translated to a positive attitude towards student clinical supervision, the researcher referred to the literature.

A search of the literature located two published articles relating to changes in clinical supervisors’ attitudes after attending clinical supervision education; however, these findings were self-reported by attendees, as no scale was used. Hancox et al. (2004) outlined the introduction of a clinical supervision education program for mental health nurses in Australia. The article noted that participants self-reported that the program had positively influenced their attitudes towards students, and that the awareness of the
The importance of the role of clinical supervisors was accompanied by a positive view towards providing clinical supervision.

The article by Smedley et al. (2010) evaluated the effectiveness of a Masters of Nursing unit on preceptorship at Avondale College in New South Wales, Australia. The program was conducted over one semester and consisted of weekly face-to-face lectures that promoted group interaction and problem-solving. Participants were asked to complete a survey at the end of the course. Smedley et al.’s (2010) review of the unit concluded that there was a logical link between an increase in the understanding of the supervisors’ role and the attitude towards students, resulting in a more positive experience for students. The data indicated that influencing nurses’ attitudes towards students also resulted in improved communication with students and supervisors’ confidence in their role.

Upon reviewing the literature, it was determined that the use of the attitude survey by Stagg (1992), although designed to determine the attitude of nursing staff towards nursing students, could be used as a measure of attitudes towards nursing clinical supervision. The theories of persuasion, which outline that attitudes and behaviours are closely linked, describe that when the goal is to change individuals’ behaviour, this process is achieved through initial attitude change (O’Keefe, 2002).

2.6 Chapter Summary

The aim of this literature review was to provide a theoretical framework for the development of the CSP. This included describing the literature in relation to the documented deficits and requirements of effective clinical supervision and clinical supervision education, the theories and principles of learning, and the theories of attitude, attitude change and measurement.

The literature review described the important role that clinical supervisors play in developing student nurses into competent registered nurses that are able to meet the role attributes outlined by the NMBA. Registered nurses require specific education to fulfil clinical supervisor role requirements. Programs need to focus on the important role of clinical supervisors in developing and assessing the clinical knowledge and skills of
students, and they need to highlight the effect that supervisors’ and workplaces’ attitudes towards students and student clinical placements can have on student learning outcomes.

The researcher utilised these literature findings in conjunction with the theories and principles of learning and attitude change in the development of the teaching plans and the resource work file. The application of this literature review to the CSP will be discussed in further detail in Chapter 3.

***

*A nurse walked towards them. She asked what days the group would be working. Someone replied, ‘Each Monday and Tuesday for four weeks’. The nurse turned around, stating aloud, ‘I’m off to see the manager to request not to work Mondays and Tuesdays. I’m not working with any of you’.*
Chapter 3: Methodology

The clinical facilitator guided the group off the ward. She walked, following the group.

The skip was gone, replaced by feelings of trepidation. Was this what was to be expected? Did everyone feel this way about students?

3.1 Introduction

The previous chapters of this thesis described this research project, including the project context and research questions and the relevant literature. This chapter will describe the methodology and research design used for the development, implementation and evaluation of the CSP. This will include the development of the CSP, the program’s validation, the development of data collection tools with appropriate validity and reliability testing, an outline of the data analysis strategies and the application of the literature discussed in Chapter 2 to each phase.

The first section of this chapter will describe the research context and the researcher’s methodological approach to this study, as described in Figure 3.1. This will include reviewing the literature in relation to social sciences, descriptive studies, mixed method research and triangulation, as utilised within this research.
3.2 Social Sciences

The term ‘social science’ refers to the study of human behaviour. ‘Science’ provides a view of the world and how it is observed. It relies on exact measurements based on logic, data collection and analysis. ‘Social’ indicates that the social science researcher aims to discover the patterns of social life within the world. It aims to develop explanatory theory in relation to human behaviour. It helps us to understand the ‘what’ and ‘why’ of the world around us, and to find patterns, but it does not tell us what is better or worse; this is dependent on the values and judgements of society (Babbie, 2008; Punch, 2009).

Within the field of social sciences, researchers determine which research method will best assist them with achieving their research aims.
3.3 Methodology of the CSP Research Project

The methodology used by a researcher is the plan of how the research will be conducted (Punch, 2009). The chosen methodology will support the researcher to answer the research questions. For this research, the researcher aims to determine whether the CSP meets the learning needs of nurses in order to assist them to supervise students on clinical placement. For this reason, the researcher required a method that would explore changes in participants’ knowledge and attitudes while allowing them to describe the effect of the program on their knowledge and clinical supervision practice in their own words.

To achieve this, a mixed method approach of qualitative and quantitative data collection and analysis was utilised. This assisted the researcher to determine the effect of the program on the knowledge and attitudes of the participants related to clinical supervision, as well as an understanding of the effect of the program on participants’ clinical supervision experiences. The methodology chosen to assist with this framework of research was a descriptive study.

3.3.1 Descriptive Study

The aim of research in the social sciences is to ‘describe’. With descriptive studies, the researcher studies a population and describes the findings. This involves the description of data, enriched with meaning and interpretation. The researcher looks for the ‘why’ and searches for patterns and what these mean (Babbie, 2008). The data aim to provide a social, cultural and historical context of the phenomena being explored (Corbetta, 2003). The findings are articulated to make complicated phenomena understandable (Punch, 2005) and to provide a picture of the phenomena as they occur naturally (Gray, 2004). It provides the what, where, when and how (Babbie, 2008).

The aim of descriptive research is therefore to collect as much data as possible that will allow the researcher to capture all of the attributes of an event or phenomenon (Sandelowski, 2000). These data are then presented in everyday language (Punch, 2005; Sandelowski, 2000). While descriptive studies are not deeply interpretive, they have an interpretive component. The researcher writes an accurate account of the events that
occurred, which other observers would agree is an accurate observation. This includes the meanings that were applied to the event by the participants (Sandelowski, 2000).

The descriptive methodology is particularly useful when the aim of the research is to determine answers to questions that relate to policy-makers and practitioners. The descriptive method aims to provide straightforward descriptions of the phenomena when the answers required are clear and are ‘minimally theorized or otherwise transformed or spun’ (Sandelowski, 2000, p. 337).

As stated, to achieve the description of the effect of the CSP, a mixed methods approach was used.

### 3.3.2 Mixed Method Research

Mixed method research is a combination of quantitative and qualitative research methods. However, it is increasingly being referred to as the third methodological approach to research rather than a combination of the two (Punch, 2009). This is because it is more than two data sets; a mixed method research approach provides a different viewpoint of data collection and analysis. All methods examine data with different views, and using more than one view adds to the breadth of the data and can uncover aspects not covered by other methods. This combination offers richness in the data collection and provides rigour and depth (Berg, 1998; Bloor, Frankland, Thomas & Robson, 2001; Borbasi, Jackson & Langford, 2008; Denzin, 2012; Punch, 2009).

The mixed method researcher must have a comprehensive understanding of the two research methods—not only relating to the collection and analysis of the data, but also in relation to how these two methods can be used to complement each of the findings (Punch, 2009).

#### 3.3.2.1 Quantitative

Quantitative research consists of approaches to data collection and analysis based on the measurement of numbers. It is an objective process that involves gathering information that is used to investigate cause and effect or test relationships. The data can explain and
predict relationships through the use of statistical trends (Borbasi et al., 2008; Punch, 2009; Wolfer, 2007).

Quantitative statistical trends are generalised to larger populations. Populations are used to achieve this large sample. The researcher forms conclusions that are supported and explained through the use of tables, charts and graphs (Punch, 2009; Wolfer, 2007).

According to Gray (2004) and McCabe (2008), the quantitative researcher in the social sciences uses descriptive statistics. This is the transformation of data into percentages; it displays what the data are. Descriptive statistics use graphs, charts and tables to display the information, which will often relate to individuals and/or subgroups that highlight the characteristics of data, which can be used to highlight trends. They show a picture of the population sample and the key variables that are being explored. Tables often show frequency distribution, mean, median, mode and the spread of responses through their normal distribution (Gray, 2004; Macnee & McCabe, 2008).

Quantitative research can be further defined into experimental, non-experimental and quasi-experimental groups (Borbasi et al., 2008):

- The experimental group involves the concepts of ‘randomisation, control and manipulation’. Participants are randomly allocated into different groups, which consist of a control group (the current norm) and an intervention group/s that receive the manipulation/s. Results are then compared between the groups.
- The non-experimental group involves no manipulation; instead, participants are observed in their natural state.
- The quasi-experimental group is based on the experimental group; however, for ethical or logistical reasons, not all variables can be controlled. For example, rather than being allocated into groups, all participants may be observed for their response to an intervention. Due to the ethical and moral implications in nursing, this is the most common form of quantitative research employed.

In relation to this research project, all of the research participants attended the CSP; therefore, there was no group allocations and a true experimental design could not be
achieved. Instead, the quantitative data were utilised to describe the effect of the CSP through the use of:

- a pre-survey on the day of the program
- a post-survey on the day of the program
- an eight-week survey after the program.

This provided the researcher with data over a period of time. These data related to the knowledge and attitudes of participants related to the principles of clinical supervision.

3.3.2.2 Qualitative

Borbasi et al. (2008), Punch (2009) and Wolfer (2007) described qualitative research as the collection and analysis of data that are words or other forms of communication rather than numbers. Qualitative research aims to provide an in-depth understanding of the research topic, and it uses smaller participant numbers. The researcher forms conclusions that are supported through quotations from interviews, focus groups and the written word. It does not claim that the information can be generalised to a larger population; instead, it is context-specific and attempts to gain a greater insight into the phenomena using a holistic approach.

Qualitative research aims to gain this holistic approach to understanding participants and their experiences by focusing on understanding the phenomena rather than the cause and effect. This is achieved through the collection of rich descriptive data using small sample sizes. The researcher aims to select a sample that will provide the data related to the phenomenon of interest. These are termed samples of purpose or convenience. The researcher plays a central role; it is his or her ability and skill to retrieve data from participants that will add to the quality and depth of the data collection (Borbasi et al., 2008).

Researchers using qualitative methods do not use the terminology of reliability and validity; instead, they demonstrate credibility, auditability and transferability. This will be explored in further detail as it applies to this research project (Borbasi et al., 2008).
For this descriptive study, a thematic analysis for ‘identifying, analysing and reporting patterns within data’ was utilised, with the aim of producing a description of participants’ experiences and reality, as well as their meanings (Braun & Clarke, 2006, p. 81).

Thematic analysis assisted the researcher within the descriptive methodology to provide a rich source of findings that was able to describe participants’ knowledge and attitudes towards clinical supervision both before and after attending the program. These data consisted of participants’ written and spoken words.

3.3.3 Application of Mixed Methods Research

The mixed method researcher requires the skills to undertake both qualitative and quantitative research. The combination of the two methods often results in more complex planning and implementation processes whereby the researcher must ensure that both methods are incorporated. This increases the complexity of data collection, analysis and the forming of conclusions (Punch, 2009).

Mixed method research is popular within the field of nursing, as it provides a flexible and broad approach to understanding complex research areas. However, valid reasons for its use must be clearly articulated. Borbasi et al. (2008, p. 184) suggested six possible rationales, which they referred to as the ‘six purposes:…confirmation, complementary, initiation, development, expansion and enhancement of significant findings’. Researchers may use a mixed method research approach for one or more of the following reasons:

1. confirmation: corroborate results, converge findings from different data sources
2. complementarily: seek clarification or illustration; adds greater meaning of findings, provides illustrations and clarification
3. initiation: increase the depth and understanding of the phenomenon so that new perspectives can be investigated
4. development: sequential design of data collection—that is, one informs the other of the data required
5. expansion: increase and expand the level of enquiry of the phenomenon
6. enhance significant findings: significant findings in initial data collection within subgroups can result in further enquiry and analysis.
The mixed method approach for this research was implemented to provide:

- **corroboration of results**: did the quantitative data related to changes in knowledge and attitudes towards clinical supervision result in a change in clinical supervision practice as evidenced through written survey statements, reflections and interviews?
- **complementary**: did the study day affect participants’ clinical supervision practice in unanticipated ways?
- **initiation**: as a new education program, the research had the potential to highlight new areas to be explored further
- **expansion**: the quantitative component allowed for a greater number of participants for generality
- **enhance significant findings**: the use of qualitative data could provide greater insight into the complex relationship of clinical supervision and therefore enhance the quantitative findings.

The mixed method researcher plans the sequence and use of the two methods—that is, what priority or significance will be placed on each, when and how each stage will be integrated, and what overall perspective will be used to guide the study. This is known as the research design (Borbasi et al., 2008).

According to Creswell and Plano Clark (2011), the design of mixed methods research can be divided into six options: convergent parallel design, explanatory sequential design, exploratory sequential design, embedded design, transformative design and multiphase design. For this research, a convergent parallel design approach was adopted. Utilising Creswell and Plano Clark’s (2011) description of a convergent parallel design, the researcher conducted both the qualitative and quantitative phases of the research at the same time separately. The purpose of the two data sets was to confirm and corroborate the findings. Priority is given to both data sources, with the individual findings reported. The integration of the data occurs with the comparison of findings (Chapter Six) and implications (Chapter Seven) sections of the thesis. This is demonstrated in Figure 3.2.
To achieve research validity and creditability, this mixed method approach included a variety of data sources in the areas of quantitative and qualitative research methods. This approach to data collection and analysis is termed ‘triangulation’.

### 3.3.4 Triangulation

A mixed method approach combines the methods of quantitative and qualitative research, and it can meet the criteria of triangulation; however, triangulation is not mixed methods. A pure quantitative or qualitative research design can also include triangulation (Borbasi et al., 2008; Gray, 2008). Triangulation is another method that researchers can use to obtain a depth of data and corroborate findings (Borbasi et al., 2008; Gray, 2008; McDavid & Hawthorn, 2006; Williamson, 2005).

Triangulation involves the use of multiple methods of data collection and analysis, and a comparison of the findings (Borbasi et al., 2008; Gray, 2008; McDavid & Hawthorn, 2006; Williamson, 2005). The use of multiple methods assists with avoiding potential errors or biases that may occur when using only one method. It is one way to increase the validity and credibility of the research and offer confidence in the research findings (McDavid & Hawthorn, 2006; Williamson, 2005).
Triangulation provides the researcher with the ability to provide rigorous and quality research. The research undergoes deeper scrutiny than would occur with a one-method approach. It offers different viewpoints of the data that can complement findings and provide a more comprehensive analysis. It also provides the researcher with a validity of interpretations (Adami & Kiger, 2005; Gray, 2008; McDavid & Hawthorn, 2006; Williamson, 2005).

The researcher should not rely solely on triangulation to ensure the elimination of errors, as the reliability of the research can still be lost if the tools are inappropriate or if the researcher observing/interviewing lacks the skill set to do so (Gray, 2008; Williamson, 2005). Therefore, for triangulation to provide a more comprehensive exploration of the topic, it is important that the researcher adheres to the principles of triangulation theory (Gray, 2008; Williamson, 2005).

There are four types of triangulation that provide methods to achieve the reliability of findings: data triangulation, investigator triangulation, theory triangulation and method triangulation (Turner & Turner, 2009; Williamson, 2005). These will now be described in relation to their application to the CSP, as shown in Figure 3.3.

![Figure 3.3: Application of ‘triangulation methods’ to the CSP research](image)
3.3.4.1 Data Triangulation

Data triangulation is the use of multiple data sources (Adami & Kiger, 2005; Turner & Turner, 2009; Williamson, 2005). It is utilised as a strategy to provide confirmation of findings, and it may assist in providing a more complete view of the data. It aims to provide more sources of data within one study to provide a more complete picture of the topic (Adami & Kiger, 2005). For example, this research project included the use of pre- and post-implementation surveys consisting of open (qualitative) and closed (quantitative) questions, online reflective feedback and interviews.

To increase the credibility of findings, data triangulation can be further subdivided into different times, different locations and different people (Turner & Turner, 2009; Williamson, 2005). The theme of ‘different people’ was not clearly defined by Turner (2009) and Williamson (2005). Adami (2005) suggested that further discussion is required about the meaning of ‘different people’ and outlined that it has traditionally encompassed the exploration of phenomena from the perspective of different groups. However, Adami suggested that this description is widening and may also be achieved through the use of one group with subgroups within the sample population. The following strategies were applied to this research to achieve these three themes:

- Different times: Survey completion before and after the day of the program and after eight weeks. In determining the time period for the follow-up eight-week survey, the researcher reviewed the literature relating to the effect of education programs on nursing staff. Desy, Prohaska and Plaines (2008), MacDonald, Stodel and Chambers (2008), Michel (2008) and Steginga et al. (2005) described the implementation of an education program for nursing staff where the effects of the program on participants’ knowledge and attitudes were analysed both prior to, and between six weeks and four months after, the education program. The reasons for these time periods for the program evaluations were not explained in any of the projects, except by Michel (2008), who noted a lack of literature on the topic. The researcher was unable to locate any publications that recommended appropriate time intervals for the re-evaluation of the programs’ effects on participants. For this project a discussion between the research student, university supervisors and the university biostatistician resulted in the agreed timeframe of after eight weeks. However, surveys would be accepted from participants until the conclusion of the
research phases; that is, surveys were received from participants up to four months after attending the program.

- Different locations: Participants for the program were employees from both metropolitan and regional Western Australia, as well as the public and private health care sectors.
- Different people: The application of different people for this research could be viewed as not applicable, as only the registered nurses attending the program were involved in gathering the data. The participants’ managers, students and colleagues were not involved. However, Adami’s (2005) argument for ‘different people’ could be used to relate to the subgroup created within the research group. This could be the different locations of the participants, as they were from both the metropolitan and regional areas of Western Australia, as well as both the public and private health care sectors. In addition, the subgroups of different nursing specialities, level of education in clinical supervision, age of the participants, years of nursing and frequency of clinical supervision could offer different views of the phenomena.

3.3.4.2 Investigator Triangulation

This is the use of more than one researcher in the collection and analysis of data (Turner & Turner, 2009; Williamson, 2005). This is usually used with qualitative research for the coding of data to demonstrate the reliability of the process (Turner & Turner, 2009). This was not included in this research as a PhD project because two university supervisors and the university biostatistician closely observed the project.

3.3.4.3 Theory Triangulation

This is the use of more than one theoretical approach to the collection and interpretation of a study’s findings (Williamson, 2005). The use of triangulation has demonstrated its usefulness in providing rigour to research findings, with Turner and Turner (2009, p. 174) stating that it can ‘produce rewarding conclusions’. For this study, a mixed method approach was utilised, which incorporated different data collection and analysis processes, including the thematic analysis of qualitative data and the use of quantitative data for descriptive statistics.
3.3.4.4 Method Triangulation

This can involve the use of different data collection tools within a paradigm or across different paradigms. A research paradigm is how the research views the world. It provides a set of principles and techniques for exploring phenomena, as well as how research should be conducted (Punch, 2009). The use of one paradigm only is referred to as ‘within method’ and increases the risk of the same findings being replicated. The researcher may use different tools to obtain the data; however, these often sit within either the quantitative or qualitative approach (Williamson, 2005). The ‘between method’ approach involves the use of both qualitative and quantitative methods, which sit within different research paradigms and therefore provide different sources of data and analysis that can assist the researcher to gain a wider, more complete, picture (Williamson, 2005).

The application of method triangulation was achieved through the study day program participants completing the quantitative knowledge survey and attitude survey towards nursing students. These findings were then corroborated through the qualitative data, which involved participants’ thoughts and reflections in the survey with open-ended questions, online reflections and interviews about clinical supervision.

As outlined by Punch (2009), the mixed method researcher must plan each stage of the research in detail to ensure that all of the requirements of both research methods are met. The application of the mixed research methods for this project involved the researcher determining each phase of the research and the planning and actions required within each phase to ensure that the project was implemented in a timely manner that met the requirements of the research. This is referred to as research techniques.

3.4 Research Techniques

The techniques employed for this research are outlined in the phases of the research project articulated through Figure 3.4. These include the development of the CSP and research tools, validity of the program, validity and reliability testing of the research tools, implementation of the program and data collection processes.
These phases were designed to provide a clear process for the development and implementation of the research; it is the method of the research. Each phase will now be described in detail, including the role of the researcher in the implementation of each phase, the communication and processes that occurred, and the challenges encountered and problem-solving strategies utilised.

![Figure 3.4: Phases of the research process](image)

Prior to the implementation of these research phases, the researcher sought approval for the research. This involved submitting the research proposal to the School of Nursing and Midwifery Research Committee at the University of Notre Dame, Australia (Fremantle...
campus) and to the University of Notre Dame Human Research Ethics Committee (HREC). The received approvals are provided in Appendix 1. These documents were also provided to the Western Australian Government Department of Health (DoH) as a requirement to recruit participants into the project. An email confirmation of the DoH’s participation is also included in Appendix 1. Ethics approval was also obtained for the inclusion of the private metropolitan hospital and is included in Appendix 1.

### Phase 1

- Development of the program
- Development of the research tools

#### 3.4.1 Development of the Program

The intent of this research was to design, implement and evaluate the effect of a new education program for nursing staff that would assist them to effectively supervise nursing students on clinical placement. For the purpose of this project, the program was called the ‘Clinical Supervision Program for Registered Nurses’, or CSP.

In developing the CSP, the researcher considered the findings from the national and international literature, as well as HWA’s (2010, 2011, 2012) publications. The aim of the program was to provide an environment conducive to learning for nursing clinical supervisors that would assist them to understand the bigger picture of student placements in Australia, the future directions of HWA and clinical placements, the role of clinical supervisors and the positive and negative influences of clinical supervisors.

The theories of persuasion, as described by O’Keefe (2002) and Katz (1960), which explore the human development of attitude and the process for changing attitude, was used in the development of the program’s teaching plan as a strategy to assist the study day participants to reflect upon their own attitude and determine whether this matched the profession’s expectations.
The research on belongingness led by Levett-Jones (2007, 2008, 2009) was a key topic in the study day to provide participants with an opportunity to develop strategies that could create a positive attitude towards students and student placements, while also highlighting the effect of negative and poor behaviours.

The sessions on communication, feedback, reflection, learning styles, critical thinking and clinical reasoning were included to give participants the knowledge and confidence to provide effective teaching and supervision.

Consumer input into the program was sought (phase two) with the development of an expert group for content validity. This process was augmented by the experience of the author, who has extensive experience in this area, as evidenced by the completion of her Masters in Health Science, Education (including mentorship, principles of adult learning, clinical reasoning, clinical teaching and supervision), Certificate Four in Workplace Training and Assessment, Facilitator of the ‘Teaching on the Run’ program by the University of Western Australia, and previous experience in preceptorship and mentorship education (Coordinator of Preceptorship Program Fremantle Hospital and Health Service (FHHS) 2006–2008; Coordinator of Undergraduate Mentorship Training Program, School of Nursing and Midwifery, the University of Notre Dame Australia, Fremantle 2009–present) and the implementation and research of the Team Leader Model for Clinical Supervision 2006–2009 in conjunction with FHHS and Curtin University of Technology, Perth, Western Australia published in the Australian Journal of Advanced Nursing 2011, and included in the HWA’s ‘Promoting quality in clinical placements: literature review and national stakeholder consultation’ as an example of an alternative model for the management of clinical placements (Siggins Miller Consultants, 2012).

The first stage of developing the CSP was the application of the literature to the study day in order to determine the program’s content and delivery.

3.4.1.1 Program Content and Delivery

The CSP’s content was based on the findings from the literature review, the researcher’s experience as an educator of this topic and the publications of HWA. The program’s delivery methods were based on the theories and principles of adult learning and the
theories of persuasion. Each of these areas and their application to the CSP will now be described.

3.4.2 Application of HWA’s Publications and Literature

As discussed in the first two chapters, HWA has released a number of reports related to clinical supervision education in Australia. HWA’s (2010, p. 15) CSSP Discussion Paper outlined that the clinical supervisor required a number of core skills:

1. clinical skills and knowledge
2. adult teaching and learning skills
3. ability to give and receive feedback
4. communication
5. appraisal and assessment
6. remediation of poorly performing students
7. interpersonal skills.

The development of ‘clinical skills and knowledge’ was not incorporated into the program, as this relates to the clinical speciality knowledge that clinical supervisors require in relation to their employment area. This was outside the scope of this study, as registered nurses are required to up-skill and maintain the essential knowledge, skills and attitudes for their chosen area of nursing and declare this when renewing their professional registration with the NMBA.

The CSP was designed to meet points 2–7 (HWA, 2010), which were consistent with the findings in the literature. To master each of these core skills would require extensive education. Therefore, it was the intent of this program to assist participants to gain an insight into their current clinical supervision knowledge, skills, behaviours and attitudes, and to explore avenues for potential change and growth through the provision of the essential knowledge with the required attitude to provide effective supervision.

The topics included within the study day program are articulated in Appendix 2 and include:

- The Big Picture
- Clinical Supervision
HWA also outlined the use of the relevant theories of learning and principles of adult learning to achieve a program that promoted participants’ learning. Figure 3.5 outlines the application of HWA’s (2010) requirements, which are summarised according to the four key points of CSSP core skills, the principles of learning, national consistency and supervisor competency.

**Figure 3.5: Application of HWA’s four key points to the CSP**
3.4.3 Application of the Theories of Learning and Principles of Adult Learning

To meet industry demands for succinct education in a climate where staff can be released from the workplace for a limited time, the program consisted of an intensive one-day program (Appendix 2) with a comprehensive resource file (supplied on a thumb drive).

The program incorporated a number of teaching strategies based on the theories of learning and the principles of adult learning, as outlined in the teaching plan (Appendix 3) and discussed in Chapter 2. The theories of learning incorporated into the program included Behaviourist, Cognitive and Constructivism.

The behaviourist learning theory incorporates the concept of role modelling (Knowles et al., 2011). For the CSP, the facilitator ensured that positive examples and practices were rewarded with praise, and negative examples were highlighted as detrimental to the profession. The facilitator also provided positive strategies and attitudes towards clinical supervision through storytelling and group discussions.

Cognitivist theory requires that the facilitator determines the current knowledge level and experience of the participant group so that teaching can be pitched at the appropriate level, which facilitates participants to build upon their current knowledge base with new information (Knowles et al., 2011). For the CSP, the facilitator was able to determine each group member’s previous experience and knowledge through the first session of introductions. Participants were asked to introduce themselves, including their current role, involvement with students, previous education and learning goals for the day. By listening to the participants’ statements, the facilitator was able to ensure that the program was pitched according to these comments. Throughout the study day program, participants were encouraged to provide their input and ask questions, which gave the facilitator the opportunity to provide information that was important and relevant to the participants.

Constructivism, which involves learning through a cycle of reflection after a concrete experience (Knowles et al., 2011), was incorporated into the program with the inclusion of a number of learning activities. This involved a combination of PowerPoint slides, case studies, discussions, storytelling and reflection. These learning activities promote experiential learning, which is learning through experience (Kolb, 1984). The experiences
in the CSP were provided in the classroom through the sharing of knowledge, information, ideas, experiences and problems by the facilitator and the participants. This strategy provided a framework and the participants were then able to reflect on this information and plan strategies for application in the clinical setting. To promote this group interaction and discussion, attendance to the program was restricted to 10–25 participants.

Figure 3.6 outlines the relationship of each of these theories of learning with the CSP.

Figure 3.6: Theories of learning applied to the CSP

In addition to these theories of learning, the application of Knowles’ (1978) principles of adult learning to the CSP provided strategies to incorporate different teaching styles to suit the different styles of learning by participants. The use of different teaching styles provided for the different ways that adults may like to learn. This ensured that all learners in the study day program were provided with the opportunity to receive education in an environment that promoted deep learning (Knowles et al., 2011; Warburton, 2003). Deep learning provides participants with the opportunity to understand the meaning of information; it allows learners to think about its application. To achieve deep learning, learners need to feel engaged with the topic and be motivated to understand rather than just
repeat the information. The role of the facilitator is to assist this process by making the learning relevant and teaching styles varied (Warburton, 2003). The application of the principles of adult learning is articulated in Table 3.1, which displays the application of the CSP to the two different learning styles of andragogy and pedagogy according to the core principles of learning (Knowles et al., 1998):

1. learner’s need to know
2. self-concept of the learner
3. prior experience of the learner
4. readiness to learn
5. orientation to learning
6. motivation to learn.

These core principles are then supported by the ‘individual and situational’ differences of the learners and the ‘goals and purposes for learning’ (Knowles et al., 1998).
Table 3.1: Pedagogy and andragogy principles of learning, application to CSP, according to the core principles of learning by Knowles et al. (1998).

<table>
<thead>
<tr>
<th>Core principles of learning</th>
<th>Pedagogy (P)</th>
<th>Andragogy (A)</th>
<th>Application (A or P) to the CSP’s Teaching Style</th>
</tr>
</thead>
<tbody>
<tr>
<td>The need to know</td>
<td>Students do not need to understand why they need to learn the information presented, only that the teacher states that it is necessary.</td>
<td>Adults need to understand why they need to learn new information before it is presented to them. If learners can see a purpose, they invest more energy into the process and gain more.</td>
<td>A: Introduction: Outline national and international trends, HWA publications, relate to workforce, all nursing staff are expected to be clinical supervisors, effect on future workplace management of student placements.</td>
</tr>
<tr>
<td>The learner’s self-concept</td>
<td>The students’ self-concept is when they are dependent on the teacher for the learning experience.</td>
<td>Adults have developed their self-concept and thus a need to feel responsible for their own direction. Adults can often resist change and learning if they feel it is forced upon them. As learners, they need to feel empowered by the facilitator to be active and self-directed in the learning.</td>
<td>P: Teaching incorporates knowledge and skill content according to HWA and literature. A: Empower participants by highlighting the relevance of this information and application to their workplace.</td>
</tr>
<tr>
<td>The role of experience</td>
<td>The learner is not required to utilise past experience as a resource for learning. The teacher’s experience and the learning resources provided are all that is required.</td>
<td>Compared to children, adults have a wealth of life experience. Experiences define adults; they are the accumulation of their lives. Therefore, they bring to the classroom a rich resource of information. Adult education encourages experiential techniques to draw out this information. However, this may also bring with it negative experiences or opinions, and learners are encouraged to reflect and open their minds to new possibilities.</td>
<td>P: Where participants are not able to provide appropriate examples, these are provided by the facilitator. It is essential that the facilitator has his or her own bank of stories to share. A: Throughout the program, group discussion is encouraged and utilised as examples of practice. Note: The facilitator must have the experience to manage poor examples without embarrassing participants and be able to manage negative participants.</td>
</tr>
<tr>
<td>Pedagogy (P)</td>
<td>Andragogy (A)</td>
<td>Application—A or P</td>
<td></td>
</tr>
<tr>
<td>-------------</td>
<td>-------------</td>
<td>------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Readiness to learn</strong></td>
<td>The learner is expected to learn when directed to do so by the teacher.</td>
<td>Adults learn information when it becomes relevant to life. Education must therefore be timed to have immediate application. In some cases, adults may need to be encouraged to reach this level of readiness through feedback, setting goals and simulation activities.</td>
<td><strong>A</strong>: Participants attending the program are currently involved in clinical supervision; this is a criterion for attendance. All nurses in Australia are required to supervise students as part of their role. Therefore, the learning is relevant, but it often competes against clinical and other learning in the workplace. The facilitator needs to highlight the importance of this information in order to improve the future workplace.</td>
</tr>
<tr>
<td><strong>Orientation to learning</strong></td>
<td>Learning is subject-based rather than application-based. Information is categorised according to a logical sequence.</td>
<td>Learning for adults is centred on application rather than the subject. Adults are motivated when application to life can be made, knowing that the knowledge, skills and attitudes gained will result in a positive outcome.</td>
<td><strong>A</strong>: Application of information is then achieved through group discussion, case studies and group activities to give a real-life practical approach to the topic. <strong>P</strong>: PowerPoint to be used to outline theory/content knowledge required, as this may be new information to the participants, or incorrect knowledge may be known.</td>
</tr>
<tr>
<td><strong>Motivation</strong></td>
<td>The learner is motivated by the teacher and other intrinsic factors— for example, grades.</td>
<td>Motivation can take two forms. External motivation relates to such things as job promotions or higher pay, while internal motivation relates to one’s sense of self-satisfaction, which can only be gained when the adult has felt empowered in the learning process. This can be achieved through self-direction, respecting prior knowledge and experiences, and promoting learning opportunities.</td>
<td><strong>A</strong>: External motivation to be provided through a Certificate of Participation, which nurses can use in their professional portfolios, and internal motivation is encouraged through role modelling by the facilitator of the benefits of clinical supervision through group discussions. <strong>P</strong>: The facilitator acts as a role model to the group, rewarding the group through positive feedback.</td>
</tr>
</tbody>
</table>

Source: Knowles et al. (1998)
The goals and purposes of the learning may be the learners identifying the learning as necessary, their employers initiating the learning requirement, or as determined by society. For the CSP, participants’ reasons for attending the program may have been due to a self-awareness to learn about, or refresh their understanding of, the role of clinical supervisors, or as a result of their employers requesting/suggesting that they attend the program. This reason can affect learners’ attitudes towards the learning and the six core principles of learning as described by Knowles et al. (1998) and outlined in Table 3.1. Therefore, the facilitator may need to gain the participants’ desire to be involved in the learning at the start of the day. The program facilitator planned for this in the teaching plan by including background information about the importance of the information and relevance to participants in their workplace using a cognitivist approach, and by including the behaviourist approach of role modelling a positive attitude towards the program and topic.

The ‘individual and situational differences’ also support the core principles of learning (Knowles et al., 1998). The different learning styles of learners requires that the facilitator uses different strategies for teaching and learning. Therefore, a mixture of content delivery is encouraged. This was achieved in the CSP by using PowerPoint to share background information and content, and it was supported with group discussion, group work, case studies and storytelling.

Situational differences also relates to the social and cultural differences among participants (Knowles et al., 1998). These can include the learning site (regional versus metropolitan) and group sizes, as well as the effect of previous learning experiences and the influence of participants’ beliefs. This was managed with the learning being face-to-face at both the metropolitan and regional sites, and the group sizes were restricted to 10–25 participants to facilitate the teaching style. In addition, the principles of attitude and attitude change assisted the facilitator to ensure that participants were guided in the learning journey through role modelling and the persuasion of the benefits of the program.

The use of these theories of learning and the principles of adult learning guided the researcher in developing the CSP’s teaching plans—that is, the delivery method of the content. However, an essential component of the program was to stimulate participants to reflect upon their current attitudes towards students and student supervision. As discussed in Chapter 2, it was envisaged that by increasing the knowledge of nursing staff in relation
to the principles of clinical supervision, and by being a positive role model as the facilitator, this would improve any deficits in attitude towards the supervisor role. However, the researcher believed that it was important to refer to the theories of attitude and attitude change for further strategies for promoting attitude change. Therefore, the findings of the literature review in relation to attitude and attitude change also needed to be considered in the development of the CSP.

### 3.4.4 Application of the Theories of Attitude and Attitude Change

In relation to attendees at the CSP, participants may have had:

- a negative attitude towards clinical supervision
- a positive attitude towards clinical supervision
- an indifferent attitude towards clinical supervision.

One of the aims of the study day was to promote a positive attitude towards clinical supervision. A strategy adopted to achieve this included the implementation of the work of Katz (1960), related to the theories of persuasion, which are outlined in Chapter 2 and Table 3.2. The program facilitator achieved the principles of persuasion by implementing the theories of learning as outlined by the behaviourist theories of learning—that is, by role modelling the behaviour and rewarding and encouraging positive attitudes (Knowles et al., 2011).
Table 3.2: Application of the theories of persuasion to the CSP

<table>
<thead>
<tr>
<th>Attitude Held</th>
<th>Goal</th>
<th>Strategy</th>
<th>Rewards</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Positive</strong></td>
<td>Reinforce positive behaviour; provide further knowledge and strategies to perform in the role.</td>
<td>Encourage participants to share their examples as a positive role model for group discussion.</td>
<td>Positive feedback from facilitator and encourage positive group feedback.</td>
</tr>
<tr>
<td><strong>Indifferent:</strong> May be due to a lack of knowledge, confidence or poor role modelling in the workplace.</td>
<td>Promote strategies for providing effective clinical supervision.</td>
<td>Facilitator to role model positive approach. Use case studies and group discussion to highlight the importance of the topic and implication to their workplaces.</td>
<td></td>
</tr>
<tr>
<td><strong>Negative:</strong> May be due to a lack of knowledge, confidence, previous negative experience or poor role modelling in the workplace.</td>
<td>Highlight negative consequences of poor clinical supervision. Promote strategies for providing effective clinical supervision.</td>
<td>Use case studies and group discussion to highlight the negative consequences of poor supervision. Use group to encourage individuals to analyse/reflect upon their attitudes.</td>
<td></td>
</tr>
</tbody>
</table>

To assist participants to reflect on their current clinical supervision practice the program also incorporated research by Levett-Jones and her research on belongingness (2007, 2008, 2009). The importance of belongingness and its impact on student learning highlighted that the attitude of the clinical supervisor had a significant impact on the ratings of clinical placement satisfaction by students. As a strategy to promote these findings the study day program included a 90-minute session critiquing this research and developing implementation strategies. This was achieved through participants each reviewing one of the four articles on belongingness included in the participants work file and highlighting five significant points of the article, then sharing this with their group. Each group (allocated a different article) then shared their articles significant findings. The whole group then discussed the relevance of this literature and application strategies.

The application of these theories of learning, the principles of adult learning and theories related to attitude to the CSP are outlined in Figure 3.7.
Figure 3.7: Theories and principles of learning and attitude applied to the CSP

- **Theories of Adult Learning:**
  - Behaviourism: Role-modelling the desired behaviour
  - Cognitivism: Learning through experience
  - Constructivism: Facilitating to the participants’ level of knowledge and experience

- **Principles of Adult Learning:**
  - Andragogy: Encouraging self-direction, group discussion through activities, case studies and storytelling
  - Pedagogy: Providing foundations of knowledge related to the principles of clinical supervision

- **Behaviourism:** The facilitator role models the desired behaviour, i.e. positive attitude towards students and student supervision. The facilitator requires the appropriate skills set to achieve this.

- **Andragogy:** The learner needs to feel empowered by the facilitator to achieve self-directed learning.

- **Theory of Persuasion:** The facilitator develops a persuasive message that provokes the individual to analyse and change their attitude. The facilitator discourages poor behaviour and attitude towards students.

- **Literature Review:**
  - HWA core skills of the clinical supervisor and principles of clinical supervision include the principles of adult learning, critical thinking, clinical reasoning, reflection, feedback, competency and assessment
  - Belongingness: Its importance to facilitate student learning

  - **Principles of Adult Learning:** Encourage group discussion, group activities, storytelling and case studies

- **Theory of Persuasion:** Positive message delivery throughout program to encourage self-evaluation of attitudes and their appropriateness

- **Measurement of attitude:** Use of the Stagg Attitude Tool to measure participants’ attitudes before and after program attendance.
3.4.5 Ongoing Learner Support

To support the learner, a resource work file was produced based on the Microsoft PowerPoint slides. Slides were converted into text and further information was added to supplement the main points. The activities included within the study day (e.g. learning-style survey) were also incorporated into the work file so that participants could write down their thoughts and answers to take with them. Further resources of information were also included; these related to the relevant literature, including journal articles, a learning-style survey and the relevant nursing codes and standards.

While developing the CSP, the researcher used this time to develop the research tools for the project. The researcher ensured that these tools sought to answer the research questions by providing enough data to describe the participants’ understanding of, and attitudes towards, clinical supervision.

3.4.6 Development of the Research Tools

The research tools for the project were used to collect the following data:

1. quantitative data to determine the level of understanding/knowledge related to the principles of clinical supervision before and after attending the CSP
2. quantitative data to determine the attitudes of participants towards students before and after attending the CSP
3. written statements and online reflections about the experiences of participants supervising students after attending the CSP; in particular, their application of the principles presented
4. interview data about the CSP and its effect on participants’ clinical supervision experiences.

These tools and their application to the research questions are described in more detail in Table 3.3.
### Table 3.3: Data collection tools

<table>
<thead>
<tr>
<th>Research question</th>
<th>Data required</th>
<th>Data collection method</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the pre-program knowledge of nursing staff in relation to the principles of clinical supervision?</td>
<td>A score to determine the level of knowledge of the participants</td>
<td>• Multi-choice questions&lt;br&gt;• Short-answer questions, score allocated according to marking sheet</td>
<td>Quantitative</td>
</tr>
<tr>
<td>Is there a change in knowledge related to the principles of supervision after attending the program? If so, what is the perceived change of participants’ knowledge?</td>
<td>• A score to determine the level of knowledge of the participants&lt;br&gt;• Participant words, written and spoken, related to their perceptions of change</td>
<td>• Multi-choice questions and short-answer questions, score allocated according to marking sheet&lt;br&gt;• Short-answer questions for participants to articulate their self-perception of learning</td>
<td>Quantitative, Qualitative</td>
</tr>
<tr>
<td>Upon completion of the program, what do nursing staff perceive has changed about their knowledge and attitudes towards providing effective student supervision?</td>
<td>Participant words, written and spoken, related to their perceptions of knowledge and attitude change</td>
<td>• Short-answer questions for participants to articulate their self-perception of learning&lt;br&gt;• Online reflective feedback&lt;br&gt;• Interview</td>
<td>Qualitative</td>
</tr>
<tr>
<td>Do participants perceive a different effect from this program compared to other clinical supervision education? If so, why? If not, why not?</td>
<td>Participant words, written and spoken, related to their perceptions of knowledge and attitude change</td>
<td>• Short-answer questions for participants to articulate their self-perception of learning&lt;br&gt;• Online reflective feedback&lt;br&gt;• Interview</td>
<td>Qualitative</td>
</tr>
<tr>
<td>Do nursing staff believe that the program assisted them to undertake this role more effectively? If so, why? If not, why not?</td>
<td>Participant words, written and spoken, related to their perceptions of knowledge and attitude change</td>
<td>• Short-answer questions for participants to articulate their self-perception of learning&lt;br&gt;• Online reflective feedback&lt;br&gt;• Interview</td>
<td>Qualitative</td>
</tr>
<tr>
<td>Do participants perceive that they have changed their attitudes towards nursing students after attending the program?</td>
<td>Participant words, written and spoken, related to their perceptions of knowledge and attitude change</td>
<td>• Short-answer questions for participants to articulate their self-perception of learning&lt;br&gt;• Online reflective feedback&lt;br&gt;• Interview</td>
<td>Qualitative</td>
</tr>
<tr>
<td>Is there a change in participants’ attitudes towards nursing students after attending the program?</td>
<td>A score to determine the attitude of the participants</td>
<td>• Five-point Likert scale attitude survey by Stagg (1992)</td>
<td>Quantitative</td>
</tr>
</tbody>
</table>

Each of the four areas of tool development will now be described in further detail.

*Quantitative data to determine the level of understanding/knowledge related to the principles of clinical supervision before and after attending the CSP*
As there was no current survey tool that could be utilised for the knowledge component, the tool was developed in phase one and then underwent appropriate validity and reliability testing. The tool was divided into pre- and post-program attendance surveys.

The pre-knowledge survey (Appendix 6) included general demographic data, nursing background, and previous experience and education in supervising students. These data were necessary to determine the groups’ demographics and ascertain whether the participants met the population selection requirements for the data to be included. This information also provided background information that could be used to create subgroups for the descriptive statistics. This included information such as:

1. area of practice: hospital/inpatient, community, mental health, education
2. location of practice: metropolitan or regional
3. frequency and history of supervision of students: level of experience
4. attendance to alternate student supervision education: prior knowledge

Questions to determine the participants’ knowledge and understanding of supervision were also explored. Due to the amount of information presented in the program, key features, or the take-home points of the day, were included to determine the knowledge and understanding of supervision in line with the core skills of HWA (2010). These questions had both an open and closed approach (multiple-choice questions and short answers).

As the pre-survey was administered prior to the session (on the day), this set the base line of knowledge held by the participants—essentially a pre-course knowledge test. The immediate and eight-week surveys (Appendix 7) provided evidence of the knowledge gained and retained. They also provided participants with the opportunity to explain how they intended to (immediately post-program), or had (eight-week post-program), applied the knowledge into their practice. These questions were designed to ensure that they assisted with answering the research questions and the learning outcomes of the program.

Quantitative data to determine the attitude of the participants towards students before and after attending the CSP

The attitude tool constructed by Stagg (1992) and utilised by Aghamohammadi-Kalkhoran et al. (2011) was used to determine the nurses’ attitudes towards students. The attitude survey
Appendix 4) required minor changes due to the differences in terminology between the countries that had used the survey (US and Iran) and Australia. This also involved the removal of two questions that related to the different options of nursing education available to registered nurses, which is not applicable in Australian nursing education. Permission to use the survey was sought and confirmed with Stagg (Appendix 5).

The attitude survey consisted of a five-point Likert scale. Respondents could choose from a range of responses, from ‘strongly agree’ to ‘strongly disagree’, with the midpoint being ‘undecided’. The scale was designed to measure the attitudes of registered nurses towards registered nurse students. The questions were divided into the areas of ‘time, motivation, knowledge, personal issues and professional issues’ (Stagg, 1992, p. 36). Stagg developed the tool from a review of the literature and by surveying nurses and nursing academics. Following this, the tool was validated for content and clarity by four university nursing instructors responsible for clinical supervision, and it was used on a pilot study of 41 participants to determine the reliability of the survey. Feedback from the pilot study resulted in the correction of a number of typing errors by Stagg and the removal of one question that contradicted the legal supervision requirements within the United States. Stagg then presented the tool to two hospitals involved in the research for their feedback; this resulted in the removal of one further question. The Committee on Human Volunteers, Saisby State College then endorsed the tool in 1991 (Stagg, 1992).

Stagg’s (1992) research involved 79 nurses from two acute care hospitals, with 54 completed surveys returned. Analysis of the data mentioned no deficits in the tool design. No changes to the tool were made by Aghamohammadi-Kalkhoran et al. (2011), who used the tool with 82 participants across two wards in an Iranian Hospital in 2011. Again, the data analysis made no mention of deficits with the tool.

After reviewing the tool and the literature, it was determined by the researcher, supervisors and the university research committee that the tool for the study did not require any further validity or reliability testing, as evidence of its validity and reliability was confirmed in the literature. However, questions were removed that were not relevant to the Australian context.

The next stage of tool development required for this research related to the participants’ experiences of clinical supervision after attending the CSP.
3.4.6.1.1 Online Reflections About the Experiences of Participants

The aim of the feedback/reflections was to provide the researcher with the actions and reflections of participants when supervising/interacting with students. From this, the researcher wanted to determine whether participants had applied the principles of the program in their work practices.

This mode of data collection can be referred to as a research diary, log or journal. The purpose of this is to provide participants with an opportunity to document their feelings, reactions to feelings and/or experiences so that the researcher can monitor the progress of participants (Burton & Bartlett, 2005). Burton and Bartlett suggested that headings should be provided to participants and an agreed time interval for entries should be made. This could be daily, weekly or monthly depending on the time allocated for data collection.

To obtain this information, participants were provided with guidelines (Appendix 8) on the day of the program and via email. The guidelines directed participants to write a narrative of their interactions with students. These statements could relate to the summary of a shift or a particular instance of teaching, providing feedback or interacting with students and/or other staff. Participants were asked to explore whether these experiences related to their development as supervisors. Other guidelines related to the confidentiality of staff, students and health care facilities. Participants were asked not to include names or students’ university details.

The final tool for this research project was the development of the research interview questions and guidelines.

3.4.6.1.2 Interview Statements About the Program’s Effect on Participants

The purpose of the interviews was to provide an opportunity to seek further clarification of the phenomena; that is, the effect of the CSP on the participants. With descriptive studies, interview questions should be minimally structured to obtain a broad range of data about the phenomena (Sandelowski, 2000). To obtain these data, the researcher asked the following questions (Appendix 9):
1. What experiences have you had in your career of being a mentor/preceptor/buddy to nursing students?

2. Can you comment on your experiences supervising students since attending the program?

It was anticipated that these questions would provide the descriptive data necessary to allow the researcher to describe the phenomena both before and after attending the program through the participants’ experiences.

Upon the conclusion of phase one of the research project, the researcher had developed the program (PowerPoint, teaching plan and work file), survey tools, online reflection guidelines and interview questions. The researcher then proceeded to phase two of the research process.

**Phase 2**

- Feedback from the expert group regarding the program
- Pilot presentation of the program with participant feedback
- Validity and reliability testing of the survey tools by the expert group

### 3.4.7 Feedback from the Expert Group Regarding the CSP

An expert group consisting of Western Australian nursing educators involved in the education of nursing staff was invited to review the program and validate the survey tools. This consisted of senior registered nurses from health care facilities and education providers. Due to the limited specialist roles within Perth in this field, all were invited in order to gain maximum participation. Five nurses with expertise in this role agreed to participate in the expert group.

Members of the expert group were initially contacted by phone. All five participants that agreed to participate were forwarded the:

1. Letter for request of validation of the program and survey tools (Appendix 10)
2. Program: PowerPoint and teaching plans (Appendix 11)
3. Resource work file (Appendix 12—supplied on thumb drive)
4. pre- (Appendix 6) and post-attendance knowledge survey tool (Appendix 7)
5. expert group feedback form (Appendix 10).

The expert group participants’ details are provided in Appendix 13 and the expert group’s feedback is included in Appendix 10. This feedback related both to the program and the knowledge survey tools. There was consensus among the expert group that the program was of a high quality. This is evidenced by the following:

Participant 1 in expert group 1 stated that:

The program is comprehensive, well written and logically sequenced. There appears to be ample time for lecture content and discussion groups. This allows for the adult learner to acquire new skills according to their needs. The program not only meets but it exceeds the core skills as the program allows group interaction and discussion, which will open interesting discussion topics and perhaps new concepts.

Participant 4 in group 1 stated that:

The program seems extensive and appears to meet core content and skills required. Session length is appropriate and teaching strategies vary to keep participants engaged. Learning objectives for each session are measurable and achievable. The progression of the topics throughout the day seems logical and I like the idea of the final session to bring everything together and summarise. Content and presentation of PowerPoint slides is professional and accurate. Looks good!

No changes to the program content occurred as a result of this feedback. The next stage of the research process was the implementation of the program as a pilot.

3.4.8 Pilot Presentation of Program with Participant Feedback

The aim of the pilot presentation was to provide the researcher with participants’ feedback about the study day program. This would provide direct feedback from those whom the program was developed to assist. It also gave the researcher the opportunity to present the day for the first time and weed out any flaws with the flow of the program, presentation style, PowerPoint slides, timings allocated for each session and scenarios developed.

The pilot presentation of the program was conducted at a regional public hospital in Western Australia; however, participants also included staff from a nearby private hospital and two district nursing posts. The pilot presentation process involved:
1. Site and applications: This site was chosen because it was the first to respond to the request for ‘nomination to participate’ in the program. An email was sent to all health care facility sites in the public health department, with approval from the Director of Workforce Education and Reform, DoH. The researcher liaised with the Staff Development Educator for the site to find an appropriate date and venue. The Staff Development Educator emailed the program flyer and application form to registered nurses within the catchment zone of the health service. Applications were accepted per the health services’ operational processes. A list of 23 attendees’ details was forwarded to the researcher in the week prior to the presentation.

2. Explanation of project and pilot requirements: On the day, the researcher used the first 15 minutes to explain the pilot research process. This involved participants writing comments on the provided feedback forms at the end of the day (Appendix 14). The form was open-ended so as not to limit the feedback provided. All participants provided verbal consent to participate.

3. Presentation: The researcher/educator presented the eight-hour study day using the PowerPoint program and resource work-file.

4. Feedback forms: At the end of the day, participants completed the feedback form, which took approximately 5–10 minutes. Participants were thanked for their time and feedback.

5. The researcher undertook an analysis of the feedback forms. The raw data are included in Appendix 15.

3.4.8.1 Pilot Themes

Themes from the pilot presentation were:

- ability to apply the information, great use of practical information
- enjoyed the use of the varied styles of teaching, very interactive, great discussions, felt relaxed
- information provided was relevant, very comprehensive, realistic solutions
- outlined the role of clinical supervisors
- explained the importance of the clinical reasoning cycle
- can be applied to working with graduates as well
- articles in the workbook were very helpful.
Suggested feedback to improve the day:

- allocation of pre-reading
- difficult to follow the day in the workbook.

As a result of this feedback and the researcher’s own notes about the flow of the session in relation to the teaching plan and PowerPoint slides, the following minor changes were made:

- While the feedback in relation to the contents of the resource manual was positive, the presenter and participants found it difficult to find the sections of the manual during the session. As a result, the manual was converted into a file with file dividers. This also allowed for more content, as the presenter referred to a number of documents related to the nursing profession.
- The PowerPoint presentation underwent minor changes. The amount of text on the slides was reduced, as the presenter was confident in her knowledge regarding the content, so only key points were required to highlight the information being presented.
- The order of some slides was changed to allow for a better flow of content.
- Despite the request for pre-reading from two of the participants, this was not logistically possible because of the size and cost of forwarding the work files.

Upon conclusion of the pilot presentation and the analysis of the findings, the researcher was able to finalise the teaching processes of the CSP. During this period, the researcher was also engaged in the final component of phase two: the completion of the validity and reliability testing of the knowledge survey tool for the research program.

### 3.4.9 Validity and Reliability Testing of the Knowledge Survey Tool by the Expert Group

Two survey tools were used for the research: an attitude survey and a knowledge survey. The participants completed these surveys on three occasions during the data collection phase:
1. pre-program attendance, on the day
2. immediate post-program, on the day
3. eight-week post-program.

As discussed, Stagg’s (1992) attitude survey did not require further validity and reliability testing, as it was accepted by the School of Nursing and Midwifery Research Committee at the University of Notre Dame, Australia. As a new tool designed for this research, the knowledge survey underwent appropriate validity and reliability testing.

3.4.9.1 Knowledge Survey

Upon completion of the development of the knowledge survey tool, it was forwarded to the members of the program’s validity expert group, which comprised five Western Australian nurse educators along with the program. The validity of the knowledge survey’s content was determined through written feedback. The group was asked to provide written feedback regarding both the pre- and post-program knowledge surveys (Appendix 10); in particular, in relation to the ease of clarity, comprehension, ambiguity and ease of response (Punch, 2003). The group was also asked to comment on the relevance of the survey to assist in answering the research questions. This provided face and content validity of the documents; that is, on face value, the questions in the tool seemed appropriate to measure the information required to answer the research questions (Wolfer, 2007).

This feedback was converted into a table, and adjustments to the tool were made as appropriate. Minor changes to the surveys included the correction of spelling errors, more space for writing answers and numbering the questions.

Statements of feedback included:

The feedback tool was very clear in what the participants were asked. There was no underlying ambiguity and the participant can easily follow what is needed (expert group 1, participant 3).

Would recommend numbering questions, more lines needed for positive/negative feedback (expert group 1, participant 1).

The reliability of the tool was tested by a second expert group. Members of this expert group consisted of nine staff from the School of Nursing and Midwifery at the university who
worked clinically with students, and 21 members of the nursing profession who undertook clinical supervision. Participants were approached via email or face-to-face (hospital visits) and given a fact sheet outlining the request (Appendix 16). The pre-knowledge survey and the feedback form were attached to the fact sheet (Appendix 17).

As the expert group members had not attended the program, the participants completed the ‘pre-survey’ only in order to confirm its reliability. These surveys were forwarded to participants two weeks apart via email and site visits (Appendix 18).

Through the written information provided (Appendix 17), participants were asked not to research the content after the initial completion of the survey in order to ensure that the test–retest was accurate in its data retrieval. Test–retest reliability is concerned with the stability of the tool and its ability to provide the same responses across time (Wolfer, 2007). Participants’ scores are provided in Appendix 19.

As shown in Figure 3.8, a Pearson’s correlation coefficient was utilised to confirm the reliability of the tool. This calculation is used to measure predictability (Punch, 2009). Scores were allocated per the marking scale for the survey (Appendix 20) and then compared. The research student met with the university biostatistician, who assisted with the data analysis. While the data were initially saved in a Microsoft Excel spreadsheet, they were then converted and entered into the Statistical Package for Social Sciences (SPSS). The following information was provided via email (Appendix 21) and confirmed the stability of the tool.

<table>
<thead>
<tr>
<th>Reliability Statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cronbach’s Alpha</td>
</tr>
<tr>
<td>0.976</td>
</tr>
</tbody>
</table>
### Intraclass Correlation Coefficient

<table>
<thead>
<tr>
<th></th>
<th>Single Measures</th>
<th></th>
<th>Average Measures</th>
<th></th>
<th>F Test with True Value 0</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Intraclass Correlation</td>
<td>.953</td>
<td>.904</td>
<td>.977</td>
<td>.976</td>
<td>41.482</td>
<td>29</td>
</tr>
<tr>
<td>b</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>df1</td>
<td>df2</td>
</tr>
<tr>
<td></td>
<td>.949</td>
<td>.989</td>
<td></td>
<td></td>
<td>29</td>
<td>.000</td>
</tr>
<tr>
<td>95% Confidence Interval</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower Bound</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upper Bound</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Value</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>df1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>df2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sig</td>
<td>.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Figure 3.8: Pearson’s correlation coefficient results for the pre-knowledge survey reliability test**

As suggested by Punch (2003), participants were asked to confirm the clarity, comprehension, ambiguity, ease of completion and time taken to complete the tool. This ensured that the researcher was able to allocate appropriate time on the study day for the completion of the surveys, and that participants would not be distracted by grammatical errors or a lack of clarity of the tool. Participants’ feedback is provided in Appendix 19.

Positive feedback regarding the tool included:
- easy to understand/unambiguous
- easy to complete
- questions related to topic
- thought-provoking.

Suggestions to improve the tool included:
- more space to write answers
- numbering the questions
- felt uncomfortable completing the form not having attended the study day program.

Concerns by participants mainly related to their sense of discomfort in completing the tool without having attended the study day:

- Did not like completing the form before the training, unsure if answers are right, will be easier to complete after training (expert group 2, participant 4).
- Felt like an exam I hadn’t studied for (expert group 2, participant 28).

To address these concerns, the researcher implemented a number of strategies on the day to reduce this feeling. These strategies are discussed in further detail in phase 4.
Upon completion of phase 2 of the research project, the researcher had obtained the necessary feedback related to the program’s validity and the knowledge survey’s validity and reliability. The researcher then commenced phase 3 of the research process.

**Phase 3**

- Modify the program and/or tools as a result of phase 2

### 3.4.10 Modify the Program and/or Tools as a Result of Phase 2

Feedback from the expert group members who reviewed the tool for validity and reliability resulted in no significant changes to the program. Changes made to the tool were minor and generally related to formatting, as discussed in the previous section. The feedback and actions taken are outlined in Appendix 10.

Feedback by the expert group participants regarding their discomfort in completing the tool prior to the study day resulted in the researcher implementing a strategy to ensure that this was addressed. This is discussed in phase 4 of the research process. It involved creating an atmosphere in the seminar room where participants felt comfortable and relaxed in completing the survey.

Upon completion of this phase, the researcher was able to proceed to the next phase of the program: the implementation and collection of data.
3.4.11 Implementation of the Program

The implementation of the CSP occurred after the validation of the program by the expert group and reliability testing of the data surveys. However, while this validation and reliability testing occurred, the researcher commenced population recruitment.

3.4.11.1 Population Selection

The cohort of registered nurse clinical supervisor participants for this research program was one of a population of convenience (Johnson & Christensen, 2012; Punch, 2009). Populations of convenience are best used when the researcher is seeking to target a select group within a population. This can be based either on the researcher’s ability to easily access the selected group or the participants’ ability to partake and assist in answering the research questions (Johnson & Christensen, 2012; Punch, 2009).

Johnson and Christensen (2012) stated that convenience samples are often used for practical reasons—for example, so the researcher can gain access to individuals who are able to partake in the research process in order to provide the researcher with the information he or she seeks. In these circumstances, the researcher must clearly articulate why he or she is using a sample of convenience, and sufficiently describe the characteristics of those included in the study so that readers can be assured that the population sample is representative of the wider population (Johnson & Christensen, 2012).
For this population of convenience, the group was determined according to the following set criteria, which assisted with answering the research questions. The criteria for acceptance into the research program included:

1. Currently working as a registered nurse: The researcher wished to assess the immediate effect of the program on nurses’ clinical supervision practice.

2. Working within the acute care sector or community (e.g. public and private hospitals, health care clinics): Nurses working within the aged-care sector were not included in this study. Due to the allocation of workloads within this sector, many students are allocated to work with carers or enrolled nurses. Registered nurses provide an overall supervisor role that may involve them being on site but not directly supervising students.

3. More than one year of work experience: First-year nurses were excluded from the study due to their current involvement in a learning program in which they are also mentored/precepted within the organisation.

All participants from the convenience sample were asked to participate in the pre- and post-program survey and online reflective feedback. The demographic details of the group were obtained in the pre-knowledge survey. This enabled the researcher not only to analyse data according to the different group demographics, but also to compare the group to the Western Australian and Australian nursing population, as suggested by Johnson and Christensen (2012). This gives readers confidence that the sample of convenience provides findings that are transferable to the general nursing population. This comparison will be outlined in Chapter 6.

To determine those who were to be included in the face-to-face interviews, the researcher:

- asked for consent to be interviewed in the post-knowledge survey; only participants who consented were included
- identified in the eight-week survey that they had directly supervised students since attending the program.

The sample of participants for the interview group is referred to as a purposive sample. That is, they were intentionally selected due to the determination that they may provide data that are central to the phenomenon being explored (Johnson & Christensen, 2012; Punch, 2009).
This is the impact of the CSP, and are therefore able to assist with answering the research questions.

Purposive samples consist of participants that have been chosen specifically by the researcher because of a set of identified characteristics. This is a non-random method sampling technique (Johnson & Christensen, 2012; Punch, 2009). Once these individuals have been identified, they are asked by the researcher to participate in the research process. When the researcher has obtained the necessary data, he or she does not seek out any further participants (Johnson & Christensen, 2012).

The researcher chose this method of selection for the interviews because of the need to interview participants who had supervised students since attending the CSP. Therefore, only participants who had returned the eight-week survey and identified that they had supervised students since attending the study day, and who had ticked the box to provide consent for an interview, met the criteria for interview.

3.4.11.2 Participant Selection

Within social research, it is difficult to conduct research that will include the entire population of the group. Instead, social science researchers determine a sampling process that will allow them to pick out a group within the population that will facilitate the results to be related to the entire population (Borbasi et al., 2008).

As discussed, a population of convenience was utilised for this study; however, the researcher had to determine the number of participants that would be required to meet the statistical requirements for the qualitative and quantitative data analysis processes (Corbetta, 2003).

Sampling numbers in the quantitative method for the use of statistics is different to the qualitative method due to the use of interviewing and reviewing text. Therefore, different population selections and numbers were utilised for both (Borbasi et al., 2008).

According to O’Leary, the quantitative sample size depends upon the ‘nature of your research and the shape and form of the data you intend to collect’ (2004, p. 104). Consideration must be given to the objectives of the research, the population group, the characteristics of the
population and the type of data to be collected. O’Leary (2004) stated that ‘the basic rule of thumb is to attempt to get as large a sample as possible within time and expense constraints’ (p. 104).

In considering the quantitative component of this study and the time and resources required for each participant, a goal of 200 participants was determined. This study size was agreed upon after the researcher consulted the literature, the researcher’s supervisors and the university biostatistician. Given the nature of the study, commitment of the participants, time and cost of the program (resource manuals, snacks, presenter’s time), it was agreed that this number would provide a sample size that would fit within the parameters of the study.

In determining the number of participants for the interviews, the researcher adopted O’Leary’s argument that interviews should be conducted until a point of credibility is achieved. This occurs when the interview data reaches a state of saturation. O’Leary (2004, p. 115) outlined that saturation is ‘to finish collecting data only when additional data no longer adds richness to understanding or aids in building theories’.

Therefore, no set number of interviews was pre-determined, and it was expected that 10–15 interviews would be required to reach saturation. The researcher commenced analysis of each interview immediately so that a point of saturation could be identified.

To add to the depth of the qualitative data, more than one source of data was included. To achieve this, the qualitative data collection and analysis included the use of short-answer questions in the knowledge survey and the use of online reflective feedback. All participants in the project were invited to complete the short-answer questions in the knowledge survey and the online reflective feedback.

3.4.11.3 Recruitment

The recruitment of participants for the CSP included those employed from all of the health care sectors (public and private) in Western Australia.

The public health sector in Western Australia is called, the Government of Western Australia, the DoH, and is divided into the Metropolitan Health Service and the Western Australian Country Health Service. The Metropolitan Health Service is further divided into the North
Metropolitan Health Service, the South Metropolitan Health Service and the Child and Adolescent Health Service (http://www.health.wa.gov.au/services/).

The private health service in Western Australia is divided between a number of private organisations, including Ramsey, Healthscope, Mercy Care and St John of God Healthcare. All organisations provide inpatient and community services, mainly within the metropolitan area, but also some regional services (http://www.health.wa.gov.au/services/).

Participants in the CSP were identified as employees of either the public or private health care sector. To ensure that all of these health care sector employees were able to gain access to the study day, participants were able to attend the study day program through two different recruitment processes.

3.4.11.3.1 Recruitment Process

Two different processes were used for the recruitment of participants: one for the presentation of the program at the university and one for the DoH sites. The use of the university was not intended to promote the program as a university program for nurses supervising students. Rather, it logistically provided a place for conducting the education program. Utilising a local hospital was considered; however, there is a current shortage of staff development seminar rooms, and outside organisations are often charged and have last-date options provided, of which these may be cancelled due to the needs of the organisation. The university also provided the opportunity for staff to attend from any health care facility rather than only one facility.

3.4.11.3.2 University Recruitment Process

An overview of the process for recruitment for the university presentations is shown in Figure 3.9. The university-based program’s recruitment process involved using flyers to advertise and recruit for the program. Two months prior to the presentation dates, these flyers were forwarded to appropriate health care facilities that regularly place student registered nurses on site. The researcher contacted the staff development departments via email (Appendix 22) and phone to promote the program and organise the distribution of the flyers. Applications to
attend the program were received by the researcher (via email, fax and post), and places were offered according to the date of receipt.

3.4.11.3.3 DoH Recruitment Process

Recruitment of the DoH sites involved liaising with the local staff development departments, as outlined in Figure 3.10. Five sites were utilised, as selected by the DoH, with a total of six presentations. These sites were within the four areas of:

- metropolitan public—one site
- metropolitan private—one site
- regional public—two sites
- regional public/private—one site.

Figure 3.9: Process of participant recruitment for research program—university
Figure 3.10: Process of participant recruitment for research program—DoH

Due to the limited educational opportunities for regional participants from DoH sites, participants who did not meet the criteria were not excluded from the program; however, none of their data were included in the study. The survey questionnaires included questions to ensure that data were captured only from participants who met the study criteria. During the course of the study, the following exclusions occurred:

- two occupational therapists
- five physiotherapists
- two speech therapists
- one dietician.

Hospitals selected by the DoH were responsible for advertising the program through their standard processes of providing staff development and training. A letter outlining the program, research, program requirements and logistics was sent to each hospital’s contact person (Appendix 23). Hospitals were asked when advertising the program to ensure that this included information stating that the program was part of a research project and that participants would be asked to voluntarily participate. Participants applied to attend the program using their hospital staff development processes. This generally consisted of an
application form to their allocated departments. These were logged and applicants were informed of their acceptance into the program. The local staff development services compiled the attendance lists and forwarded these to the researcher.

With the allocation of the sites for the presentation of the program finalised, and the advertising and recruitment of participants completed, the researcher was then able to present the CSP.

3.4.11.4 Program Implementation

The program was presented on 13 occasions from May to December 2012 at multiple sites across the metropolitan and regional areas of Western Australia. Participants attended from both the public and private sectors. A total of 199 participants who met the data inclusion criteria attended the program.

During the program, the researcher collected the participants’ Consent forms to participate in the research project, the completed pre- and post-program knowledge and attitude surveys, and the Consent forms to participate in the online reflections.

3.4.12 Completion of the Pre-survey and Immediate Post-survey

The phases of data collection as outlined in Figure 3.5 were chosen as the most appropriate to provide data to answer the research questions. These methods provided a mixture of quantitative and qualitative data at different stages within the research project. The tools required for this first component of data collection included the pre-program knowledge survey, the attitude survey and, at the end of the day, the post-program knowledge survey and the attitude survey. Participants were also asked to provide consent on the Reflective Feedback Sheet if they wanted to participate.

At the start of each study day, the researcher:

- welcomed participants into the room and used this as an icebreaker opportunity
- utilised the first 5–10 minutes of the session to introduce herself, explain the purpose of the research in greater detail and answer any questions
• collected signed Consent forms from participants; where participants had not brought the Consent forms with them, they were reissued and then collected
• handed out the attendance record for participants to sign
• informed each participant of his or her code for the research, which was saved on the researcher’s attendance list
• distributed the pre-program knowledge survey and attitude survey, provided 20–30 minutes for participants to complete them, and then collected the surveys
• presented the study day program.

At the end of each study day, the researcher:
• reminded the participants of their research codes for the surveys
• distributed the post-program knowledge survey and the attitude survey, provided 20–30 minutes for participants to complete them, and then collected the surveys
• distributed the ‘Online Reflective Feedback’ Consent sheet for participants to add their details if they wanted to participate, as explained to participants in the morning and on the Information Sheet/Consent
• reminded participants that their Certificate of Attendance would be posted with the eight-week surveys
• after all attendees had completed the surveys, each participant’s pre- and post-program surveys were placed into individual plastic sleeves
• the ‘Online Reflection’ Consent form was collected and placed into a plastic sleeve for filing.

3.4.12.1 Maximising Participant Involvement in the Data Collection Phases

To promote maximum participation in the completion of the surveys, the researcher ensured that the tools were easy to read, the questions could be easily answered and it was professionally presented (Punch, 2003). To assist with this, an appropriate amount of time was allocated during the day to allow participants to complete the surveys.

As there were no late participants to the program, all nurses were able to complete the pre-knowledge and attitude surveys. Two participants needed to leave at the conclusion of the teaching and therefore were not able to complete the immediate post-program survey at the
time; however, the researcher encouraged the participants to complete them and return the surveys as soon as possible. As a result, one participant faxed the survey through the following day and the other posted the survey, which was received within one week. Therefore all participants completed the pre-program knowledge and attitude surveys; however one participant did not complete the immediate post-program knowledge and attitude survey (discussed below).

The completion rate of the surveys during the study day was achieved by allocating time during the day to complete the surveys. The facilitator ensured that the study day did not exceed a maximum nursing shift length of eight hours. In addition, during this time, participants were invited to have coffee/tea and snacks.

Another strategy to ensure that participants completed the surveys was that the facilitator took time at the start of the day to meet each person as they arrived and to explain the research process, assist participants to feel welcome and establish a rapport prior to completing the surveys. As participants had received the Information and Consent sheets prior to the start of the day, participants were aware of the research and surveys.

Unfortunately, for the first presentation of the program at the metropolitan public hospital, the Staff Development Department had not ensured that all participants received the Information and Consent sheets. At the start of day two staff members were upset and cross with the health care facility because they had not been informed. The researcher explained the research in further detail. Both staff then agreed to participate; however, at the end of the day, one of these staff members left without completing the surveys. Due to this incident, the researcher met with the Director of Staff Development to confirm the process of information dissemination. After the discussion, the researcher was assured that staff would receive the information prior to the study day. A further two study days were held at the hospital without incident.

At the end of the study day, participants were asked to consent to the next phase of the research project—the online reflections—as discussed in phase 5 of the research.
3.4.13 Online Reflective Feedback

At the end of the program day, participants were asked to confirm their intent to participate in the online reflective feedback. Acceptance to participate was confirmed by participants providing their email details to the researcher on the day by completing the consent form to participate (Appendix 24). Participants were then sent weekly emails by the researcher inviting them to respond with their feedback/reflections (Appendix 25).

Received emails were saved on the researcher’s computer and printed and filed according to the week. The researcher acknowledged the receipt of each email by replying to the email and expressing gratitude for the information.

After eight weeks, participants were thanked for their online reflections. All program participants were then invited to complete the eight-week survey again.

3.4.14 Post-program Survey After Eight Weeks

The eight-week survey was posted to all participants with their Certificate of Attendance. It was hoped that, as the participants were expecting the certificate, including the survey with the certificate would seize their attention and improve the return rate. Further, to maximise the response rate, reply paid envelopes were supplied. The intent of online weekly contact for reflective feedback rather than a written journal was also used as a strategy to remain engaged with the cohort and encourage ongoing participation. Participants were able to contact the researcher via email or phone with any questions or concerns they had while completing the eight-week survey. However, no emails or phone calls were received from participants.
Participants were also forwarded the surveys by email after one week. This served as a reminder to participants to complete the survey either online or on the hard copy they had received. The researcher sent a number of emails over a four-month period to remind participants to complete the surveys. After four months, the researcher ceased this phase so that phase 6 could be started.

3.4.15 Interviews

Participants were asked to comment on the post-program knowledge survey at the end of the study day and on the eight-week knowledge survey if they would like to be interviewed. As outlined in phase 1, the researcher reviewed the surveys of participants who had agreed to be interviewed to determine whether they met the criteria.

This sample of participants is referred to as a purposive sample. They were intentionally selected so they could provide data related to the effect of the CSP (Punch, 2009). This selection criteria included participants agreeing to participate in an interview on the post-program survey, that they had supervised students since attending the study day program, and that they had completed the eight-week survey. Twelve participants were interviewed as a result of this process.

Selected participants were contacted individually by email, and the interviews were conducted at an agreed time and place. Before the interviews began, participants were asked to confirm their consent for the interviews to be recorded; this verbal statement of agreement was recorded at the start of the interviews.

The aim of the interviews was to give the researcher the opportunity to explore participants’ ‘perceptions, meanings, definitions of situations and constructions of reality’ (Punch, 2009, p.
To achieve this depth of information, the interview time allocated for each participant was one hour. The interviews consisted of two semi-structured questions, with additional questions for prompting the interviewee or where questionnaire responses required further clarification.

Punch (2009) suggested that researchers should gain experience in interviewing to ensure the success of the process. The researcher had facilitated focus groups in a previous research project and observed professional focus groups for experience.

Before starting the interviews, the researcher ensured that she developed rapport with the participants to help them feel comfortable and open to discussing their thoughts. To establish rapport, it was essential that the interviewer first gained the trust of the participants by engaging with them at the start of the session. During the interview, the principles of active listening were utilised, allowing participants to discuss their thoughts rather than the researcher’s; therefore, the interviewer was mainly listening rather than talking. While taking notes, it was important to keep them brief so that eye contact was maintained with the participants (Punch 2009).

At the end of each interview, the review process of the interview transcript was confirmed and thanks were extended. All participants were given a letter of appreciation (Appendix 26).

An iPad with audio note-taking capability was utilised to record the interviews. This program allowed the researcher to add notes as the audio was recorded. The application links the notes to the exact time within the audio so that visual cues or points can be directly linked (iTunes 10.0, 2013). The audio was transcribed verbatim by a professional typist. A confidentially signed contract was provided to the researcher. All transcripts were saved onto the researcher’s laptop, which was located either at the university or the researcher’s home.

The researcher interviewed 12 participants and stopped when no new themes or data emerged. This was possible because the researcher commenced reviewing and theming interviews as each interview occurred, as recommended by Braun and Clarke (2006).
3.5 Summary of Research Phases

To ensure the rigour of these data collection methods and phases of the research process, the researcher used a number of different strategies, as suggested by Miles and Huberman (1994) and Punch (2005). These involved:

- the development and use of appropriate tools to capture the data necessary to answer the research questions
- ensuring that the tools measured the level of detail necessary to produce sufficient data for precise analysis
- giving the research process the opportunity to identify all phenomena of interest.

With these stages completed, the researcher then ensured that:

- the analysis process maximised the opportunity to find relationships and themes
- that a documentation trail of the data collection process and analysis was maintained.

In conjunction to meeting these strategies to ensure the rigour of the research project, both before and during the implementation of these phases of the research project, the researcher ensured that they adhered to the ethical considerations for research.

3.6 Ethical Considerations

The purpose of research is to uncover new knowledge. The integrity of this knowledge can only be assured through the practice standards of those undertaking the research. Without truth and honesty, integrity and credibility are lost. Research is reliant on the ethical and professional behaviour of those involved (Denscombe, 2002; O’Leary, 2005).

In Australia, the National Health and Medical Research Council (NHMRC) is responsible for providing leadership and policy in relation to the regulatory requirements of health and human research. The updated National Statement on Ethical Conduct in Human Research (2013) includes a number of guidelines in accordance with the NHMRC Act 1992. For this study, the ethical issues related to risk and benefit, consent, justice and beneficence. Each of these areas will now be outlined according to ethics approval, informed consent, privacy and
confidentiality, conflict of interest and security of data (National Statement on Ethical Conduct in Human Research, 2007).

3.6.1 Ethics Approval

Prior to the implementation of the research phases, the researcher sought ethics approval from the University of Notre Dame HREC. This process involved submitting an ‘Application for Low Risk Review of a Project Involving Human Participants’. The receipt of this approval is included in Appendix 1.

Included in this application was an outline of the project, the survey tools and other methods of data collection. A copy of the Information Sheet (Appendix 27) and Consent (Appendix 28) were also included. These documents were based on the template supplied by the HREC (http://www.nd.edu.au/research/hrec/apply.shtml).

Approval letters were also forwarded to the Western Australian Government, DoH, as a requirement for participation in this research project. The metropolitan private hospital included in the study was also forwarded this documentation with their required application form. Approval of the project is included in Appendix 1.

3.6.2 Informed Consent

Informed consent was obtained by including an Information Sheet (Appendix 27) with the written Consent form (Appendix 28). The Information Sheet used plain language to outline the reasons for introducing the education program, it provided a summary of the program and the research processes that participants might be asked to partake in, and it explained that participation was voluntary and they were free to withdraw from the research at any time. The university policy relating to the protection of research participants’ privacy and confidentiality was described, and the contact details of the university were supplied for any enquiries or complaints. This information ensured that participants were fully informed about the project and what might be asked of them during the research phases.
3.6.3 Benefit and Risk

The National Statement on Ethical Conduct in Human Research (2007) includes beneficence and justice as an ethical standard. This is the right of participants to be free from harm as a result of their inclusion, and their involvement should in some way be of benefit to them or society. People should also be fairly included or excluded from the research and should not be identifiable in any information disseminated unless they have given consent.

The population recruitment processes for this project clearly articulated the reason for inclusion and exclusion to the study day, and while some applications did not meet the criteria, they were not excluded from attending the program. However, their data were not included. This included a number of allied health staff from regional Western Australia.

The Information and Consent sheets outlined the requests of time and data collection methods. At no time were participants offered gifts or incentives for participating in the program. The benefit for participants was the ability to attend a study day program with no cost attached. Study day programs in health can range from no cost to many hundreds of dollars. Participants were given a Certificate of Attendance, which included the allocation of two hours for their research time. Nurses can include this in their professional portfolios for the registration requirements of the NMBA.

Participants’ details were protected throughout the research process with the allocation of codes, and these were not disseminated in any way. There were no other perceived risks of involvement in the research.

3.6.4 Privacy and Confidentiality

Throughout the research process, it was essential to ensure that the privacy and confidentiality of the participants was maintained. Due to the nature of the research involving a study day program, the researcher was not able to provide complete anonymity due to the nature of presenting to a group of participants. Nursing is a small community within Western Australia, and participants often knew each other. This was either due to currently working in the same location or previously working at the same organisation. It was therefore not possible to shield participants’ identities from other participants that attended the same session.
Confidentiality of the research data was maintained in the project by removing any identifying information gained from the research. Names were not used at any time from any of the information that was obtained. All of the survey documentation and interviews were coded to ensure that individuals could not be linked to the data source. Only the researcher had the initial list so that participants could be given their codes. After all of the data collection phases had been completed, the list was deleted from the researcher’s computer.

The researcher was also responsible for ensuring the confidentiality of the organisations involved in the research. This included the DoH sites and the workplaces of those attending the university. Where individuals made comments that might implicate their workplace, or gave any information that could be used to identify them, this was removed from the public documentation. In addition, there was no reference made to individual sites. To achieve this, data were allocated to the categories of public or private and metropolitan or regional.

3.6.5 Conflict of Interest

Conflict of interest relates to power between the researcher and participants. O’Leary (2005) discussed the power of the researcher and how being in a position of authority to undertake research equates to power. When power is not recognised or accounted for, researchers can lead themselves into dangerous territory. As the author, organiser, facilitator and reviewer of the program, it was essential that participants did not feel:

1. that, as the designer/presenter of the program, the researcher only wanted to receive positive feedback
2. uncomfortable providing negative feedback due to the researcher’s connection with the program.

These concerns were addressed in the Information Sheet (Appendix 26). While another person could have been asked to conduct the interviews, as a PhD student, it was preferred that the student participated in the teaching and obtaining of data. This allowed the researcher to become immersed in the topic and gather information that was specific to the research questions. If independent persons had conducted the interviews, their lack of depth of knowledge of the program could have resulted in a lack of relevant information being collected.
3.6.6 Security of Data

File notes, surveys, online reflections and audio transcripts were secured in a security-locked computer, with all printouts kept at the university while the research was conducted. Upon completion of transcribing the interviews, the audio was deleted. All of the online reflection emails were printed and stored with the surveys and deleted from the researcher’s computer and email account.

All of these printed data will be kept at the university in a secure location until five years have elapsed. At this time, the documentation will be destroyed following the university’s process for disposing of sensitive documents.

3.7 Chapter Summary

This chapter outlined the methodology for this research project and the phases of the research process. This included a review of the chosen methods of this research and the justification for the use of a mixed method approach of quantitative and qualitative data and analysis.

The implementation of the research phases was articulated to outline the role of the researcher in this project. All of the researcher’s actions were clearly outlined to demonstrate her understanding of, and adherence to, the principles of research.

Integral to all research was the final clarification of the implications of ethical considerations. The ethical considerations relevant to this research were outlined with an explanation of their incorporation. Further, evidence of their inclusion and intent was discussed.

With the implementation of the program completed, the researcher was able to commence the phase of data analysis. This will now be explored in Chapter 4.

***
The clinical facilitator spoke kindly, clearly cross with what had just occurred. She explained how some nurses felt threatened. We were a new breed; we were university-trained. She encouraged us, gave us strategies and told us to feel proud and that we had a right to be there.
Chapter 4: Quantitative Data Analysis and Findings

Her placement felt like an eternity. Each shift was a lucky dip. Would she be allocated to someone nice or someone who simply disliked students? The nice ones let her practice, guided her and explained to her what she was seeing. She felt relaxed to ask questions and excited by the answers and what she learnt. On other days, she simply followed or was left alone—not allowed to practice, as she was told she could not be trusted: ‘university students had heads full of stuff but didn’t know how to nurse’.

4.1 Introduction

In the previous chapter, the methods and phases of the research project were discussed. This included the development and expert validation of the CSP, and the development and reliability testing of the research surveys and tools. Upon completion of these phases, the study day program was presented and the data collection phases were completed.

This chapter will present the analysis and discuss the findings of this mixed method research study from the quantitative data collection methods. As discussed in Chapter 3, the methodology of this research project involved the collection and analysis of the quantitative and qualitative data separately, with a comparison of the findings presented in Chapter 6.

This chapter will also include a description of the demographic details of the study population, as collected in the pre-program knowledge survey. This will be followed by a description of the pre- and post-program knowledge survey findings and Stagg’s (1992) attitude survey scores and findings. These survey score results will be compared according to the demographic details of the group described within the study population to determine whether there were any influencing factors that may have contributed to the participants’ results. A final analysis of the results of Stagg’s attitude survey will involve a comparison of the data with previous study findings utilising Stagg’s tool.
4.2 Study Population

For this research project, quantitative data were collected from the attendees of the CSP that met the inclusion criteria. Data were collected from two primary sources: the knowledge survey and Stagg’s (1992) attitude survey.

4.2.1 Surveys: Knowledge Survey and Stagg’s Attitude Survey

Participants were allocated 30 minutes at the start of the CSP and at the end of the study day to complete both the knowledge and attitude surveys. The eight-week surveys were both posted and emailed to participants after the completion of the eight-week period of online reflections. These surveys were received from participants up to four months after being forwarded.

A total of 199 participants that attended the clinical supervision study day met the criteria for the research sample group, as described in Chapter 3. Table 4.1 outlines the return rate for these participants.

| Table 4.1: Number of completed knowledge and attitude surveys |
|-----------------|-----------------|-----------------|-----------------|
|                 | Knowledge       | Attitude        | Knowledge       | Attitude        | Knowledge       | Attitude        |
| Pre-survey      | (100%)          | (100%)          | Immediate post-program survey | (99.5%)          | (99.5%)          | Eight-week survey |
| Total           | 199             | 199             | 198             | 198             | 67              | 71              |

As these data sources were collected from the participants and confirmed by the researcher as meeting the criteria for inclusion in the research sample, the researcher commenced the data analysis phase.

4.3 Analysis of Quantitative Data

The quantitative data analysis for this research consisted of two sources of data:

1. Knowledge survey
2. Stagg’s attitude survey
Each of these sources of data collection methods was analysed using descriptive statistics, which summarise the patterns of participants’ responses. They provide a simple format of describing data, often through the use of numerical and graphical diagrams (Fisher & Marshall, 2008).

For the knowledge survey, participants’ pre-program, immediate post-program and eight-week surveys were collated. The researcher used a marking grid (Appendix 20) to allocate a score for each survey question. A total score of 24 was allocated for the tool. The questions consisted of a combination of both multi-choice and open-ended questions. The researcher was the only person responsible for marking the surveys to ensure a consistency of score allocation. The researcher read all of the surveys on at least two occasions to confirm the allocation of marks.

For Stagg’s (1992) attitude survey, participants were asked to complete the survey at the same time as the knowledge survey—that is, before the start of the study day program, at the end of the day and after eight weeks. Unlike the knowledge survey, Stagg’s attitude survey utilised a five-point Likert scale. Likert scales are the most commonly used method of combining participants’ responses to groups of questions that relate to one area or variable (O’Keefe, 2002). The variables included in the survey were the seven themes of time, motivation, knowledge, personal issues, professional issues, instructor–student relationship and background information (Stagg, 1992, p. 36).

The analysis of Stagg’s (1992) attitude survey involved two methods, as per Stagg’s analysis process mentioned above. The first involved analysing the themes of the survey by reviewing individual participants’ responses according to the Likert scale, which included the choices of ‘Strongly Agree’, ‘Agree’, ‘Undecided’, ‘Disagree’ and ‘Strongly Disagree’. Each question had a preferred response as provided by Stagg.

The second process of analysis for the attitude survey involved the allocation of scores. Each question’s responses were allocated a score of 1, 2 or 3. To assist with this process, the scale was collapsed into three areas: ‘Agree’ (combination of ‘Strongly Agree’ and ‘Agree’), ‘Disagree’ (combination of ‘Strongly Disagree’ and ‘Disagree’) and ‘Undecided’. Where a positive attitude response was entered, a score of ‘3’ was allocated, while a negative response was allocated a score of ‘1’ and a score of ‘2’ was allocated for ‘Undecided’. The score range
was 37–117. According to Stagg (1992), the higher the score, the more positive the attitude towards students.

Each participant’s results for the two surveys were entered into an Excel spreadsheet. As Stagg’s (1992) survey was divided into seven themes, the questions were grouped in the spreadsheet according to these themes to assist with the next stage of the analysis. Both spreadsheets also included the participants’ demographic details as collected in the pre-program knowledge survey. This allowed for the creation of subgroups, including age, gender, position level, area of employment, specialty of employment, previous education related to clinical supervision, frequency of clinical supervision and years of nursing experience.

Both the knowledge survey and Stagg’s (1992) attitude survey data were then imported into the SPSS version 20 (IBM, 2013) to assist with data management and statistical analysis. This program is widely used by researchers—particularly within the social sciences—for descriptive statistics (IBM, 2013).

For the knowledge survey and the score allocation for Stagg’s (1992) attitude survey, the mean results of the participants’ surveys were used for comparison between the three survey phases completed—that is, the pre-program, immediate post-program and eight-week surveys. The mean was used as the main measurement for describing the data, as it is the most common form of statistic used for demonstrating the central tendency of data. It provides the average result for the data being explored (Punch, 2009).

According to Punch (2009), the mean is particularly useful when there is little variation in the range of responses. Where the responses to the quantitative data vary considerably, the researcher should refer to the variation of the data, which can be expressed as the standard deviation. The standard deviation is the measurement of each variable from the mean, which is then averaged. This information assists the researcher in determining the spread of the data.

To determine the correct interpretation and depth of enquiry of the data, the university biostatistician was consulted and confirmed that the use of the mean was acceptable to give a true measure of the responses for the knowledge survey and Stagg’s (1992) attitude survey. However, as a measure of good practice, the standard deviation was also included. On the
advice of the university biostatistician, when it was identified that the subgroups became small in number, these were combined, or if no appropriate combination existed, they were not included in the more detailed analysis. When this occurred, the researcher provided written explanation under the relevant heading. An example of this is the combination of the regional/public and regional/private subgroups. This combination was due to the small numbers of participants that were employed in the regional areas of Western Australia in the private health care system.

The survey data for both the knowledge and attitude surveys was reviewed from a number of perspectives. The researcher wanted to determine whether any of the population characteristics affected the level of knowledge or attitudes of the participants before and after attending the program. These possible influences were categorised into the following subgroups:

- age
- area of employment: regional or metropolitan
- previous education in clinical supervision
- frequency of providing clinical supervision
- years of nursing experience.

This level of data analysis is described as ‘descriptive analysis’, as it provides an initial analysis of the data. This process provided an understanding of the data as they related to the possible variables between participants (Punch, 2009).

Where the data indicated trends of interest—that is, differences between the groups were noticed—cross-examinations between the subgroups were also conducted. This is referred to as a ‘two-variable relationship’ (Punch, 2009, p. 277) for example, the relationship of one area of the population to another population characteristic. One cross-tabulation example used in this study was determining the effect of participants’ previous clinical supervision education on their area of employment. These results are articulated in Tables 4.16 and 4.17.

The university biostatistician supervised this process of quantitative data analysis in conjunction with the two university supervisors to ensure that the correct data management
principles were applied. The data were then converted into appropriate diagrams and figures to illustrate the information required to answer the research questions.

The first stage of this data analysis outlined the demographic details of the participant group so that the subgroups could be identified for further analysis. Further, it outlined a summary of the participant group, which will be compared to the Western Australian and Australian nursing demographic details in Chapter 6. The demographic details will now be described, followed by the knowledge survey findings and then Stagg’s (1992) attitude survey findings.

4.3.1 Participant Demographics

On the pre-program knowledge survey, participants were asked to identify a number of demographic details. These data were used to identify the main characteristics of the study group, and for the creation of subgroups for further data analysis. The details describing the participants included participant numbers, workplace characteristics, age and gender, previous education in clinical supervision, reason for attending the program and frequency of clinical supervision.

4.3.1.1 Participant Numbers

A total of 209 participants attended the CSP. Of these, 199 met the criteria for inclusion in the research project. Those excluded from the research included two occupational therapists, five physiotherapists, two speech therapists and one dietician. All of these participants attended the regional presentations; they were not refused attendance to the study day due to the limited educational opportunities for allied health professionals in clinical supervision in these areas.

4.3.1.2 Workplace Characteristics

Participants were invited to attend the program from both the private and public health care sectors in Western Australia. Flyers to attend the program were forwarded to the staff development departments of these health care facilities. The study day presentations were held at the university and five health care facilities (two in the metropolitan area and three in regional Western Australia).
On the pre-program knowledge survey, participants were asked to identify whether they were employed in regional Western Australia and in the public or private health care sector. Table 4.2 outlines the total population of the participants according to the categories of metropolitan or regional and public or private sector.

| Table 4.2: Total number of research participant according to area of employment |
|---------------------------------|-----------------|-----------------|
| **No. of participants**         | **Metro**       | **Regional**    |
| Public                          | 84 (41.7%)      | 47 (23.6%)      |
| Private                         | 65 (32.7%)      | 4 (2%)          |
| Total                           | 149 (74.5%)     | 51 (25.5%)      |

As shown in Table 4.2, there was a slight difference in attendance between the public and private health care sector within the metropolitan area; however, within regional Western Australia, the majority of the participants were from the government sector. Of the three regional areas visited, only one site had a private component to the health care service. This site was managed separately, and the researcher was unable to confirm whether the program was widely advertised at this site.

On the pre-program knowledge survey, participants were also asked to identify the characteristics of their employment sites and work areas. The individual health care facilities/areas of employment were categorised by the facilities/services provided. These category details were based on the definitions provided by the Government of Western Australia, DoH, Consumer Health Directory Services (2013) and are listed in Table 4.3.
Table 4.3: Description of participants’ health care facilities

| Tertiary: | Large teaching hospitals including acute care, mental health, outpatients, rehabilitation, community services and staff development. |
| Secondary: | Smaller-sized health care services including acute care, mental health, outpatients, rehabilitation, community services and staff development. |
| Mental health: | Inpatient and outpatient services within mental health and drug and alcohol services. |
| Community: | Child health, school health and community nursing. |
| Education: | University, hospital staff development, and vocational education and training (VET). |
| Regional: | Smaller-sized health care services including acute care, mental health, outpatients, rehabilitation, community services and staff development. |

Of the 199 participants, 57% attended the program at the university, while the remaining 43% attended presentations held at the five health care facility sites. The university attendees’ summary of areas/sites of employment are described in Table 4.4.

Table 4.4: Characteristics of employment sites and attendance numbers for university attendees

<table>
<thead>
<tr>
<th>Total no. of university participants = 114 (57% of total study group)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Site classifications listed by participants</strong></td>
</tr>
<tr>
<td>No. of participants and % of total group</td>
</tr>
<tr>
<td>Tertiary</td>
</tr>
</tbody>
</table>

Of the 57% of study participants who attended the program at the university, the largest group consisted of the metropolitan groups from the public and private sectors. These participants worked within the tertiary hospital sector, secondary hospital sites, community centres, mental health services and education. Education included the university and vocational education sector. Given the location of the university in the metropolitan area, participants
who attended the university from the regional area consisted of only six from the public sector and three from the private sector.

The remaining 43% of study participants attended the program at the designated health care facility sites of the Western Australian Government, DoH. The two hospitals involved in the metropolitan presentations were both classified as secondary hospitals with similar bed numbers. One was public while the other was private. The three sites outside of the metropolitan area were classified as regional. These descriptions of secondary and regional are defined in Table 4.3. Two of the regional sites had similar bed numbers of 108 and 114, while the final presentation was at a smaller regional hospital of 43 beds.

Similar attendee numbers were achieved between the metropolitan and regional sites at these health care facilities as can be seen in Table 4.5.

<table>
<thead>
<tr>
<th>Area</th>
<th>No. and % of participants</th>
<th>Site characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metro</td>
<td>44 (22%)</td>
<td>No. of sites: 1</td>
</tr>
<tr>
<td>Public</td>
<td>34</td>
<td></td>
</tr>
<tr>
<td>Private</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Regional</td>
<td>41 (21%)</td>
<td>No. of sites: 2</td>
</tr>
<tr>
<td>Public (2 hospitals)</td>
<td>17, 14</td>
<td></td>
</tr>
<tr>
<td>Private/public</td>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

4.3.1.3 Age and Gender

Participants were asked to identify their age and gender on the pre-program knowledge survey. Age was divided into six categories; however, no participants ticked the final category of 71–80. All participants ticked their gender; however, three participants did not reveal their age. As shown in Table 4.6, the majority of the participants were female and only 5% were male. The majority of the participants were in the age categories of 41–50 and 51–60 (30% and 30.5% respectively). The smallest group was the 61+ age category (4.5%). Due to the small numbers within this group, it was combined with the 51–60 age group and called the 51+ age group.
Table 4.6 identifies participants’ area of employment with their age and gender. For each group, the trend of the age of the participants was similar, except for the regional/private group; however, given the small participant numbers, it is difficult to compare this to the rest of the group.

Table 4.6: Age and gender

<table>
<thead>
<tr>
<th>Area</th>
<th>Gender</th>
<th>Age</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>20–30</td>
<td>31–40</td>
<td>41–50</td>
<td>51–60</td>
<td>61+</td>
<td>Not completed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metro/public</td>
<td>3%</td>
<td>39%</td>
<td>6%</td>
<td>10.5%</td>
<td>9.5%</td>
<td>14%</td>
<td>1.5%</td>
<td>0%</td>
</tr>
<tr>
<td>Metro/private</td>
<td>1%</td>
<td>31.5%</td>
<td>4%</td>
<td>7.5%</td>
<td>9%</td>
<td>20%</td>
<td>2%</td>
<td>0%</td>
</tr>
<tr>
<td>Regional/public</td>
<td>1.5%</td>
<td>22%</td>
<td>1.5%</td>
<td>3%</td>
<td>10%</td>
<td>6.5%</td>
<td>1%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Regional/private</td>
<td>0%</td>
<td>2%</td>
<td>0.5%</td>
<td>0.5%</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>5.5%</td>
<td>94.5%</td>
<td>12%</td>
<td>21.5%</td>
<td>30%</td>
<td>30.5%</td>
<td>4.5%</td>
<td>1.5%</td>
</tr>
</tbody>
</table>

4.3.1.4 Speciality of Practice

Participants were asked to identify their current nursing speciality of practice. Where participants were employed in more than one area/speciality, they were asked to identify their role that had the greatest interaction with students. Table 4.7 outlines these areas of speciality of employment for the participants.

The findings in Table 4.7 show that the majority of nurses were employed in the hospital services area, this included all nurses employed within a hospital role, except staff development and mental health. Mental health was allocated its own speciality, as recognised by AHPRA (2013), and staff development was included in the education group. Educational roles included hospital-based staff development educators, staff development ward-based nurses and clinical facilitators from the hospital and university/VET sector. The researcher felt that this grouping of positions across the sectors was appropriate due to its possible influence on participants’ knowledge and attitudes towards students. This education group was the second-largest group of participants. A significant number of community nurses attended, with the smallest group specialising in mental health.
Table 4.7: Area of employment and speciality of practice

<table>
<thead>
<tr>
<th>Speciality of practice</th>
<th>Metro/ public</th>
<th>Metro/ private</th>
<th>Regional/ public</th>
<th>Regional/ private</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital services</td>
<td>20%</td>
<td>17.5%</td>
<td>14%</td>
<td>0%</td>
<td>51.5%</td>
</tr>
<tr>
<td>Community</td>
<td>11%</td>
<td>2.5%</td>
<td>4.5%</td>
<td>0%</td>
<td>18%</td>
</tr>
<tr>
<td>Education</td>
<td>9%</td>
<td>8.5%</td>
<td>3%</td>
<td>1.5%</td>
<td>22%</td>
</tr>
<tr>
<td>Mental health</td>
<td>1.5%</td>
<td>4%</td>
<td>2%</td>
<td>0.5%</td>
<td>8%</td>
</tr>
</tbody>
</table>

4.3.1.5 Years of Nursing Experience

Participants also identified the number of years of experience they had of being registered nurses. To participate in the program, participants must have been working as nurses for more than one year. Table 4.8 highlights the years of experience as registered nurses according to their area of employment. Four participants chose not to answer the question; however confirmation of meeting the criteria was determined by the program attendance list that confirmed position title and length of experience.

The years of nursing experience varied between the areas of employment. The majority of nurses from the metropolitan/public sector had been working for 1–10 years, while the metropolitan/private sector was evenly dispersed across 1–30 years, as was regional/public. Due to the small numbers in the regional/private sector, there were few to nil participants in each category of years of experience.

Table 4.8: Years of nursing experience

<table>
<thead>
<tr>
<th>Area of employment</th>
<th>Years of nursing experience</th>
<th>Not answered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1–10</td>
<td>11–20</td>
</tr>
<tr>
<td>Metro/public</td>
<td>15%</td>
<td>9.5%</td>
</tr>
<tr>
<td>Metro/private</td>
<td>9%</td>
<td>7.5%</td>
</tr>
<tr>
<td>Regional/public</td>
<td>4.5%</td>
<td>5.5%</td>
</tr>
<tr>
<td>Regional/private</td>
<td>0.5%</td>
<td>1%</td>
</tr>
<tr>
<td>Total</td>
<td>29%</td>
<td>23.5%</td>
</tr>
</tbody>
</table>

The study participants’ average length of experience is shown in Table 4.9, including the median and range of numbers of years of experience. There was a significant range of attendees at the program; however, both the mean and median indicate that the majority of participants had experience as registered nurses for 19–20 years. These findings were possible
because participants were asked to state their number of years of nursing experience on the pre-program knowledge survey. The researcher then classified these into categories, as shown in Table 4.8, and used the individual responses to determine the findings shown in Table 4.9.

<table>
<thead>
<tr>
<th>Years of nursing experience</th>
<th>Mean</th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>19</td>
<td>20</td>
<td>2–44</td>
</tr>
</tbody>
</table>

4.3.1.6 Reason for Attending the Clinical Supervision Program

Participants were asked to write their reason for attending the CSP on the pre-program knowledge survey. Many of the responses related to an identified need by the individual to gain further knowledge and understanding of the role of clinical supervisor. Other staff attended due to a request from their manager or to gain an Australian context. The following themes were identified in response to the question:

- improve/refresh knowledge
- better support staff who supervise
- asked to attend by manager/executive
- recommended to attend by colleague
- educator of the topic
- learn current context of Australian nursing education.

4.3.1.7 Previous Clinical Supervision Education

Participants were asked to document any previous education related to clinical supervision. The responses are provided in Table 4.10. Over 50% of participants had not been involved in any type of education in relation to clinical supervision, while 32% had attended an in-service or study day. Only four participants had completed a post-graduate qualification encompassing clinical supervision.
Table 4.10: Previous education related to clinical supervision

<table>
<thead>
<tr>
<th>Education level</th>
<th>No. of participants</th>
<th>% of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>No previous education</td>
<td>102</td>
<td>51%</td>
</tr>
<tr>
<td>In-service/study day</td>
<td>64</td>
<td>32%</td>
</tr>
<tr>
<td>Short course</td>
<td>15</td>
<td>8%</td>
</tr>
<tr>
<td>Post-graduate qualification</td>
<td>4</td>
<td>2%</td>
</tr>
<tr>
<td>Not completed survey question</td>
<td>14</td>
<td>7%</td>
</tr>
</tbody>
</table>

Further analysis of the data highlighted that there was no significant difference in the education undertaken between employment areas, as outlined in Table 4.11.

Table 4.11: Previous education in clinical supervision cross-tabulated with area of employment

<table>
<thead>
<tr>
<th></th>
<th>No answer</th>
<th>No education</th>
<th>In-service/study day</th>
<th>Short course</th>
<th>Post-graduate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metro/public</td>
<td>6%</td>
<td>55%</td>
<td>28%</td>
<td>8.5%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Metro/private</td>
<td>1.5%</td>
<td>49.5%</td>
<td>41.5%</td>
<td>6%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Regional/public</td>
<td>14%</td>
<td>49%</td>
<td>24.5%</td>
<td>8%</td>
<td>2%</td>
</tr>
<tr>
<td>Regional/private</td>
<td>0%</td>
<td>40%</td>
<td>60%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Table 4.11 outlines the percentages in each category that have attended various educational opportunities relating to clinical supervision. Participants employed in the metropolitan public sector had the highest non-attendance rate for clinical supervision education (55%), followed by the metropolitan private sector (49%) and the regional public sector (49%). The regional/private sector had only four participants; therefore, the results comprise a small percentage of the group. The metropolitan private sector had the highest rate of in-service/study day attendance (41%), which was significantly higher than both the metropolitan public sector (28%) and the regional public sector (24.5%). All areas, except regional/private, had similar attendance rates for short course and post-graduate qualifications.
4.3.1.8 Frequency of Providing Clinical Supervision

Participants were asked to identify their level of current involvement in clinical supervision in the workplace. This was a multiple-choice question in which participants were asked to circle the statement that most strongly represented their involvement with students. Table 4.12 presents a summary of these responses cross-tabulated with the participants’ area of employment. One participant did not complete the question.

Table 4.12: Frequency of clinical supervision cross-tabulated with area of employment

<table>
<thead>
<tr>
<th>Frequency of clinical supervision and area of employment</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
</tr>
<tr>
<td>Most days (more than 50% of weekly shifts)</td>
<td>34</td>
</tr>
<tr>
<td>Metro/public</td>
<td>15</td>
</tr>
<tr>
<td>Metro/private</td>
<td>13</td>
</tr>
<tr>
<td>Regional</td>
<td>6</td>
</tr>
<tr>
<td>Some days (less than 50% of weekly shifts)</td>
<td>51</td>
</tr>
<tr>
<td>Metro/public</td>
<td>21</td>
</tr>
<tr>
<td>Metro/private</td>
<td>16</td>
</tr>
<tr>
<td>Regional</td>
<td>14</td>
</tr>
<tr>
<td>Infrequently (on occasions each month)</td>
<td>66</td>
</tr>
<tr>
<td>Metro/public</td>
<td>23</td>
</tr>
<tr>
<td>Metro/private</td>
<td>23</td>
</tr>
<tr>
<td>Regional</td>
<td>20</td>
</tr>
<tr>
<td>Rarely (once or twice in the past six months)</td>
<td>39</td>
</tr>
<tr>
<td>Metro/public</td>
<td>20</td>
</tr>
<tr>
<td>Metro/private</td>
<td>10</td>
</tr>
<tr>
<td>Regional</td>
<td>9</td>
</tr>
<tr>
<td>Not at all</td>
<td>8</td>
</tr>
<tr>
<td>Not completed the survey question</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>198</td>
</tr>
</tbody>
</table>

The first two categories of ‘most days’ and ‘some days’ include participants who supervised students each week; however, to provide further detail, this group was divided into ‘most days of the week’ and ‘some days of the week’. These findings highlight that 42.5% of participants supervised students each week, while 33% supervised students each month. Only 19.5% had rarely supervised students within the previous six months. This number reflected the large
percentage of community nurses (18%), of which 86% identified that they supervised students infrequently, rarely or not at all.

Of the eight participants who had no involvement with clinical supervision, four held senior registered nurse roles involved in staff development or management; therefore, they were responsible for the process and management of students, but not direct clinical supervision. The remaining four staff consisted of two metropolitan medical/surgical nurses, one community nurse and one regional critical care nurse. No reason for their involvement level was identified in the participants’ survey entries.

For participants employed in the metro/public area, the majority supervised students each week (43%), while 27% supervised each month and 23% had supervised on occasions in the previous six months. The ‘rarely’ group (20%) was further analysed to show that the majority of these participants were employed in the community sector of nursing. Sixty-one per cent of community nurses who attended the program were employed in the metro/public area.

The metro/private participants showed similar findings, with 44% supervising each week; however, the ‘infrequently’ group was increased to 35%, with fewer participants in the ‘rarely’ group (15%), which consisted of all areas of nursing with no one particular area of speciality.

The regional group comprised 39% of participants in both the ‘each week’ and ‘infrequently’ groups, with 17% in the ‘rarely’ group. There was no pattern in the areas of speciality shown within these groups.

The analysis of the frequency of clinical supervision was cross-tabulated with participants’ area of employment and is displayed in Graph 4.1. Due to the small numbers in the regional/private group, the two regional areas were combined for this cross-tabulation. This graph highlights that for participants in the metropolitan area, a similar spread across the frequency of clinical supervision options for the question was chosen for both the public and private sectors, with the largest group being participants who supervised every week. The majority of participants from regional Western Australia supervised less frequently. Given the small number of education providers in regional Western Australia and the logistics of
placing students in these areas (including distance/travel and accommodation costs), these results were not unexpected.

Graph 4.1: Frequency of clinical supervision cross-tabulated with area of employment

With the demographics of the study group described, the researcher was able to directly examine the research findings. As discussed in the introduction of this chapter, the researcher referred separately to the quantitative and qualitative data at this stage of the project.

4.3.2 Quantitative Data Analysis—Knowledge Survey

To determine the knowledge of the nursing staff in relation to the principles of clinical supervision, participants were asked to complete the pre-program knowledge survey at the start of the day of the program; 199 surveys were completed that met the program inclusion criteria.

The scores of the pre-program knowledge survey across the study participants were articulated by using the statistical measurements of the mean, mode, median and standard
deviation in Table 4.13. The total score for the pre-program knowledge survey was 24. The mean result for the group was 10.2 (42.5%).

Punch (2009, p. 261) stated that using the mean as a statistical measure is ‘a very effective statistic where scores within a distribution do not vary too much’. Therefore, it is also important to display the standard deviation as a measure of the variance of the data in order to confirm the findings of the mean. Therefore, the researcher has displayed both the mean and standard deviation for each area in all future tables.

**Table 4.13: Pre-program knowledge survey mean score with mode, median and standard deviation**

<table>
<thead>
<tr>
<th>Mean</th>
<th>Mode</th>
<th>Median</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.2 (42.5%)</td>
<td>10.5</td>
<td>10.5</td>
<td>3.2</td>
</tr>
</tbody>
</table>

These data were further explored and described according to the subgroups that were established from the demographic questions in the pre-program knowledge survey. The first area to be analysed was the age of the participants. This will be followed by area of employment, previous education in clinical supervision, frequency of providing clinical supervision and years of nursing experience.

**4.3.2.1 Age of Participants**

The mean scores and standard deviations for the age of participants are presented in Table 4.14. The mean results for the group are almost identical, with the standard deviation showing a difference of 0.6 between the highest and lowest mean scores. These data indicate that age was not an influencing factor on the mean scores for the knowledge surveys for the participant group.
### Table 4.14: Pre-program knowledge survey mean scores and standard deviations for age of participants

<table>
<thead>
<tr>
<th>Age</th>
<th>No. of participants</th>
<th>% of participants</th>
<th>Mean</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>20–30</td>
<td>24</td>
<td>12%</td>
<td>10.2</td>
<td>2.9</td>
</tr>
<tr>
<td>31–40</td>
<td>43</td>
<td>21.5%</td>
<td>10.3</td>
<td>3.5</td>
</tr>
<tr>
<td>41–50</td>
<td>57</td>
<td>30%</td>
<td>10.2</td>
<td>3.0</td>
</tr>
<tr>
<td>51+</td>
<td>72</td>
<td>30.5%</td>
<td>10.2</td>
<td>3.3</td>
</tr>
</tbody>
</table>

#### 4.3.2.2 Area of Employment

Participants were asked to identify their main area of employment in relation to the clinical supervision of student nurses. Table 4.15 outlines the number of participants from each area of employment and the mean results for each group in the pre-program knowledge survey. This is further represented in Graph 4.2, which outlines the mean result for each group. These tables and graphs also compare the results to the overall study group result.

As shown in Table 4.15 and Graph 4.2, there is no apparent difference in the pre-program knowledge survey scores across areas of employment. While the regional/private mean was slightly higher, this is difficult to relate to the population due to the small number of participants. Further analysis of this group also highlighted that three of the four staff listed their area of speciality as education.

Due to the small numbers of participants in the regional/private group (2%), the researcher and the university biostatistician decided that the following categories would be used when analysing data according to area of employment:

- metropolitan/public
- metropolitan/private
- regional.

This change involved combining the two subgroups of ‘regional/public’ and ‘regional/private’.
Table 4.15: Pre-program knowledge survey mean scores for area of employment

<table>
<thead>
<tr>
<th>Area</th>
<th>No. of participants</th>
<th>% of participants</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metro/public</td>
<td>83</td>
<td>41%</td>
<td>9.4</td>
</tr>
<tr>
<td>Metro/private</td>
<td>65</td>
<td>32.5%</td>
<td>10.2</td>
</tr>
<tr>
<td>Regional/public</td>
<td>47</td>
<td>23.5%</td>
<td>9.2</td>
</tr>
<tr>
<td>Regional/private</td>
<td>4</td>
<td>2%</td>
<td>13.75</td>
</tr>
<tr>
<td>Total group</td>
<td>199</td>
<td>100%</td>
<td>9.7</td>
</tr>
</tbody>
</table>

4.3.2.3 Previous Education in Clinical Supervision

In the category of ‘previous education in clinical supervision’, the findings were viewed from a number of perspectives. As outlined in Table 4.16, the first area explored was in relation to the level of previous education of all participants who attended the CSP. Just over 50% of participants had not attended any previous education in relation to the clinical supervision of students, with another 32% attending an in-service or study day.

Participants who had attended a short course had the highest pre-program survey mean score of 12.4, followed by those who had attended an in-service or study day (9.9). This was
followed by the ‘no previous education’ group (9.6). It was surprising to note that the group with the lowest mean comprised attendees who had completed a post-graduate qualification, including clinical supervision. It is difficult to determine the effect of this finding given that the group consisted of four participants.

Table 4.16: Pre-program knowledge survey mean scores and standard deviations for previous education in clinical supervision

<table>
<thead>
<tr>
<th>Previous education</th>
<th>No answer</th>
<th>No previous education</th>
<th>In-service/study day</th>
<th>Short course</th>
<th>Post-graduate</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of participants</td>
<td>13</td>
<td>102</td>
<td>65</td>
<td>15</td>
<td>4</td>
</tr>
<tr>
<td>% of participants</td>
<td>6.5%</td>
<td>51.3%</td>
<td>32.7%</td>
<td>7.5%</td>
<td>2%</td>
</tr>
<tr>
<td>Mean</td>
<td>7.3</td>
<td>9.9</td>
<td>10.6</td>
<td>12.4</td>
<td>9.6</td>
</tr>
<tr>
<td>Standard deviation</td>
<td>2.2</td>
<td>3.2</td>
<td>3.3</td>
<td>1.9</td>
<td>3</td>
</tr>
</tbody>
</table>

The standard deviation in each group was between 1.9 and 3.3, which indicated that participants’ responses were closely grouped. This provided confirmation of the mean as a true indicator of each group’s responses.

A more detailed analysis explored participants’ attendance to previous education, with the mean results in the pre-program survey cross-tabulated with the area of employment. The researcher wanted to determine whether previous education and participants’ area of employment was significant. Table 4.17 outlines participants’ mean scores according to their previous education in clinical supervision in addition to their area of employment. As 84% of the total group were in the ‘no previous education’ or ‘in-service/study day’ categories, this left the remaining categories with small participant numbers of less than 5%; therefore, they were not included on the advice of the university biostatistician.

Table 4.17: Pre-program knowledge survey mean scores for area of employment cross-tabulated with previous education in clinical supervision

<table>
<thead>
<tr>
<th>Previous education</th>
<th>Metro/public</th>
<th>Metro/private</th>
<th>Regional</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>Score</td>
<td>%</td>
</tr>
<tr>
<td>No previous education</td>
<td>23%</td>
<td>10</td>
<td>16%</td>
</tr>
<tr>
<td>In-service/study day</td>
<td>11.5%</td>
<td>10.9</td>
<td>13.5%</td>
</tr>
</tbody>
</table>

Table 4.17 highlights that there was no significant difference between participants’ mean scores according to their area of employment with further reference to their previous
education in clinical supervision. Those who had attended an in-service/study day continued to have a slightly higher mean regardless of their area of employment. Therefore, the effect of participants’ area of employment appeared to be insignificant. This was not a surprise to the researcher given that the area of employment did not have a significant effect on the mean scores of the participants, as outlined in Table 4.15.

4.3.2.4 Frequency of Providing Clinical Supervision

Table 4.18 displays the frequency of clinical supervision for participants and their mean pre-program knowledge survey scores and standard deviations.

Participants with the highest mean scores were from the ‘most days’ group and also had the largest standard deviation of four, indicating a greater variability in the results within this group compared to the other groups. As shown in Table 4.18, the mean scores across the different clinical supervision frequency groups were very similar and seemed to have little effect on the results.

Table 4.18: Pre-program knowledge survey mean scores and standard deviations for frequency of clinical supervision

<table>
<thead>
<tr>
<th>Frequency of clinical supervision</th>
<th>No. of participants</th>
<th>% of participants</th>
<th>Mean score</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most days (more than 50% of weekly shifts)</td>
<td>34</td>
<td>17%</td>
<td>11.3</td>
<td>4</td>
</tr>
<tr>
<td>Some days (less than 50% of weekly shifts)</td>
<td>51</td>
<td>25.5%</td>
<td>10</td>
<td>2.5</td>
</tr>
<tr>
<td>Infrequently (on occasions each month)</td>
<td>66</td>
<td>33%</td>
<td>10.2</td>
<td>3.1</td>
</tr>
<tr>
<td>Rarely (once or twice in the past six months)</td>
<td>39</td>
<td>20%</td>
<td>9.9</td>
<td>3.2</td>
</tr>
</tbody>
</table>

4.3.2.5 Years of Nursing Experience

Table 4.19 outlines the mean scores and standard deviations of the pre-program knowledge survey according to the number of years of experience as a registered nurse. As with the other groups, the mean between the groups was very similar. The highest mean result was for the ‘21–30’ group (10.9), closely followed by the ‘11–20’ (10.8) and ‘31–40’ (10.1) groups. The ‘40+’ group had a mean of 8; however, only five participants out of 199 fitted into this
category. While the ‘40+’ group has been included in the table, with less than 2.5% of the population, this group was too small to offer statistical significance. For future analysis involving the years of nursing experience, the researcher and the university biostatistician decided to merge the ‘31–40’ and ‘40+’ groups.

Table 4.19: Pre-program knowledge survey mean scores and standard deviations for years of nursing experience

<table>
<thead>
<tr>
<th>Years of nursing experience</th>
<th>No. of participants</th>
<th>% of participants</th>
<th>Mean score</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1–10</td>
<td>58</td>
<td>29%</td>
<td>9.6</td>
<td>2.9</td>
</tr>
<tr>
<td>11–20</td>
<td>47</td>
<td>24%</td>
<td>10.8</td>
<td>3.2</td>
</tr>
<tr>
<td>21–30</td>
<td>54</td>
<td>27%</td>
<td>10.9</td>
<td>3.2</td>
</tr>
<tr>
<td>31–40</td>
<td>30</td>
<td>15%</td>
<td>10.1</td>
<td>3.3</td>
</tr>
<tr>
<td>40+</td>
<td>5</td>
<td>2.5%</td>
<td>8</td>
<td>3.5</td>
</tr>
</tbody>
</table>

This completes the analysis of participants’ pre-program knowledge survey results. The next section will review the post-program’s mean attendance results.

4.3.3 Comparison of Results—Knowledge Survey

Participants were asked to complete the knowledge survey again at the completion of the CSP day and after eight weeks, when the surveys were emailed and posted. A total of 198 (99.5%) knowledge surveys were completed on the day of the program and 67 (33.5%) were returned after eight weeks. Participants were forwarded the survey by post and email, and they were contacted again by email after four weeks and then again at the conclusion of all of the data collection phases. Surveys were received up to four months after being initially forwarded to participants.

In reviewing the scores in the post-program surveys in greater detail, the same demographic groups were explored as the pre-program survey to show a comparison between the mean results. To assist with relating the post-program attendance results to the pre-program knowledge survey scores, the pre-program survey mean score has been included in this section for comparison.
4.3.3.1 Participants

The overall mean results for the study participants for the pre-program, immediate post-program and eight-week surveys are articulated in Table 4.20. The mean scores for the group increased with each phase of the data collection, indicating an increase in participants’ understanding of the CSP’s contents. The standard deviation for these results have also been included; the results are similar across each of the phases, showing a similar level of spread of the scores across the group.

As previously stated, the return rates for each phase of the research project were 199 for the pre-program survey, 198 for the immediate post-program survey and 67 for the eight-week survey. The number of eight-week surveys received compared to the pre-program and immediate post-program surveys were of concern to the researcher. As a result, a further analysis of the group was undertaken to determine whether the eight-week survey results could be used as a comparison. Table 4.20 presents the results of all participants in the pre-program and immediate post-program surveys compared with the results of participants who completed the eight-week survey across the three phases of survey completion.

As shown below, the mean results across the total ‘participant group’ and only those who completed the eight-week survey are similar in their mean and standard deviation for the pre-program and immediate post-program surveys.

| Table 4.20: Knowledge survey mean scores with standard deviations across the phases of data collection |
|---------------------------------|------------------------------|-------------------------------|---------------------------------|
|                                | Participants | Mean                         | Standard deviation          |
|                                |              | Participant group | 8-week group | Participant group | 8-week group |
| Pre-program                    | 199          | 10.2 (42.5%)       | 10.6 (44.1%) | 3.2 | 3.1 |
| Immediate post-program         | 198          | 14.1 (58.7%)       | 14.8 (61.6%) | 3.8 | 3.7 |
| Eight-week post-program        | 67           | -                | 16.4 (68.3%) | -  | 3.5 |

As outlined in Table 4.20, the results for the knowledge survey showed that participants had improved the pre-program mean from 10.2 (42.5%) to 14.1 (58.7%) in the immediate post-program survey and 16.4 (68.3%) in the eight-week survey. The paired scores of the 67
participants who completed all three data sources were then analysed using a Paired Sample T Test to determine whether there was a statistically significant difference between these scores. The pairs consisted of:

1. pre-program survey (M = 10.6, SD = 3.1) and immediate post-program survey (M = 14.8, SD 3.7)
2. pre-program survey (M = 10.6, SD = 3.1) and eight-week survey (M = 16.4, SD =3.5)
3. immediate post-program survey (M = 14.8, SD = 3.7) and eight-week survey (M = 16.4, SD = 3.5).

The comparison between each of these survey mean scores for the group determined a P value of <0.001 for each pairing. This finding indicated that there was a statistically significant difference between the survey responses, which supported the finding that the CSP positively affected participants’ results. Therefore, with each phase of the research data collection, a statistically improved mean score was achieved. This improved mean score for the knowledge survey in the eight-week survey may have been a result of participants having the opportunity to apply their learning from the CSP into practice.

To provide further demonstration and clarification that the eight-week completion group could be relied upon as a sample of the total group, the participant group and eight-week group were also compared in the area of employment.

4.3.3.2 Area of Employment

Table 4.21 outlines the return rates for each area of employment, with the mean for all participants. In addition, only the participants who returned all three surveys, called the ‘eight-week’ group, have been included to show a comparison between the whole participant group and the eight-week group.

The researcher explored the mean for the eight-week group for each phase to determine whether the group was representative of the larger study day participant group. In all categories, the study day participants and the eight-week group showed no significant differences between their mean results.
To further confirm that the eight-week group was appropriate to represent all CSP participants in the eight-week results, the standard deviations were compared. As shown in Table 4.21, the standard deviations are closely aligned, with the greatest deviation being 0.6 in the metro/private pre-program and immediate post-program surveys.

This provided further confirmation of a positive outcome for the researcher to deduce that the eight-week results were appropriate for comparison to the whole group across the data collection phases.

Table 4.21: Return rates with mean scores for the knowledge survey at the pre-program and immediate post-program phases for all participants, and eight-week group only (across pre-program, immediate post-program and eight-week surveys), according to area of employment

<table>
<thead>
<tr>
<th>Area of employment</th>
<th>Groups</th>
<th>No. and % of participants</th>
<th>Mean (standard deviation)</th>
<th>Pre-program survey</th>
<th>Immediate post-program survey</th>
<th>8-week survey</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Metro/public</td>
<td>Participant group</td>
<td>83 (41.5%)</td>
<td>10.4 (3.2)</td>
<td>14.7 (3.9)</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8-week group</td>
<td>32 (38%)</td>
<td>10.3 (3.2)</td>
<td>15.6 (4.1)</td>
<td>17.1 (3.4)</td>
</tr>
<tr>
<td></td>
<td>Metro/private</td>
<td>Participant group</td>
<td>65 (32.5%)</td>
<td>10.3 (3.5)</td>
<td>13.8 (3.7)</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8-week group</td>
<td>25 (38%)</td>
<td>11.4 (2.9)</td>
<td>14.2 (3.1)</td>
<td>15.7 (3.6)</td>
</tr>
<tr>
<td></td>
<td>Regional</td>
<td>Participant group</td>
<td>51 (26)</td>
<td>9.6 (2.8)</td>
<td>13.5 (3.6)</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8-week group</td>
<td>10 (24%)</td>
<td>9.3 (2.9)</td>
<td>14.2 (3.4)</td>
<td>16.2 (4)</td>
</tr>
<tr>
<td></td>
<td>All areas</td>
<td>All completed surveys</td>
<td>100%</td>
<td>10.2 (3.2)</td>
<td>14.1 (3.8)</td>
<td>16.7 (3.5)</td>
</tr>
</tbody>
</table>

In reviewing the results of the effect of the area of employment on participants’ mean results across the research phases, Graph 4.3 outlines the mean knowledge survey scores for the pre-program, immediate post-program and eight-week surveys. As shown, all of the area of employment groups had an increase in their mean score for each of the survey completion phases. The metro/public sector maintained the highest mean in each survey. The regional sector also continued to increase; in the third survey, it went from the lowest mean result across the groups to second behind metro/public. The metro/private sector experienced a slight drop in the eight-week survey results compared to the increases experienced by the
other two groups; however, despite this, the group continued to increase its overall mean result. The researcher was unable to determine the reason for this change in the results between the groups.

**Graph 4.3: Knowledge survey mean scores for area of employment across the phases of survey completion**

4.3.3.3 Age of Participants

The mean scores for age of participants are represented in Table 4.22. Each group experienced an increase in the mean score between the pre-program and eight-week surveys. Due to the small participant numbers within the eight-week survey that were in the ‘20–30’ age category, these were not included.

The group with the highest mean score after eight weeks was the 51+ age category, which also had the largest change (6) between the mean scores of the pre-program and eight-week surveys, as did the ‘41–50’ age category. These findings have also been articulated in Graph 4.4.
Table 4.22: Knowledge survey mean scores for age of participants across the phases of survey completion

<table>
<thead>
<tr>
<th>Age</th>
<th>% of participants</th>
<th>Mean (standard deviation)</th>
<th>Pre-program</th>
<th>Immediate post-program</th>
<th>8-week</th>
</tr>
</thead>
<tbody>
<tr>
<td>20–30</td>
<td>12%</td>
<td></td>
<td>10.2</td>
<td>13.8 (3.2)</td>
<td>-</td>
</tr>
<tr>
<td>31–40</td>
<td>21.5%</td>
<td></td>
<td>10.3</td>
<td>14.1 (3.9)</td>
<td>15.5 (3.1)</td>
</tr>
<tr>
<td>41–50</td>
<td>30%</td>
<td></td>
<td>10.2</td>
<td>14.4 (3.5)</td>
<td>16.5 (3.5)</td>
</tr>
<tr>
<td>51+</td>
<td>30.5%</td>
<td></td>
<td>10.2</td>
<td>13.9 (4.2)</td>
<td>16.9 (4)</td>
</tr>
</tbody>
</table>

Graph 4.4: Knowledge survey mean scores for age of participants across the phases of survey completion

4.3.3.4 Previous Education in Clinical Supervision

The knowledge survey mean scores were also compared according to the previous education that participants had received in relation to clinical supervision. Table 4.23 outlines the mean results across participants’ previous clinical supervision education categories. As outlined in the table, each group experienced an increase in the mean score of the survey across the phases of the data collection. As the majority of participants were allocated to the ‘no previous education’ or ‘in-service/study day’ groups, this left small participant numbers in the last three groups. As a result, the eight-week survey responses were not included in Table 4.23 and Graph 4.5. The percentage of the total CSP participants’ return rates for each group is indicated in Table 4.23.
Table 4.23: Knowledge survey mean scores for previous education in clinical supervision across the phases of survey completion

<table>
<thead>
<tr>
<th>Previous education/training</th>
<th>% of participants</th>
<th>Mean (standard deviation)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-program and immediate post-program</td>
<td>8-week</td>
</tr>
<tr>
<td>No previous education</td>
<td>52%</td>
<td>17.5%</td>
</tr>
<tr>
<td>In-service/study day</td>
<td>33%</td>
<td>12%</td>
</tr>
<tr>
<td>Short course</td>
<td>7.5%</td>
<td>2%</td>
</tr>
<tr>
<td>Post-graduate qualification</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Not completed</td>
<td>6.5%</td>
<td>1%</td>
</tr>
</tbody>
</table>

The mean scores across the groups showed that the ‘short course’ group started with the highest mean; however, the group with the lowest mean—the ‘post-graduate’ group—experienced the highest increase to the immediate post-program survey. This may have been a result of these staff refreshing lost knowledge and building upon the knowledge in the day more effectively as a result, as per the adult theory of constructivism discussed in Chapter 2.

The two largest groups—‘no previous education’ and ‘in-service/study day’—showed an increase in the mean across the phases of the surveys, with both groups starting within one point of each other and finishing on similar results of 16.

Graph 4.5 highlights these changes in the knowledge survey mean score for the ‘previous education in clinical supervision’ group, as per Table 4.23.
Graph 4.5: Knowledge survey mean scores for previous education in clinical supervision across the phases of survey completion

Further analysis of the eight-week survey findings was undertaken in relation to a cross-tabulation with area of employment to determine whether the area of employment combined with previous clinical supervision education affected participants’ scores. However, due to the small group sizes in the educational groups involved in short courses and post-graduate studies, these were not included. Further, the numbers of regional participants in these categories were less than 5% and therefore not included on the advice of the university biostatistician.

The majority of the program participants (84%) had either not attended any previous education or had attended an in-service/study day. The findings within these two groups showed a similar response in participants’ mean knowledge scores—both pre- and post-program—despite the area of employment. These results are displayed in Table 4.24.
Table 4.24: Knowledge survey mean scores according to previous education in clinical supervision cross-tabulated with area of employment, both pre- and post-program attendance

<table>
<thead>
<tr>
<th>Previous education/training</th>
<th>Metro/public</th>
<th>Metro/private</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-program</td>
<td>Immediate post-program</td>
</tr>
<tr>
<td>No previous education</td>
<td>10</td>
<td>14.1</td>
</tr>
<tr>
<td>In-service/study day</td>
<td>10.9</td>
<td>14</td>
</tr>
</tbody>
</table>

4.3.3.5 Frequency of Providing Clinical Supervision

Table 4.25 reviews participants’ frequency of providing clinical supervision and the mean scores of these groups. The group with the highest pre-program score maintained this status in the post-program scores; this was the group that supervised most days.

The frequency with which participants were involved in clinical supervision positively influenced all three phases of the survey data collected. The group that supervised on most days had the highest pre-program, immediate post-program and eight-week results. In contrast, groups that supervised rarely or not at all had the lowest mean scores across the phases of data collection. While the ‘most days’ and ‘rarely’ groups improved their mean results across the phases, the ‘not at all’ group, while initially improving its mean result in the immediate post-program survey, lost part of this gain in the eight-week survey. This decrease in the mean may have resulted from no interactions with students. Guided by the principles of adult learning, adults learn when engaged with the topic, and as acknowledged in all theories of learning, a lack of involvement with the content eventually leads to a loss of learning. These findings are also displayed in Graph 4.6.
Table 4.25: Knowledge survey mean scores for frequency of clinical supervision across the phases of survey completion

<table>
<thead>
<tr>
<th>Frequency of providing clinical supervision</th>
<th>Mean (standard deviation)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-program</td>
<td>Immediate post-program</td>
</tr>
<tr>
<td><strong>Most days</strong> (more than 50% of weekly shifts)</td>
<td>11.3</td>
<td>14.8 (4.8)</td>
</tr>
<tr>
<td><strong>Some days</strong> (less than 50% of weekly shifts)</td>
<td>10</td>
<td>13.8 (3)</td>
</tr>
<tr>
<td><strong>Infrequently</strong> (on occasions each month)</td>
<td>10.2</td>
<td>14.2 (4)</td>
</tr>
<tr>
<td><strong>Rarely</strong> (once or twice in the past six months)</td>
<td>9.9</td>
<td>13.5 (3.9)</td>
</tr>
<tr>
<td><strong>Not at all</strong></td>
<td>8.1</td>
<td>13.1 (4.4)</td>
</tr>
</tbody>
</table>

**Graph 4.6: Knowledge survey mean scores for frequency of clinical supervision across the phases of survey completion**

4.3.3.6 Years of Nursing Experience

Table 4.26 articulates the mean scores of the pre-program, immediate post-program and eight-week surveys in relation to the number of years of experience as a registered nurse. Due to the small participant numbers (2.5%) in the 40+ group, these were combined with the 31–40 age group to create a new group of 31+. 
Each of the groups for years of nursing experience had an increase in the mean score across the survey collection phases. The group with the highest mean score after eight weeks had 21–30 years of experience. However, the difference between all of the groups was not more than 2.3 points. These results are presented in Graph 4.7.

Table 4.26: Knowledge survey mean scores for years of nursing experience across the phases of survey completion

<table>
<thead>
<tr>
<th>Years of nursing experience</th>
<th>% of participants</th>
<th>Mean (standard deviation)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Pre-program</td>
<td>Immediate post-program</td>
</tr>
<tr>
<td>1–10</td>
<td>29%</td>
<td>9.6</td>
<td>13.2 (3.9)</td>
</tr>
<tr>
<td>11–20</td>
<td>24%</td>
<td>10.8</td>
<td>14.7 (3.5)</td>
</tr>
<tr>
<td>21–30</td>
<td>27%</td>
<td>10.9</td>
<td>14.9 (4)</td>
</tr>
<tr>
<td>31+</td>
<td>17.5%</td>
<td>9.8</td>
<td>13.5 (3.3)</td>
</tr>
</tbody>
</table>

Graph 4.7: Knowledge survey mean scores for years of nursing experience across the phases of survey completion
Each of the areas of the pre-program, immediate post-program and eight-week surveys in relation to participants’ knowledge has now been articulated. Due to similar findings detailed in each of the groups created among the participants that attended the study day, it was agreed by the researcher’s supervisors and the university biostatistician that further cross-tabulation of results was unlikely to show any contingent variables. Given the close scores across the areas of the mean, mode, median and standard deviation, it would appear that the demographic groups had no significant effect on the outcome of the study day on participants’ knowledge, as demonstrated in the pre-program, immediate post-program and eight-week survey responses, other than showing a marked increase across the groups in their knowledge of clinical supervision from pre- to post-program attendance.

A comparison of the quantitative results will be discussed at the end of this chapter, with further discussion and implications of these findings provided in Chapters 6 and 7.

The second phase of data collection and analysis for the quantitative component of the research was the use of Stagg’s (1992) attitude survey to determine whether a change in attitude towards students and clinical supervision by participants had occurred after attending the CSP.

4.3.4 Quantitative Data Analysis—Attitude Survey Results

Participants were asked to complete the attitude survey on the day of the program—both immediately before and after the teaching sessions—and eight weeks after the program. Before the start of the day, 199 surveys were received, 198 (99.5%) were received at the end of the day and 71 (35.5%) eight-week surveys were returned. The return rate for the eight-week survey was higher than the knowledge survey. The researcher received four replies that included the attitude survey only.

Stagg’s (1992) attitude survey involved two stages of data analysis according to Stagg’s previous use of the survey. The first involved reviewing the responses to each individual question in the survey according to the survey themes, and the second stage involved allocating an overall score to the survey. These will be explored separately in this section, with the implications of the findings discussed in the conclusion of this section. The first area to be explored is the themes of the survey.
4.3.4.1 Stagg’s Attitude Survey Analysis by Themes

Stagg’s attitude survey was divided into seven themes. Each theme had a number of questions related to positive and negative statements regarding student nurses. The themes were:

- time
- instructor–student relationship
- motivation
- personal issues
- knowledge
- background comparisons
- professional issues.

The following sections refer to each of the seven themes. Results from the surveys have been articulated into table format according to the questions and responses of Strongly Agree (SA), Agree (A), Undecided (U), Disagree (D) and Strongly Disagree (SD) in order to compare the immediate pre-program survey on the day (P), the immediate post-program survey on the day (IP) and the eight-week survey (8). The results have been presented in relation to the percentage of all responses received. As per Stagg (1992), the preferred responses for the survey, which indicate a positive attitude towards students, have been shaded in grey.

4.3.4.1.1 Time

Six questions in the attitude survey related to time factors. The time questions referred to the effect of students on nurses’ ability to complete their workload, the assistance they received in supervising students from clinical facilitators and the ability of students to provide timely care.

Findings from the surveys indicated that nurses felt that having new students on the ward did not provide them with more time to complete their work. Over 70% of participants in the pre-program survey felt this to be true; however, in the immediate post-program survey, this decreased to 58% and then 52% in the eight-week survey. However, with nursing students who had become familiar with the ward, this was viewed more positively, with 56% of participants agreeing in the pre-program survey, 69% in the immediate post-program survey
and 82% in the eight-week survey. Nurses disagreed that there was too much to do to supervise (75.5% in the pre-program survey followed by 89.5% and 88.5% in the immediate post-program and eight-week surveys respectively.

Nurses disagreed that student nurses were more trouble than they were worth, with 94% in the pre-program survey followed by 97% in the immediate post-program and eight-week surveys. They also disagreed with the statement reflecting the need to have clinical facilitators providing more clinical teaching (69% in the pre-program survey followed by 81% and 71% in the immediate post-program and eight-week surveys respectively). There was a belief that students had time to provide patient care (81% in the pre-program survey followed by 89% and 94.5% in the immediate post-program and eight-week surveys respectively).

The findings of the survey responses in relation to the theme of ‘time’ were generally positive throughout the three phases of data collection. The findings indicated that the positive attitudes displayed improved between the pre- and post-program surveys. While the first question in relation to saving time with new students saw the majority of responses in the non-preferred response, participants stated that with students’ short placements, there was often a reduced opportunity for orientation and settling in. Therefore, getting students straight into the area of work was considered important, but it slowed students and themselves in completing the day’s workload. These survey response findings are articulated in Table 4.27.
Table 4.27: Stagg’s (1992) attitude survey theme of ‘time’ across the phases of survey completion

<table>
<thead>
<tr>
<th></th>
<th>SA</th>
<th>A</th>
<th>U</th>
<th>D</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>P IP 8</td>
<td>P IP 8</td>
<td>P IP 8</td>
<td>P IP 8</td>
<td>P IP 8</td>
</tr>
<tr>
<td>With nursing students who are new on the unit, nurses have time to do other things.</td>
<td>0 1.5</td>
<td>1.5</td>
<td>16 33</td>
<td>32</td>
<td>15 15 14</td>
</tr>
<tr>
<td></td>
<td>54</td>
<td>43.5</td>
<td>38.5</td>
<td>15 7</td>
<td>14</td>
</tr>
<tr>
<td>With nursing students who are familiar with the unit, nurses have time to do other things.</td>
<td>3 7</td>
<td>14</td>
<td>53 62</td>
<td>68</td>
<td>11 9 4</td>
</tr>
<tr>
<td></td>
<td>24</td>
<td>31</td>
<td>11.5</td>
<td>10 6</td>
<td>3 4</td>
</tr>
<tr>
<td>There is too much to do to have to worry about students.</td>
<td>0.5</td>
<td>0 0</td>
<td>10 2.5</td>
<td>1.5</td>
<td>14 7 10</td>
</tr>
<tr>
<td></td>
<td>58.5</td>
<td>67</td>
<td>70.5</td>
<td>17 22.5</td>
<td>18</td>
</tr>
<tr>
<td>Nursing students are more trouble than they are worth.</td>
<td>0 0</td>
<td>0 0</td>
<td>0 0</td>
<td>5.5 3</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>54</td>
<td>54.5</td>
<td>48</td>
<td>40 42.5</td>
<td>49</td>
</tr>
<tr>
<td>I would not have to spend extra time with nursing students if the instructor would supervise the nursing students.</td>
<td>1 0</td>
<td>3 15</td>
<td>6 7</td>
<td>15 13 19</td>
<td></td>
</tr>
<tr>
<td></td>
<td>57</td>
<td>67</td>
<td>47</td>
<td>12 14</td>
<td>24</td>
</tr>
<tr>
<td>Nursing students have time to attend to patients’ needs.</td>
<td>5 5</td>
<td>12.5</td>
<td>76</td>
<td>84</td>
<td>82</td>
</tr>
<tr>
<td></td>
<td>15 10</td>
<td>5.5</td>
<td>3 0.5</td>
<td>0 1</td>
<td>0.5 0</td>
</tr>
</tbody>
</table>

4.3.4.1.2 Motivation

There were four survey questions in relation to motivation. Motivation related to the students’ use of their time while in the clinical environment. The first three questions related to positive statements of student behaviour in the clinical area with assisting and completing patient care, while the final question related to students only completing work as assigned.

Participants indicated that they believed students willingly assisted with completing work (72% in the pre-program survey followed by 86% and 84.5% in the immediate post-program and eight-week surveys). However, they were a little unsure about students’ willingness to
help other students (53.5% in the pre-program survey agreed with this statement followed by 66.5% and 60.5% in the immediate post-program and eight-week surveys).

In relation to students’ eagerness to learn, 88% of participants in the pre-program survey agreed with this, increasing to 92% and 96% in the immediate post-program and eight-week surveys.

Similar to concerns regarding students helping other students, participants were again unsure about students who only completed assigned work. Participants were evenly divided between agreeing, disagreeing and undecided. While the percentage of participants that agreed with this statement decreased between the pre-program, immediate post-program and eight-week surveys, a number of participants changed to being undecided by the eight-week survey. These results are articulated in Table 4.28.

Table 4.28: Stagg’s (1992) attitude survey theme of ‘motivation’ across the phases of survey completion

<table>
<thead>
<tr>
<th></th>
<th>SA</th>
<th>A</th>
<th>U</th>
<th>D</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>P</td>
<td>IP</td>
<td>8</td>
<td>P</td>
<td>IP</td>
</tr>
<tr>
<td>Students willingly help nurses to get things done.</td>
<td>6.5</td>
<td>6</td>
<td>10</td>
<td>65.5</td>
<td>80</td>
</tr>
<tr>
<td>Nursing students help other students to get things done.</td>
<td>2.5</td>
<td>2.5</td>
<td>1.5</td>
<td>51</td>
<td>64</td>
</tr>
<tr>
<td>Nursing students are eager to learn.</td>
<td>11</td>
<td>13</td>
<td>10</td>
<td>77</td>
<td>79</td>
</tr>
<tr>
<td>Nursing students do only what they are assigned.</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>37</td>
<td>28</td>
</tr>
</tbody>
</table>

4.3.4.1.3 Knowledge

There were eight questions in the survey related to knowledge. This covered the students’ training at their universities, use of questions in the clinical area, ability to receive feedback and decision-making abilities. These results are outlined in Table 4.29.

The majority of participants disagreed with the statement that ‘you cannot tell nursing students anything because they know everything’ (88% in the pre-program survey and 90% in
the eight-week survey), as well as the statement that ‘students ask too many questions’ (92% in the pre-program survey followed by 98% in both the immediate post-program and eight-week surveys). The majority of participants agreed that nurses learnt from students, with 10% in the ‘undecided’ category shifting to the ‘agree’ category in the immediate post-program and eight-week surveys, which changed the results from 88% to 96%.

Participants seemed unsure about the quality of nursing education provided by education providers. In the pre-program survey, 30% of participants were undecided, and this decreased to 14.5% in the immediate post-program survey; however, it rose to 20% in the eight-week survey. The researcher was unable to determine the reason for this increase in the eight-week survey. In the pre-program survey, 66% of participants agreed that quality education was provided, and this increased to 88% in the eight-week survey.

In each of the survey phases, one-third of the participants were undecided about the ability of students to make time-appropriate decisions. The responses improved over the phases of the surveys, with an increase from 53.5% in the pre-program survey disagreeing that students are not too hasty, to 64% and 62% in the immediate post-program and eight-week surveys respectively.

In contrast, the majority of nurses believed that students asked good questions; in each phase, over 90% of participants agreed with this statement. However, nurses were concerned that students lacked common sense. While the immediate post-program survey showed an improved attitude from 65% to 74%, by the eight-week survey, this decreased to only 61% disagreeing with this statement. In the pre-program survey, 27% of nurses were unsure about students’ common sense, and while this decreased to 22% in the immediate post-program survey, by the eight-week survey, the number increased to 28%. The researcher was unable to identify the reason for this change in attitude regarding students’ level of common sense.

The final question related to the amount of clinical experience that students received in their nursing education. The majority of participants felt that students did not receive enough clinical experience (71% in the pre-program survey and 69% in the eight-week survey). Between 15% and 17% of participants remained unsure from the pre-program survey to the eight-week survey, while 11% in the pre-program survey and 15% in the eight-week survey
disagreed with this and felt that the education was appropriate. The amount of clinical practice was a significant concern to many of the participants at the CSP.

Table 4.29: Stagg’s (1992) attitude survey theme of ‘knowledge’ across the phases of survey completion

<table>
<thead>
<tr>
<th></th>
<th>SA</th>
<th>A</th>
<th>U</th>
<th>D</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>P</td>
<td>IP</td>
<td>8</td>
<td>P</td>
<td>IP</td>
</tr>
<tr>
<td>You cannot tell nursing students</td>
<td>0</td>
<td>0.5</td>
<td>3</td>
<td>1</td>
<td>1.5</td>
</tr>
<tr>
<td>anything because they know</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>everything.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing students ask too many</td>
<td>1.5</td>
<td>0</td>
<td>0</td>
<td>1.5</td>
<td>0.5</td>
</tr>
<tr>
<td>questions.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses learn new information</td>
<td>15.5</td>
<td>20.5</td>
<td>24</td>
<td>73</td>
<td>75</td>
</tr>
<tr>
<td>from nursing students.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Today’s nursing schools provide</td>
<td>8</td>
<td>12</td>
<td>11</td>
<td>58</td>
<td>72</td>
</tr>
<tr>
<td>quality education.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decisions are made too hastily by</td>
<td>0.5</td>
<td>0</td>
<td>0</td>
<td>11</td>
<td>3</td>
</tr>
<tr>
<td>nursing students.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing students ask good</td>
<td>10</td>
<td>10</td>
<td>17</td>
<td>81</td>
<td>84</td>
</tr>
<tr>
<td>questions.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing students lack common</td>
<td>1.5</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>3.5</td>
</tr>
<tr>
<td>sense.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing students do not get</td>
<td>27</td>
<td>26</td>
<td>17</td>
<td>44</td>
<td>47</td>
</tr>
<tr>
<td>enough clinical experience.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4.3.4.1.4 Professional Issues

There were six questions in the survey related to professional issues. These questions related to students maintaining professional standards and their role in the health care team. For each question, participants’ responses were mostly in the desired response category. These responses are articulated in Table 4.30.

The first question asked participants to rate the statement ‘I believe nursing students respect nurses as practitioners’. No participant rated ‘strongly disagree’, and an improvement in responses was noted after attending the program, with ‘disagree’ changing from 2% to 0% in the immediate post-program and eight-week surveys. In the pre-program survey and the eight-week survey, 94% and 96% of participants agreed with this statement respectively.
The second question asked whether nurses consider nursing students part of the nursing team. In the initial survey, 20% of participants disagreed or strongly disagreed with this statement. In the immediate post-program survey, this decreased to 9.5%—a considerable proportion of the group. However, it increased again to 11% in the eight-week survey. The number of participants who remained unsure decreased from 18% in the pre-program survey to 13% in the eight-week survey. In the pre-program survey, 62% of participants agreed that students were part of the team, and this increased to 76% in the eight-week survey.

The majority of participants had a positive view about the role of clinical facilitators, with over 80% disagreeing with the statement that ‘nurses should not have to do the teaching that clinical instructors are paid to do’ for each of the survey phases. Of surprise to the researcher was the response by participants that their perception of the relationship between student nurses and medical staff is too friendly. The researcher had considered removing this question when first reviewing the tool, as it was felt that this was not applicable in the multidisciplinary team approach to patient care. However, approximately 20% of participants across the three phases were undecided about this relationship, with the majority of the remaining responses disagreeing with this.

The majority of participants agreed that nursing students’ questions stimulated new practice, with the undecided group reducing from 17% in the pre-program survey to 3% in the eight-week survey, and the agreed rate increasing from 81% in the pre-program survey to 96% in the immediate post-program and eight-week surveys.

The majority of participants agreed that students looked professional, with a decrease in those who were undecided from 19% in the pre-program to 16% in the immediate post-program to 10% in the eight-week survey, with no participants strongly disagreeing.

### Table 4.30: Stagg’s (1992) attitude survey theme of ‘professional issues’ across the phases of survey completion

<table>
<thead>
<tr>
<th></th>
<th>SA</th>
<th>A</th>
<th>U</th>
<th>D</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>16</td>
<td>18</td>
<td>21</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>IP</td>
<td>78</td>
<td>79</td>
<td>75</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>8</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Nurses consider nursing students part of the nursing team. | 9  | 8  | 8.4 | 53 | 70 | 68 | 18 | 12 | 13 | 19 | 9.5 | 11 | 1 | 0.5 | 0  
Nurses should not have to do the teaching that clinical instructors are paid to do. | 1  | 0  | 0  | 6  | 5  | 7  | 11 | 7  | 4  | 62 | 64 | 65 | 20 | 24 | 24 |  
Nursing students are too chummy with the doctors. | 1  | 0  | 0  | 2  | 1  | 1  | 22 | 18 | 18 | 52 | 61 | 65 | 23 | 19 | 16 |  
Nursing students’ questions stimulate new ways of doing things. | 11 | 20 | 23 | 70 | 76 | 73 | 17 | 3.5 | 3  | 2  | 0.5 | 1  | 0  | 0  | 0  
Nursing students look professional. | 6  | 7  | 11 | 70 | 73 | 73 | 19 | 16 | 10 | 3  | 4  | 6  | 2  | 0  | 0  |  

4.3.4.1.5 Instructor–Student Relationship

Three questions related to the instructor position (clinical facilitator), student and staff relationships. These relationships were widely discussed at all of the CSP study days. The results are articulated in Table 4.31.

The first question related to the relationship between clinical facilitators and students. There was no significant change in the survey results between the phases. In the pre-program survey, approximately 70% of participants disagreed with the statement that students were too friendly with their facilitators; this increased to 75% in the immediate post-program survey, but decreased to 69% in the eight-week survey. Between 22% of participants in the pre-program survey and 27% in the eight-week survey were undecided.

The second question referred to the reliance of nursing students on their clinical facilitators. The majority of participants agreed that nursing students were not reliant on clinical facilitators. An improvement in the results was seen over the phases of the surveys, with undecided participants decreasing from 24% to 14%, and disagreeing participants increasing from 65.5% in the pre-program survey to 75% in the immediate post-program and eight-week surveys.

The final question asked whether ‘it is about time instructors eased up on the nursing students’, with a preferred response of ‘Agree/Strongly Agree’. In all three phases,
participants disagreed with this statement (54% in the pre-program survey followed by 60% and 64% in the immediate post-program and eight-week surveys respectively). The researcher noted that participants were concerned about a lack of professionalism by many students. It is possible that these concerns were linked to this response as a strategy to maintain professional standards.

Table 4.31: Stagg’s (1992) attitude survey theme of ‘instructor–student relationship’ across the phases of survey completion

<table>
<thead>
<tr>
<th></th>
<th>SA</th>
<th>A</th>
<th>U</th>
<th>D</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing students are too friendly with their instructors.</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Nursing students rely on their instructors more than ward nurses.</td>
<td>0.5</td>
<td>0</td>
<td>1</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>It is about time instructors eased up on nursing students.</td>
<td>0.5</td>
<td>2</td>
<td>1.5</td>
<td>7.5</td>
<td>11</td>
</tr>
</tbody>
</table>

4.3.4.1.6 Personal Issues

The theme of personal issues included eight questions; it was the largest of the themes. These questions related to a number of issues raised in other themes; however, they were from a more personalised perspective of participants. These findings are articulated in Table 4.32.

While the majority of participants believed that students accepted constructive criticism, 26% in the pre-program survey were undecided. This decreased to 20% in the immediate post-program and eight-week surveys, with these numbers increasing in the ‘agreed’ category from 66% in the pre-program survey to 76.5% and 77% in the immediate post-program and eight-week surveys.

The second question provided a range of responses by participants; this related to students becoming overwhelmed if caring for more than one or two patients. Approximately 20% of participants across the three phases agreed with this statement, with between 26% in the pre-program survey and 38% in the eight-week survey being undecided, and 41% and 52%
disagreeing respectively. This response may relate to participants’ concerns regarding students’ lack of clinical experience rather than negative attitudes towards students. This was also relevant to the following question, which relates to students’ level of dependence on ward staff. Despite concerns over students’ abilities to care for more than one patient, after attending the program, over 70% of participants did not agree that students were too dependent; this increased from 56% in the pre-program survey.

Participants were concerned about students’ sense of self-confidence. Approximately 20% of participants across the three survey phases agreed that students were not confident. In the pre-program and eight-week surveys, 31% and 22% were undecided respectively, and 44% and 56% disagreed respectively.

The majority of participants agreed that they enjoyed working with nursing students, with 95% agreeing with this statement in the pre-program survey, 97.5% in the immediate post-program survey and 98.5% in the eight-week survey. Participants agreed that nursing students provided good patient care overall, with those who were undecided decreasing from 25% in the pre-program survey to 12% in the eight-week survey, and those who agreed increasing from 71% to 84% respectively. Those who disagreed remained at 3%. However, a number of participants remained concerned that students did not always admit when they did not know something. In the pre-program and eight-week surveys, 22% and 24% remained undecided, while those who disagreed dropped from 14.5% in the pre-program survey to 8.5% in the immediate post-program survey and 4% in the eight-week survey.

Participants were also concerned about students’ assertiveness. These concerns may be related to participants’ results about students also lacking self-confidence. Approximately 50% of participants across the survey phases believed that students were assertive, while 33% in the pre-program survey and 38% in the eight-week survey remained undecided. Those who disagreed decreased from 16% to 9% from the pre-program to eight-week surveys.
Table 4.32: Stagg’s (1992) attitude survey theme of ‘personal issues’ across the phases of survey completion

<table>
<thead>
<tr>
<th>Theme</th>
<th>SA</th>
<th>A</th>
<th>U</th>
<th>D</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>P</td>
<td>IP</td>
<td>8</td>
<td>P</td>
<td>IP</td>
</tr>
<tr>
<td>Nursing students accept constructive criticism.</td>
<td>0.5</td>
<td>1.5</td>
<td>0</td>
<td>66</td>
<td>75</td>
</tr>
<tr>
<td>Nursing students are too dependent on the ward nurses.</td>
<td>1.5</td>
<td>0</td>
<td>0</td>
<td>13</td>
<td>6</td>
</tr>
<tr>
<td>Nursing students do not have enough confidence in themselves.</td>
<td>1.5</td>
<td>0</td>
<td>0</td>
<td>22</td>
<td>24</td>
</tr>
<tr>
<td>I enjoy working with nursing students.</td>
<td>34</td>
<td>34.5</td>
<td>38</td>
<td>61</td>
<td>63</td>
</tr>
<tr>
<td>Overall, nursing students provide good patient care.</td>
<td>2</td>
<td>3.5</td>
<td>3</td>
<td>69.5</td>
<td>84.5</td>
</tr>
<tr>
<td>Nursing students admit when they do not know something.</td>
<td>3.5</td>
<td>2.5</td>
<td>6</td>
<td>60</td>
<td>60</td>
</tr>
<tr>
<td>Nursing students practice assertiveness.</td>
<td>1.5</td>
<td>0.5</td>
<td>1.5</td>
<td>48</td>
<td>50</td>
</tr>
</tbody>
</table>

153
4.3.4.1.7 Background Comparisons

Background comparisons involved four questions. The purpose of these questions was to encourage participants to compare their training to the nursing school experiences of today. The findings are articulated in Table 4.33.

The first question related to ‘we were all students once, so we should be nice to nursing students’. Between 1% and 1.5% of the group were undecided or disagreed with this statement across the three survey phases. The remaining participants agreed with this statement.

The second question referred to the amount of clinical experience that students undertake in their programs compared to the amount of clinical experience that participants received as students. Stagg (1992) allocated ‘disagree’ as the preferred response. While it could be argued that this is a statement of fact, many participants were unsure of how many hours they had completed during their nursing education or the number of hours completed by today’s students, so participants’ responses were based on their perceptions. The responses varied across the choices, with 36% and 38% strongly agreeing in the pre-program and eight-week surveys, while 30% and 31% agreed, and 20% and 18% disagreed respectively.

The third question referred to having it ‘tough’ at nursing school. The majority of participants across the surveys disagreed with this comment (95% and 92% in the pre-program and eight-week surveys); however, 3% in each phase remained undecided and 4% agreed in the eight-week survey. The increase in the eight-week survey may have resulted from participants’ ongoing concerns about the lack of professionalism of some students, and as discussed previously, being tough may be seen by some as a strategy to improve this. The difficulty for the researcher is that participants’ interpretations of ‘tough’ may be different for different people.

The final question related to the relationship between students and their instructors. Participants’ responses were spread across the five-point Likert scale, with the majority of participants across the three phases disagreeing with the statement that they would not have referred to their instructors by their first names. However, 12% remained undecided in the
pre-program survey, which decreased to 8% in the eight-week survey. In the eight-week survey, 38% of participants agreed.

Table 4.33: Stagg’s (1992) attitude survey theme of ‘background comparisons’ across the phases of survey completion

<table>
<thead>
<tr>
<th>Theme</th>
<th>SA</th>
<th>A</th>
<th>U</th>
<th>D</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>We were all students once, so we should be nice to nursing students.</td>
<td>52</td>
<td>54</td>
<td>53.5</td>
<td>47</td>
<td>44.5</td>
</tr>
<tr>
<td>When I was in nursing school, I had more clinical experience than the nursing students do now.</td>
<td>36</td>
<td>35</td>
<td>38</td>
<td>31</td>
<td>34</td>
</tr>
<tr>
<td>I had it tough in nursing school, so nursing students of today should too.</td>
<td>0.5</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1.5</td>
</tr>
<tr>
<td>I would never have dreamed of calling my instructors by their first names.</td>
<td>11</td>
<td>7</td>
<td>8.5</td>
<td>17</td>
<td>25</td>
</tr>
</tbody>
</table>

This concludes the reviewing of the themes included in Stagg’s (1992) attitude survey. Overall, the findings of the survey results highlighted that participants had a positive attitude towards nursing students, and after attending the CSP, this continued to improve as demonstrated in both the immediate post-program and eight-week surveys. This related to all seven themes of Stagg’s (1992) tool.

A key concern articulated in participants’ responses related to the amount of time that students spent in clinical placements. A number of participants remained concerned that student nurses did not have enough time in their clinical placements and that they became overwhelmed when allocated to care for more than one or two patients. However, despite this, participants did not feel that students were dependent on them or clinical facilitators.

The second stage of analysis of Stagg’s (1992) attitude survey involved allocating a score for each question within the survey. This also allowed for a comparison of the results between the demographic details of the participants.
4.3.4.2 Stagg’s (1992) Attitude Survey Analysis by Mean Scores

Participants were allocated a total score of 37–117 for Stagg’s (1992) attitude survey. According to Stagg’s instructions for the survey, a score of 3 was allocated for a preferred response, 2 for undecided and 1 for an undesired response.

In Stagg’s (1992) research, the median score was used to separate the group into high or low scores of attitude. Stagg determined the median result and used this for comparison. Those who were rated as having a high attitude towards nursing students were equal to, or above, this median, and those who were below the median were referred to as having a low attitude (Stagg, 1992). Aghamohammadi-Kalkhoran et al. (2010) used Stagg’s tool to determine the attitudes of participants by dividing the scores between those with low, moderate and high attitudes. To determine this, the survey scores were divided into thirds. Therefore, those with a score of:

- 37–63 = low attitude
- 64–89 = moderate attitude
- 90–117 = high attitude.

For this study, these two different approaches were discussed with the university biostatistician, and it was agreed that both methods would be investigated to provide a comparison between the studies; this will be discussed in further detail in Chapter 6.

The continued focus of this chapter is to analyse and compare the data between the pre-program, immediate and eight-week surveys. As the two previous studies did not involve any intervention or post-intervention measures, this will provide additional information that is not included in the current literature.

Table 4.34 outlines the mean score for the attitude survey across the phases of data collection, with the maximum score for the survey being 117. The results were based on 199 pre-program surveys, 198 (99.5%) immediate post-program surveys and 71 (35.5%) eight-week surveys.
Table 4.34: Study group mean scores with the standard deviation for Stagg’s (1992) attitude survey

<table>
<thead>
<tr>
<th></th>
<th>Stagg’s (1992) attitude survey</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-program</td>
</tr>
<tr>
<td>Mean</td>
<td>97.6 (83.4%)</td>
</tr>
<tr>
<td>Standard deviation</td>
<td>8.4</td>
</tr>
</tbody>
</table>

% indicates the mean average survey score

The scores of the 71 participants who completed all three phases of the research process were analysed with a Paired Sample T Test. The results showed that there was a statistically significant difference between both the pre-program survey’s mean results and the immediate post-program survey (p value <0.001) and eight-week survey (p value 0.004). The slight drop of the mean score with the eight-week survey compared to the immediate post-program survey means that it was not statistically significant (p value 0.699). This supported the researcher to confirm that the CSP positively affected participants’ attitudes, and despite the slight drop between the immediate and eight-week surveys, this was not statistically significant.

Graph 4.8 compares the mean results between the three phases of data collection with greater detail. The mean score is outlined with the standard deviation in red and the range of responses. The pre-program survey scores showed the largest range and standard deviation. After participants attended the CSP, the mean scores for the attitude survey showed a reduced standard deviation and range.
Graph 4.8: Attitude surveys’ mean scores with standard deviation and range across the phases of survey completion

The findings of these results will now be explored in relation to the subgroups of the study population, as described within the demographics of this chapter, in order to determine whether any of the characteristics affected the results. Where the numbers in the subgroups were small, this affected the researcher’s ability to determine the effect the program. Therefore, as suggested by the university biostatistician, they have not been included. The first area to be analysed relates to the age of the participants.

4.3.4.2.1 Age of Participants

Table 4.35 and Graph 4.9 outline the effect of participants’ ages on the mean scores for the attitude survey. Due to the small participant numbers in the ‘20–30’ age group for the eight-week survey, these results were not included. Each age group experienced an improvement in the mean score of the attitude survey between the pre-program survey and the immediate post-program survey, which was maintained in the eight-week survey. However, only the participants in the ‘41–50’ age group continued to increase the mean in the eight-week survey.
Table 4.35: Stagg’s (1992) attitude survey mean scores and standards deviations relating to the age of participants across the phases of survey completion

<table>
<thead>
<tr>
<th>Age</th>
<th>% of total population</th>
<th>Mean (standard deviation)</th>
<th>Pre-program</th>
<th>Immediate post-program</th>
<th>8-week</th>
</tr>
</thead>
<tbody>
<tr>
<td>20–30</td>
<td>12%</td>
<td></td>
<td>97.1 (8)</td>
<td>103.1 (7.1)</td>
<td>-</td>
</tr>
<tr>
<td>31–40</td>
<td>21.5%</td>
<td></td>
<td>100.2 (9.1)</td>
<td>101.9 (7.2)</td>
<td>100.9 (8.1)</td>
</tr>
<tr>
<td>41–50</td>
<td>30%</td>
<td></td>
<td>97.6 (7.8)</td>
<td>101.9 (7.1)</td>
<td>103.1(7.2)</td>
</tr>
<tr>
<td>51+</td>
<td>30.5%</td>
<td></td>
<td>96.2 (8.5)</td>
<td>101.8 (6.8)</td>
<td>101.5 (4.8)</td>
</tr>
</tbody>
</table>

Graph 4.9: Stagg’s (1992) attitude survey mean scores relating to the age of participants across the phases of survey completion

4.3.4.2.2 Area of Employment

Table 4.36 articulates the change in the mean scores of the attitude survey according to area of employment. Each area experienced an increase in the mean result from the pre-program survey to the immediate post-program survey. All groups maintained this increase in the mean in the eight-week survey compared to the pre-program survey. The mean score for the metropolitan/public sector continued to increase for the attitude survey at each phase; however, the metropolitan/private and regional sectors both had a slight drop in their score of two points off the mean.
Table 4.36: Stagg’s (1992) attitude survey mean scores and standard deviation relating to area of employment across the phases of survey completion

<table>
<thead>
<tr>
<th>Area of Employment</th>
<th>% of participants</th>
<th>Mean (standard deviation)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Pre-program</td>
<td>Immediate post-program</td>
</tr>
<tr>
<td>Metro/public</td>
<td>41%</td>
<td>98.6 (7.8)</td>
<td>101.1 (7.1)</td>
</tr>
<tr>
<td>Metro/private</td>
<td>32.5%</td>
<td>97.5 (8.3)</td>
<td>102.4 (6.5)</td>
</tr>
<tr>
<td>Regional</td>
<td>25.5%</td>
<td>96.2 (9.5)</td>
<td>103.4 (7.5)</td>
</tr>
</tbody>
</table>

These results have been converted into Graph 4.10. The first column for each area of employment represents the percentage of the total group. The final group of columns—‘study population’—outlines the mean for the study group as a visual means of comparison for each of the survey phases.

All of the groups in the area of employment had a mean result that was similar. No significant difference was identified in the findings of the mean score of the attitude survey between the different areas of employment.

Graph 4.10: Stagg’s (1992) attitude survey results relating to area of employment across the phases of survey completion
4.3.4.2.3 Previous Education in Clinical Supervision

Table 4.37 outlines the mean scores according to previous education in clinical supervision. Seven participants did not complete the survey question in relation to previous education and have been identified in the ‘not completed’ group. Due to the small numbers of participants that had completed a short course, an insufficient number of eight-week surveys was received to provide a mean result. As only 2% of the study day group had completed a relevant post-graduate qualification, there was an insufficient number of responses to determine a valid mean result.

<table>
<thead>
<tr>
<th>Previous education/training</th>
<th>% of participants</th>
<th>Mean (standard deviation)</th>
<th>Pre-program</th>
<th>Immediate post-program</th>
<th>8-week</th>
</tr>
</thead>
<tbody>
<tr>
<td>No previous education</td>
<td>51%</td>
<td>97.4 (8.1)</td>
<td>100.6 (6.8)</td>
<td>102.3 (6)</td>
<td></td>
</tr>
<tr>
<td>In-service/study day</td>
<td>32%</td>
<td>96.7 (9.4)</td>
<td>102.5 (7.2)</td>
<td>101.9 (6.7)</td>
<td></td>
</tr>
<tr>
<td>Short course</td>
<td>8%</td>
<td>100.5 (5)</td>
<td>104.9 (4.8)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Post-graduate</td>
<td>2%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Not completed</td>
<td>7%</td>
<td>100.4 (9.8)</td>
<td>107 (8)</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

The first two groups of ‘no previous education’ and ‘in-service/study day’ showed similar pre-program survey results. The immediate post-program survey for the ‘in-service/study day’ group showed a slightly higher mean; however, by the eight-week survey, there was less than 0.5 difference between the two groups. These results are demonstrated in Graph 4.11.
4.3.4.2.4 Frequency of Providing Clinical Supervision

Table 4.38 reviews the frequency of supervision of the participants and the mean scores of these groups. Due to the small numbers in the subgroups of those who chose not to answer the question, or who did not supervise at all, they have not been included.

As shown in Table 4.38 and Graph 4.12, the mean increased across all areas between the pre-program survey and the immediate post-program survey. However, for the eight-week survey, the ‘rarely’ group experienced a 3-point drop in the mean. This may have resulted from a lack of interaction with students. The ‘some days’ group also experienced a drop of 0.8 points.
Table 4.38: Stagg’s (1992) attitude survey mean scores and standard deviation for frequency of clinical supervision across the phases of survey completion

<table>
<thead>
<tr>
<th>Frequency of providing clinical supervision</th>
<th>% of participants</th>
<th>Mean (standard deviation)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Pre-program</td>
<td>Immediate post-program</td>
</tr>
<tr>
<td>Most days (more than 50% of weekly shifts)</td>
<td>17%</td>
<td>97.1 (9.5)</td>
<td>101.1 (8)</td>
</tr>
<tr>
<td>Some days (less than 50% of weekly shifts)</td>
<td>25.5%</td>
<td>99.4 (8.4)</td>
<td>103.9 (6.6)</td>
</tr>
<tr>
<td>Infrequently (on occasions each month)</td>
<td>33%</td>
<td>96.7 (8.8)</td>
<td>101.4 (8.3)</td>
</tr>
<tr>
<td>Rarely (once or twice in the past six months)</td>
<td>20%</td>
<td>97.4 (6.6)</td>
<td>102.3 (6.1)</td>
</tr>
</tbody>
</table>

Graph 4.12: Stagg’s (1992) attitude survey mean scores for frequency of clinical supervision across the phases of survey completion

4.3.4.2.5 Years of Nursing Experience

Table 4.39 articulates the mean scores of the pre-program, immediate and eight-week surveys in relation to the number of years of nursing experience. The mean scores across the years of experience showed no significant difference, except for the ‘21–30’ range, with a mean of 94.9 in the pre-program survey, which was just over 3 points less than the next closest mean;
however, this group continued to improve across the three phases of data collection, with a resulting mean that was similar to the rest of the age groups.

Each area improved after the study day program, with this increase being maintained in the eight-week survey. As shown in Graph 4.13, the immediate and eight-week survey scores remained significantly unchanged.

**Table 4.39: Stagg’s (1992) attitude survey mean scores and standard deviation relating to years of nursing experience across the phases of survey completion**

<table>
<thead>
<tr>
<th>Years of nursing experience</th>
<th>% of total population</th>
<th>Mean (standard deviation)</th>
<th>Pre-program</th>
<th>Immediate post-program</th>
<th>8-week</th>
</tr>
</thead>
<tbody>
<tr>
<td>1–10</td>
<td>29%</td>
<td></td>
<td>99.2 (7.3)</td>
<td>103.1 (6.6)</td>
<td>102.7 (8.1)</td>
</tr>
<tr>
<td>11–20</td>
<td>24%</td>
<td></td>
<td>98.8 (9.4)</td>
<td>101.8 (7.7)</td>
<td>101.9 (7.3)</td>
</tr>
<tr>
<td>21–30</td>
<td>27%</td>
<td></td>
<td>94.9 (7.8)</td>
<td>100.6 (6.7)</td>
<td>101.2 (7.3)</td>
</tr>
<tr>
<td>31+</td>
<td>17.5%</td>
<td></td>
<td>96 (8.5)</td>
<td>101.5 (6.7)</td>
<td>101.6 (4.9)</td>
</tr>
</tbody>
</table>

**Graph 4.13: Stagg’s (1992) attitude survey mean scores relating to years of nursing experience across the phases of survey completion**
This section reviewed the quantitative findings from Stagg’s (1992) attitude tool according to the allocation of scores for each question, and it described the results according to the different demographic details for this research group. These findings highlighted that the demographics related to age, area of employment and previous clinical supervision education did not significantly affect the participants’ results. The most influential factors related to the number of years of nursing and the frequency of clinical supervision.

For the number of years that the participants had been nursing, those with 21 years of experience or more had a lower mean attitude score. This may have been due to a number of factors, including additional responsibilities in the workplace due to their level of experience. Therefore, having students was another consideration in the shift or a lack of understanding of the current bachelor requirements of nursing students.

In relation to the effect of the frequency of clinical supervision, the ‘some days’ group had a higher mean than all other groups across all three surveys, with the ‘rarely’ group showing the least significant change. The results for the ‘rarely’ group may have resulted from a lack of opportunities to supervise students during this period of evaluation.

For further analysis of these findings, the researcher reviewed previous findings from the use of Stagg’s (1992) attitude survey.

4.4 Stagg’s Attitude Survey

The attitude survey by Stagg (1992) was also utilised by Aghamohammadi-Kalkhoran et al. (2010). Both of these studies involved the completion of the attitude survey by registered nurses in acute care hospitals on one occasion. No intervention occurred, and the results were used to establish a base line of data for determining the attitudes of nursing staff within each of the organisations towards nursing students at each time point. The findings of these studies will be reviewed in further detail and compared to the findings of this research project.

Stagg’s (1992) study involved 53 registered nurses working in two acute care hospitals in the UK. Participants’ ages ranged from 25 to 60 years, with 1–20 years of nursing experience. Of the participants, 98% were female, and the frequency of clinical supervision ranged from one
to more than 10 students per year. Participants completed Stagg’s survey once only. No intervention occurred, and the aim of the study was to determine the participants’ attitudes towards nursing students at the time of completing the survey (Stagg, 1992).

The research population for Stagg’s (1992) study showed similar demographic details of the nursing population as the current study; however, the frequency of clinical supervision was difficult to compare due to the unknown length of the clinical placements at these hospitals. Nursing students also consisted of Baccalaureate and Diploma students according to the nursing education options in the UK for registered nurses.

Stagg analysed the survey from two perspectives, including the overall allocation of a score for the survey and examining responses to individual questions and themes within the survey. As this survey was conducted at only one time point, it allowed for the comparison of only the pre-survey findings within this research project (Stagg, 1992).

The second study to use Stagg’s (1992) attitude survey was by Aghamohammadi-Kalkhoran et al. (2010). The study aimed to determine the attitudes of nursing staff towards nursing students in order to gain an understanding of the supervision context to inform and guide clinical facilitators and authorities. The study involved two acute care teaching hospitals, and 72 completed surveys were received. The demographic details of the group were not included in the publication. The participants were asked to complete the survey on one occasion.

Both of these studies’ findings offer a snapshot of the attitudes of the participants towards nursing students at the time of completion, without any intervention. The pre-program survey completed by the participants attending the CSP was the only criterion that was comparable to both previous studies. This comparison is presented below.

Both Stagg (1992) and Aghamohammadi-Kalkhoran et al. (2010) undertook two different analyses of the survey that was also implemented in this study. This involved reviewing the individual responses of each participant to each question within the survey and allocating an overall score to the survey. The findings of these studies will be discussed in relation to these two data analysis methods.
Table 4.40 compares the findings of Stagg’s (1992) study and this research project. Stagg divided participants into low and high attitudes towards nursing students. Stagg determined the median score of participants’ surveys and used this to divide the scores into two groups. Those below the median score were allocated as having a low attitude and those above the score where allocated as having a high attitude. Stagg’s median result was not used for comparison in this research, but the technique was—that is, the median score for the first survey in this research project, which was 98. Unlike Stagg, this median score was used across the research phases of the project due to the completion of the survey by participants on three occasions. These findings are displayed in Table 4.40.

**Table 4.40: Overall comparison of findings of Stagg’s (1992) attitude survey—score allocation with the CSP**

<table>
<thead>
<tr>
<th>Survey</th>
<th>% of participants</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low attitude</td>
<td></td>
<td>High attitude</td>
</tr>
<tr>
<td></td>
<td>52%</td>
<td></td>
<td>48%</td>
</tr>
<tr>
<td>Stagg (2002)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CSP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-program</td>
<td>44.7%</td>
<td></td>
<td>55.3%</td>
</tr>
<tr>
<td>Immediate post-program</td>
<td>23.7%</td>
<td></td>
<td>76.3%</td>
</tr>
<tr>
<td>Eight-week</td>
<td>25.3%</td>
<td></td>
<td>74.7%</td>
</tr>
</tbody>
</table>

Stagg’s (1992) findings showed that 52% of nurses had a low attitude towards nursing students and 48% had a high attitude. Compared to the CSP, the majority of participants had a high attitude in all three phases of data collection; however, the pre-program survey results were similar to Stagg’s, with 44.7% having a low attitude and 55.3% a high attitude. These results improved significantly from the pre-program survey to the immediate and eight-week surveys; however, there was a slight drop of 1.6 from the immediate to the eight-week surveys.

Aghamohammadi-Kalkhoran et al.’s (2010) study determined the overall status of the participants as low, moderate or high, which was a variation on Stagg’s (1992) method of low and high. The overall range of scores was divided into thirds, with participants allocated according to their mean score. Due to the small numbers of participants that met the criteria for a low attitude, Aghamohammadi-Kalkhoran et al. (2010) combined the ‘low’ category with the ‘moderate’ category, therefore having two categories of findings in the article of ‘moderate’ and ‘high’.
To compare the findings with this research, the researcher divided the possible score allocation of the attitude survey into thirds and allocated the participants’ scores into these. A comparison of these findings is presented in Table 4.41.

Table 4.41: Overall mean score of Stagg’s (1992) attitude survey divided between low, moderate and high—comparison of finding between Aghamohammadi-Kalkhoran et al. (2010) and the CSP

<table>
<thead>
<tr>
<th>Study group</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aghamohammadi-Kalkhoran et al. (2010)</td>
<td>80%</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Pre-program</td>
<td>0%</td>
<td>12%</td>
<td>88%</td>
</tr>
<tr>
<td>Immediate post-program</td>
<td>0%</td>
<td>4.5%</td>
<td>95.5%</td>
</tr>
<tr>
<td>Eight-week</td>
<td>0%</td>
<td>5.6%</td>
<td>94.4%</td>
</tr>
</tbody>
</table>

A comparison of the findings between Aghamohammadi-Kalkhoran et al. (2010) and the CSP highlighted that the CSP participants had significantly higher attitudes towards nursing students. Only 20% of Aghamohammadi-Kalkhoran et al.’s (2010) participants had a high result compared to 88% of participants from the CSP. The results of the CSP participants continued to improve across the phases of the research project compared to the pre-program survey results. The differences in, and a comparison of, these findings are discussed in further detail in Chapter 6.

The second phase of data analysis for Stagg’s (1992) research survey involved individual reviews of each question in the seven allocated themes. As both Stagg (1992) and Aghamohammadi-Kalkhoran et al. (2010) combined the responses of the survey into the three response ranges of ‘Agree’, ‘Undecided’, and ‘Disagree’, the CSP researcher also combined these for the CSP findings. Therefore, ‘Strongly Agree’ and ‘Agree’ were combined under ‘Agree’, and ‘Strongly Disagree’ and ‘Disagree’ were combined under ‘Disagree’. The preferred responses by Stagg to each question were also highlighted in grey, and where significant differences between the surveys existed, the font was highlighted.

In comparing the results of these two studies to this research project, each of the seven themes was reviewed. The themes were: time, motivation, knowledge, personal issues, professional issues, instructor–student relationship and background information (Stagg, 1992).
**Time:** There were six questions in the attitude survey related to time; the findings of the three studies are outlined in Table 4.42. These questions referred to the effect of students on nurses’ ability to complete their workload, the assistance they received from clinical facilitators in supervising students and the ability of students to provide timely care.

The comparison of findings between these three studies highlighted that 50% of the participants in Aghamohammadi-Kalkhoran et al.’s (AKKA) (2010) study felt that they had less time to complete other duties when they were with new nursing students; however, when this question changed to students who were familiar with the environment, this decreased to 37.4%. No explanation for these findings was articulated in the study. Further, AKKA’s study outlined that only 20% of participants disagreed with the statement that students were more trouble than they were worth, and only 11% agreed that students had time to provide patient care.

### Table 4.42: Comparison of Stagg’s (1992) attitude survey for the theme of ‘time’ for Stagg, AKKA and the CSP

<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th>U</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>With nursing students who are new on the unit, nurses have time to do other things.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stagg</td>
<td>17</td>
<td>50</td>
<td>17</td>
</tr>
<tr>
<td>AKKA</td>
<td>13.2</td>
<td>27.1</td>
<td>15</td>
</tr>
<tr>
<td>CSP</td>
<td>69.2</td>
<td>22.8</td>
<td>69</td>
</tr>
<tr>
<td><strong>With nursing students who are familiar with the unit, nurses have time to do other things.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stagg</td>
<td>64.1</td>
<td>37.4</td>
<td>56</td>
</tr>
<tr>
<td>AKKA</td>
<td>11.3</td>
<td>11.4</td>
<td>11</td>
</tr>
<tr>
<td>CSP</td>
<td>23.1</td>
<td>51.4</td>
<td>33</td>
</tr>
<tr>
<td><strong>There is too much to do to have to worry about students.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stagg</td>
<td>5.8</td>
<td>2.8</td>
<td>10.5</td>
</tr>
<tr>
<td>AKKA</td>
<td>11.3</td>
<td>2.8</td>
<td>14</td>
</tr>
<tr>
<td>CSP</td>
<td>81.2</td>
<td>94.3</td>
<td>75.5</td>
</tr>
<tr>
<td><strong>Nursing students are more trouble than they are worth.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stagg</td>
<td>0</td>
<td>45.7</td>
<td>0.5</td>
</tr>
<tr>
<td>AKKA</td>
<td>1.9</td>
<td>34.2</td>
<td>5.5</td>
</tr>
<tr>
<td>CSP</td>
<td>98.1</td>
<td>20</td>
<td>94</td>
</tr>
<tr>
<td><strong>I would not have to spend extra time with nursing students if the instructor would supervise the nursing students.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stagg</td>
<td>13.2</td>
<td>8.5</td>
<td>16</td>
</tr>
<tr>
<td>AKKA</td>
<td>15.1</td>
<td>15.7</td>
<td>15</td>
</tr>
<tr>
<td>CSP</td>
<td>71.7</td>
<td>75.7</td>
<td>69</td>
</tr>
<tr>
<td><strong>Nursing students have time to attend to patients’ needs.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stagg</td>
<td>86.8</td>
<td>11.4</td>
<td>81</td>
</tr>
<tr>
<td>AKKA</td>
<td>13.2</td>
<td>21</td>
<td>15</td>
</tr>
<tr>
<td>CSP</td>
<td>0</td>
<td>68.5</td>
<td>4</td>
</tr>
</tbody>
</table>
In comparison, the results from Stagg (1992) and the CSP showed trends of similar results for each question in the ‘time’ theme. Within each category, there was less than a 10% difference in the ‘agree’ and ‘disagree’ findings. While participants’ responses in these two studies were positive for the majority of the questions, the Stagg and CSP studies both highlighted that nurses did not feel that having students provided them with time to do other things. However, both groups believed that they had more time when allocated a student who was familiar with the unit.

**Motivation:** There were four questions in the attitude survey in relation to student motivation. Motivation related to students’ use of their time while in the clinical environment, including assisting the nursing staff and other students, being eager to learn or only completing work as assigned.

The results for the three studies are outlined in Table 4.43. The findings in AKKA’s (2010) study showed that participants were not convinced that students helped other students to complete work, or that they were eager to learn; however, they disagreed that students only completed work that was assigned to them. These findings were in contrast to the Stagg (1992) and CSP findings, which provided overall positive responses to each question.

**Table 4.43: Comparison of Stagg’s (1992) attitude survey for the theme of ‘motivation’ for Stagg, AKKA and the CSP**

<table>
<thead>
<tr>
<th></th>
<th>A Stagg</th>
<th>A AKKA</th>
<th>A CSP</th>
<th>U Stagg</th>
<th>U AKKA</th>
<th>U CSP</th>
<th>D Stagg</th>
<th>D AKKA</th>
<th>D CSP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students willingly help nurses to get things done.</td>
<td>60.4</td>
<td>54.3</td>
<td>72</td>
<td>13.2</td>
<td>22.8</td>
<td>23</td>
<td>26.5</td>
<td>22.8</td>
<td>5</td>
</tr>
<tr>
<td>Nursing students help other students to get things done.</td>
<td>71.7</td>
<td>25.7</td>
<td>53.5</td>
<td>15.1</td>
<td>35.7</td>
<td>29</td>
<td>11.3</td>
<td>38.5</td>
<td>17.5</td>
</tr>
<tr>
<td>Nursing students are eager to learn.</td>
<td>94.3</td>
<td>27.1</td>
<td>88</td>
<td>3.8</td>
<td>22.8</td>
<td>11</td>
<td>1.9</td>
<td>50</td>
<td>4</td>
</tr>
<tr>
<td>Nursing students do only what they are assigned.</td>
<td>45.2</td>
<td>4.2</td>
<td>39</td>
<td>3.8</td>
<td>8.5</td>
<td>25</td>
<td>51</td>
<td>87.1</td>
<td>36</td>
</tr>
</tbody>
</table>

**Knowledge:** The theme of knowledge related to the current education that students received at the university, their use of questioning in the clinical area, their ability to receive feedback and their ability to make decisions. The findings of the three surveys are outlined in Table
4.44. Aghamohammadi-Kalkhoran et al. (2010) did not include the final two questions of the eight in their findings. This exclusion was not discussed or explained.

Table 4.44: Comparison of Stagg’s (1992) attitude survey for the theme of ‘knowledge’ for Stagg, AKKA and the CSP

<table>
<thead>
<tr>
<th>A</th>
<th>U</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Stagg</td>
<td>AKKA</td>
</tr>
<tr>
<td>You cannot tell nursing students anything because they know everything.</td>
<td>1.9</td>
<td>74.2</td>
</tr>
<tr>
<td>Nursing students ask too many questions.</td>
<td>5.7</td>
<td>44.2</td>
</tr>
<tr>
<td>Nurses learn new information from nursing students.</td>
<td>73.6</td>
<td>54.2</td>
</tr>
<tr>
<td>Today’s nursing schools provide quality education.</td>
<td>66</td>
<td>55.7</td>
</tr>
<tr>
<td>Decisions are made too hastily by nursing students.</td>
<td>5.7</td>
<td>11.4</td>
</tr>
<tr>
<td>Nursing students ask good questions.</td>
<td>83</td>
<td>27.4</td>
</tr>
<tr>
<td>Nursing students lack common sense.</td>
<td>3.8</td>
<td>-</td>
</tr>
<tr>
<td>Nursing students do not get enough clinical experience.</td>
<td>64.1</td>
<td>-</td>
</tr>
</tbody>
</table>

As with the previous themes, the findings between the three surveys showed similar results, with Stagg’s (1992) and the CSP findings being similar. The AKKA (2010) differed with the data trends in relation to ‘you cannot tell nursing students anything because they know everything’, with only 15% of AKKA participants disagreeing with this statement compared to 88% for both Stagg and the CSP. These negative responses continued with questions related to nursing students asking too many questions or poor questions. Nurses also learning from working with students was only perceived by 54% of respondents. Forty-one per cent of the AKKA group also remained undecided regarding whether students made decisions too hastily.

**Professional issues:** The theme of professional issues related to students maintaining the professional standards of the profession and their role in the health care team. The findings for the three studies are outlined in Table 4.45.
For each of the six questions, participants from the CSP and Stagg’s (1992) study responded mostly with a positive attitude; as with previous themes, this was in contrast to the results of AKKA’s (2010) study, in which 72.8% of participants felt that students did not respect them as practitioners and only 14% felt that nurses considered students part of the nursing team. Further, 28.5% of AKKA’s participants disagreed that nurses should undertake the teaching role of clinical instructors, and 70% felt that students were too ‘chummy’ with medical staff. Around 42.8% believed that students stimulated new ways of doing things, and 48.5% agreed that students looked professional. Large numbers of AKKA’s participants were again in the ‘undecided’ category, with the overall results indicating negative or undecided attitudes towards the factors influencing ‘professional issues’. Participants in both Stagg’s study and the CSP again had an overall positive response to the questions.

Table 4.45: Comparison of Stagg’s (1992) attitude survey for the theme of ‘professional issues’ for Stagg, AKKA and the CSP

<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th>U</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Stagg</td>
<td>AKKA</td>
<td>CSP</td>
</tr>
<tr>
<td>I believe nursing students respect nurses as practitioners.</td>
<td>98.1</td>
<td>10</td>
<td>94</td>
</tr>
<tr>
<td>Nurses consider nursing students part of the nursing team.</td>
<td>92.4</td>
<td>14.2</td>
<td>62</td>
</tr>
<tr>
<td>Nurses should not have to do the teaching that clinical instructors are paid to do.</td>
<td>35.8</td>
<td>45.7</td>
<td>7</td>
</tr>
<tr>
<td>Nursing students are too chummy with the doctors.</td>
<td>3.8</td>
<td>70</td>
<td>3</td>
</tr>
<tr>
<td>Nursing students’ questions stimulate new ways of doing things.</td>
<td>75.4</td>
<td>42.8</td>
<td>81</td>
</tr>
<tr>
<td>Nursing students look professional.</td>
<td>58.5</td>
<td>48.5</td>
<td>76</td>
</tr>
</tbody>
</table>

**Instructor (facilitator)–student relationship:** Three questions in the survey related to the relationship between students and their clinical facilitators. The results of these questions for the three studies are outlined in Table 4.46. Aghamohammadi-Kalkhoran et al. (2010) did not provide a table for these results; however, they included some findings within the publication,
and these have been included in the table. Where no data were available from within the publication, the letters ‘ND’ (no data) have been entered into the table.

The findings showed similar trends to the previous themes, with AKKA’s (2010) participants in contrast to Stagg’s (1992) study and the CSP. AKKA’s participants had significantly different percentages within the questions’ responses for all three questions, demonstrating a low attitude to the student–clinical instructor relationship.

**Table 4.46: Comparison of Stagg’s (1992) attitude survey for the theme of ‘instructor–student relationship’ for Stagg, AKKA and the CSP**

<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th>U</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Stagg</td>
<td>AKKA</td>
<td>CSP</td>
</tr>
<tr>
<td>The nursing students are too chummy with their instructors.</td>
<td>9.4</td>
<td>71.4</td>
<td>8</td>
</tr>
<tr>
<td>Nursing students rely on their instructors more than ward nurses.</td>
<td>32.1</td>
<td>64.2</td>
<td>10.5</td>
</tr>
<tr>
<td>It is about time instructors eased up on nursing students.</td>
<td>5.7</td>
<td>28.7</td>
<td>8</td>
</tr>
</tbody>
</table>

**Personal issues:** There were seven questions in the attitude survey that related to personal issues. The findings of Stagg’s study (1992) and the CSP are outlined in Table 4.47. Aghamohammadi-Kalkhoran et al. (2010) did not include a table referring to the findings of personal issues. The article stated that in relation to personal issues, ‘A majority of nurses (67.14%) feel that nursing students were determined enough and 45.71% disagreed with their self-confidence’ (p. 479).

In comparison to Stagg (1992) and the CSP, participants showed similar responses of positive attitudes in relation to nursing students accepting constructive criticism, enjoying working with students, students providing good patient care and students admitting when they did not know something. Differences of opinion were found in relation to students becoming overwhelmed if they were responsible for more than one or two patients. In Stagg’s study, 62.2% of participants agreed with this statement compared to 25% in the CSP. Further, Stagg’s participants were less positive about students’ level of confidence and assertiveness compared to the CSP group.
### Table 4.47: Comparison of Stagg’s (1992) attitude survey for the theme of ‘personal issues’ for Stagg, AKKA and the CSP

<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Stagg</td>
<td>AKKA</td>
<td>CSP</td>
<td>Stagg</td>
<td>AKKA</td>
<td>CSP</td>
<td>Stagg</td>
</tr>
<tr>
<td>Nursing students accept constructive criticism.</td>
<td>71.7</td>
<td>66.5</td>
<td>22.6</td>
<td>26</td>
<td>5.7</td>
<td>7.5</td>
<td></td>
</tr>
<tr>
<td>Nursing students become overwhelmed if they have to care for more than one or two patients.</td>
<td>62.2</td>
<td>25.5</td>
<td>17</td>
<td>33</td>
<td>18.9</td>
<td>41.5</td>
<td></td>
</tr>
<tr>
<td>Nursing students are too dependent on ward nurses.</td>
<td>13.2</td>
<td>14.5</td>
<td>9.4</td>
<td>29</td>
<td>71.7</td>
<td>56.5</td>
<td></td>
</tr>
<tr>
<td>Nursing students do not have enough confidence in themselves.</td>
<td>49.1</td>
<td>24</td>
<td>24.5</td>
<td>31</td>
<td>24.5</td>
<td>44.5</td>
<td></td>
</tr>
<tr>
<td>I enjoy working with nursing students.</td>
<td>90.5</td>
<td>95</td>
<td>5.7</td>
<td>4</td>
<td>1.9</td>
<td>1.5</td>
<td></td>
</tr>
<tr>
<td>Overall, nursing students provide good patient care.</td>
<td>79.2</td>
<td>71.5</td>
<td>7.5</td>
<td>25</td>
<td>9.4</td>
<td>3.5</td>
<td></td>
</tr>
<tr>
<td>Nursing students admit when they do not know something.</td>
<td>71.7</td>
<td>63.5</td>
<td>20.8</td>
<td>22</td>
<td>7.5</td>
<td>14.5</td>
<td></td>
</tr>
<tr>
<td>Nursing students practice assertiveness.</td>
<td>28.3</td>
<td>49.5</td>
<td>45.3</td>
<td>33</td>
<td>26.4</td>
<td>17.5</td>
<td></td>
</tr>
</tbody>
</table>

**Background information:** Four questions were related to this theme. This encouraged participants to compare their own experiences with current students. The findings of the three surveys are presented in Table 4.48.

Findings for the three research projects showed that the majority of participants agreed that nurses should be nice to nursing students, with 98% or more within each study group. The majority of participants disagreed that they did not receive more clinical hours in their nursing training or that students should have it tough. The responses for the final question indicated a difference between all three surveys; this related to the inappropriateness of calling clinical instructors by their first names. Over 70% of Stagg’s (1992) participants agreed with this statement compared to 31% in AKKA’s (2010) study and 28% in the CSP.
A comparison of the findings for the seven themes of the attitude survey highlighted that the results for Stagg’s (1992) study and the CSP showed similar trends in the data. Differences were noted in the questions related to confidence, assertiveness and students’ ability to provide patient care, with the CSP results showing a more positive response. In comparison, findings from Aghamohammadi-Kalkhoran et al.’s (2010) study showed significantly different responses. This was demonstrated in each of the seven themes, with the responses overwhelmingly negative towards students and clinical supervision compared to Stagg’s study and the CSP. Possible differences for these findings will be discussed in Chapter 6.

4.5 Quantitative Findings

The quantitative findings included in this chapter were retrieved from the knowledge survey and Stagg’s (1992) attitude survey. Participants completed these surveys both before and after the program on the day, and after a period of eight weeks.

The purpose of these surveys was to determine participants’ knowledge and attitudes prior to attending the study day program, and the effect of the program on participants’ knowledge and attitudes after attending the program on the day and after a period of eight weeks.
The quantitative findings demonstrated that participants experienced an increase in the mean score in the knowledge survey from the pre-program to the immediate surveys, and that this occurred across all subgroups that were analysed. These subgroups included the participant demographics of age, area of employment, years of nursing, frequency of clinical supervision and previous education relating to clinical supervision.

The analysis of the attitude survey involved two different analyses, including allocating an overall score for the survey and examining each question within the survey with the ranges of responses received. Both data analyses demonstrated that an improvement in the attitudes in the CSP participants was achieved between the pre-program and immediate post-program surveys. This was again demonstrated in the eight-week surveys across both analyses. It must be noted that the mean scores of the eight-week survey were slightly lower (101.6) than the immediate survey completion mean (102); however, the results still showed a positive attitude towards clinical supervision, with a pre-program mean score of 97.6 out of a possible 117. Similar to the knowledge survey, no significant difference was found between the different subgroups within the study population.

Although not statistically significant, it was noted in the knowledge surveys that participants who were employed in the metropolitan/public health care service, had the most involvement in clinical supervision, had 21–30 years of nursing experience and were 41 years or older had the highest mean score.

In comparison, Stagg’s (1992) attitude survey highlighted that participants who were employed in the metropolitan/public health care service and who were over the age of 41 had the highest attitude mean score towards students. However, in contrast to the knowledge survey, the attitude survey participants who supervised students most days had a lower result in the attitude survey compared with those who supervised some days, with the most positive results found within the ‘some days’ group across all three phases of data collection. These two groups always supervised students each week; however, it would appear that the ‘some days’ group also had an opportunity each week to experience some time without students. This is a significant finding for educators and ward managers to consider when allocating students to clinical supervisors in the workplace.
The second difference between these survey results highlighted that nurses with 1–10 years of experience had the highest mean scores across all three phases of the attitude survey. This was followed by the group with 11–20 years of experience. Again, this is in contrast to the knowledge survey, in which those with the most years of experience had the highest mean results.

From these findings, the researcher concluded that while knowledge may be improved by the frequency of clinical supervision and the number of years of experience as a registered nurse, participants who supervised ‘some days’ each week and who had the least nursing experience provided the most positive attitude results across all phases of data collection. This may have been a result of these participants feeling a greater connection with students, as they had recently been students themselves. However, the differences between these groups were minimal, and all groups across all stages of data collection improved the mean score with both surveys.

The findings from the analysis of both the knowledge and attitude surveys indicate that the program positively affected participants’ knowledge related to the principles of clinical supervision and attitudes towards students and the clinical supervision relationship. These findings will be discussed in further detail in Chapter 6, and their implications for future practice and standards in the education of clinical supervision will be discussed in Chapter 7.

4.6 Chapter Summary

This chapter presented and analysed the data in relation to participants’ knowledge and attitudes towards the clinical supervision of nursing students on clinical placement. It incorporated the quantitative data collection and analysis of participants’ knowledge and attitudes before and after attending the CSP through the use of the survey tools. It also included a review of the findings of the previous use of Stagg’s (1992) attitude tool to facilitate a further comparison in Chapter 6.

Chapter 5 will analyse and discuss the findings of the qualitative data analysis in accordance with a convergent parallel design, as shown in Figure 3.1, as utilised for this research. Chapter 6 will present a comparison of these data findings with the literature, and Chapter 7 will
present the implications and recommendations of these findings for future practice, education and research.

***

She wondered whether nursing was for her. She had loved the course so far and had been so excited to start her clinical placement. But now, in the real world, she began to question whether it was always going to be like this. Her clinical facilitator was a godsend. She continued to encourage the students and highlighted their achievements. She shared stories with them about her own nursing career and all the possibilities that awaited them. But would she alone be enough?
Chapter 5: Qualitative Data Analysis and Findings

The placement was finished, the assessment was passed, and she no longer had to return. She talked to her nursing friends and many had experienced the same as her—they all wondered whether nursing was for them. But they heard some positive stories and saw students glowing with excitement and discussing how wonderful the nurses were and how they couldn’t wait to go back. Perhaps they should stay and hope for the same.

5.1 Introduction

In the previous chapter, the quantitative data were analysed and described. This chapter will analyse the qualitative data collected from the CSP participants, including the open-ended questions in the knowledge surveys, the online reflections and the individual interviews. Each data source was separately analysed, and an overall comparison of both the quantitative and qualitative findings will be discussed in chapter six.

Upon completing the comparison of the qualitative findings, this chapter will also present an evaluation of the program. The researcher felt that it was important to provide a program evaluation to gain comprehensive feedback about the program. The immediate and post eight week knowledge surveys included program evaluation questions. It is important to ensure that the educator receives feedback about the program content, delivery method, presentation style and recommendations for the future delivery of the program. This information may be of importance to future educational departments that want to implement this program.

5.2 Qualitative Data Collection

Data collection methods for the qualitative data included open-ended questions from the knowledge surveys, as well as the online reflections and interviews. A total of 198 participants completed the immediate post-program survey and 67 completed the eight-week survey, providing the researcher with a number of completed forms with participants’ open-ended survey comments.
At the conclusion of each CSP presentation, participants were invited to participate in the online reflections. Consent to participate was received from 94 participants, and 117 emailed reflections were received over the eight-week period.

On the immediate post-program survey, participants were asked to indicate their willingness to be interviewed. Participants who agreed to be interviewed needed to have completed the eight-week survey and circled that they had supervised students since attending the CSP. Sixteen participants met all three criteria to be interviewed, as displayed in Table 5.1.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>No. of participants</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Agree to be interviewed</td>
<td>80</td>
<td>40%</td>
</tr>
<tr>
<td>2 Agree and completed the 8-week survey</td>
<td>40</td>
<td>20%</td>
</tr>
<tr>
<td>3 Agree, completed the 8-week survey and supervised students since the CSP</td>
<td>16</td>
<td>8%</td>
</tr>
</tbody>
</table>

5.3 Qualitative Data Analysis

The qualitative data analysis process consisted of three sources of data: knowledge survey open-ended questions, online reflections and interviews. Each data source was analysed in relation to the principles of thematic data analysis according to Braun and Clarke (2006).

For this research, thematic analysis is defined by Braun and Clarke (2006, p. 79) as “a method for identifying, analysing and reporting patterns (themes) within data”. The method of analysis utilised was a ‘realist’ method, which “reports experiences, meanings and the reality of the participants” (Braun & Clarke, 2006, p. 79).

Braun and Clarke (2006, p. 87) recommended the following stages for thematic analysis:

- becoming familiarised with the data
- generating initial codes
- searching for themes
- reviewing themes
- defining and naming themes
- producing the report.
The first stage of analysis—familiarisation with the data—involved the researcher reading the survey responses, online reflections and interview transcripts multiple times. This strategy was designed to immerse the researcher within the data in order to become familiar with the content and depth of information (Braun & Clarke, 2006).

Analysis of the data then involved generating initial codes. The researcher first highlighted significant statements that explained an understanding of the participants’ experiences of the phenomenon (Braun & Clarke, 2006). This gave the researcher examples to summarise into keywords/codes.

An example of several significant statements within one quotation by a participant (CSP68) in the eight-week (8wk) survey is shown below, with the initial codes of ‘belongingness’, ‘student learning’ and ‘reflection’ identified within the text by the researcher:

Make a much bigger effort to make students comfortable, introduce them, write down their name on the board, provide more time for observation if required as not all students ready to jump in straight away, use more supportive and reflective sessions to ensure coping with the routine, break skills down more and give them parts to do they are confident with (CSP68 8wk).

Allocation of codes to text:

- **Belongingness**: “Make a much bigger effort to make students comfortable, introduce them, write down their name on the board”.
- **Student learning**: “Provide more time for observation if required as not all students ready to jump in straight away, use more supportive and reflective sessions to ensure coping with the routine, break skills down more and give them parts to do they are confident with”.
- **Reflection**: “Use more supportive and reflective sessions to ensure coping with the routine”.

Upon further reading of the open-ended answers of the surveys, the online reflections and the interviews, the initial codes were continually refined until the researcher felt confident that no new codes were necessary. The researcher then used these codes to form themes. According to Braun and Clarke (2006, p. 82), a theme “Captures something important about the data in relation to the research question, and represents some level of patterned response or meaning with the data set”.
The initial development of themes for the open-ended survey questions included the ‘principles of student learning’, ‘providing feedback and reflection’ and ‘belongingness’. These themes were then continually reviewed and refined while re-reading the data. The final review resulted in the creation of two overarching themes of ‘effect on participant’ and ‘strategies for improving clinical supervision’. These then included the subthemes of ‘improved self-confidence’, ‘renewed enthusiasm and attitude’, ‘consolidation of knowledge and skills’, ‘understanding of current context of nursing education’ and, within the second theme, ‘embracing the power of belongingness’, ‘empathy for the student experience’, ‘improving the student learning journey’, ‘improving communication’ and ‘promoting staff knowledge and culture change’ (see Figure 5.1).

Due to the phases of the research process, the data analysis occurred at different times for each data source, and each set had its own thematic analysis. As the data from the surveys and online reflections were collected and read, this also guided the researcher in ensuring that the interviews were then used to confirm the findings and explore areas of interest.

As suggested by Braun and Clarke (2006), during the process of reading, coding and theming the three qualitative data sources, the researcher continually referred back to the research questions to ensure that the findings had been clearly articulated to answer the questions. The researcher was confident that this had been achieved and commenced the final stage of analysis—producing the report. The report was formulated in accordance with the phases of the research process discussed in Chapter 3; that is, each data collection was analysed separately, with confirmation of the findings across the sources upon completion of the analysis stage.

Each of the qualitative data collection methods will now be described in relation to the findings. The comparison of the study’s findings with the literature will be discussed in Chapter 6, and the implications of the findings will be discussed in Chapter 7.

The following codes were allocated to identify each data source:

- IP: immediate post-program survey completed at the end of the study day
- 8wk: eight-week survey sent to participants eight weeks after the program
• OR: online reflections, which were received for eight weeks via email
• I: interviews.

The first qualitative data to be analysed will be the knowledge survey open-ended comments made by the participants in the IP and 8wk surveys, followed by the ORs and the Is.

5.3.1 Knowledge Surveys

The general findings of the knowledge survey open-ended questions can be summarised by the following quotation: “I think I feel more confident having done this course to be more assertive and a better advocate for them…I feel I have a greater understanding of the importance of my role” (CSP90 IP). Figure 5.1 outlines the concept map of the themes and subthemes identified in the findings of the open-ended survey questions.

Figure 5.1: Concept map of the open-ended survey themes and subthemes
In developing these themes, the researcher used the knowledge surveys from the immediate post-program and eight-week surveys. The survey contained four questions that were not included in the quantitative survey score. For these four questions, participants were asked to comment directly about the program and its effect on their knowledge and practice.

On receipt of the surveys, the researcher read and re-read each entry. In doing so, the researcher was mindful of the research questions and the need to identify data that assisted with answering these. Using a notebook, the researcher then wrote notes and ideas that could be used for the establishment of initial codes in relation to the research questions, and statements of interest were also highlighted. The researcher then re-read all of the open-ended answers and began applying codes. An example of a highlighted statement is shown below, with codes written next to the text:

I can be a more effective clinical supervisor than I have been by: welcoming, belongingness, role modelling, and teaching them in different ways, that can help them to understand in a better way, as different people have different learning ways (CSP45 IP).

Allocation of codes to text:

- **Increase confidence**: ‘I can be a more effective clinical supervisor than I have been by welcoming, belongingness, role modelling, and teaching them in different ways’.

- **Belongingness**: ‘I can be a more effective clinical supervisor than I have been by: welcoming, belongingness, role modelling, and teaching them in different ways’.

- **Student learning**: ‘that can help them to understand in a better way, as different people have different learning ways’.

The researcher read the surveys on several occasions to ensure that all of the significant statements had been highlighted and that the necessary codes had been applied appropriately.

When it was felt that no further codes or themes were required, the researcher re-read all of the surveys to confirm the findings on two more occasions. Slight adjustments to the codes and themes were made, which involved merging some themes into a more concise list. For example, the initial themes used by the researcher—‘improved self-confidence’, ‘improved attitude’ and ‘refreshed passion and enthusiasm’—were combined under the theme of ‘impact on participants’, with the creation of the subthemes of ‘improved self-confidence’, ‘renewed enthusiasm and attitude’ and the inclusion of ‘consolidation of knowledge and skills’ and
‘understanding of current context of nursing education’. A second theme was also consolidated under the heading of ‘strategies for improving clinical supervision’, with the subthemes of ‘embracing the power of belongingness’, ‘empathy for the student experience’, ‘improving the student learning journey’, ‘improving communication’ and ‘promoting staff knowledge and culture change’. The themes identified from the post-program surveys were:

- effect on participants
- strategies for improving clinical supervision.

Each theme will be explored in relation to the immediate post-program and eight-week surveys. The themes consist of a number of subthemes due to the depth of the findings within each theme. To support the researcher’s findings, direct statements have been included from the participants’ surveys. Due to the space constraints of the survey and the time limit during the study day, these written quotations were succinct and short, but were beneficial to the researcher in providing insight into the thoughts, perceptions and concerns of the participants. The first theme that will be reviewed is ‘effect on participants’.

5.3.1.1 Effect on Participants

An example of the general feelings of the CSP participants in relation to the effect of the program can be seen in this quotation: “I feel a lot more informed now and have realised the complexity and importance of the supervision of students, a real learning curve” (CSP25 IP).

The first theme—‘effect on participants’—consisted of a number of subthemes in relation to the effect of the CSP study day. These subthemes all related to the effect of the program on participants as identified in the immediate post-program and eight-week surveys. Effects included an improvement in self-confidence, improved attitude and renewed enthusiasm for the clinical supervision role. For some, it provided an opportunity to consolidate their knowledge and skills, and for others, it related to understanding the current Australian nursing education requirements. Each subtheme within ‘impact on participants’ will now be explored.
5.3.1.1.1 Improved Self-confidence

The majority of participants wrote general statements about how the study day program had improved their self-confidence as clinical supervisors due to a better understanding of the role and requirements. While these comments were generally one-line statements, the number of comments provided confirmed that they were important thoughts shared by the participants. An example of these comments is provided below.

In the IP survey, participant CSP119 stated that the program “Gave me more confidence and expertise to be an effective mentor for my students”, while CSP177 IP wrote that the program “Gave me the confidence and education to work with students to improve needs, on role modelling, and working with them”. CSP184 IP confirmed this view: “It increased my confidence in my ability to supervise students and taught me things that I had not thought about before”. Participant CSP17 IP stated that “I was expecting to leave the program with a better understanding of teaching undergraduates. I have that and feel empowered to take action”. In closing, CSP90 IP stated that “I think I feel more confident having done this course to be more assertive and a better advocate for them (students)”.

Participants also related this increase in self-confidence to particular aspects of the clinical supervision role. This affected participant CSP26 IP’s willingness to accept the allocation of a student: “Makes you feel more comfortable to accept having a student as well as being able to provide a better situation for the student”. CSP116 IP was inspired by this increase in self-confidence to provide a better clinical placement for students: “More confidence, more genuine interest in encouraging best outcome for the prac experience”. This was also expressed by CSP182 IP: “Will feel more confident when supervising students, be more constructive”.

Participants also discussed how the program had been the catalyst for renewing their enthusiasm for the role and reflecting upon their attitudes. This is discussed in the next section.
5.3.1.1.2 Renewed Enthusiasm and Attitude

Statements about renewed enthusiasm and attitudes related specifically to participants’ attitudes towards students and student clinical supervision, as well as revitalised enthusiasm for the role of clinical supervisors. Participants used the terms ‘enthusiasm’ and ‘attitude’; therefore, both are used to highlight the significance of this theme.

An improved attitude was demonstrated through participants’ statements that highlighted a self-awareness of their own attitude, the effects it could have and how it needed to change. Statements by participants in relation to self-reflection of their own attitudes towards nursing students and clinical supervision included CSP173 IP, who stated that the program “Gave me an insight into my opinions”. This was also commented on by CSP103 IP, who stated that the program “Has changed some pre-conceptions”. Participant CSP60 IP highlighted how the program had been of assistance: “Made me reflect, and the desire to support students to the best of my ability”. Participant CSP184 IP stated that “I will be more aware and sensitive to students’ needs, thoughts and feelings in the future”. The program gave participant CSP74 IP an opportunity for self-examination from a perspective that was broader than just the clinical supervisor role: “Gave me better understanding about myself as a RN”.

Linked closely to one’s attitude, participants commented about how the program had renewed their passion and enthusiasm for the role of clinical supervisors. These comments were generally related to an overarching feeling that they expressed after attending the study day program and included the use of terms such as ‘motivated’, ‘encouraged’ and ‘more willing’. Participant CSP30 8wk felt “More motivated, structured, organised approach, and open attitude”, and this enthusiasm inspired CSP173 IP to engage in further learning: “You have generated an interest and I am looking forward to reading some of the articles to improve my clinical supervision”. CSP89 IP stated that the program had, “Motivated me to demonstrate via role modelling and an understanding where students may be coming from, i.e. identify fears/anxieties”. Participant CSP91 IP discussed how the program had provided encouragement to continue in the role: “Continued to give me encouragement to give students a positive experience, ensure they’re welcomed, introduced to staff, goals set and learning opportunities provided”. CSP183 IP also articulated these thoughts: “More willing to take in a student and teach…gained more knowledge regarding how to be a better preceptor to a student.”
Participants also made reference to how the program had made them reflect on their workplaces’ practices. This included comments about negative attitudes held by some staff, a lack of general interest in student placements and the students themselves: “Very interesting and has made me realise that we could be doing a lot better” (CSP25 IP).

These perceptions of the work environment were documented on numerous occasions and are discussed in more detail in Section 5.3.1.2. The next section will review the findings related to participants’ consolidation of their knowledge and skills.

5.3.1.1.3 Consolidation of Knowledge and Skills

For some participants, the CSP provided an opportunity to confirm what they thought they were required to do and if what they were doing was best practice. In addition, they were able to clarify difficult or poorly understood concepts, and the importance and effects of the clinical supervision relationship.

Participant CSP121 8wk stated that the program ‘Supported what my preferred practice would be and renewed my skills/understanding of the process’. CSP36 IP stated that “It reinforced what I am doing correctly and helped me to identify areas I could improve in”. CSP71 IP stated that the program provided “Consolidation of my thoughts on the need for a positive attitude and the benefits to students in their outcomes”. Participant CSP169 IP wrote that “I have a further understanding on how I can assist students in enabling them to have a positive placement”. CSP89 IP commented that the program was “Comprehensive, informative and insightful. Good analogies to assist with understanding situations…enabled better understanding of the role as a clinical supervisor”.

For some participants, clarifying concepts or taking their understanding of a topic or concept to a more meaningful or practical level was an important outcome of the day. Participant CSP64 IP wrote that the program provided a ‘Simple explanation of sometimes difficult concepts’ and participant CSP44 IP was “able to consolidate own knowledge and feel supported by this day by the theories I have learned”. CSP57 IP wrote that the program “Reinforced concepts I already held as important by outlining why it’s important, e.g. belongingness relationships with motivation, learning, reduced anxiety”.

188
These thoughts were confirmed by a number of participants. CSP64 IP stated that the program “Reinforced things I knew, could build on things I didn’t know, or different ways of dealing with situations”. CSP73 IP wrote that ‘I found the whole day informative even though parts was refreshing already known knowledge…it was a wealth of information”. Participant CSP32 8wk said that ‘I gained so much extra information to assist with students and it also felt good that we were doing so many thing[s] well”.

The next subtheme related to a better understanding of the current nursing education context.

5.3.1.1.4 Current Context of Nursing Education

Participants identified that the CSP had given them a better understanding of Australian nursing education requirements. A number of participants wrote that they were new to practicing nursing in Australia and had been unfamiliar with the Australian education system and the requirements of these programs. For other participants, it provided an opportunity to gain an understanding of the current system, as they had trained under a different nursing education system in Australia.

In particular, a number of participants identified themselves as overseas-trained nurses. These participants commented how the program had assisted them to understand the Australian nursing education system: “It gave me a better understanding into the Australian nurse training and student expectations” (CSP156 IP) and “It gave me an insight into the Australian nurse training system” (CSP82 8wk).

Some of the internationally trained nurses commented that they had attended the Royal College Mentorship training program in the UK, and they explained how the CSP had consolidated their previous learning to relate to the Australian system: “Refresher mentorship skills, as from UK, has given me insight into Australian student nursing, what is expected of supervisors” (CSP163 IP), and “Update previous learning on mentorship course/assessors course from UK. Good to have Australian perspective/differences” (CSP179 IP).

Participants also outlined how the program had provided them with a better understanding of the current system, even though they were Australian-trained themselves. This was discussed during the study day as the ‘students’ journey’. Participant CSP99 8wk stated that the
program “Gave ideas that stimulated new ways of connecting with students…beneficial to understand nurse training today” and CSP42 IP wrote that the program “Increased my understanding of the student journey”. CPS77 IP said that “The program thoroughly addressed the roles and terms…to better understand the supervision of nursing students”, while CSP89 IP stated that the program was “Comprehensive, informative and insightful, good analogies to assist with understanding situations, enabling a better understanding of the current role”.

The second theme identified from the open-ended survey findings was the strategies that participants gained from attending the program that they could use in their role as clinical supervisors to assist them with their students.

5.3.1.2 Strategies for Improving Clinical Supervision

Participants’ comments in the surveys related to strategies for improving clinical supervision. Participants identified this as an important outcome of the program, as articulated in a statement by CSP21 8wk: “It is important to be up to date with educational trends and learning principles of the current generation of students”.

The strategies that participants outlined in the surveys to assist them to provide a more positive learning experience for students on clinical placement related to a number of discussions and topics that were presented during the CSP. These strategies were refined into the subthemes of ‘embracing the power of belongingness’, ‘empathy for the student experience’, ‘improving the student learning journey’, ‘improving communication’ and ‘promoting staff knowledge and culture change’. These themes are discussed in more detail below.

5.3.1.2.1 Embracing the Power of Belongingness

On the study day, participants explored the literature in relation to belongingness and discussed strategies for incorporating it into their workplaces. A number of entries referred to the concept of belongingness, from learning about the definition of belongingness to the interest that the session raised regarding its effect on the clinical supervision relationship. CSP130 IP stated that “The section on belongingness, most interesting, I used the topic with
the students”, while CSP66 IP commented on the program session as an important take-home point of the day: “Group work activities with the ability to critically reflect on the various articles relating to belongingness”.

Participants discussed that the session had provided them with an insight into the importance of belongingness: “I was not bothered by belongingness before the seminar and the seminar gave me an insight of the importance of being belonged” (CSP45 IP). CSP25 IP stated the importance of “Realising the impact on students if they feel they don’t belong in a department”, and CSP114 IP “Will now be more informed as to student feelings and importance of belongingness and the power of this…heightens importance of the need to guide, support, recognise student RNs on prac”. CSP68 IP stated that “The need to ensure a sense of belongingness for the students—had not realised how imperative it is to the student’s progress”.

Participants discussed some simple strategies to create an environment of belongingness to support the student. Examples of ideas included, “Ensure their names are on the rosters…have allocated staff for continuity” (CSP120 IP) and “Ensure there is an orientation package for the work area for students, as not in place” (CSP181 IP). Other ideas included to be “Better at welcoming them and guiding them, asking what they want to achieve and involving other staff to attain their goals” (CSP191 8wk), as well as “To encourage confidence, belonging to a team, welcoming of new knowledge and experiences students can share with us. Trust students with tasks where possible, be more active in reflections with students” (CSP31 IP), and “I think I will be more conscious in welcoming students with a more comprehensive orientation” (CSP39 IP).

Participants also wrote comments linking the importance of belonging to the ability of students to learn effectively. CSP54 8wk “Also realise(d) more that how the students are welcomed and included affects their learning capability”. Further, “The importance of belonging and how we support them and how this effects their learning in this clinical placement’ (CSP58 IP). CSP190 IP was ‘more aware that students need to have a positive culture to learn in’.

As discussed within the subthemes related to participants’ knowledge and attitudes, participants expressed concerns about the attitudes of staff in their workplaces. They linked
the concept of belongingness to staff attitudes as a strategy to improve attitudes towards students: “The idea of belongingness would probably be beneficial to some of my colleagues who are generally not keen on having students” (CSP88 IP). CSP155 IP stated that “All staff should be aware of students needs and the importance of promoting a culture of support towards students”. Participant CSP78 IP wrote about his or her role in creating a ward environment that was conducive to creating a sense of belonging: “I understand better how students feel when in my ward and I understand I have to break the barrier of some staffs’ negative mindset”.

Participants’ comments relating to belongingness were echoed in many of the other themes of the qualitative findings and will continue to be discussed in the following sections. The next section refers to the students’ experiences.

5.3.1.2.2 Empathy for Students’ Experiences

Participants stated that they had acquired a better understanding of students’ journeys and the challenges they faced during their nursing education programs: “Students’ perspectives and nurses’ perspectives, useful information that I can apply to my work…greater understanding of the wider picture and the students’ needs” (CSP128 IP).

During the study day, participants discussed what they believed the effects of these challenges must be on the students. Discussions included the workload of students who were studying and working, the cost of studying at university and the many challenges that the youth of today were faced with (e.g. social media). For many participants, these group discussions highlighted that the student clinical experience was just one part of the student’s life, with many other elements competing for their time and energy.

For some participants, the study day reminded them of what it felt like to be a student and brought back memories of their own student journey: “I have been reminded of what it means to be a student or new staff member” (CSP42 8wk). This was also commented on by CSP191 8wk: “More attune to their needs and remembering how hard it was and be a student in a new area”. While CSP64 8wk stated that it “Made me think of what it was like to be a student and how to improve things for future students”. These feelings and thoughts continued to be expressed throughout the day’s discussions and surveys.
Participants also commented on how the program had assisted them to see the placement from the students’ point of view: “Gave insight into the students aspects of clinical placement, long time since I was a student…helps with understanding students needs” (CSP149 IP). This was supported by CSP72 8wk: “It has made me more aware of the importance of inclusion into the team and some of struggles students of today face”.

Participants wrote about how their improved understanding of the students’ journeys helped them to understand how they could best support students as clinical supervisors: “It has changed the way I would supervise students. I know the right way to do things…gives us more insight on the students perspective to clinical” (CSP152 IP). Another participant stated that “(We) discussed how students feel and how to see things from their perspective in order to support them appropriately and sensitively…increased awareness of own practice” (CSP184 IP). Further, participant CSP164 8wk said that:

To highlight the importance of student nurses coming through and the value of putting effort into enriching their clinical experience…to be reminded of what it is like to be a student and prompt simple actions an experienced nurse can do to improve the clinical experience of a student.

For some participants, their reason for attending the program was to support staff in their workplaces who supervise students. These managers, educators and staff development nurses commented on how this understanding was important to take back to the team to help them to support students:

It has helped me understand from a student nurse’s point of view. I rarely supervise students but am in charge of a ward that does so it will help me help my nurses be better educators and make the students feel more welcome and part of the team (CSP84 IP).

Participant CSP49 8wk “Feel[s] I can better instruct staff on how to work with students”.

Participants also suggested that greater staff attendance to the program would assist with the development of a positive culture and an understanding of students’ journeys so that a team approach could be used to support students. Of recommending the program, CSP166 IP wrote: “To help ensure continuity and uniformity for all students experience on prac. Improve team approach to clinical supervision”, while CSP89 IP said “Feel it (program) is important in
maintaining continuity of clinical supervision for student nurses and implementing ideas to ease integration of student with the nursing team”.

The subtheme of ‘improving the student learning journey’ was closely linked to ‘empathy for the student experience’; however, it was created separately, as participants commented specifically about how understanding students’ experiences assisted them with providing an effective learning placement.

5.3.1.2.3 Improving the Student Learning Journey

During the study day program, participants were asked to complete a self-assessment of their own learning style and how they liked to learn. Participants soon realised the differences in the room and discussed the implications of these in the fast-paced clinical setting, where many barriers can exist to prevent or diminish learning. Statements in the surveys related back to these conversations: “I will have more awareness of the students’ needs, and will be more active in their education, I will also encourage my colleagues to embrace the role” (CSP109 8wk).

Participants commented about the different learning styles and how this information had made them reflect on their teaching practices: “I liked exploring different learning styles and applying research to practice” (CSP55 IP). CSP74 IP stated that “It gave me more guidance about different ways of teaching and providing education”, while CSP120 IP wrote that the session was “Very useful in supervising future students and understanding about their learning needs”.

Participants documented how they had enjoyed learning more about this topic and how they believed it would be of benefit to them: “I learnt how to be effective as a mentor and the factors which can enhance or fail the students learning experience” (CSP87 IP), and “I have skills to guide learning and also to describe the processes involved in how to support/supervise/facilitate students” (CSP29 IP).

Comments also related to the concept of clinical competency, what this meant and how it related to students’ clinical placement. CSP131 IP would “be more understanding of students’
level of competency”, while CSP72 IP wrote that “I have a better understanding of their tool competencies that require to be completed”.

Participants wrote comments about the session on belongingness and its relationship to achieving competency. Participant CSP155 IP would be “More aware of the need for security/belonging etc. to learning and eventual competence”, and participant CSP49 IP said that “I have to provide students with safety, a sense of belonging, so the student gains a positive self-concept and gains positive learning and competence”. Participant CSP161 IP wrote that “I will be more mindful of making them feel they are part of the team and orientating them to the ward so that they can feel comfortable and confident to start learning”.

Participants also linked the previous subtheme of ‘empathy for students’ experiences’ to the students’ learning journeys and creating positive placements. CSP139 IP “Will have more empathy for students, more understanding of how students learn”, and CSP93 IP said that “It was very informative and enlightened attendees to the concerns of students and how their placements can be made more of a positive learning experience”.

Participants also provided examples of how a greater understanding of the students’ learning process had assisted them to think about how they would teach, or how they had taught, in the clinical area since attending the program: “I will try to explore and understand what the student wants/needs to get out of their practical placement and make sure their needs are met in a timely manner” (CSP133 IP).

In both the immediate post-program and eight-week surveys, CSP33 8wk made the following comments on student learning:

Ask them what they would like to learn, and how they learn. Empower them and work together [IP]…and It helped me to better assess and learn individual learning styles for the students I have encountered over this time [8wk].

Other strategies outlined by participants included:

Gave me an insight into different learning ways, having some idea of student levels and expectations…[I] will talk at the beginning of a shift with my student and find out how they learn and pick out 1–2 things to teach that shift (CSP35 IP).
Further, CSP23 IP stated that the program “Gave me an easy and effective way of teaching students, and how to approach their learning expectations while providing my nursing care”. In the eight-week survey, CSP21 shared the strategies that he or she had put into practice: “I take more time to seek the student’s history and describe their goals, achievements and expectations of the clinical placement”.

Some participants discussed taking this information back to their workplaces and discussing it with their colleagues: “To feedback to ward staff to change our practice/understanding of what students need, set up a conducive learning environment” (CSP27 IP).

In the eight-week survey, CSP34 wrote of changes that he or she had introduced not just for themselves, but also for the team, since attending the program: “It changed the way we mentored students in our work area and the feedback from other staff and students was extremely positive”. For participant CSP77 IP, this sense of taking information back to the team was from a multidisciplinary view: “To highlight to all health professionals the importance of guiding/supporting students in the clinical setting and recognising different learning styles”.

Learning about the effects of different learning styles was also related to the concepts of critical thinking and clinical reasoning. For some participants, understanding these terms was new, and it was a highlight of the program: “The explanations/clarification of terminology used such as critical thinking vs clinical reasoning” (CSP71 8wk), while CSP41 IP “Enjoyed learning about giving feedback to students and working through critical thinking/reasoning with students”. CSP187 IP wrote that “This has given me knowledge on how to give students better support in critical thinking and awareness”. CSP10 8wk wrote that:

I particularly enjoyed the styles of learning and also to have an understanding of how to promote clinical reasoning, critical thinking and reflection in practice…it will certainly aid me in trying to ascertain how my students learn best and adapt my supervision to optimise their learning and development while on prac.

Participants also discussed their new awareness of the nursing education context in Australia, the number of hours that students complete in the clinical area and the amount of time spent in the different areas of nursing. This included the effect of short placements and the need to start learning straight away. This was discussed along with working with different staff every day, and sometimes in different areas:
We have changed our workplace practice from switching a student to a new areas/staff each day to now only one staff member mentors one student for the whole two weeks. I set goals on the first day, I have a range of options for what we can accomplish and ask the student to identify what she believes will be the most beneficial for her learning. We then focus on the identified areas of learning for the two weeks until the student nurse demonstrates and reflects to me that she is and feels competent with that skill set (CSP32 8wk).

Other comments included: “Yes I now understand how critical it is that students make every minute count in their practicum” (CSP130 IP), and “I am also more mindful of making each day count in terms of them gaining as much experience as possible” (CSP47 IP).

Participants also discussed the session on ‘barriers to learning’. In listing the most helpful sessions of the day, CSP61 IP mentioned the “Detailed explanation of learning processes, barriers to learning and what facilitates better outcomes”, as did participant CSP47 IP: “Learning about the barriers to clinical supervision, gives me the ability to improve my supervision of undergrads”.

The next subtheme of ‘improving communication’ was very closely aligned with this subtheme of student learning, as participants appreciated that for effective learning to occur, students require the ability to reflect on their practice and receive constructive feedback.

5.3.1.2.4 Improving Communication

Participants commented about the sessions related to communication—these being the provision of feedback and reflection. Participants stated that they often struggled with these areas; however, after attending the program, they felt that they had acquired the necessary skill set and appreciated the importance of feedback and reflection: “I particularly liked the practical examples that you gave about providing students with feedback” (CSP135 IP), and “I will work on giving more feedback to all” (CSP150 IP). Further, participant CSP35 IP wrote about gaining ‘a better understanding of how to supervise nursing students and giving feedback both positive and negative’. CSP12 8wk stated that:

I have learnt a lot about how to help students…about how to provide feedback, especially when I have a certain issue or problem area to discuss. I used to find giving negative feedback extremely hard, but I now find by using the [strength, weaknesses, opportunities, opportunities] SWOT tactic and with practice it has become a little easier.
This newfound confidence was again related to the strategies presented during the day, as well as the group discussions, including challenges faced by participants and how these could be better managed: “I believe I now feel much more confident that we have the necessary tools for more effective intervention and guidance should this (struggling student) arise again” (CSP32 8wk).

CSP48 IP “Feel[s] more equipped in how I supervise students and provide feedback” and CSP129 IP said that “I feel more confident in being able to give feedback both negative and positive”. Participants again discussed in their comments how this information could benefit others in the workplace: “All ward staff would benefit from this course. Learning about appropriate ways to give feedback to students, ways to positively guide them, ask them what they want to again from this ward experience” (CSP62 IP).

The next subtheme relates to staff reflecting upon their own workplace practices and attitudes towards students and clinical supervision.

5.3.1.3 Promoting Staff Knowledge and Culture Change

In addition to the self-reflection of participants in relation to their own attitudes towards students and clinical supervision, participants documented that they had thought about the knowledge and attitudes held by others in their workplaces: “Students are sometimes considered unimportant and a hindrance in busy clinical areas” (CSP164 IP). CSP108 IP stated that “All practicing staff need this info, especially dare I say those who don’t have the enthusiasm to attend”.

Comments by participants related to the concerns of attitudes held by members of staff and the general lack of seriousness, understanding and effects of the clinical supervisor role on future career choices. The following comments relate to concerns by participants about this general lack of understanding of the effect of the clinical supervisor role on students: “Many other nurses at my workplace are clinical supervisors of students, I am sure they really have little or no awareness of just how important the role is” (CSP196 IP). CSP109 8wk stated that “Others need to be more aware of their responsibilities to nursing students and the role they play in their development”, and CSP55 IP said that “RNs are role models, they need to have
an understanding of how their practice impacts on student nurses, it is important for the profession”. CSP177 8wk highlighted the need for supervisors to understand their role to ensure that they provided a positive experience: “There needs to be more awareness and understanding among the experienced/practising nurses about student nurses’ needs and the benefits of giving them a good experience”. This was also discussed by CSP15 IP: “Nursing staff need increased awareness of students and clinical placements. Some of us need to change our attitudes and approaches”.

Participants related these concerns to the general knowledge of staff in relation to the clinical supervisor role: “I feel the majority of staff don’t understand how to supervise students to enhance their experience” (CSP127 8wk), and “It should be compulsory to all staff who work with students. I can think of a number of people who should have been here…we must be aware not to eat our young” (CSP105 IP).

Participants commented that the CSP could be one strategy to address these knowledge and attitude concerns: “It should be mandatory, annually or every 2–3 years to update changes” (CSP163 IP). In addition, CSP105 IP stated that “It should be compulsory to all staff who work with students”. Others believed that “It is an essential program for any staff member supervising or facilitating students” (CSP29 IP), while participant CSP17 8wk said that “I hope every hospital takes this program on board”.

Participants commented about the general importance of the program in assisting nursing staff to understand their role, as well as how the program could be of benefit to all nursing staff to achieve this: “A real requirement for preceptors, educators to understand students’ perception of nursing and the tools needed to support them” (CSP92 IP). CSP47 IP wrote that “As all staff are expected to be clinical supervisors it would give them tools to be effective teachers…it covered extra information not given in preceptorship course”, and CSP72 IP commented that “I have gained further knowledge in being able to support undergraduate students…I feel this session would be valuable to all student preceptors”.

Many participants highlighted how the program could assist in changing the attitudes of staff in clinical areas. CSP174 8wk stated that “It would change some people’s attitudes towards having students on the wards”, while CSP121 8wk wrote that “We should all undertake mentoring and preceptorship but not everyone has the desire or skills naturally, this supports
development of skills, even for those that find it more challenging”. This belief was supported by a number of participants—for example, CSP93 8wk wrote that “It created an awareness and identified issues both for the student and other supervisors…it encourages clinical staff to consider the role they have in supporting students” (CSP93 8wk). CSP179 IP stated that it was necessary to change the culture of the ward area and that the program was “Very positive with assisting changing attitudes towards student nurses”. CSP153 IP added that it would be “Better if all staff came and learnt for effective change”, and CSP190 IP agreed that “The more people that get to attend the easier it will be to establish a culture suited to students”. CSP97 IP also agreed with this belief: “Training for all nursing staff to educate about clinical supervision, (and) reduce stigma, negative thoughts about having a student”. Lastly, “I think it is a valuable tool (program) in accurately assisting/ensuring we as clinical supervisors warmly embrace students and ensure they have a positive experience and that we promote this to our nursing peers” (CSP32 8wk).

Participants also stated that the program was important for nursing educators and managers to assist them in understanding the role of clinical staff in supervision so they could better support them. CSP124 IP stated that “I feel all nurse educators could benefit from this course”, while CSP122 IP commented that the program provided “Very useful information for SDNs and nursing staff who work with students in the clinical area”.

This concludes the review of the data from the knowledge surveys both immediately on the day of the program and after eight weeks. These findings will be discussed in further detail in Chapter 6. The next section will review the findings of the online reflections from participants who attended the CSP.

5.3.2 Online Reflections

The participants’ online reflections echoed many of the same themes identified in the surveys, including general comments about the program and particular topics that they found to be the most interesting and useful. The following statement is a reflection of the general comments made by the participants: “Incorporating the materials from your Undergraduate Clinical Supervision seminar/training on ‘Belongingness’ as well as ‘Competency and Assessment’ sections proved quite useful” (CSP75 OR).
The online reflections offered a richer story of participants’ experiences of clinical supervision and their feedback about any concerns, ideas and thoughts that they had considered since attending the program. Figure 4.3 outlines the main themes and subthemes identified.

**Figure 4.3**

In order to obtain these online reflections, participants who had consented on the study day were invited by email to forward their online reflections for a period of eight weeks after attending the CSP. Participants were given guidelines for the structure of the reflections (Appendix 25) to assist them with their writing. The researcher received a number of reflections whereby participants discussed their interactions with students and/or staff or statements about their thoughts, queries and concerns in relation to clinical supervision.

As the reflections were received, they were saved onto the computer and printed in hard copy. Each reflection was read upon receipt and an email reply was immediately sent to thank the participant for his or her time and reflection. As the reflections were received, they were read by the researcher so that an understanding of the data and the emerging codes and themes.

**Figure 5.2: Concept map of the online reflection themes and subthemes**

In order to obtain these online reflections, participants who had consented on the study day were invited by email to forward their online reflections for a period of eight weeks after attending the CSP. Participants were given guidelines for the structure of the reflections (Appendix 25) to assist them with their writing. The researcher received a number of reflections whereby participants discussed their interactions with students and/or staff or statements about their thoughts, queries and concerns in relation to clinical supervision.

As the reflections were received, they were saved onto the computer and printed in hard copy. Each reflection was read upon receipt and an email reply was immediately sent to thank the participant for his or her time and reflection. As the reflections were received, they were read by the researcher so that an understanding of the data and the emerging codes and themes.
could commence. The aim of reviewing the data was to find data that related to the research questions.

Upon conclusion of the eight-week reflection period, all of the collated reflections were re-read several times. At this time, the researcher highlighted significant statements relating to the research questions, which assisted with coding and identifying emerging themes. An example of a significant statement is shown below, coded to ‘student learning’:

- **Student learning:** “From the study day we know how to give the students a more productive role in the working unit” (CSP185 OR).

The researcher then re-read the online reflections several more times to confirm the themes of the data. As identified in Figure 5.2, the themes for the online reflections were:
- effect on participants
- strategies for improving clinical supervision
- perceived lack of staff support.

The first of the themes to be explored will be the effect of the program on participants in their clinical supervision practice, followed by the strategies learnt from the day and the work file resource, and then the concerns highlighted by a number of participants in relation to staff support.

5.3.2.1 Effect on Participants

The general feeling of participants in relation to the effect of the study day program is highlighted by CSP42 OR, who documented that the take-home point of the study day was the role of clinical supervisors: “Characteristics of a clinical supervisor: creates a positive non-threatening environment, role modelling, developing safe and competent practice, identifying learning opportunities, provide regular and constructive feedback and assist the student to relate theory to practice”.

The effect of the CSP in the online reflections highlighted previous opinions and changes in participants’ thoughts towards students and the clinical supervision relationship. The
subthemes identified were ‘improved self-confidence’, ‘renewed enthusiasm and attitude’ and ‘personal reward’.

Although not included as a theme, participants also commented on how the eight-week reflective process had assisted them: “Doing the reflective feedback had made me look at my practice, how I interact with students…thank you for the opportunity” (CSP198 OR).

For CSP42 OR, the opportunity to write weekly reflections provided encouragement to refer to the resource file provided on the study day to assist with reflecting and confirming his or her actions: “It has been interesting to apply the workbook to my reflections so far. I have found it very appropriate in a variety of settings and situations…very beneficial for my personal and professional development”.

5.3.2.1.1 Improved Self-confidence

Participants provided statements relating to how they felt greater self-confidence in undertaking the role of clinical supervisors, as well as examples of how their increase in self-confidence affected their thoughts and actions. Statements outlining participants’ general feelings of improved self-confidence are provided below: “(The) clinical supervision seminar and resource file has allowed me to gain knowledge, terminology, confidence and leadership skills to apply the theory to practice” (CSP42 OR). Participant CSP170 OR stated that “After the study day I realised that I have the capabilities of assisting students achieve their clinical placement objectives, and aid in their career development as well as my professional development”. CSP59 OR also “really enjoyed the study day…I am now able to make the most of new skills when working with students”. These feelings were also expressed by CSP34 OR: “I personally have felt more relaxed and in control of how I should be mentoring the student”. Participant CSP27 OR applied this reflection to a recent experience of supervising a student: “I found that after your study day I had a very different approach to supervising the student, which I feel was beneficial for both of us. I was confident I was directing him towards what he needs to accomplish”.

This increase in self-confidence was often linked by participants to an increase in enthusiasm and improved attitudes, as explored in the next subtheme.
5.3.2.1.2 Renewed Enthusiasm and Attitude

Participants provided comments about their recharged enthusiasm for students and how the program had made them think about, and reflect upon, their attitudes. Participants stated that this renewed enthusiasm and attitude provided them with the opportunity to realise the responsibility of their role as clinical supervisors and the effect they could have on students and others: “I came away from the day with feeling how much of an impact the role of the mentor can have on a student nurse both positive and negative” (CSP31 OR). Participant CSP42 OR stated that:

All nurses are busy, but I do remember that when I was a student and a brand new practitioner that having a kind and caring mentor made such a difference to my confidence. So I remember that…People remember how you made them feel, they don’t necessarily remember the words that you may have said.

Participants provided examples of how their renewed enthusiasm and positive attitudes towards students had resulted in them responding differently to situations that they normally would have responded to quite differently. This change in response is highlighted in the following examples of reflective entries:

There was a mix-up initially because I wasn’t aware that there would be students on and it took me a bit to organise who they would work with. Initially I felt that it was a lot of bother for me, but I thought about it and realised that it wasn’t their fault the communication was poor (CSP191 OR).

Participant CSP34 OR’s reflection provided an insightful story of how a clinical supervision experience with a student in the community setting did not go well in the first week of the placement, leaving the participant questioning whether he or she wanted to continue with the supervision into the second week; however, after reflecting on the program, the participant was able to renew his or her enthusiasm and determination to make it work:

I had such a horror first week…over the weekend I thought about all the information I had gained…I am surprised at how easy it was to turn my negative thoughts into positive ones once I found the right pathway for this student nurse to express herself. She really is a very sincere and passionate nurse but I think she may have felt slightly disillusioned in the beginning…she developed a much more positive attitude also.

For participant CSP132 OR, the program had changed her opinion towards students in general. The participant wrote of the time she took teaching the student on the ward, giving
the student the opportunity to practice rather than just watching and following her. This had been a significant change in how she supervised students and she was surprised at how this benefited the relationship and made her day easier:

I have a student who is finishing second year in a few weeks…I found her some jobs that she could do by herself without me standing by all the time. I found after your study day that I now see the student as a help not a hindrance…it was a nice experience.

For participant CSP116 OR, this improved attitude and enthusiasm encouraged him or her to be more willing to accept students: “I must say the session at (the university) certainly encouraged me to put my hand up to take students. A learning experience for all”. Participant CSP170 OR said that “I have also found that I enjoy a teaching role, be it as a preceptor, mentor or just colleague, and have found that I can help bring theory into practice”.

Participants also included statements about wanting to inspire others in the workplace to feel more enthused and have positive attitudes towards students. This feeling was expressed by CSP27 OR: “I want to stimulate discussion to change our ward approach to how we can meet the student’s needs while they are with us”. Others provided comments on the need for the program to be more widespread to assist with improving staff attitudes: “I have encouraged all staff to attend the study day because it gives a positive approach to good practice” (CSP185 OR).

Participants included reflections about witnessing poor examples of attitudes towards students, and how this had been concerning to them. One participant—a registered nurse in an emergency department—described her concerns when transferring a patient to a medical ward. The nurse on the ward had a student with her and had been openly ‘disgruntled with the [patient care assistant] PCA and myself’, as they had to change the patient to a different bed:

The…student with her helped us more than the RN did…I thanked the student for her help. The attitude the ward RN displayed in front of the student was not very appropriate…this unprofessionalism reflects badly on [hospital named]. I just wondered what the student must have thought? (CSP198 OR).

Another participant shared her experience of witnessing a poor display of attitude and how this made her feel and think about how the student would be feeling following this interaction:
I witnessed a senior RN supervising a student RN semester 6…I was handing over after night shift. She came in and said ‘Good I have a student, I can drink my coffee and you do all the work’. I don’t know if it was in jest but if I was the student I wouldn’t have felt very appreciated? I think she could have been a little more professional (CSP198 OR).

Participant CSP28 OR shared how, by simply asking a student how her time was going on the ward, she uncovered a disturbing situation that she felt empowered to respond to:

On asking one of the students how she was settling in on the ward, she responded by explaining that she wasn't having a good experience at all. She further stated that her mentor had been less than supportive or friendly…I spoke to the student at some length and we discussed various different options to deal with the situation…I also felt a need to take it a little further myself because I wanted ‘bat’/’smooth things’ for the student with the hope that things would end well.

She was even more shocked when she approached the clinical supervisor to try and discuss her concerns:

very little eye contact and most of her responses were grunts, but I think she did nod once or twice…I don't think some people understand/appreciate how much of an impact/damage they can cause!! How much easier it would be for everyone, if a bit of common courtesy was applied (CSP28 OR).

For one participant, her reflection centred on an experience she witnessed while a patient in a hospital. Despite being in the position of a patient, she still felt the need to intervene, and she discussed how she followed through with these concerns of the poor attitude towards the student with another staff member at the facility:

While a patient I did observe some extraordinary nurse/student interaction…the nurse addressed this student in a rude and offensive manner to which he only replied politely. I was horrified, I’ve never seen anything like this behaviour towards students before, I stepped in and spoke up for the student (CSP108 OR).

The final subtheme related to staff effect is ‘personal reward’.

5.3.2.1.3 Personal Reward

Participants shared their stories and examples of positive student experiences that had left them with a sense of personal reward. These experiences were based on either interactions with students who were struggling with their placements and, due to their actions, a more
positive learning placement had been achieved, or simply in their normal interactions with students, which had left them with a sense of self-satisfaction:

One of the students had had a particularly difficult practicum…she had reflected well on all that she had learnt and how much personal growth had taken place. It was rewarding for me to hear how I had supported her in this and how I had also helped to facilitate her learning by negotiating good support strategies (CSP29 OR).

Participant CSP170 OR stated that:

She thanked me for my patience and said she felt more at ease and was looking forward to the rest of the placement. This made me feel pleased that I had provided a welcoming and calming orientation and first day for her.

Participants also related this sense of personal reward to the teaching and learning experience: “I enjoyed sharing my knowledge and skills with someone who was appreciative of the time that I had given to him” (CSP42 OR). Participant CSP34 OR said that:

As I reflect on this students two week clinical time I feel we both enjoyed each other’s company so it seemed quite easy…[I] will be back at work on Monday with a new student beginning her two week placement, I am quite looking forward to meeting the next student.

These subthemes of ‘improved self-confidence’, ‘improved attitude and renewed enthusiasm’ and ‘personal reward’ continue to appear throughout the next section of this chapter in the strategies adopted by participants. From the statements provided by the participants in these themes, the effect of the program on the participants provided the foundations for them to implement the strategies that they believed were of the most importance to them.

5.3.2.2 Strategies for Improving Clinical Supervision

The second theme of the online reflections relates to the strategies that the participants discussed when engaging with students on clinical practice or the ideas and thoughts they had considered since attending the study day program. These strategies have been subdivided into the themes of ‘understanding the student learning journey’, ‘improving communication’ and ‘embracing the power of belongingness’.
5.3.2.2.1 Improving the Student Learning Journey

Participants discussed how the knowledge learnt in various sessions at the study day program, which were related to learning styles, critical thinking and clinical reasoning, had assisted them to apply new strategies in their roles as clinical supervisors to assist students with their learning in clinical areas. The participants’ improved communication skills were also linked to this concept of student learning.

In the online reflections, participants provided a mixture of general comments about their thoughts regarding student learning, and examples of situations in which they had changed and/or applied this new knowledge. The following online reflections are examples of the general statements provided by participants:

I felt that the most positive aspect of the course for me was learning to be able to listen and ask for clarification from the student as that was the easiest way to learn what their expectations and desired outcomes were (CSP36 OR).

For participant CSP191 OR, ‘I have learned to ask students for their input and enabled them to set goals for their time with us’.

The following statements from the online reflections outlined how participants reflected on providing better learning opportunities for their students:

After the study day I realised that I have the capabilities of assisting students achieve their clinical placement objectives…I have recently had students on shift with me, and have found that when I have asked how the student likes to learn, it takes a weight off their shoulders and is a way to open up communication with the individual (CSP170 OR).

CSP31 OR also outlined his or her strategy for promoting learning:

On introduction to the student I enquired on what previous placements they had been on, what units they had covered so far in their course. To gain an idea at what level of knowledge base and competency skills the student should have. I also enquired in what areas they enjoyed.

CSP36 OR discussed an interaction with a student on an afternoon shift and how an embarrassing incident in front of a patient resulted in the participant rethinking his or her communication strategies to determine students’ learning styles in order to assist them to develop the necessary skills and confidence:
The student…was asked to empty a catheter leg bag and attach a night drainage bag. She reacted with a very shocked expression…The patient was quite shocked by her response…Through better listening and communication skills, I was able to identify with the student that she had not seen a night drain bag before, she was unsure as to what was expected of her in relation to emptying the catheter leg bag as she had not done it before and she was in fact scared. Between us, I was able to show the student through the procedure with spoken step by step instructions on the first patient, which I then prompted and encouraged her through the same procedure with the second patient.

Some participants also related sharing this better understanding of student learning with their colleagues in the workplace:

We’ve had some interesting discussion here since I attended your study day…one good thing is that we’ve been able to clarify a little of what we could expect students to be capable of doing during prac time here…we want to turn students out to be good nurses (CSP188 OR).

Participant CSP29 OR also used this as an opportunity to confirm with his or her manager what was expected of the participant’s role as the students’ supervisor so they could facilitate a better learning outcome together:

I relied heavily on the role of the clinical supervisor lecture notes…I used this in my meetings with management to clarify what each of our roles were in working together to facilitate the learning and development of the students…I felt I was able to manage this situation effectively, having the skills acquired from the study day.

Participants also discussed experiences where learning had occurred for them with a student present, how this had been a positive experience and how he or she had not felt threatened by this in front of the student:

Doing meds I found to be a good wake-up call re-checking the 6 rights and also the whys and wherefores of particular meds for particular patients. This enhanced my own learning and was enjoyable to do it together (CSP116 OR).

For participant CSP40 OR:

One very pleasing moment I had, was when we both went to an agency new to us both. I found myself feeling like a student again and on a 'level playing field' with the student. I think moments like this demonstrate to students that we are never too experienced to learn and essentially we are always learning.
Participants also discussed the effect of students’ outside lives on their ability to learn, as well as how, through better communication and understanding the requirements and barriers to learning and competence, these situations were handled positively:

At the beginning of the meeting we reassured her that we were there to help her if she had any issues that were interfering with her performance and were very keen to first hear her own assessment of how she was performing on this placement…It became clear that the stress of her sleeplessness, fatigue and worry about her father’s situation was interfering with her performance. She finally accepted that she had to care for herself first, otherwise she would fail her prac…she finally stated that she realised that the options we had offered for solving her problem were worth taking seriously (CSP75 OR).

Participants’ better understanding of students’ learning was also assisted by their improved communication skills. Participants used these skills to discuss their preferred learning styles with students to ensure a positive learning environment. However, improved communication also assisted with reflection, feedback and other strategies; therefore, it will be explored separately to student learning.

5.3.2.2.2 Improving Communication

Communication skills encompassed a number of sessions at the CSP, including using appropriate communication skills to promote critical thinking and clinical reasoning, providing feedback, reflection, promoting learning, managing difficult situations and promoting a welcoming environment.

Participants discussed their interactions with students and staff, and how they had changed their communication and feedback style and practice:

Well I know giving feedback is an essential skill. It improves situations and the relationship…it improves communication…[the] course we did actually helped me change myself for the better. I can now take time to understand…listening is really really helping me understand, I mean active listening not just hearing what someone has said but the depth of the message and its meaning. I have now developed self-awareness (CSP153 OR).

One participant discussed how she adopted the communication and reflection strategies discussed on the day when asking a group of students about their clinical placement. Her changed approach to engaging with students resulted in her uncovering a number of communication issues and poor clinical practices witnessed by the students the day before,
which the students had initially not disclosed. This enabled her to take action and empower the students for their ability to be patient advocates:

I offered them the opportunity to discuss any concerns with me any time that they needed, and also reminded them of the availability of the student counselling services at Uni. After I reflected on the importance of asking the right questions. Had I stopped at ‘how is prac going for you’ and the response ‘good’ I would not have received the true and honest response of how they were really going (CSP29 OR).

Another staff member related a similar experience: “I now try to make a point of talking to each student to allow them the opportunity to share and talk through any concerns or difficulties individually rather than in a group setting” (CSP21 OR). Another participant shared her experience of implementing reflections with her student:

Recently, a student and I had an unwell patient who over the course of the shift had deteriorated and sadly passed away. This was the student’s first time of being a part of that sort of experience. The student had never seen anyone pass away…I went through verbally with the student what happened, we debriefed together and I did encourage the student to write a reflective piece in order to get thoughts out on paper and distress (CSP170 OR).

Other participants discussed the effect of a better understanding of providing feedback, as well as its importance. Some realised they still had work to do in order to do this better or in a more timely manner. For others, it was confirmation that they were on the right track:

I do recall most of what was discussed in the workshop regarding feedback and that, most of the information I hoped I followed. Even though I felt that my interactions with the student were properly managed it did prompt me to have another look at the notes to see if I handled the situation as best I could (CSP1 OR).

Another staff member discussed a busy shift in the perioperative theatre, where the student had been very proactive and helpful in managing a stressful event:

Given the time restraints I wasn’t able to give her feedback on her performance, something I will do today. Better late than never? This is one of those areas I recognise I need to pay a bit more attention to, i.e. give feedback in a more timely manner (CSP47 OR).

Participants also discussed how providing feedback where problems are discussed and improvements are necessary remains difficult, with the aim to provide encouragement and support without destroying students’ self-confidence:
One (student) is awkward in her interpersonal skills and seems to compensate by being over confident in the clinical area. She is giving her opinion when it has not necessarily been asked for…It is interesting to note that one of her objectives in her CPAT is to focus on her interpersonal skills in relating to both patients and staff. I have so far used this goal as a way of clearly addressing some of the issues with her. I am aware that the issues are multifaceted for her and I do not want to contribute to what I already feel is a confidence issue (CSP114 OR).

Another participant wrote about a student nurse who complained about the way an elderly confused patient spoke to her. The student had been very upset and refused to continue caring for the patient. The participant discussed this issue over a number of email reflections about how it had affected her and the strategies she had used to communicate her concerns about this scenario with the student:

When we sit down to talk this over I will ask the nurse what her reflection on this incident has been, and if she has thought of any resolutions to the problem. I then hope to discuss with her the professional role of the RN using the code of ethics and code of conduct as a guide. Sharing my experience as an RN of similar situations, encouraging the nurse to always maintain that professional approach to all without reacting to patients’ behaviour or taking it personally (CSP21 OR).

Other participants discussed how remaining in communication with their students can become difficult when students move around the work area to gain further experiences and how, despite this, they have a responsibility to know where the students are and how they are progressing. This highlighted another area of thought regarding how communication between students and clinical supervisors could or should occur:

This week has been a struggle in the supervising role as my designated student has been on visits to other agencies within the specialty. I have not seen the student for the last 2 days so other than direct feedback from their supervisors on the day I have not been able to supervise their practice. I have not heard from their supervisors on the day…it feels a bit awkward not having direct contact (CSP40 OR).

The same participant in another online reflection continued to go back to this point of students being allocated offsite and the implications of this. The participant’s student was identified as ‘missing’ during one shift, when no one at the base site knew where the student was:

I have also learnt that when students are visiting other agencies within our specialty they should indicate exact start times and finish times so we are not worrying about their attendance and safety to and from placement. This is something I can do better in future supervisory roles (CSP40 OR).
The final subtheme of strategies relates to the concept of belongingness, which was mentioned by many participants throughout the research project and continued in the online reflections.

5.3.2.2.3 Embracing the Power of Belongingness

Participants provided many reflections and statements about how belongingness was an important concept to them since attending the study day program, or how they had used this to structure their interactions with, and placements of, students in their work areas. Below is a statement that encompasses this general theme from participants:

First impressions given to the student such as a friendly welcome and a sense that they are a valuable inclusion of the team and not a burden really influences students. This can either encourage learning with increasing independence or promote anxiety with apprehension impeding learning…Belonging can have an impact (CSP32 OR).

Other comments by participants about how they had incorporated this concept of belongingness included:

I’ve been reminded of how scary coming onto a new ward is and endeavour to make the students feel welcome…we had a lot of our general discussions around the dining table, which helps us get to know each other. The student was very helpful on a busy week and we thanked her for her help. She had lost her nervousness and seemed to enjoy her time (CSP191 OR).

Participant CSP63 OR stated that:

I have had two undergraduate students for the last 2 weeks. I provided them with a comprehensive ward orientation after the hospital orientation and discussed their rosters and allocations. I have always been aware of making sure they understand how the placement will work. Your course has reinforced how important this is to make the students feel welcome.

CSP29 OR provided detailed reflections of taking the time to ensure that new students to the area had received an appropriate welcome and felt supported on their placement:

I am now asking the students more about their orientation and what their welcome to the area was like. I did ask them more detailed questions about their orientation process based on the study day, as I felt it may be an indication of how well supported they were on the floor…I do try to build a rapport and be approachable and understanding…I was certainly conscious of what I had learnt.
Another participant discussed how encouraging the student to be an active member of the team had helped to encourage the student’s sense of belonging to the team:

There was a couple of situations where the student was challenged to get out of their comfort zone…it was good to check the student could identify what was relevant and important and to encourage them to be part of the team (CSP116 OR).

This sense of team was also discussed by another participant, who remembered how important it was to assist students by initiating relationships in the workplace, as students can often feel uncomfortable to do so themselves as a new person to the area and team:

One particular request made by the students was to have a greater understanding of the roles of the Occupational therapist and Physiotherapist…I encourage students to liaise with the therapists during their placements; however, I have noticed that the majority of students do not feel confident enough to approach other members of the interdisciplinary team…I decided to invite both the physiotherapist and the occupational therapist to introduce themselves…and to explain their roles and both openly encouraged the students to join activities…The students felt able to freely ask questions and gained understanding of how the clients can benefit from a team approach…In the past I have encouraged students to communicate with therapy staff but now realise that I need to initiate the relationship (CSP21 OR).

Participants also provided examples and comments of practice that provided a poor sense of belongingness for students in their workplaces. For some, it was a shock to realise that such incidents occurred; for others, it provided the opportunity to think about making changes:

The message that resonated the most for me this last week…related to Belongingness. It hit me during the course of a student orientation day…students were issued with new rosters…I couldn’t help but wonder what sort of impact it had on students…I did feel a little impotent and frustrated. I decided to let the dust settle, reflect and if appropriate perhaps very carefully reopen discussion at a later date to see if something could be put in place that is a workable solution for everyone involved (CSP28 OR).

Another participant was shocked by the opinions expressed on the study day by staff during a break in regards to the concept of belongingness and providing an effective and welcoming orientation to students: “I was disturbed by the conversation that was being discussed. I did not challenge the statement because it would be unprofessional to intervene at that moment. I did interact later, privately” (CSP185 OR).

Another participant commented on her reflections during the course of the study day as they related to belongingness, and she asked how they can prepare students better:
I was able to reflect on interactions with particular students during the course of the study day...the experience for these students reflected lack of belonging and it made me think about how we could brief and prepare students...I am now wondering if there might be intervention with the students themselves that might assist (CSP189 OR).

Participants also provided examples in which students had responded positively to the sense of belongingness in the clinical area. Participant CSP21 OR described providing a comprehensive orientation to a student who had commenced in the ward area and how the student was grateful for the time:

I feel this is important to familiarise the students with all this...they have a smooth beginning to their clinical experience. The student thanked me for this as they stated it was nice to be welcomed and made feel part of the team.

Participant CSP170 OR provided a similar experience:

It was her first day in our area and the SDN left me all the orientation paperwork to go through with the student. We had a patient who was unwell and required a fair bit of nursing care, I could tell that my student was nervous so I decided to let the student know that it was alright to be nervous perfectly normal in fact, this seemed to help her settle...Towards the end of her first day she thanked me for my patience and said she felt more at ease and was looking forward to the rest of the placement. This made me feel pleased that I had provided a welcoming and calming orientation and first day for her.

The final theme to be explored within the online reflections related to participants’ perceived lack of staff support when undertaking the clinical supervisor role.

5.3.2.3 Perceived Lack of Staff Support

Participants wrote comments in which they felt they were unsupported in their roles as clinical supervisors. This related to the hospital support provided and the support from the students’ education providers. This was a new theme identified within the online reflections compared to the previous post-program survey entries.

The below comment by participant CSP115 OR was reflective of many statements made by participants regarding why they had struggled to develop a positive attitude towards students—that is, the perceived increase in workload in an already demanding environment:
I know for myself it is very difficult to get enthusiastic about having a student allocation when one can’t get through the workload in paid time, one ends up staying back even later! Seriously I feel that a good part of student learning and retention problems would be overcome if learning environments were adequately staffed. Do we need to look from ‘the top down’ rather than ‘the bottom up?’

Another example of these concerns was raised by CSP42 OR: ‘Barriers to clinical supervision and mentoring are busy workloads and the absence of prioritisation due to lack of leadership vision by manager’.

Other concerns raised by participants related to the role of the university in providing support through clinical facilitators:

I had two patients who required [Medical Emergency Team] ‘MET’ calls…thankfully both patients were stabilised and I was able to explain the process to the students, reflect on the experience and go through the learning that was involved…I would have appreciated a visit from a clinical coordinator or the person overseeing the students while on placement as it is important to communicate to them experiences like these (CSP82 OR).

Others commented on the different student tools, the amount of paperwork and not knowing the university’s expectations:

I really think that we need a very simple, clear written overall guideline as to what student nurses can do when they come to us. I feel this would help us…even though we tell staff that students can do assessments and even take a patient load with supervision, staff, particularly in a speciality such as ED, have a great fear of letting the student go and do anything (CSP188 OR).

Participant CSP82 OR compared her experiences with mentoring students in the UK as a clinical coordinator and mentor with nursing students in Australia, and the difference in documentation requirements:

Although I’ve only been here a few weeks and only had exposure to students on clinical placement I see that they have too much documentation to complete which takes away from their learning in the clinical environment.

Other participants also commented on students’ documentation requirements, the time involved and how confusing it could become:

After carefully going through signing off the student’s workbooks last week, I had a call from the manager she had been approached by the student regarding the fact that I had signed them off as being dependent and not independent. I was mortified; I reflected that I had signed them off as dependent in their first week in order to show
progression and development by their last week of clinical placement. I had signed in the wrong column! However, I felt that the terminology was confusing, as they were in their first placement and needed direct supervision. I felt awful for signing incorrectly and upset that I had caused distress for the student (CSP21 OR).

Another frustration expressed by participants on a number of occasions outlined examples of students arriving on placement, with no staff awareness of this. This had placed staff in a difficult situation as they managed their immediate workload and tried to organise students’ placements while not wanting to affect students’ placements in a negative way:

New student this week—very nervous and excited. A little hiccup because we weren’t aware of her pending arrival and is often the case, it took a bit to get someone to orientate her and then allocate…I know that this has been commented on before by me so it is a situation that occurs too often (CSP191 OR).

CSP34 OR said that:

I have had a student with me this week, stage six. I first found out about her placement last Friday at 3.30pm, I finish work at 4pm…anyway we had a brief chat on the phone, she was not notified of her placement with our area until earlier that day and felt very unsure of what she was meant to do, so it was all very confusing for both of us…I did my best to reassure her.

This concludes the findings from the online surveys from the participants who attended the CSP. The next section will review the participants’ interviews, which occurred at the conclusion of the eight-week reflections.

5.3.3 Interviews

The general themes identified by participants in the interviews related to the effect of the program on their own knowledge, attitudes and understanding of students’ journeys, as well as a number of skills to assist with clinical supervision. In particular, participants discussed the program’s presentation style and the resources given to them. The below statement is an example of the feelings of the interview group:

The opportunity to network with other people that do it was fantastic, to discover the same issues, what other people have done, was it what you would have done, and perhaps brainstorm out some solutions, but very much the networking and just feeling that you’re all working in the same way or dealing with the same issues and all getting the same benefit by actually getting some education on helping us all stay on that same track (CSP76 I).
The themes identified from the findings of the interviews highlighted two main themes with a number of subthemes. These are presented in Figure 5.3.

**Figure 5.3: Concept map of the interview themes and subthemes**

To obtain these data, the researcher contacted participants via email who met the criteria to be interviewed. The aim of the interview process was to interview until data saturation had been achieved. Therefore, participants were contacted in groups of 3–4 until this was achieved. A total of 16 participants met the criteria. All participants were contacted during this cycle. Two did not respond to the request for an interview and two initially responded but did not confirm a meeting time through a follow-up email. A total of 12 interviews were conducted.

With each interview, the location and timing were as per the interviewees’ request. Interviews were conducted at either the university or the participants’ workplaces. All of the interviewees appeared relaxed during the process and consented to be recorded. All participants requested a copy of the findings at a later date.

The aim of the interviews was to confirm the emerging themes from the surveys and online reflections and to seek any clarification of themes that the researcher felt required further exploration.
The interviews were 20–60 minutes in length, which was appropriate for the clarification of themes. Some participants had more information to share; therefore, this accounted for the time differences. All interviewees were asked an open question at the end of the interview so they could add any further information about the day if they wanted to; thus, no information was left unsaid. It must be noted that the shortest interviews were also the first to be conducted; this may reflect the researcher’s beginning skills at interviewing.

Upon completion of the interviews, the audio was converted into text. Each interview was printed to be read and re-read by the researcher. The researcher then read the interviews again, highlighting significant statements and making notes of possible codes. An example of a quotation is presented below, followed by the allocation of codes:

I do like that mixture of the sort of formal side, if you like, of PowerPoint type presentations, followed by opportunities to engage with material, such as the great discussion, and having a workbook to take [a]way does mean that there is something to refer back to (CSP76, I).

- **Group work**: ‘I do like that mixture of the sort of formal side, if you like, of PowerPoint type presentations, followed by opportunities to engage with material, such as the great discussion’.
- **Work file**: ‘Having a workbook to take [a]way does mean that there is something to refer back to’.

Notes were made regarding the data trends and emerging themes. Throughout this process of analysis, the researcher referred to the research questions to ensure that the theming process assisted with answering the questions. With each interview, the researcher was able to refine the questions to ensure that themes could be confirmed and consolidated. The themes that emerged from the interviews were:

- effect on participants
- strategies for improving clinical supervision.

The first theme to be explored from the interview participants of the CSP is the ‘effect on participants’.
5.3.3.1 Effect on Participants

All of the participants commented in the interviews about the benefits of the CSP. An example of these thoughts is presented in the below statement:

It had the opportunity to put people on the right program and process to probably deliver the best standard of practice of the clinical teaching. It had all the elements in there…the opportunity to engage with other people…Opportunity to express your thoughts or feelings or questions or deliver an idea that you have so you could do some brainstorming…it certainly familiarised the terminology…you consolidate your practice ‘I’m ok, I’m on the right track’ (CSP28 I).

For the interviews, the ‘effect on participants’ theme included a number of subthemes related to staff reflecting and developing an awareness of others’ knowledge and attitudes, as well as the current education and training provided to staff in relation to nursing clinical supervision. Participants also explained that the program had consolidated their knowledge and extended their understanding in unfamiliar areas. The subthemes for ‘effect on participants’ included:

- perceptions of staff knowledge and attitudes
- current staff education
- consolidation of own knowledge and attitude
- current context of nursing education.

5.3.3.1.1 Perceptions of Staff Knowledge and Attitudes

Participants made comments related to their peers’ knowledge and attitudes at the study day program and in clinical settings. One interviewee with extensive experience as a clinical facilitator believed that the program provided her with a better insight into the attitudes and perceptions of clinical staff. While she stated her shock at some of the poor attitudes displayed during the study day, this was confirmed by feedback and discussions with students. Participants felt that the program was beneficial for these staff in assisting them to develop appropriate clinical supervision skills:

Some seemed really interested to being here and some that didn’t…that was so overtly displayed that they were kind of told by management that they were meant to be here, and I guess that helps with your understanding…of what the students are facing when they go out (CSP114, I).
Another participant who shared these concerns stated that:

It’s almost as if they’re out to destroy the students and this I find really distressing…(students) don’t feel comfortable with their supervisors…some of them get really nervous, but when they realise you’re actually there to try and support them, they actually change the way they interact with you (CSP68 I).

Participant CSP101 I discussed that working in the community setting allowed her more one-on-one teaching time compared to when she had worked as a nurse in the perioperative area. In the community, she was able to spend the entire 2–3 week clinical placement with the student. While she did not understand the negative attitudes towards students, she could appreciate the differences between settings and the effects this could have on supervisors’ attitudes:

There’s all that traditional attitude that’s been with the nursing profession…which I’ve never understood…I guess there’s a level of frustration…I guess from an environment where they don’t have as much time to spend with the students.

Participants also commented about current staff knowledge and the understanding of the role of clinical supervisors and students’ placements. CSP68 I stated that:

I think there’s a huge gap out there in nursing…I think a lot of education needs to come in…most of them (nurses) don’t have a clue what the code of conduct is, or the code of ethics, let alone professional boundaries.

Participant CSP76 I related this current concern about a lack of staff knowledge to the ability of staff to manage students who are struggling in their placements:

It’s an easy option to pass a student if you’re a staff member and not ‘rock the boat’. It’s a lot of work if you start to say there’s a problem because you’ve got to start doing lots of documentation, so yeah…I think staff are still a little bit uncertain, I guess about how to manage if there’s a problem.

This was confirmed by participant CSP28 I:

There is still a number of staff that need to say it is okay to acknowledge there’s a problem, because you’re ‘protecting the student’ this bit of mentality worries me…people are reluctant to say ‘you know what they’re not functioning as well’…it’s just about teaching people about that and thanking them for that and why it’s important, basically, for the patient but for that person as well.
The second subtheme to be explored related to the current education and training that staff receive in relation to clinical supervision. This was closely aligned to the subtheme of ‘perceptions of staff knowledge and attitude’.

5.3.3.1.2 Current Staff Education

CSP92 I discussed her concerns regarding current staff knowledge of clinical supervision, and she questioned why the standards between university educators and clinical supervisors were different:

Education in clinical supervision is really poor, very poor…the education from the university is expected to be given by people with Masters and above, not only in their clinical skills but also in their education ability…so why when you’re on the front line can we expect people to suddenly become expert teachers? We can’t. We have to teach them how.

Participants commented on the current education provided to staff in their workplaces, as well as discussions that had taken place with their colleagues in regards to clinical supervision. There was a feeling that the current education was not inspiring staff or assisting them to acquire the necessary knowledge, or that it was simply not available: “There is in-house preceptorship and clinical teaching. I know in our unit nobody wanted to go because they’d been before and they said it was not interesting, quite boring, and that needs to change” (CSP82 I). In relation to in-house education, participant CSP40 I stated that it was “Not in our service…I guess it’s probably available, but it hasn’t probably been promoted the way it should be”. This lack of apparent staff education was also of concern to CSP92 I:

You often hear, ‘it’s a part of your [Job Description Form] JDF’. Well if I’ve never been taught how to do something in my JDF, how am I going to know how to do it? So sticking it on a JDF does not make it happen, you’ve got to put it in support.

Participants discussed the CSP being made more available to staff as an option to improve the current clinical supervision provided to students:

I think it was an excellent initiative to have a proper study day, and it would be nice if it would be, the best word I can think of is compulsory, to get facility staff to take seriously the role of working with students and developing students, that we can’t just pretend I’m a nurse, I’ve got a student, I know about nursing. We can do with it being quite a formal part of staff members development that they come to study days such as that, that they’ve got a decent insight into what the role of the supervisor and the mentor is and how to deal with having a student (CSP76 I).
Clinical supervision education should be taken more seriously...each nurse [should] get the opportunity to get that education...I hope to goodness it [study day] does continue along to get bigger and bigger.

Participant CSP82 I stated that “I think it [program] should be made more available to registered nurses throughout Western Australia and through the metro hospitals”. Participant CSP29 I: “I thought it was a very valuable in-service and I really think that every person, every registered nurse across the state that’s mentoring students should be required to attend, imperative learning”. Participant CSP28 I was full of optimism for the future and the current strategies put in place by health care facilities and education providers; however, the participant still believed that issues existed and that there was a lot more work to be done: 

I’m quite optimistic about the future of nursing and people’s knowledge and I think people are on the right career pathways and I think there is problems in the system...But I see a lot of organisations and facilities doing their absolute best to coordinate things...I have noticed that there’s more strategies, and that’s got to be a good thing...and it’s coming from the hospital. It’s coming from the universities, things are formulating. I think it can get a little bit more sophisticated, but I’m impressed that is being examined.

Participants also reflected on their own level of knowledge and understanding of the clinical supervision relationship, which will be discussed in the next subtheme.

5.3.3.1.3 Consolidation of Own Knowledge and Attitude

Participants discussed how attending the program had consolidated the knowledge and skills they had developed in relation to the principles of clinical supervision:

I just found it was a very positive experience for me...it just raised my awareness of where the students are coming from and picked up the little fine points that perhaps we weren’t doing as well as we could have done with them, and being very conscious of their need to achieve their competencies and to make the most of every moment that they were there, and also trying to give them the best experience that was the most appropriate for them (CSP21 I).

This was also commented on by CSP29 I: “Prior to attending that study day I thought that I was reasonably well skilled...but since attending, it may sound a little corny, but I have had some revelations”. For participant CSP92 I:
I thought I’ve been doing this for years, I know what I’m doing, and it was really nice that there was something that…I didn’t know before…I found it useful…I found that it was interesting because you brought a lot of the points together that are often bandied about in education, that you actually looked extensively at different factors.

For participant CSP68 I:
It was really good…to talk about issues that we’ve had, to actually get that information, what does it all mean, what is it all about…I’ve never done anything like that and I know it’s helped about…not being afraid to say, well this is what’s meant to happen, how do you think we can, so probably my style of discussing problems has changed a bit.

For participant CSP76 I, the study day program provided:
Quite a considerable amount of structure, basically hand[y] hints if you like for dealing with situations and as I say putting a structure in place…the opportunity to network…to discover the same issues, what other people have done, was it what you would have done, and perhaps brainstorm out some solutions.

Participant CSP40 I related this consolidation to refreshing his or her attitude:
I really enjoyed it. It was just a motivator, I think, more so than anything else. I think it probably should go into orientation and staff updates…I think we have a responsibility, and there’s a lot of people that are still dodging that…it wasn’t that long ago where I was saying…‘I’m too busy, I don’t want to have students today’, and right in front of the student’s face…I’m sure that still happens now with a lot of people who just don’t have that respect.

A number of participants related this consolidation of practice to gaining a better understanding of the current nursing education requirements for registered nurses. This related to both nurses trained in Australia and those trained overseas.

5.3.3.1.4 Current Context of Nursing Education

In particular, two of the interviewees discussed the effect of the program as nurses who were trained outside of Australia. Participants in the post-program surveys also described this finding. It has been included as a finding in this interview section due to its collaboration of the survey findings and because both interviewees who discussed this had recently moved to Australia. Both interviewees were trained in the UK and had completed the Royal College endorsed Mentorship Program. This comprehensive program is discussed in the literature.
review, and it is not the intent of this program to replace such an intensive program. Both participants expressed that they felt they had not learnt anything new in relation to the principles of clinical supervision; however, both discussed with the researcher that their intent was to gain an understanding of the Australian context. Both participants were very positive about the CSP; they enjoyed the opportunity for group discussion with their Australian peers and gained a better understanding of the Australian nursing students’ journey and assessment processes:

I attended the program for two reasons…a personal interest…[and] because I was new to Australia and just wanted to get a bit of a background and information about undergraduate nurse training…I really enjoyed it because it was a good chance to discuss with other people from other areas their experiences…and the information that we got to bring home was very helpful (CSP82 I).

Other participants discussed how the program highlighted the current requirements of nursing education in Australia, which differed to their own or those of the staff they worked with, and the effect this could have:

We take for granted that everybody has come through the system, which of course they haven’t, and so then they don’t understand the curriculum…they do need to understand about the clinical tools, the curriculum…staff need to understand some of the difficulties that perhaps some of them go through as well. I remember that section you talked about what students go through and I think that shouldn’t be underestimated (CSP92 I).

Other participants struggled with the different requirements of the universities, trying to assist students to achieve their competencies in a short timeframe in specialised areas without compromising their assessment requirements or the assessment documentation. Some participants also outlined how the study day had assisted them with understanding this better:

The issue I’ve always had is some universities or TAFEs have a high expectation of their students, whereas when I know that they’re only coming for one week or two weeks and it’s their only mental health placement, it’s trying to find that balance…what the universities expect and what we go through here (CSP81 I).

For CSP82 I:

I was always used to a cohort of students from one university, whereas here (Australia) there’s three or four and everyone does things differently and every student does things differently, they’ve got different booklets and that…attending the day was really helpful for when I came back to my clinical area I remembered what unis they were from and what year they were in and what they could and couldn’t do.
Participant CSP101 I stated that:

I think the main difficulty is that there’s so many differences between the expectations from each university with their writing reports…that’s really confusing…We really try to work at those [Clinical Placement Assessment Tool] CPATs, crazy things. They seem a lot of work. I can’t quite see the benefit of them, mainly for the students. It seems an awful lot of creative writing to a certain extent, testing their creative writing skills.

For participant CSP42 I, the study day program provided a guide to supervising students in the community setting:

I think for us in community health, no one’s really actually shown us or told us what’s expected, really, of our role with students…so I think it’s really good that we’ve actually now got some, like a model, if you’d like, that we can actually work through with the students. I can actually have a greater understanding of how to deal with them when they are here.

The second theme of the interviews related to the strategies that the participants gained from attending the CSP.

5.3.3.2 Strategies for Improving Clinical Supervision

The strategies adopted by participants that were discussed in the interviews included the concepts of belongingness and student learning. While each theme has been given its own heading below, due to the unique nature of each theme, there is also an overlap between the two.

5.3.3.2.1 Embracing the Power of Belongingness

A number of participants in the interviews discussed the effect of the concept of belongingness and how they viewed it as an important strategy to improve the clinical supervision of students in their workplaces. For some participants, the ideas were not new; they were about giving names to the actions involved. For others, the ideas led them to explore their effects further, particularly in relation to student learning and the placement experience:

I’ve never actually connected the need for belongingness on a ward and feeling part of a team to allowing the student to then actually go to the next level…that was the most outstanding thing for me…I’ve been able to use a lot. I really make the student feel comfortable…I had never thought that people wouldn’t feel comfortable…they
actually seem much happier…they probably run things past me a bit more now because you’ve got more of a relationship with them (CSP68 I).

This was also commented on by CSP92 I:

The one thing (that) did strike me as well was something that I suppose I hadn’t put a name to and that was the belongingness. It is an understanding that students need to feel integrated and part of a team and not to be outside, and afraid to speak.

For participant CSP42 I:

Belongingness, I really didn’t appreciate that so much before. And I think even though you go through the motions, just having the words attached to it actually give it more meaning, which you then act that out more so—so that’s what I found, actually, was really important. Just really trying to reflect back what it’s like to be a student and how nice it would be if someone was really considerate of my needs and involved me as one of the team.

For participant CSP40 I, belongingness and the importance of orientation was a key take-home point from the program:

I really took away the importance of a good solid orientation to students when they first arrive, that welcoming, how important that was. I guess I didn’t really realise the impact of that until I sort of reflected on my own experiences of some of the poor welcomes that I got as a student. We tend to forget about that, I think, and that was a nice reminder. So if I got anything, that was my number one thing, I think, that I got out of the day…[also] greater preparation, and I guess looking at students more importantly than I possibly did in the past, but really plan for their arrival, obviously offer them a greater commitment than what I have done in the past.

Participant CSP81 I, discussed an example of his or her approach to promoting belongingness—that is, planning to implement a diary for students to offer continuity on the placement, to assist them with working with different staff, to make it feel like a team approach and to ensure that students’ learning opportunities were maximised, feedback was provided and their learning objectives were reviewed:

What I’m aiming to do, if I get the time, I want to do some kind of passport kind of thing, really, just like a diary, days of the week or whatever, and the buddy nurse can put in whatever, a little bit quiet today, not very assertive today, worked on this, did this really well. And it’s not to go in their CPAT, it’s purely a very honest thing so that someone the next day knows, okay, I need to work on this to support the student.
Participants also spoke of the importance of belonging and ensuring that students felt comfortable and part of the team, as well as giving them strategies to encourage belongingness. Participant CSP29 I stated that:

The sense of belongingness for a student, I think, is huge because they’re coming from a foreign environment and into an environment that’s comfortable and familiar to us…A big thing in my mentoring…I’m very much making them feel part of the team, I’m also giving students ideas of how they can promote that belongingness, sort of initiating it if it’s not being offered to them.

Participant CSP21 I said that:

Making sure that they are introduced to everybody and understand what everybody’s role is and feel free to approach them; and just take that extra time to introduce the cleaner or the OT or the doctor…sometimes there can be that oh we’ll just introduce you to the nurses on the floor and the coordinator and maybe the manager and everybody else is a mysterious person wandering around…they’re all important so it’s important to know who they are, where they fit and to be made part of that team.

For participant CSP42 I:

I like to ask them for their input so that they feel part of the consultation that we happen to be doing at the time…even things that don’t involve the client…like inviting them to lunch…[or] if a question comes up we don’t actually know the answer to, going through…it together.

Participants also discussed how belongingness affected students’ ability to achieve competence in clinical environments. During the study day, participants discussed belongingness and its link to learning and acquiring competence: ‘To be conducive to learning, you’ve got to feel you belong. You’ve got to feel you’re in a nourishing, nurturing environment, so we take great lengths to incorporating the new person to the ward’ (CSP21 I).

Participant CSP101 I, stated that:

I think that feeling a part of the community enables you to—I don’t know if trust is the right [word], but develop relationships and positive relationships within that environment, whereas if you’re feeling alienated, then you’re less likely to be able to learn effectively.

Participant CSP29 I, stated that:

Having a perspective from the students that actually…they feel that once they’ve been accepted into the environment their ability to learn and to have a bit of confidence to seek out learning opportunities is much greater than when they’re sort of shoved into an office and given a manual to read.
This concept of student learning is the next subheading under the strategies theme. Under the theme of belongingness, student learning has been discussed in regards to its relationship to belonging. The next section will review student learning from a broader perspective related to the CSP.

5.3.3.3 Improving the Students’ Learning Journey

Participants discussed how they had changed their practice when supervising students due to a greater understanding of learning styles. This also linked into a better understanding of the nursing competencies, how to identify and write goals and objectives with students, more thought about what was achievable in the timeframe of the students’ placement, and how they could improve the learning process for students by adapting their teaching and communication styles while also being aware of the limited time that students have in the clinical setting to consolidate the transfer of theory to practice. This was also improved by a better understanding of critical thinking and clinical reasoning, and again the concept of improving the students’ sense of belongingness:

There’s so many different ways that we all learn. And I have really taken that back into the clinical environment in trying to not extract from my students but just trying to gauge from them how it is that they learn best and how they retain information the best…[I] try to use tools that are going to aid them to retain information and to learn to their optimum potential (CSP29 I).

Participant CSP101 I stated:

That there’s different learning styles, and that probably is the best way to teach someone nursing, to identify that. I guess that helps in this environment when I’ve got students, so that I can be aware that there are different types of learners.

Participant CSP29 I highlighted the importance of critical thinking and clinical reasoning:

I also really liked the critical thinking and clinical reasoning, how you really went into that in great detail. And I knew a little bit about it, and I think we all use it in our practice, but to have it actually really spelled out in detail consolidated that for me.

Other participants discussed the importance of good communication skills and applying these principles to improving students’ learning:
There was a flowchart you had in your file that you gave to us, and I love using that in just assisting students…it’s easy to kind of go through and reflective practice is just essential for all of us clinical practitioners, students (CSP29 I).

For CSP21 I, the number of clinical hours that students had for clinical practice had a significant effect on their view of the placement:

The importance of the clinical time in the wards because I think up until then I hadn’t really realised how limited their clinical experiences were, and so it made me much more aware to be more conscious of making sure that each hour was actually used properly and to advantage…they need every moment they can on the ward in their clinical experience.

For participant CSP42 I, the students’ learning experience was improved by asking students about how they liked to learn by reflecting on previous experiences. It also reminded the participant of his or her own time as a student:

I thought of what it must be like to be the student again…understanding where they’re at and what do they want to get out of the day. What has been their past experiences…what’s been a good thing, a good way that they’ve been mentored…so I can try and make it as comfortable for them.

Participant CSP42 I, also discussed how he or she’s supervising style had changed since attending the study day program:

I think it is really helpful that even though you might have more experience than the person you’re mentoring, it doesn’t mean you actually know everything, and that is nice for them to know hey, here’s this person that I look up to, but she doesn’t know either, and I think that makes the student feel like we’re only human at the end of the day…previously they [students] would have done a lot of observing me in practice, whereas now I actually let them observe what I’m doing and then with clients’ permission I ask, would it be okay if she could actually do what I’ve done, so she can learn from the experience. So I think maybe involving them, involving them more that way, I think I’ve definitely changed that practice…I suppose having attended your day, just being more aware of what their needs are.

For participant CSP68 I, the concept of belongingness was an important strategy for assisting a student who was struggling with his learning on the placement:

He was really struggling…and he actually became much more confident…I think when we were able to show him that we were actually there to support him, not just to mark him down or fail him or knock him off, I think that might have made a difference because of that whole belongingness aspect. So it was very interesting.
This completes the analysis of the data from the surveys, online reflections and interviews. These methods of data collection and analysis provided the researcher with a rich description of the effect of the CSP on the participants. A comparison of the findings using the qualitative method will now be discussed in further detail.

5.4 Qualitative Findings

The qualitative data collection and analysis methods involved collecting participants’ words about the effect of the CSP through short statements in the post-program knowledge surveys, online reflections and interviews. These words were then analysed using a thematic approach. Upon reviewing the findings from each of these methods, the researcher determined that similar themes were evident in all of the data collection methods. The overarching theme of the qualitative data has been entitled ‘extending oneself and others’. The overall finding of the qualitative component of the research project is articulated in the concept map in Figure 5.4.
5.4.1 Extending Oneself and Others

Extending oneself and others relates to the overall theme of the qualitative data. Throughout the different qualitative data collection methods, participants commented on the effect of the program on themselves and how they could use this information and renewed enthusiasm and attitude to benefit students and other staff. Each of these will now be described in further detail in terms of comparing the findings between each of the data sources.

5.4.1.1 Effect on Staff

The effect of the CSP on participants included a number of perspectives, which were divided into:
• improved self-confidence, knowledge and attitudes
• improved understanding of the current context of nursing education
• concerns regarding current staff knowledge, attitudes and education.

Participants discussed these three subcategories and their importance in all of the qualitative data collection methods.

5.4.1.1.1 Improved Self-confidence, Knowledge and Attitudes

A number of participants stated in the surveys that the CSP had improved their knowledge of the role, which had increased their confidence in providing a more effective clinical placement. Comments related this increase in knowledge to a better understanding of the role of clinical supervisors and students’ learning requirements, including learning styles, critical thinking, clinical reasoning, reflection and feedback. Further, the group discussions and viewing the placement from the students’ perspective had improved their attitudes towards students and the clinical supervisor role.

These statements were also confirmed with examples of practice in the online reflections and interviews. Participants provided examples of their increased confidence, improved attitudes and increased knowledge when engaging with students in the clinical area.

5.4.1.1.2 Improved Understanding of the Current Context of Nursing Education

A number of participants commented that they had learnt more about the current context of nursing education in Australia. A number of participants discussed that they were from overseas and the day had provided them with a local context of the training and expectations of their role with students. Other learnt about the university education system, and even for those who had been trained in the current system, the degree courses have changed since territory education was first introduced.

Participants articulated that understanding the students’ journey through these programs and realising the hours of clinical practice and the universities’ expectations of the students had helped them gain a better insight into students’ needs and how they could better support them.
5.4.1.3 Concerns Regarding Current Staff Knowledge, Attitudes and Education

A number of participants described their concerns regarding the current lack of education of staff in clinical supervision. In the knowledge survey, a number of staff documented that they had not attended any previous education in relation to clinical supervision and that their reason for attending was to update their understanding of the role.

Participants discussed witnessing poor examples of clinical supervision, poor attitudes towards students and a lack of general understanding of how the role can affect students’ learning and career choices. Many participants documented that more education was required for nursing staff, that a greater emphasis on the role was required, and that action needed to be taken to improve staff knowledge and attitudes towards student supervision. Participants articulated strategies for improving staff knowledge and attitudes through the use of the CSP.

5.4.1.2 Strategies for Improving Clinical Supervision

Strategies that participants felt they had gained by attending the CSP related to:

- embracing the power of belongingness
- improving communication
- improving the student’s learning journey.

5.4.1.2.1 Embracing the Power of Belongingness

Throughout all of the data collection methods, a strong focus was placed on the concept of belongingness. Participants found this knowledge to be powerful in its effect on students’ placements. Participants articulated that this concept was so simple, and yet it was not thought about or seen as important, and its implications for students’ placements, both positive and negative, were inspiring to participants to ensure that belongingness was provided. This was a key take-home point of the day, and it was strongly related to creating a positive attitude towards students and student placements. Participants’ comments in the eight-week surveys, online reflections and interviews all included comments on, or examples of, demonstrating belongingness.
The finding in relation to the effect of belongingness on participants is articulated in Figure 5.5, which outlines how the participants described that they were first made aware of the concept of belongingness in the study day by reading and discussing the journal articles included in the participants’ work files. Reading and discussing these articles resulted in the participants reflecting on their own practice and their workplaces’ practices, as well as the possible strategies they could implement, or had implemented, to promote belongingness.

![Figure 5.5: Effect of belongingness on CSP participants](image)

This concept of belongingness was also related by the participants to staff in their workplaces—in particular, the graduate population (first-year nurses)—and it was also seen as a strategy for improving workplace culture and recruiting students as future staff.

During the study day program, participants were asked to provide strategies of how they could or would promote belongingness in their workplaces. These comments were then included in many of the participants’ surveys, online reflections and interviews. The participants provided a number of strategies, which are shown in Figure 5.6.
The participants shared how important it was to create an initial atmosphere of belongingness, and this started with an appropriate orientation to the health care service and the local work area. Participants also discussed forwarding information relating to the specific details of their area or making it available to students on the hospital or university websites. This information was broad and related to information such as parking, bus/train timetables, nursing care and common patient conditions within the work area.

Participants also felt that the adoption of the principles related to communication strategies would then assist students to become actively involved in the placement and feel comfortable to practice and ask questions. By taking the time to plan the day with the student and set learning objectives each day, this would allow students to be at ease and know what to expect.

The final theme to emerge from the group discussions related to organisations providing a positive workplace for students. This related to nurse managers taking the time to meet and talk to students, and for workplaces to support staff so they were better able to support
students. Participants articulated their concerns about a current lack of support for themselves and students, as well as the poor culture towards students and how this needed to change.

5.4.1.2.2 Improving Communication

The second component for the theme ‘strategies to improve clinical supervision’ related to communication. This included the topics and concepts of learning styles, barriers to learning, critical thinking, clinical reasoning, reflection and feedback. Participants discussed that the strategies from these concepts assisted them to ensure that students were the centre of clinical placement learning experiences. Participants enjoyed the practical application of these sessions, with the provision of realistic examples and problem-solving strategies, while being provided with the underlying theory to support this practice.

In the surveys, participants provided comments about the importance of communication-focused sessions, how they had helped participants to realise that communicating with students was a vital tool, and that this tool was perhaps not used to its best advantage. Participants recounted the themes of the study day program in linking these sessions together. A number of participants articulated in the surveys how these often-difficult concepts—in particular, critical thinking and clinical reasoning—now made sense in a practical way. Statements highlighted the concepts’ importance and how participants now felt confident to use these strategies. As with previous themes, the online reflections and interviews then provided examples of participants using these strategies in practice.

Participants’ online reflections provided rich examples of their use of these communication strategies—in particular, the strategy of asking students how they liked to learn—and how this had made supervision easier for both the students and the supervisors. These examples also related to participants changing their behaviour as clinical supervisors, allowing students to practice and ensuring that the goals for the day were appropriate to the students’ overall learning journeys.

These findings are articulated in the concept map in Figure 5.7. Included with these findings are the course content strategies that were provided to participants during the day, and which the participants themselves highlighted in their responses.
5.4.1.2.3 Improving the Student Learning Journey

Participants in the study discussed that they now had a better understanding of students’ learning journeys. This included a number of aspects, from the different learning styles of students to the current context of nursing education, including the limited time on clinical placements, and from frequently short and changing clinical placements to the effect of external stressors on students’ time.

Participants shared their better understanding of these issues in their survey comments and provided examples in the online reflections and interviews. This understanding was linked by participants to the importance of ensuring that students felt a sense of belongingness to help reduce stress and anxiety, and by promoting good communication skills to determine students’ previous clinical placements, level of clinical practice and learning styles. This finding is articulated in Figure 5.8.
Figure 5.8: Influencing factors on improving students’ learning journeys

5.4.1.3 Perceived Lack of Support

In the online reflections in particular, participants described a lack of support in relation to the amount of support offered by the educational facilities responsible for the students, as well as a lack of health care facilities’ support for their staff who supervised students. Participants shared these concerns through the online reflections by sharing comments, thoughts and stories—in particular, related to episodes of patient care when the shift had been stressful or when there had been a lack of preparation and organisation with students’ placements.

Participants related the feelings and concerns of their perceived lack of support to a lack of acknowledgment for their time invested in the role, the support that they needed to facilitate a positive placement, and just knowing that there was someone to reassure them and their students of the placement requirements and learning outcomes.

While this was a strong theme in the online reflections, these concerns were also documented in the knowledge surveys and by participants in the interviews. In particular, the surveys and interviews focused on a lack of current education for staff undertaking the role. All three data sources discussed the future of the program and its availability to assist staff to undertake this role. The CSP was seen as a strategy to improve staff knowledge and promote a cultural
change in staff attitudes towards students, by providing the speciality education requirements to achieve this.

### 5.5 Qualitative Findings in Summary

The comparison of findings from the qualitative data indicated that all three sources of data collection supported the findings of each individual source. Different depths of information and stories were obtained by using these different data collection methods within the qualitative phase.

The qualitative findings of the research indicated that participants found the CSP to be a positive learning experience that should also be shared with others. This positive experience was achieved by improving participants’ understanding of the role of clinical supervisors, describing the bigger picture and the students’ learning journey, discussing the skills of effective clinical supervision, highlighting the implications of both poor and positive clinical supervision, promoting the importance of belongingness and positive attitudes, and developing a sense of teamwork and collaboration towards the role of clinical supervision. A further discussion of these findings will be presented in Chapter 6.

This final section of the comparison of the findings will review findings that are not specifically related to the research questions, but that are important for the evaluation of the program.

### 5.6 Program Evaluation

Although not a component of the research objectives, it was decided to provide an evaluation of the program from the perspective of the nurses who undertook the study day program because of the possibility that it may be used for determining the future implementation of the program. The following statement is an example of the overarching positive commentary received about the program: “Thorough presentation of a ‘whole of picture’ approach to student learning, particularly in relation to student learning outcomes and how much these are influenced by the placement” (CSP108 IP).
Participants were asked to identify whether the CSP had met their learning requirements, whether they would recommend the program and whether they would recommend any changes. While these data entries were also used to answer the research questions, due to the nature of the entries provided, their main focus was program evaluation.

The majority of participants stated that the CSP had met their learning needs and that they would recommend the program to other nursing staff. However, two participants stated ‘no’ on the form. These participants were both nursing educators, and they provided further feedback for these responses, which related to a misunderstanding of the program’s contents. One participant stated that she was asked to attend the program by her department executive, and she was under the impression that it was about a new national financial incentive to promote clinical supervision; however, she felt that the program was very good and would recommend it for clinical staff. The second participant, who was from a different hospital, was a facilitator of the preceptorship program and was also asked to attend by an executive. She felt that as a senior educator, she gained no new knowledge and she did not feel that staff from her organisation needed to attend, as appropriate content was included in her organisation’s own study day.

The researcher read all entries by participants in the post-program surveys in relation to program satisfaction, as well as any comments included in the online reflections and interviews. Together, these sources of data were utilised to undertake a program evaluation. The following five themes were identified and will now be discussed, with supporting comments by the participants. These related to the following areas:

- program content and presentation
- potential availability of program
- consequence for recruitment and retention
- application for graduates and new staff
- taking back to the team.

The first of these themes to be described is ‘program content and presentation’.
5.6.1 Program Content and Presentation

Comments in relation to the program’s content and presentation outlined a number of key points. These related to the specific sessions included in the day, the style of the presentations and the skills of the facilitator in presenting the program.

A general comment is included below by participant CSP71 IP, about the program and its effect:

I had no idea at the start what to expect but this has been the most comprehensive and informative session I have been to on preceptor role and what it entails…It has given me a great resource in the way of the folder. Much more confident in what I am supposed to be doing and what my role entails.

Examples of comments made by participants in relation to the presentation of the program by the facilitator outlined the professional presentation and the facilitation skills of the presenter. Many participants commented on the relaxed flow of the day and the ability of the facilitator to manage the group discussions and highlight significant points.

The following statements related to participants’ general thoughts about the facilitator’s presentation: “You have a very positive and professional approach; encouraging nurses to provide a great opportunity for our future nurses, thank you” (CSP91 IP). Participant CSP191 OR stated that “I found the workshop informative and interesting and your teaching was well received. Your knowledge and enthusiasm for the subject shone through”.

A number of participants highlighted the extensive knowledge and ability of the facilitator to provide appropriate solutions: “The presenter was very knowledgeable and was aware of the students’ needs but also the realistic situations within the placements. Gave good practical advice with great research articles to back up presentation” (CSP93 IP). This was also commented on by CSP1 IP: “The presenter was very well prepared and demonstrated knowledge of relevant clinical experience with student nurses”. Further, CSP108 IP stated that “The sessions were well explained and the problems faced, rather than glossed over”.

Many of the participants’ comments related to the inclusion of the different teaching and learning styles used in the presentation. In particular, participants discussed their enjoyment of the group discussions. Participants enjoyed the opportunity to meet with staff from other
health care sites and to share their experiences. For some, it was about hearing other clinicians’ views of clinical supervision and/or their experiences. CSP84 IP stated that it is “Always interesting to hear other people’s experiences/point of view”. CSP156 IP had “Enjoyed group discussion, made me aware of my peers views”, while CSP188 IP enjoyed “The varied content and group discussion, which enabled us to hear about other people’s ideas/concerns when supervising students”.

Some enjoyed discussing the case studies and thinking about possible solutions as a group: “Participating in a group environment, being able to discuss real cases and apply what and how things should have been handled” (CSP39 IP). For others, it was about confirming that the issues were the same across many sites: “We pretty much had the same concerns, so that was kind of nice to know that it wasn’t just your own opinions and stuff, it was happening right across that group” (CSP40 I).

Participant CSP73 IP enjoyed the group sessions but also liked having the work file to refer to: “I liked how we got to discuss things in groups. It was very informative and I liked having the information in front of me [work file] to, I could jot points down” (CSP73, IP). For others, it was about having different sources to learn from—both the facilitator and the group: “The variety of the day…[and the] group discussions and the way we could learn off each other as well as the lecturer” (CSP90 IP).

Participants also stated that the program’s content was useful and applicable to the workplace: “This was an enjoyable and informative day, the topics were relevant and I will utilise the skills/knowledge discussed when supervising students in the future” (CSP38 IP). Participant CSP75 OR stated that “I found the one-day training both useful and enjoyable and have incorporated much of the material”.

Participants stated that the program had clarified their role as clinical supervisors, which is a point of concern included in HWA’s publications: “Enhanced my knowledge about student expectations from the clinical supervisor, and the roles and responsibilities of clinical supervisor towards student nurse” (CSP45 IP). For CSP31 IP, it “Gave me a greater understanding of the role and responsibility of the clinical supervisor”. Further, participant CSP87 IP said that “I was hoping that the program would outline what is expected of a
Participants also enjoyed learning about the ‘big picture’ in terms of HWA, the future of clinical placements, and student numbers and current nursing education program requirements. This seemed to give them a sense of their role in this bigger picture, which is an important prerequisite for adult learners to assist them to understand their relevance and importance. CSP122 IP wrote that the program “Outlined the many important aspects of being a clinical supervisor…[and] learning about current and upcoming initiatives for undergraduates”. For participant CSP115 IP and a number of other overseas attendees, it was about learning about the Australian context “To gain a better understanding of the student training program in Australia”.

Participants also provided comments in relation to specific topics included in the program, as well as their effects on the participants. A strong underlying theme throughout the findings was that of the session on belongingness; this topic received a number of positive comments in relation to the program’s content. CSP17 IP stated that “I believe it is something all health professionals need to hear…the importance of belonging”, while for participant CSP25 IP, it was “Realising the impact on students if they feel they don’t belong in a department”. Participant CSP76 IP wrote that the highlight was the session on belongingness: “Particularly in relation to the importance and benefits of belongingness for both students and staff”.

Other general comments about the topics included in the program are presented below. These related to all sessions that were included in the study day program: “‘Insight into students’ learning in the practical settings, expectations and exposure to different pracs…emphasis on learning methods, critical thinking, reflection, discussion of application in work setting” (CSP141 IP). Further, participant CSP40 wk8 made the following statement:

Relaxed presentation, really interesting information that was research based, current and relevant. I particularly enjoyed the styles of learning and also to have an understanding of how to promote clinical reasoning, critical thinking and reflection in practice.

Participant CSP48 IP had “Enjoyed learning about giving feedback to students and working through critical thinking/reasoning with students”, while CSP29 IP explained that “I enjoyed
the explanation of clinical reasoning, the importance of belongingness and competency and assessment”.

Participants also made a number of comments about the work files that were given to them on the study day: “Excellent presentation and the folders provided valuable resources, good practical advice about helping students to maximise their potential” (CSP87 IP). Participant CSP42 I agreed, stating that “I loved the fact that we got our resource folders…I have actually re-read that again and again”.

Participants also seemed appreciative that the day was not focused on the use of PowerPoint. Participant CSP76 IP stated that the “PowerPoint was well presented, simple and to the point”, and CSP39 IP wrote that the “PowerPoint was very good, not over done”. Participant CSP40 I commented on “The various ways of learning throughout the day, as well; some of the group work and then some PowerPoint work and some activities, things like that, I kind of liked the way everything was mixed up a bit there”.

Some participants suggested changes to the program. One participant asked for the inclusion of role-play; however, this was in the initial pilot presentation and removed due to negative feedback. Other participants suggested including students in the program: “Perhaps some input from actual students, their own experiences, and some comments about what they find most beneficial on a placement” (CSP177 8wk). The inclusion of students was not considered at the time of developing the program, and this would require further consideration due to the logistics of ensuring students’ attendance, which students would attend, and ensuring their sense of safety. One possibility may be the use of recorded video statements relating to each area of the study day, asking students to relay positive and negative experiences.

5.6.2 Potential Availability of Program

A number of participants discussed how helpful they had found the CSP and how it could be of benefit to other nurses. This concept was also explored under the themes of staff attitudes: “To highlight to all health professionals the importance of guiding/supporting students in the clinical setting with recognising different learning styles” (CSP77 IP). Participant CSP87 IP stated that it was “Essential learning for all RNs who mentor students, it will enhance the students experience if all RNs know how they can contribute”.

245
Participants also discussed how they believed that more staff should attend the program, or mentioned that they had recommended the program to others: “I want remainder of my clinical team to do this course also” (CSP42 IP). In the online reflection, participant CSP185 stated that “I have been very impressed with your study day and promoting staff to attend the worthwhile session”. In the eight-week survey, participant CSP43 had “Already recommended the program to many colleagues as I found the day very informative and the take-home folder a very useful resource”. CSP8 IP said that “I would like all nurses in my area to have completed this”, and CSP42 IP agreed, stating that “My colleagues have not had any formal training and this would be invaluable for staff”.

Some participants asked whether the program could be delivered over two days to provide more time to explore each topic, or whether it could be converted into weekly sessions to allow time for reflection between the sessions:

Would prefer delivery over a few sessions spaced over a semester to allow for reflection and time to try out new strategies in the workplace and discuss these with peers, perhaps sharing reflective journal entries (CSP 8wk).

Participant CSP40 I discussed that the program could have benefited from taking place over two days:

I think it probably could have been done over two days…I think people were probably disclosing to people…because by the end of the day we were all chatterboxes and we all had really connected with each other, but I think maybe two days, or one and a half days, or something like that, just to create more discussion.

The overall review of participants’ satisfaction with the CSP was extremely positive. The majority of participants believed that the program required no changes, and they requested the program to be made more available for nursing staff to attend. The program evaluation also determined that participants had applied the contents of the study day and their learning to situations involving not only students, but also graduates and new staff. This is the next theme of this chapter.

5.6.3 Consequences for Recruitment and Retention

This theme relates to how participants had thought about or applied the principles of the study day to the recruitment and retention of students. Participants provided statements and
examples where they felt that the outcome of providing effective clinical placements not only affected the learning experiences of students, but also the students’ future career choices.

One participant discussed her surprise after a nursing student had shared her thoughts about her previous experience on an oncology ward. Her comments were very positive, which surprised the nurse, but she reflected and linked this to belongingness and realised the potential opportunity to use this for future recruitment in her work area with the student nurses:

This surprised me, as I know this is an extremely challenging area of nursing, and I personally would find it very difficult to work in there. This reminded me, during the workshop it mentioned the benefits and barriers of learning. The sense of belonging, being welcomed and inclusion of team can enhance learning and overall satisfaction of an experience. I felt that the oncology units must have embraced the students…[area named] also has trouble attracting staff and I feel that embracing students and being proactive in making their experience a positive one will only benefit both students and the future employment of new graduates in this field (CSP31 OR).

Many comments included general statements about applying the program to recruit and retain nurses and promote the profession as role models: “I will be much more conscious of being a role model and also how I can affect the student career decision and the benefit they gain from their experience” (CSP87 IP). For participant CSP57 IP, it “Reinforces the importance of nurturing students for the future, investing in the future”. Further, participant CSP29 OR said that “I do feel more and more that if you invest good quality mentorship in the early stages of a nursing career, that the reward pays off”.

CSP110 8wk related this to both students and nurses who were already employed “To help nurses…be more supportive of students, to help develop our future nurses stay in the job and enjoy their chosen career paths and put back into nursing”. CSP39 IP also touched on the future of these student nurses: “As a profession which is known to be aging it is important to know how to guide students in a caring and sufficient manner, as we need more nurses and one day they too will become facilitators to students”. CSP57 IP highlighted the negative effect of belongingness: “Put into realisation how nursing students need to be treated, and how easily they may no longer like the profession should they be treated wrongly”.

247
The next theme relates to the application of the principles of the clinical supervision study day to other staff members in the clinical area.

5.6.4 Application for Graduates and Staff

The aim of the CSP was to provide nursing staff with the knowledge and attitudes to provide effective clinical placements for students; however, participants also provided examples of where they applied these principles to graduates and staff.

Participants outlined how they had used the information from the program to assist them in their roles when supporting members of staff. In particular, this related to staff in clinical development programs who were first-year graduates or specialising in a new area. One participant discussed her concerns regarding a new graduate nurse and her difficulties transitioning from student to graduate. During the study day, the relationship between belongingness and learning was discussed, and this participant outlined how she linked these concepts to practice:

I have reflected back on the model…‘Belongingness’ as this graduate is finding it hard to become a part of the team. Having reflected on some of the articles from the study day…I think that if her sense of belongingness improves, her confidence to put theory to practice will follow (CSP92 OR).

Other examples of applying the principles of the study day program included a community health nurse supporting a new practitioner in the clinic: “I was able to constructively compliment and support her, as we explored the situation. I feel this gave her more confidence” (CSP61 OR). Other participants made similar comments: “I was pleased to participate in your seminar and have applied the principles to working with my peers—especially new practitioners, to encourage their learning pathway and so they feel supported” (CSP61 OR). Participant CSP42 I also discussed the possibilities for those benefiting outside of the nursing profession:

It’s just been really an eye opener to really reflect on how I can do better with students, and really you designed it for student nurses, but I’ve used it with…registered nurses at different levels of competency wanting different things and it works just as well. So I think that it’s a model that just can be rolled out not only the nursing profession, but I don’t know, who knows, it could be something that goes in other industries as well.
Another participant commented how she had incorporated Gibbs’ Reflective Cycle into her six-weekly team meetings with staff to use as a tool for staff learning:

We might look at any challenging cases that we might have had recently, or if we’ve had even some fantastic things that have gone really well. And by using the Gibbs’ Reflective Cycle, I think you can really unpack it to get a greater understanding of the issue that you’re talking about (CSP42 I).

The final theme related to this section on program evaluation was ‘taking back to the team’.

5.6.5 Taking Back to the Team

Participants discussed taking the information from the CSP and sharing it with their colleagues in order to generate wider change in their work areas. Some staff presented short education sessions, while others changed the way they allocated students in their work areas. Participants included comments, both positive and negative, of ‘taking back to the team’ and how this made them feel.

A number of participants shared how they had discussed the program’s effect with their line manager and other staff within their organisation:

I had a meeting with my manager and gave an overview of what had been covered in the course. My manager was very interested and supportive...I then commenced informing my other colleagues over the next three days to explain why I wanted to mentor our next few students. I had responses ranging from ‘thank goodness I just don’t have the time’ to ‘have you gone mental!!’ Interestingly enough though when I proceeded to discuss the seminar course and the enlightened way of structuring student placements, all my colleagues are in agreeance that we can improve the way we mentor students. I have now placed one of the journal articles from the seminar for discussion at our next regional journal club meeting so that other local colleagues can begin to comprehend why we need to make some changes (CSP34 OR).

Participant CSP123 IP stated that it “gave me lots of insight into clinical supervision, will take ideas back to my workplace”, and CSP33 8wk documented that “I found this beneficial for myself but also so I could provide feedback to my other colleagues who did not attend”. A number of participants echoed these thoughts: “So beneficial to my needs. I feel I can bring all this information back to my areas and benefit myself and area” (CSP67 IP). CSP176 IP would “Go back and educate/discuss prospective student support with rest of the team, to be better prepared for the student placements in order to give them a better experience”. CSP27
OR discussed it with her manager: “I fed back about your program and how we can supervise the students better, she [manager] was very enthusiastic”, as did CSP65 OR: “I have feedback informally to the staff whom I have seen on my shifts. I am preparing a summary to present to the manager and ward staff”.

Some participants discussed how they had provided short in-service sessions with the staff: “I have also presented an education session on mentoring and given RNs articles relating to the ‘experience’ of student nurses on placements” (CSP93 8wk).

Participant CSP93 OR outlined how she had shared her knowledge from the day with the staff in her area; however, the outcome had not been what she had hoped for:

We regularly receive students at the facility and I feel that staff often have a negative attitude towards students seeing them as a burden. Prior to receiving our current placement of students I presented education to staff reminding them of how they felt when they were first employed at the facility. The aim of the education session was for staff to be more understanding and considerate towards new staff members, work placement students and student nurses providing them with a positive experience which in turn will also benefit patients. Generally staff have been more accommodating with the current students we have at the facility; however, on one evening this week when the student nurse approached her assigned RN the RN explained that she was far too busy to supervise or talk to her. The carers also in that work area appeared to avoid interaction with the student nurse, leaving her feeling insecure and unsure of what to do. I felt annoyed and disappointed in the staff and sorry that she had been poorly supervised, despite attempts to educate staff (CSP93 OR).

Some participants related topics not just back to their work colleagues, but also when interacting with patients/clients. For CSP101 I, this related to her work area as a school nurse:

I’ve been making more attempts at communicating effectively…we have an indigenous population and it’s very important for them to feel a sense of belongingness if they’re going to be successful here in this school…so I’ve been using this as a tool of being able to communicate with that part of our community as well.

CSP141 IP felt “More confident to deal with students, but also on how to teach other colleagues how to teach students also”.

This concludes the CSP evaluation. These data have provided further clarification of the positive effect of the program and its ability to assist registered nurses in their role of support
and supervision to students and staff. An important implication of these findings is the effect of the role of the program’s facilitator. This implication will be discussed in further detail in Chapters 6 and 7.

5.7 Chapter Summary

Each year, thousands of student nurses attend clinical placements in a variety of health care facilities in Western Australia. The effectiveness of these clinical placements in part relies on the ability of the nurses supervising the students. Students who are welcomed, who have a clear understanding of their place in the workplace and their learning objectives, and who are supported to practice and ask questions, have an opportunity to apply theory to practice and develop the essential knowledge, skills and attitudes of the profession. However, these qualitative research findings have described that nursing staff often feel that the role of clinical supervision is one that has been taken for granted for a long time, with little staff education and support provided to create this positive atmosphere of student learning.

The findings of this chapter have confirmed that the CSP is one strategy that can assist nurses to develop the essential knowledge and attitudes to feel empowered to practice in this role. However, the findings have also indicated that the participants felt that more staff need to attend this training in order to change the current culture towards clinical supervision. Further, health care facilities and education providers must be actively engaged in the development and implementation of strategies to assist with this teaching and learning relationship.

Chapter 6 will continue to explore these findings in relation to the literature, and Chapter 7 will discuss the implications of these findings for the nursing profession.

***

Thereafter, each placement was the same—a lucky dip each day. But she always found someone there who seemed to offer a shining light. It was just enough to get her through.
Chapter 6: Comparison of Findings

On the first day of her Graduate Nurse Program, at a hospital she had never been to before, she put on her uniform with pride and pinned her granddad’s birthday gift to her chest. The word among the students was that this was a great place to be. She almost skipped as she walked into the hospital; she was now a nurse. There would be no lucky dip of whom she would be allocated to. Now she felt empowered. Now she wore the uniform.

6.1 Introduction

Further discussions in relation to the overall findings of this research and their relationship to current theory and past research findings will be discussed in this chapter. The implications and recommendations of these findings will be discussed in Chapter 7.

This section will commence with a review of the current nursing workforce in Australia and Western Australia compared to the CSP participants. This will be followed by a comparison of the qualitative and quantitative research findings. The overall research findings will then be compared with the relevant literature. Following a review of the program’s findings, a discussion outlining the new knowledge gained from this research project will be presented, followed by the research limitations.

6.2 Nursing in Australia

The CSP was presented on 12 occasions in Western Australia. Chapter 4 outlined the demographic details of the participants who attended the program. The researcher compared these demographics with the Australian and Western Australian population of registered nurses to determine the generalisability of the research findings.

Statistics regarding the demographic details of the Australian registered nursing population were obtained from the Australian Bureau of Statistics (ABS) (2005), AHPRA (2013) and HWA (2013b). The ABS’ most recent workforce report on nursing in Australia pertained to
the period between 1986 and 2001 (ABS, 2005). The AHPRA’s statistics were sourced from the nursing accreditation details of nurses in Australia in December 2012. HWA’s (2013b) ‘Australia’s Health Workforce Series (HWS), Nurses in Focus’, report is based on data obtained from 2009 to 2011. Each of these data sources has provided general information in relation to registered nursing; however, not all data were provided on a state level or to the same level of detail. Therefore, a combination of these sources was necessary.

According to the ABS, the Australian statistics for gender in the nursing workforce between 1986 and 2001 were 91% female and 9% male. The AHPRA (2013) report for Western Australia in December 2012 indicated that 90.3% were female and 9.7% male, showing little change between the state and national figures between 1986–2001 and 2012. In comparison, the CSP consisted of 95% female and 5% male participants, which was slightly different compared to the average in both of these reports.

The average age of registered nurses in Australia and Western Australia was obtained from the ABS and AHPRA. Each report utilised different age categories, which also differ to this research project’s categories. The results are displayed in Table 6.1. While an exact comparison could not be made due to the different use of age categories, the trend of the demographic data suggests that a similar age distribution was seen in the participants.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>%</td>
<td>Age</td>
</tr>
<tr>
<td>15–24</td>
<td>7.9</td>
<td>&lt;36</td>
</tr>
<tr>
<td>25–34</td>
<td>26.5</td>
<td>36–45</td>
</tr>
<tr>
<td>35–44</td>
<td>35.8</td>
<td>46–65</td>
</tr>
<tr>
<td>45+</td>
<td>29.8</td>
<td>&gt;65</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In relation to area of employment, the participants attending the program consisted of 74.5% from the metropolitan areas and 25.5% from the regional areas of Western Australia. Compared to the national statistics of the ABS (2005), 65% of nurses in Australia worked in major cities and 22% worked in inner regional locations. The regional sites that the CSP was presented at included those classified within the inner regional area. No specific data in
relation to Western Australia were available from any of the data sources. While this research project had a higher percentage of participants from the metropolitan area compared to the national average, the national average does not reflect the effect of the geographical limitations that influence the demographics of Western Australia compared to the rest of Australia. The Western Australia population statistics from the ABS for 2011–2012 showed that 78% of the state’s population live in the metropolitan area, with the remaining 22% in regional Western Australia (ABS, 2013). These statistics show a similar distribution to the study day program, with 74.5% of participants from the metropolitan area of Perth and 25.5% from regional areas.

The HWA (2013b) report outlined that 65% of nurses in Australia were employed in the public health care sector compared to 65.3% of the nurses who participated in the CSP, which is almost identical. In the areas of practice, the HWA (2013b) report outlined that 63% of nurses were employed in hospital-based positions, including both clinical and non-clinical roles, and 15% were employed in community/private practice settings. Attendees at the CSP included 51.5% in hospital-based positions, 18% in the community, 22% in education and 8% in the mental health sector. These education roles included both the hospital and education sectors, and for mental health, it included both the hospital/inpatient sector and community services. Taking into consideration these different category allocations, the percentages between the hospital and community are very similar to the national statistics.

The years of nursing practice statistics were only available in HWA’s (2013b) report, which provided the average length of years that nurses had nursed in Australia in 2009. It did not break these statistics down into years of practice ranges as utilised in this research. Fortunately, the researcher had collected the participants’ actual years of nursing and grouped these into categories when the data were analysed. Therefore, the average length of nursing for this group could be determined. The average length of nursing experience in Australia was 17.6 years (HWA, 2013b) compared to 17.3 years for the CSP participants—again, almost identical.

No statistics in the literature outlined the current level of participation in clinical supervision education or the frequency of clinical supervision by nurses across Australia. However, the HWA (2013b) report outlined an increase of 90% in student numbers between 2002 and 2011. These data also included an approximate student attrition rate, which unfortunately had
increased from approximately one-quarter of students not completing their qualification to one-third in this same period. The report did not include a discussion of this finding.

The participation of CSP attendees in previous clinical supervision education ranged from no previous education (51.3%) to an in-service or study day (32.7%), short course (7.5%) and formal post-graduate qualification (2%). Of the study day participants, 42.5% were involved with the clinical supervision of students each week, 33% were involved on occasions each month and 19.5% were rarely involved. Of those who were rarely involved, 50% commented that they were not based in clinical roles; they identified themselves as being in management or staff development support positions.

This section compared the nursing population in Australia with the attendees at the CSP. It described that the population of nurses that attended the program was representative of nurses in the Australian context. Similar percentages were achieved in relation to the number of male versus female participants, age of participants, regional versus metropolitan employment areas, areas of practice and number of years nursing. This finding provides support to the study day participants being representative of the nursing population in Australia.

6.3 Comparison of Qualitative and Quantitative Findings

For this research, the qualitative and quantitative data collection and analysis techniques were reviewed separately, as per the research method articulated in Chapter 3 of this thesis. The findings from this mixed method research project about the effect of the CSP for registered nurses suggested that the program had a positive influence on the knowledge and attitudes of the participants. These findings are supported by both the improved mean scores for the attitude and knowledge surveys, and by the words of the participants. Participants described the program as a positive learning experience that should be made available for more nursing staff as a strategy to improve workplace cultures towards supervision and to promote the important role of clinical supervisors. These qualitative and quantitative findings are articulated in Figure 6.1.
The next section will compare this comparison of findings with the literature.

6.4 Comparison of Findings to the Literature

Due to the limited published research in relation to the implementation of clinical supervision education programs, the researcher explored each theme in terms of its relationship to the principles of the clinical supervision relationship, theories and principles of learning, theories of persuasion and role theory in order to determine its implications. These theories and principles were chosen because of their ability to provide a framework to compare the findings to the research project, as will be discussed in each finding.

6.4.1 Improved Self-confidence, Knowledge, Attitudes and Enthusiasm

The mixed method findings of the study highlighted improved self-confidence, knowledge, attitudes and enthusiasm towards students and student clinical supervision. The qualitative
statements and stories of the participants evidenced these findings. The results of the quantitative knowledge survey and Stagg’s attitude survey, which were completed by the participants pre-program, immediately post-program and after eight weeks, also supported this finding.

As discussed in Chapter 2, Smedley et al. (2010) and Charleston and Happell (2004) introduced clinical supervision education programs in Australia in the tertiary education setting. Both providers determined that clinical supervision education had a positive influence on the knowledge and attitudes of the participants who attended the programs. These research findings were based on the completion of evaluation tools by participants after attending the education programs. These projects did not include an eight-week effect of the education on nursing staff, or pre- and post-program knowledge or attitude surveys. Conclusions were based on participants’ satisfaction with the program and the completion of evaluation tools after completing the programs.

In comparison to the research projects of Smedley et al. (2010) and Charleston and Happell (2004), the CSP research project involved the completion of pre- and post-program knowledge surveys, an attitude survey, online reflections, and written and verbal statements. Due to the researcher being unable to locate another program based on clinical supervision that undertook a similar evaluation method, a comparison of these findings could not be undertaken for each data collection method. However, the researcher believed that it was important to review the literature in regards to two components of this research:

- eight-week survey results, as the knowledge survey showed an increase in the mean survey, while the attitude survey showed a slight drop in the mean result
- comparison of the findings of the attitude survey with previous studies using Stagg’s (1992) attitude survey.

6.4.1.1 Eight-Week Survey Results

The behaviourist learning theories, as described in Chapter 2 of this thesis, describe that learning has occurred when a change in behaviour is present. This learning is achieved by individuals responding to a stimulus with a desired response. This can be achieved through the facilitator role modelling the desired behaviour. Once the learner no longer receives this stimulus, he or she is at risk of losing the behaviour (Knowles et al., 2011).
The concern of losing the behaviour also relates to the theories of attitude change and persuasion, as outlined by O'Keefe (2002) in Chapter 2. A participant’s ongoing attitude change and acceptance of a new attitude is dependent upon the individual continuing to perceive that the attitude is important and relevant. If this is not reinforced or supported in the environment, then the individual may lose the newly acquired attitude (O'Keefe, 2002).

To assist participants in applying their learning to the workplace, the principles of adult learning and theories of cognitivism and constructivism were also utilised as a strategy to achieve deep learning and reduce the risk of participants losing the acquired knowledge and behaviour through the behaviourism theory of learning alone (Knowles et al., 2011). As discussed by Moon (2004), the effect of education is to see a change in participants’ practice. Those with an interest in the topic will aim to achieve a sense of ‘deep’ learning versus ‘surface learning’. According to Moon, with deep learning, the learner is able to understand, apply and evaluate the learnt material, while surface learning involves only remembering information for a short period—that is, it relies on the recall of facts, and there is little ability to break the information down into its components and relate or use with other knowledge.

In applying these theories and principles to the results of the eight-week knowledge survey results, it appears that the participants were able to integrate the knowledge component of the study day into their long-term learning and, returning to their clinical areas, they may have applied this to support learners to achieve deep learning, as supported by Kolb’s learning model (1984). However, in accordance with O'Keefe’s (2002) descriptions of the requirements of attitude change, the slight decrease in the group’s mean results for the attitude survey after eight weeks may have resulted from negative attitudes in the workplace or the loss of the persuasive message provided on the study day.

The researcher also referred to publications involving similar data collection methods in determining the effect of education on course participants in the immediate phase and after a period of time. A number of articles discussed the implementation of a short course and an evaluation both before, immediately after and again after a period of 1–4 months, where knowledge and attitude changes were monitored (Desy, Prohaska & Plaines, 2008; MacDonald, Stodel & Chambers, 2008; Steginga et al., 2005).
Steginga et al. (2005) studied the effect of a short course on nursing staffs’ knowledge and attitudes towards caring for patients with cancer. Thirty-one nursing participants completed pre-program, immediate post-program and six-week post-program attitude scales and knowledge tests. The educational principles of small-group learning, group discussions and the application of the principles to the workplace (as utilised in the CSP) were described. The findings of the study determined that an improvement in knowledge was achieved across all phases of the research. The attitude results showed an initial improvement in the post-program test, and while improvement was maintained after a period of six weeks, there was a slight drop compared to the immediate post-program test, although this was not statistically significant. The researchers stated that the program had successfully achieved its goal and recommended the program as a strategy for improving nurses’ understanding within this speciality.

MacDonald, Stodel and Chambers’ (2008) study introduced an online education program for 59 nurses and members of the allied health care team related to the topic of interprofessional learning. Participants completed pre-program, immediate post-program and four-months post-program surveys. The findings again indicated an increase in knowledge; however, no statistically significant changes in attitudes were identified. Possible reasons cited included the significant change that interprofessional practice brings and the time required for workplace changes to be accepted. It stated that more time may have been required for an effective attitude change to occur once the team members had an opportunity to integrate the new procedures into the workplace.

Gesin et al. (2012) outlined the implementation of a delirium screening tool with 20 nurses. Education involved face-to-face delivery and additional online learning resources. The research findings indicated that the nurses’ knowledge continued to improve from the pre-program, immediate post-program and three-month post-program test, while there was no significant change in attitudes. Recommendations to address the lack of attitude change related to follow-up bedside education to reinforce the attitude change and to facilitate a cultural change in the work area.

A study by Desy, Prohaska and Plaines (2008) studied the effect of ‘emergency nurses in geriatric emergency nursing education’. The research involved a pre-program, immediate post-program and three-month post-program survey of 102 participants. The survey aimed to
determine whether a change in knowledge, attitudes and assessment skills had occurred in the course participants. The findings from this project determined that an improvement occurred across all three phases of the research project. Different to the previous studies and this CSP project, attitude was measured by the ability of the nurses to apply the knowledge gained from the program in a self-reported survey. This interpretation of attitude may explain why a positive attitude was recorded by the authors in this case. Participants in the CSP also reported their implementation of the CSP strategies in their qualitative statements, and they applied this learning in the short-answer questions in the knowledge survey; however, this was not interpreted as an attitude change in this research.

The literature in relation to the evaluation of participants’ knowledge and attitudes before and after an education-based intervention typically outlined improvements in the participants’ knowledge; however, an attitude change was often not present or maintained after an extended period of time. These publications appear to indicate that the findings of the CSP knowledge and attitude scores are similar to other studies that introduced education programs for registered nurses that related to changes in nursing practice.

The concept of sustaining a change in attitude will be discussed in further detail later in this chapter in relation to the concerns of participants regarding current staff knowledge, attitudes and education.

The second point of further enquiry related to this first finding of the CSP research project relates to the use of Stagg’s (1992) attitude survey, which will be explored in the next section.

6.4.1.2 Stagg’s (1992) Attitude Survey Findings Across Research Projects

A description of the results of Stagg’s (1992) research and Aghamohammadi-Kalkhoran et al.’s (2010) study was provided in Chapter 4. These findings and the findings of the CSP research project will now be compared.

Stagg’s (1992) overall findings of the research determined that participants’ attitudes showed no significant difference between their demographic details. These included the number of years nursing, age and educational background. However, there was a significant difference in the responses between the staff at the two hospital sites used in the study in relation to three
questions in the survey. The first question referred to the different education programs in the UK for entry into registered nursing, and the staffs’ attitudes towards these programs. Given that in Australia, all registered nurse education programs have been at a Baccalaureate level since the early 1990s, this statement was not included in this research project. Questions two and three related to ‘there is too much to do to worry about students’ and ‘students become overwhelmed when taking care of more than 1 or 2 patients’. The difference in the outcomes for these two questions was speculated as the result of the different numbers of students attending each hospital. The hospital whose staff agreed with these statements had significantly higher student numbers from four different nursing schools, while the hospital that did not agree had fewer students from one nursing school. It was concluded that the higher number of students in the hospital and increased exposure to student clinical supervision may have been a negative influence on these results (Stagg, 1992). Aghamohammadi-Kalkhoran et al.’s (2010) study also found no significant differences between the demographic groups within the study.

The overall findings by Stagg (1992) highlighted low attitudes towards nursing students. The results were not statistically different between the demographic details of the participants; however, Stagg suggested that student nurses be placed with nurses who were less than 40 years of age, who had been nursing for less than 10 years and who do not regularly supervise students. Recommendations for the future included a more detailed study that involved the inclusion of both quantitative and qualitative data so that a greater understanding of these results could be determined.

Aghamohammadi-Kalkhoran et al.’s (2010) study also determined that nursing staff held low to moderate attitudes towards nursing students. Nurses preferred to work independently rather than be allocated a student. Similar to Stagg’s (1992) findings, the study suggested that students were best placed with nurses below the age of 30; however, in contrast to Stagg, the years of nursing experience was reduced from less than 10 to less than three years. Recommendations of the study related to the effect of the findings on hospital and university policy-makers rather than the methodology of the study.
Both of these comparisons highlighted that the findings from the CSP participants for the mean score for attitude are higher than those of Stagg (1992) and Aghamohammadi-Kalkhoran et al. (2010). The CSP participants also continued to improve the attitude score after attending the CSP and maintained an improvement after a period of eight weeks.

The comparison of findings between Stagg (1992), Aghamohammadi-Kalkhoran et al. (2010) and the CSP highlighted that participants in the CSP had a higher attitude mean score towards nursing students than the other studies. However, similarly, all of the studies showed that there was no significant difference between the results according to the demographic details of the participants. Of interest to the researcher was Stagg’s conclusion that frequent clinical supervision had a negative effect on participants’ attitudes towards students. In comparing these findings, this research also determined that the group of participants that supervised students on most days had a lower mean attitude score than those that supervised some days each week. However, it must be noted that despite this difference, the ‘most days’ group had the second highest mean overall.

A final comparison of these studies involved reviewing the effect of the geographical location of the studies and the time period in which they occurred. Stagg’s study was conducted in the US in 1992. A review of the literature found no historical information that would have affected the attitudes of nurses towards students at this particular time. The role of nurses and their articulation to professional status in the UK had a similar philosophical and professional approach to that in Australia; however, it has struggled with achieving university Baccalaureate qualifications as the entry level (Lusk, Russell, Rodgers & Wilson-Barnett, 2001).

In more recent years, this lack of a standardised Baccalaureate education requirement in the US, as well as the external pressures of the economy and the increasing complexity of health care, has placed increased scrutiny on the nursing profession. Nursing and nursing education has been described as being in a current state of crisis (Rich & Nugent, 2010). To meet the requirements of registration, students complete a national-based written assessment; however, the training programs that are eligible to sit the exam range from a three-year hospital-based diploma to a two-year associate degree or a four-year degree (National Center for Health Workforce Analysis, 2013). With the increasing complexity of health care, these differences in nursing qualifications, which is only unique in the US to the health profession of nursing,
has resulted in a reduced professional standing within the health care team, and nursing is seen as being at risk of losing its voice in the political and social agenda items and reforms (Rich & Nugent, 2010). Currently, only 55% of the nursing population holds a Baccalaureate degree (National Center for Health Workforce Analysis, 2013).

As discussed, the results of Stagg’s (1992) survey were similar to this research, with only a 7% difference in the ‘high’ to ‘low’ allocation of the mean results. With no recent literature from the UK on the current attitudes of nursing staff towards students, it is unknown whether the current climate in nursing education and health care has affected Stagg’s findings since 1992.

For the study conducted by Aghamohammadi-Kalkhoran et al. (2010), the timeframe for this study provided a more recent set of results to compare with the findings to the CSP; however, the effect of the culture of the nursing profession in Iran may have influenced the results.

According to Farsi, Dehghan-Nayeri, Negarandeh and Broomand (2010), the health care system in Iran is close to that of developed countries. The introduction of the first nursing school in 1916 marked the start of the nursing profession, which predominately comprised females; however, the effect of the Islamic revolution in 1979 and the Iraq–Iran war (1980–1988) resulted in restricted health care budgets and the requirement for male patients to be cared for by male nurses. As a result, 50% of nursing students in 1986 were male, and difficulties emerged in maintaining the staffing requirements. By 2010, 20% of the nursing population were male; however, a negative stigma had become attached to the role, resulting in poor recruitment and retention. This is despite nursing in Iran converting from hospital-based training to a university degree in the early 1980s with the creation of post-graduate qualifications at the PhD level (Farsi et al., 2010). Nursing in Iran continues to experience difficulties in gaining its professional status in the health care system and wider community (Farsi et al., 2010; Rahimaghee, Nayeri & Mohammadi, 2010).

This negative perception of the role has added to the significant staff shortages experienced by the profession, resulting in excessive staff overtime (Farsi et al., 2010). This lack of ongoing recognition and burnout from excessive work hours has resulted in a dissatisfaction with the role, resulting in a lack of motivation and the delivery of low-level care, resulting in patient dissatisfaction (Farsi et al., 2010; Rahimaghee, Nayeri & Mohammadi, 2010).
Farsi et al. (2010, p. 16) stated that despite the introduction of the degree and post-graduate qualifications, the role of nurses and their status in the Iranian health care system and community will only improve with changes in the ‘social, cultural and economic issues of Iran’. With these current conditions and perceptions of the nursing role in the Iranian health care system, the results of Aghamohammadi-Kalkhoran et al.’s (2010) study do not seem surprising.

The second theme to be reviewed in this chapter relates to participants’ understanding of the current context of nursing education in Australia.

6.4.2 Improved Understanding of Current Context of Nursing Education

During the CSP, participants were provided with a ‘bigger picture’ session at the start of the day. This provided background information relating to HWA and the current context of nursing education in Australia.

The findings of this study highlighted that many participants were not aware of the nursing education requirements, including the hours of clinical practice, types of clinical placements and universities’ expectations of the clinical supervisor role. The information provided to participants on the study day was considered important both to locally trained nurses and to nurses from overseas.

A search of the literature was unable to identify publications that discussed this theme and its relevance or importance for nursing staff in order to support them in supervising nursing students. Both the DEST (2002) and HWA (2010) outlined the concerns of health professionals in relation to their role and the confusion surrounding it, but they also did not articulate any concerns or discussions about a lack of understanding of the education programs or their requirements of students.

6.4.3 Concerns Regarding Current Staff Knowledge, Attitudes and Education

The findings of the qualitative data indicated a concern that many participants had for the current provision of education for nursing staff in relation to clinical supervision. As discussed in Chapter 2, HWA (2010, 2011, 2012, 2013), the DEST (2002) and a number of
publications (Andrews et al., 2005; Barker et al., 2011; Brammer, 2008; Gidman et al., 2011; Gleeson, 2008; Hyrkas & Shoemaker, 2007; Landmark et al., 2003; Pellatt, 2006) described the inconsistency of clinical supervision education and the understanding of the role.

Participants were particularly concerned that nurses did not perceive the clinical supervisor role as part of their responsibility, despite it being included in the National Competency Standards for Registered Nurses (NMBA, 2006), a requirement of HWA (2011a) and part of many individual employment contracts.

As described in Chapter 2, the nursing literature discussed a number of concerns related to the clinical supervisor role and the education of nursing staff to competently fulfil this role. These included the use of inconsistent terminology (Andrews et al., 2006; Gleeson, 2008), nurses not viewing themselves as teachers or assessors or understanding assessment implications (Andrews et al., 2006; Brammer, 2008; Webb & Shakespeare, 2008), a lack of recognition for the role (Andrews et al., 2006; Barker et al., 2011; Brammer, 2008; Hyrkas & Shoemaker, 2007; Walker et al., 2007), insufficient education available for staff (Andrews et al., 2006; Barker et al., 2011; Brammer, 2008; Gleeson, 2008; Hyrkas & Shoemaker, 2007; Landmark et al., 2003; Pellatt, 2006; Walker et al., 2007; Webb & Shakespeare, 2008) and a lack of understanding of the role requirements (Barker et al., 2011; Brammer, 2008; Gidman et al., 2011; Landmark et al., 2003; Pellatt, 2006; Walker et al., 2007).

The concept of the clinical supervisor role of the registered nurse not being fully understood or accepted resulted in the researcher referring to role theory for further guidance, understanding and implications of these research findings. According to Shivers-Blackwell (2004), role theory provides a framework to view the interactions and relationships of individuals in the home, work and social environments. It provides a model from which researchers, educators, organisations and academics can determine how individuals are likely to act or respond to fulfilling a role—in this case, the clinical supervisor role—that is expected of them (Shivers-Blackwell, 2004).

6.4.3.1 Role Theory

Roles are defined by society’s norms, values and characteristics (Brookes et al., 2007). They provide a set of expectations that allows behaviour and attitudes to be seen as consistent or
inconsistent with what is expected of a given role (Brookes et al., 2007; Turner, 2001). Role expectations are society’s views of how a role is to be fulfilled (Birenbaum, 1984), and role fulfilment is the measurement of the individual fulfilling the role’s expectations (Faia, 1980).

Role theory incorporates both individual and collective roles. Individual roles refer to those in which the individual adheres to society’s norms and expectations at an individual level (e.g. parent, daughter, sibling), while organisation roles refer to groups of people joined by a common interest (e.g. community groups, workplaces, sporting groups) (Turner, 2001). The behaviours and attitudes of participants in the role are influenced by both internal and external expectations—that is, what individuals believe that society expects of them in the role and what society expects of individuals in the role (Brookes et al., 2007; Turner, 2001).

Role theory assists society to understand human relationships. It provides a framework for exploring the attitudes and behaviours of those within a role (Brookes et al., 2007; Turner, 2001). Role theory also explains that the way an individual behaves or thinks in one role may change in another. This is of particular relevance to group roles. It outlines that although individuals may come from different individual roles where behaviours, attitudes and beliefs can vary significantly, when these individuals join a group, a different common overarching role becomes the provider of the expected attitudes and behaviours (Turner, 2001).

An example of a group role is an organisational role. In an organisation, all roles exist for its benefit and to contribute towards achieving the organisation’s goals (Shivers-Blackwell, 2004; Turner, 2001). These roles tend to be predictable and are managed by the organisation. When the role no longer meets the organisation’s needs, it ceases to exist (Turner, 2001).

At times, people can experience role conflict, role strain (Brookes et al., 2007; Faia, 1980; Goode, 1960), role discrepancy (Birenbaum, 1984) role overload or role ambiguity (Brookes et al., 2007). Role conflict or strain occurs when different roles occupied by an individual are not supportive of each other; the individual is overwhelmed by the obligations of each role and is unable to meet their demands (Goode, 1960). Role discrepancy occurs when the individual believes that the role does not support his or her own behaviour and beliefs, and therefore struggles to incorporate the role (Birenbaum, 1984). Role overload occurs when an individual is not able to meet the demands of the role. This may be due to time constraints, an unmanageable workload or a lack of the required skill or knowledge set (Brookes et al.,
Role ambiguity may be the result of a lack of sufficient information provided to those undertaking the role; the role is not fully understood and its purpose may be unclear (Brookes et al., 2007).

Applied to the profession of nursing, the community has an expectation of the role of the nurse, as does the NMBA (2006), health care facilities (employers), nurses and the consumers of the health care system (patients). Nurses also form part of health care facilities’ group role expectations. These are shared by all employees within the health care facility and can include medical, allied health, administration and hospitality. At times, this can lead to role dispute—that is, the expectations of these roles are in opposition; therefore, the role of the nurse may be in dispute (Birenbaum, 1984) with the expected role of the health care facility, community or other members of the health care team. As stated by Brookes, Davidson, Daly and Halcomb (2007), ‘Nurses’ perceptions of their role are influenced by societal attitudes, government policies and trends in professional issues. Dynamic factors in contemporary health environments challenge traditional nursing roles’ (p. 146). Role theory provides a framework for health care facilities to ensure that roles are clearly defined and that role risks are identified with supportive strategies introduced to reduce the risk of the role failing (Brookes et al., 2007).

To support the success of the introduction or change of a role, role theory outlines that people will apply different levels of meaning to the roles that they enact and embrace new roles according to the mode of discovery of the role (Birenbaum, 1984). When introducing a new role, or in this case promoting the role of the clinical supervisor, participants are more likely to embrace the role if the rules of the role are communicated and understood, and their relationship to the current roles and expectations are explained. This approach reduces role ambiguity, conflict and strain (Birenbaum, 1984; Brookes et al., 2007). This can be enforced by creating supportive networks and working with others in the role, which assists with confirming the role’s routine and performance requirements (Birenbaum, 1984). This promotes role embracement and integration opposed to the downgrading and avoidance of the role (Birenbaum, 1984).

Applying role theory to the CSP provided individuals with knowledge of their expected behaviours and attitudes in their roles as clinical supervisors and their overarching roles as registered nurses and members of health care facilities. The acceptance of the clinical
supervisor role by members of the nursing profession can only succeed if the organisation places value on the role, as do those within the profession. This can be achieved through education and forming networks and support services (Birenbaum, 1984).

The future success of the clinical supervisor role can only be assured if the role is viewed as important and if those who undertake the role view it as an essential component of the overall role of being a nurse (Birenbaum, 1984; Brookes et al., 2007). As roles are defined by attitudes, behaviours and expectations, the perception of the role can only change by changing the perception of members in the community (Birenbaum, 1984; Brookes et al., 2007).

The CSP’s aim was to improve the knowledge of nursing staff about the role of the clinical supervisor and to reflect upon their attitudes and behaviours towards students and student supervision. The program aimed to provoke participants to review and reflect upon their roles as nurses and the expectations of the clinical supervisor role to encourage an appreciation of the role, its importance and their individual and group responsibility to the role. However, according to role theory, the positive attitude created at the study day program is at risk of failing to progress to a change in behaviour and long-term acceptance of the role without their organisations’ value and support (Birenbaum, 1984; Brookes et al., 2007). This theory may play a part in the slight decline of the mean results in the eight-week attitude survey.

The important role of the health care facility in ensuring ongoing support and role embracement for the clinical supervisor role relates to the theme of the perceived lack of support, which will be discussed in the next section.

6.4.4 Perceived Lack of Support

Participants’ perceived lack of support in this research was identified in the qualitative findings of the study. The online reflections and interviews shared participants’ stories and statements, which demonstrated negative experiences in which organisations had not met the requirements to assist nurses to implement their clinical supervisor roles. Participants shared their frustration of not knowing of students’ arrival until they had arrived or at the end of the shift the day before, rosters being changed at the last minute, a lack of support from clinical facilitators when students were involved in critical incidents and a general feeling that they were not appreciated for the time and effort that they put into the role.
This lack of support may have been an influencing factor on the results of Stagg’s (1992) attitude survey. Despite an increase between the pre-program and immediate post-program surveys, by the time participants completed the survey again, a minimum of eight weeks later, the attitude mean scores showed a slight decline. While the eight-week attitude survey results were still positive compared to the pre-program findings, without organisational support to maintain the positive momentum of the role and its value, it begs the question: for how long?

As discussed in the previous section, without support, a role will struggle to survive and it will cease to have importance allocated to it. The role is eventually downgraded and avoided (Birenbaum, 1984; Gass & Siter, 2011). Therefore, it is important that participants continue to have positive attitudes and that the clinical supervisor role is enforced in order to continue the desired behaviours and attitudes.

The finding of a perceived lack of support is also supported by the literature in previous studies involving a review of the clinical supervision relationship. Waldock, (2010) outlined that:

> The culture of the health provider plays a vital role in staff attitudes and actions towards students…Investments in supervision are wasted if nurses are not provided with adequate support…Nurses exert a great deal of time and effort into the complex activity of student supervision, yet they frequently report a lack of recognition…this results in nurses feeling undervalued and unappreciated for their efforts…as a result many nurses are resentful…which impacts on their attitude and behaviour towards students (p. 130).

The findings and concerns regarding this lack of support for nurses and the effect on the clinical supervision relationship was also explored by Zilembio and Monterosso (2008), who outlined that nurses required the ongoing support of health care facilities and education providers in their role preparation, and they recommended compulsory training for all nursing staff. Vallant and Neville (2006), who researched the learning relationship between nurses and students, also determined that health care facilities and education providers needed to recognise the requirements of the clinical supervisor role, that they needed to accept the time taken by nurses to provide positive learning experiences, and that it was a team approach between health care facilities, education providers and clinical supervisors. Henerson, Fox and Malko-Nyhan (2012) researched the effect of their two-day workshop for nurse preceptors, which involved 36 nurses, and noted that many preceptors felt that education
alone was not sufficient to provide positive learning experiences for students. They noted that staff needed allocated time to provide learning and feedback to students.

These research findings have confirmed the current literature relating to clinical supervisors’ perceived lack of support and acknowledgement of the role. The implications of this finding will be discussed in Chapter 7.

The next finding to be discussed relates to one of the strategies discussed in the CSP to promote the students’ role in the health care team and to develop a generally positive workplace culture.

6.4.5 Embracing the Power of Belongingness

The literature relating to the concept of belongingness utilised in this research project was sourced from Levett-Jones (2007, 2008, 2009). This research was discussed in Chapter 2 and provided evidence of the importance of students’ sense of belonging in the workplace. Levett-Jones conducted the research with nursing students living in Australia and the UK, commencing in 2005. The research articles defined belongingness, its relevance and its effect on the quality of students’ clinical placements and learning experiences. The literature to date has not appeared to explore the concept of belongingness from the perspective of the registered nurses who supervise nursing students.

Levett-Jones and Lathlean (2009) included strategies for implementing belongingness in clinical areas in a section called ‘recommendations for practice’. These were conceptualised under the heading of the ‘accent to competence’ conceptual framework, which the authors adapted from Maslow’s Hierarchy of Needs (1943) to outline the relationship between belongingness and student learning. Levett-Jones and Lathlean’s (2009) study suggested that for students to achieve competency, they needed to transition between the stages of safety and security, belongingness, self-concept and learning. Recommendations for practice were provided in each stage, including strategies for health care facilities, education providers and clinical staff. These strategies related to:

- provision of student orientation to each clinical environment
- consideration of student placement models/length of placement
• provision of trained clinical supervisors
• development of students’ assertiveness skills to reduce bullying and anxiety and to prevent conformity while promoting critical thinking and clinical reasoning
• clinical leadership to promote a learning environment that advocates for students to practice and acknowledges their contribution
• promotion of self-directed learning, lifelong learning and the development of a sense of self-concept.

The article called for all stakeholders involved with student placements to consider these strategies and their application (Levett-Jones & Lathlean, 2009). With the implementation of the CSP, this research has provided a new perspective of this concept. The participants confirmed through the surveys, online reflections and interviews that belongingness was relevant and has an important part to play in the management of student placements.

Further research regarding this valuable concept from the perspective of clinical supervisors and health care facilities would be worthwhile, as well as further development of strategies to assist students to promote belongingness in the workplace, as suggested by the CSP participants. A review of the nursing literature did not identify any further strategies for the promotion of belonging. Therefore, the researcher reviewed the wider literature in the health sciences and identified literature pertaining to belonging particularly in the fields of sociology and psychology.

The field of sociology seeks to understand the relationships between individuals and society; it views the world according to the many different groups that belong in it (Christensen, 2009; Gasparini, 2010; May, 2011). Each group influences the individual, and with social change, the individual changes. The individual is often unaware of these changes because they occur over a gradual period (May, 2011). However, belongingness is felt at an individual level; according to the field of sociology, an individual’s emotional attachment gives him or her a sense of safety (Christensen, 2009; Gasparini, 2010). It is an active feeling that implies a bond to something outside of oneself that provides stability (Gasparini, 2010). It results in the integration of the individual into a group where others are identical, thereby producing a group of like-minded individuals (Gasparini, 2010). Belonging can also create a sense of loyalty whereby members can be persuaded to follow the group as it changes and adapts.
(Gasparini, 2010). This concept of belongingness allows the field of sociology to connect at the individual level and explore the effect of group and social changes: who influences these changes, why they are allowed to do so, and what is the effect on those excluded from change discussions (May, 2011)? Sociology views that individuals who do not belong can at times be a positive outcome for society. These individuals may be able to question change and seek alternative choices (May, 2011). Different from the perspective of nursing and psychology, those who do not belong are also viewed from a group perspective rather than an individual perspective, and those who do not belong in this theory become their own group (Christensen, 2009). Sociology does not aim to apply the concept of belongingness, but instead to understand its effect on groups and the individuals in these groups (Christensen, 2009; May, 2011).

These concepts support the definitions and understanding of the concept of belongingness in the field of nursing and clinical supervision, but they do not provide guidance in its application. They also offer a new perspective of viewing those who are alienated from belonging, and the potential they have to bring about change (May, 2011). This concept was discussed by Levett-Jones and Lathlean (2009a) as ‘don’t rock the boat’. While sociology viewed these individuals as providing possible alternatives (May, 2011), in clinical supervision, other contextual factors appear to have inhibited the ability of students to fulfil this theory, and students have often complied with poor practice instead (Levett-Jones & Lathlean, 2009a). These factors may relate to the short length of time in these group situations or the hierarchy nature of the nursing profession. These factors were not explored in this CSP study.

A review of the literature in the field of psychology identified articles related to the concept of belonging and the effect of belonging in the workplace. Baumeister and Leary’s (1995) study reviewed the need for humans to fundamentally belong. They determined that belonging has a broad effect on motivation, behaviour, cognition, health and wellbeing (Baumeister & Leary, 1995). Indeed, in the Hierarchy of Human Needs, Maslow (1943) outlined that a person will strive for a place within a group, and that this desire can be so strong that the first two needs—physiological and safety—can be put to one side. As outlined by Baumeister and Leary (1995), a failure to achieve belonging can result in anxiety, depression, a sense of grief and loneliness. The desperation to regain or prevent the loss of belonging can drive individuals to conform their behaviour to meet group norms, even to the extent of destructive
acts (Baumeister & Leary, 1995). Baumeister and Leary (1995) described that individuals are most likely to form a sense of belonging with those in close proximity and to spend greater amounts of time with them, even if they are unlikely to share other familiar or social traits.

Also in the field of psychology, Cockshaw and Shochet (2010) researched the effect of belongingness in the workplace. Their study was based in Queensland, Australia, in a disability services department. It determined that the degree to which employees felt a sense of belongingness in their workplace was influenced by their perception of acceptance and respect by those around them through inclusion and support in the work environment. A negative sense of belongingness was noted to have a significant effect on a person’s wellbeing and risk of depression. Given the number of hours spent in the workplace, Cockshaw and Shochet (2010) suggested that clinicians must respect the effect of the workplace on patients’ treatment plans and that organisations that can facilitate a sense of belonging are intrinsically less likely to have a workforce suffering depressive symptoms.

Thau, Poortvliet and Aquino (2007) also researched the effect of belonging in the workplace. Similar to Cockshaw and Shochet (2010), they determined that a lack of belonging could result in individuals altering their natural behaviour patterns to the extent of displaying negative behaviour that could have detrimental effects on their ability to achieve their long-term career goals. This immediate necessity to improve the current situation drove individuals to sacrifice future plans and normal behaviour traits. Thau, Poortvliet and Aquino (2007) recommended that managers create a more socially inclusive workplace and a culture of justice and fairness in order to reduce exclusion and promote belonging.

Levett-Jones’ publications (2007, 2008, 2009) with regards to nursing students have confirmed these research findings in psychology regarding the psychological and physical effects on individuals of a lack of belongingness. The clinical supervision research project confirmed that participants believe in this important concept and that workplaces and employees need to respect the effect of belonging and develop strategies to promote it, as suggested by Cockshaw and Shochet (2010) and Thau, Poortvliet and Aquino (2007).

Despite this review of the literature confirming the importance and effect of a lack of belonging in the workplace, specific workplace strategies were still not identified. Given the
positive responses of the participants at the CSP towards belonging, further research in this area is warranted.

The next finding to be reviewed relates to the theme of ‘improved communication’.

**6.4.6 Improved Communication**

The findings relating to communication skills included the principles of reflection and feedback, and providing optimum learning experiences by communicating critical thinking and clinical reasoning.

Participants linked all teaching and learning strategies to good communication. Good communicators are able to provide students with opportunities to participate in critical thinking, clinical reasoning, reflection and feedback. However, many participants outlined that communicating was a skill that they often lacked confidence in, or they lacked the awareness of how to use it most appropriately. For example, many participants did not realise that simple strategies like ‘talking aloud’ assisted students to understand the clinical reasoning cycle (Banning, 2008; Reilly, 2007), as does the use of appropriate questioning (McKenna & Stockhausen, 2013).

The nursing literature has described the difficulties that nurses have in providing effective communication. Clynes and Raftery (2008) discussed that nursing students often received inconsistent feedback, as it could not be taken for granted that trained professionals had the required skill set to provide effective feedback. They suggested that the importance of staff education in this topic could not be underestimated; however, they provided no specific strategies.

Ramani, Gruppen and Kachur (2006) described 12 tips for effective mentorship. Within these, they discussed the importance of communication skills and outlined that mentors must have the ability to listen to their students and give positive and negative feedback. Ramani, Gruppen and Kachur (2006) believed that health professional staff are not born with these skills and they therefore require support from staff development programs. Mentors then use these effective skills to challenge mentees within a supportive environment.
These findings regarding staffs’ lack of confidence and skill sets are also discussed in HWA’s papers, which outline the importance of communication, as well as the teaching and learning strategies attached to this, as vital to clinical supervision education (HWA, 2010; HWA, 2011a; HWA, 2011b). No specific recommendations have been provided by HWA on the style of communication and communication strategies that should be adopted.

For the CSP, the researcher utilised models that provided clear and practical strategies to promote effective communication. For example, Gibbs’ Reflective Cycle (1988) was utilised as a strategy to promote reflection with students, and the Clinical Reasoning Cycle by Levett-Jones et al. (2010) was used to assist supervisors to demonstrate critical thinking and clinical reasoning relating to patient care with students.

The findings of the CSP are therefore consistent with the literature in relation to the importance of communication skills for clinical supervisors. Many participants felt that prior to attending the CSP, they did not have a thorough understanding of, or confidence to apply, effective communication, thereby affecting students’ learning outcomes.

The final theme for this clinical supervision research project is the ‘students’ learning journey’.

6.4.7 Students’ Learning Journey

The final theme in this project relates to the students’ learning journey. Participants shared that understanding the students’ learning journey gave them an insight into the factors that could promote or negatively affect students’ learning. These factors ranged from degree requirements, effect of university education, short placements and frequency of placements, previous clinical placement experiences, length of placements, teacher–learner learning styles, social/home life and work commitments.

A review of the literature was unable to locate any research that discussed the students’ learning journey from all of the factors discussed at the CSP or the use of this topic in clinical supervision education. However, the researcher was able to locate some information referring to these aspects of the students’ learning journey.
Gidman et al.’s (2011) study in the UK determined that students on clinical placement experienced a number of stressors from outside influences that affected their clinical learning experiences. These included managing a life–work balance, personal/social demands and effectively managing their time to achieve these and their university course requirements. They recommended that clinical supervisors and education providers use strategies to ensure that students are supported in managing this load and that supervisors are appropriately educated and prepared to undertake the role; however, no specific strategies were noted.

Brown and Edelmann’s (2000) research involved student nurses and first-year nurses in the UK after the introduction of university-based nursing education. Students were asked to identify what they believed to be the major stressors in their course; these were then confirmed six months into the program. Students perceived that achieving their clinical competencies would be their greatest stressor; however, after six months, students reported that their major stressors related to balancing their home, work and education commitments along with the financial implications of studying. Students also identified that they had initially thought that the university or hospital mentors would be their greatest support, when in fact it was family, friends and the development of self-reliance. The study recommended that students be supported with financial management information and that further investigation into these findings be conducted.

A study based in Thailand by Ross et al. (2005), which involved 331 Baccalaureate nursing students and used a validated stress determinate questionnaire, identified that over half of the course students met the criteria for being depressed. The leading contributors were low self-esteem, high levels of stress and a lack of emotional support. The research recommended that universities promote programs for students that assisted them with reducing their stress levels and improving their self-esteem. This could include peer-support programs, recreational programs and ensuring that staff specialists in counselling were available to support students (Ross et al., 2005).

In addition to this literature, Knowles et al.’s (1998) adapted principles of adult learning outlined that facilitators need to be aware of external motivators and influences on learners. Knowles et al. (1998) referred to these as ‘situational differences’, which include cultural influences, previous learning experiences and any social factors that may change how the learning process occurs. As a facilitator of learning, the learning experience must therefore be
shaped to meet the learning styles of the learners and the situational differences that are unique to them (Knowles et al., 1998).

Applying Knowles et al.’s principles of adult learning (1998) to the students’ learning journey provides a theoretical framework for the importance of viewing the clinical supervisor–student relationship from a learner-centred focus in which the learners’ ability to learn is influenced by many factors, including those outside of the clinical environment. Reminding clinical supervisors of the principles of adult learning, learning styles and other influences (e.g. family/social/cultural/previous experiences/different nursing programs) encourages them to establish relationships with students in which these influences are acknowledged and the students’ learning style and influences are incorporated into the teaching and learning environment (Knowles et al., 1998).

Each literature source highlighted that the learners’ ability to learn is influenced by many factors outside of the supervisors’ control. Therefore, it is surprising that the literature does not outline the importance of providing supervisors with strategies to support students in the learning environment. Providing strategies such as communication skills can assist with this; however, supervisors first need to be made aware of these influences, hence their inclusion in the CSP.

This concludes the review of the themes for this research project in relation to the current literature and theory. In addition to these themes, the researcher reviewed the program’s evaluation findings, as it was believed that this could provide important information for educators or health care facilities wanting to implement the CSP.

6.5 Program Evaluation Findings and Implications

The program evaluation highlighted the effect of not only the topics that were included in the study day program, but also the teaching strategies incorporated and the significant role of the facilitator. In Chapter 2, the researcher described the use of the theories of learning, the principles of adult learning and theories of persuasion in order to guide the development of the CSP and teaching plans. The findings from this program evaluation will now be compared to these theories and principles.
6.5.1 Principles of Adult Learning

The aim of the CSP was to provide an opportunity for registered nurses to improve their knowledge and attitudes towards students and student supervision. To achieve this, the researcher utilised the theories of learning, the principles of adult learning and the theories of persuasion to assist with the development of teaching plans and strategies to promote an environment that was conducive to achieving these goals.

The literature review in Chapter 2 provided a snapshot of the literature in relation to these theories and principles, as well as their application to the CSP. In outlining the data analysis and findings of the study day program, Chapters 4 and 5 highlighted a number of statements in the surveys, online reflections and interviews in relation to the teaching strategies utilised in the program. These statements, both written and verbal, provided a positive view of the participants’ thoughts in relation to the program presentation. This also extended to the provision of the clinical supervision work file that participants referred to during the study day program and were able to take with them as a future resource.

As discussed in Chapter 2, the strategies adopted in the program were not based on one theory of adult learning; rather, the program used key features from a number of theories and principles. This relates to Knowles (1978, 1984) and Knowles et al. (1998, 2011) principles of adult learning in that facilitators must be aware of the different learning styles of participants and cater for these differences in their facilitation.

Key findings in relation to the program evaluation included the use of different teaching formats (e.g. group work, case studies, brainstorming), the skills of the facilitator and the provision of a take-home resource. The improved results in the knowledge survey and Stagg’s (1992) attitude survey also supported that participants achieved the learning outcomes of the study day program, which supports the teaching plan’s strategies.

In addition, the participants articulated the important role of the facilitator. This role is vital to the success of any education program, particularly when the program is seeking participants to change their normal behaviours and/or attitudes (Knowles et al., 2011). As described in Chapter 2, the theories of persuasion discussed that the success of a message being accepted by a recipient is dependent on the ability of the messenger to provide a persuasive argument.
(O’Keefe, 2002). Linked to this is the credibility of the messenger. Gass and Seiter (2011) discussed that credibility is determined by those engaged in the interaction. Therefore, facilitators cannot always assume credibility with an audience. They need to ensure that they engage with their audience and provide evidence of their credibility (Gass & Seiter, 2011).

This was achieved in the CSP by the facilitator introducing herself and her background and experience in relation to clinical supervision at the start of the day. Further, the ability of the facilitator to answer questions and provide realistic strategies and approaches to clinical supervision enhanced her credibility. A number of comments by participants articulated the ability of the facilitator to not only facilitate the teaching sessions, but also to achieve these strategies.

The findings of the program evaluation confirm that the theories and principles related to learning and attitude were positively implemented in the CSP.

### 6.6 Salient Outcomes of This Research

The findings from this research project have highlighted that the attitudes of nursing staff towards students and clinical supervision prior to attending the CSP was 55% high and 45% low compared to Stagg’s (1992) finding of 48% high and Aghamohammadi-Kalkhoran et al.’s (2010) finding of 20% high. As discussed in Chapter 2, a number of publications have discussed the poor attitudes of nurses towards students (Andrews et al., 2005; Aghamohammadi-Kalkhoran et al., 2010; Brammer, 2008; Longo, 2007; Landmark et al., 2003; Mesissner, 1986; Saarikoski & Leino-Kilpi, 2002; Sauer, 2012; Stagg, 2002; Vallant & Neville, 2006; Webb & Shakespeare, 2008). The findings of this research project showed that a significant change in nurses’ attitudes towards students and clinical supervision could be achieved by attending the CSP, with an increase in the high category from 55% to 74% after the eight-week survey.

The implementation of the CSP has demonstrated that it is an effective strategy for improving nursing staffs’ attitudes towards students and clinical supervision, as well as the knowledge of the principles of clinical supervision. The findings have also demonstrated that it is not only the theory of clinical supervision that participants wanted to learn about; a better
understanding of the current context of nursing education in Australia and the students’ journey were also important to participants to help them understand their students and develop a clinical supervisor relationship with them.

Belongingness was also an important finding from the research. Participants provided both written and verbal accounts of how this concept had affected them and given them a simple strategy to promote the success of student placements. This was seen as a strategy to promote a positive workplace culture, which was important for graduate nurses, new nurses and all employees in the workplace. Many participants felt that the current workplace culture was not supportive of students or student–supervisor relationships.

This research confirmed the lack of support that many nurses feel in the clinical supervisor role, as well as the failure of many health care facilities to acknowledge the importance and effect of the role. Education providers and health care facilities were seen to take the nurses’ role for granted, without providing the necessary support to promote the success of students’ placements.

In acknowledging this new information, the researcher felt that it was important to refer back to the research questions.

6.6.1 Research Questions

The research questions for this project where provided in Chapter 1 of this thesis. A review of these questions and a summary of the findings will now be outlined.

1. What is the pre-program knowledge of nursing participants in relation to the principles of clinical supervision?

The clinical supervision research project in Chapter 4 described the participants’ knowledge prior to attending the study day program by using descriptive statistics taken from the completed pre-program knowledge survey. These results were described according to a number of demographic details of the group, including age, area of employment, previous education in clinical supervision, frequency of providing clinical supervision and years of
nursing experience. The findings determined that there was no significance difference in survey results between the different subgroups.

The findings from the knowledge survey provided quantitative data for comparison with the participants’ results after attending the CSP. This provided the researcher with the opportunity to determine the effect of the program on the participants’ knowledge.

2. Is there a change in nursing participants’ knowledge related to the principles of supervision after attending the program?

The pre-program knowledge survey was compared to the immediate post-program and eight-week surveys to examine whether a change in participants’ knowledge had occurred regarding the principles of clinical supervision. These findings were described from a whole group perspective and according to the subgroups defined in question one. As articulated in Chapter 4 and the findings of this thesis, a statistically significant change occurred between the pre-program and post-program survey results. This indicated that participants had improved their knowledge in relation to the principles of clinical supervision. Participants’ statements in the post-program surveys, online reflections and interviews then corroborated these quantitative findings.

Participants’ comments discussed that they felt they had improved their knowledge and understanding of the clinical supervisor role. These statements were supported with examples of practice, as outlined in Chapter 5.

3. Upon completion of the program, do nursing participants perceive that their knowledge and attitudes towards providing effective student supervision has changed?

The descriptive statistics included in Chapter 4 articulated an improved knowledge base and attitudes of the participants. This finding was supported by the words of the participants in the post-program surveys, online reflections and interviews. These statements described how the participants had perceived that their clinical supervision practice had positively changed. These words confirmed the changes in the participants’ knowledge and attitude survey results towards students, student–supervisor relationships and how the program had assisted them in making these changes.
Participants provided examples of changes in practice using their improved knowledge base and attitudes. This related to their approach towards the supervision relationship and even a willingness to accept students. Supervisors shared stories of viewing issues from the students’ perspective, taking students’ learning styles into consideration, allowing students to practice, and taking time to reflect on practice and confirm that the learning had been understood. Participants also noted the poor behaviour of others in the workplace and their concerns about their colleagues’ knowledge, attitudes and practices.

4. Do nursing participants perceive a different effect from this program compared to other clinical supervision education? If so, why? If not, why not?

This project sought to determine the effect of this program compared to other clinical supervision programs. Unfortunately, the majority of the participants had not attended previous clinical supervision education. The survey results identified that there was no significant difference in both the knowledge and attitude survey results according to previous attendance to clinical supervision education.

The qualitative findings clearly articulated that participants believed that this program assisted them to undertake the clinical supervisor role more effectively and to appreciate the importance and effect of the role on students. Participants commented that this education program had explained concepts that, although known to them in the past, never really made sense, or they had not been aware of how they could apply them with students (e.g. critical thinking, clinical reasoning and reflection).

Participants strongly advocated for the continued presentation of the program throughout Western Australia.

5. Do nursing participants believe that the program assisted them to undertake their role more effectively? If so, why? If not, why not?

As described in Chapter 5, participants provided rich statements in the post-program knowledge surveys, online reflections and interviews related to the effect of the program on their self-confidence, knowledge and ability to undertake the clinical supervisor role. Participants provided statements outlining these changes and examples of practice in their
workplaces. Participants articulated that the practical examples, group discussions and concepts such as belongingness had provided them with new information and strategies that they had not been aware of before. Further, a greater understanding of how to apply previously known concepts such as critical thinking, clinical reasoning and reflection with students improved participants’ self-confidence in their ability to fulfil the clinical supervisor role requirements.

6. Do nursing participants perceive that they have changed their attitudes towards nursing students after attending the program? If so, why? If not, why not?

As described in Chapter 5, participants’ results for the attitude surveys demonstrated improved attitudes towards students and student supervision after attending the CSP. This finding was corroborated by the rich statements of the participants’ self-reflection of their attitudes towards students and supervision, and of their workplace culture and attitudes towards students and student supervision. In the post-program knowledge surveys, online reflections and interviews, participants articulated how they had changed their practice, reviewed their workplace practices and encouraged others to review their supervision and change their practice.

7. Is there a change in participants’ attitudes towards nursing students after attending the program?

The results of Stagg’s (1992) attitude survey, which were outlined in Chapter 4, described the significantly improved mean results of the group across all demographics. This improvement in the attitude mean score was supported in practice by the participants’ qualitative statements, in which they shared comments, stories, concerns and ideas about their own attitudes and those of their workplace colleagues.

In seeking to answer these research questions, the researcher will acknowledge the limitations of this research project.
6.7 Limitations

The main limitation for this study related to the evaluation of the effect of the program in the workplace. Feedback regarding the effectiveness of the program related to the participants who attended. While results from the data indicated a change in knowledge and attitudes, a change of practice was not measured other than through reflections. The researcher considered including fieldwork to observe the nurses in practice. This would have involved pre- and post-program observations to measure a change in practice. This was not included for the following reasons:

- various sites where participants work (within the metropolitan and regional areas of Western Australia)
- short notice provided for the researcher to attend these sites (staff often find out on the day whether they are supervising a student)
- ethical considerations regarding the effect on students, patients and other staff.

As a result of these concerns, the use of online reflections by participants was included to give the researcher access to participants’ thoughts and examples of supervision experiences using the eight-week survey and interviews.

The researcher also acknowledges that in the recruitment process, the participants chose to attend the program; therefore, they may have had a stronger interest in this role than the general nursing population. This may have resulted in bias in the data results. However, the findings from the data indicated that participants had numerous reasons for attending the program, which were outlined in Chapter 4. These related to personal interest, identified self-deficit in knowledge of the role, recommendation by a colleague (later study days) and the request of management or executives. In addition, the results of the pre-program survey showed that only 55% of participants had a positive attitude towards nursing students and clinical supervision before the CSP.

6.8 Chapter Summary

Chapter 6 provided a comparison of findings from the CSP from both the quantitative and qualitative data with the current literature and theory that underpin these. Finally, a review of
the research findings and research questions provided further support for the use of this mixed method research process to answer the research questions.

In summary, the CSP research project findings are a valuable addition to the current knowledge regarding the effect of clinical supervision education on registered nurses. These findings may assist hospital executives and education departments that seek to promote the clinical supervisor role and the effectiveness of clinical supervision within their health care facilities. The implications of these findings and recommendations for future practice will be discussed in Chapter 7.

***

The hospital was wonderful and the staff were so welcoming and kind. This was the place to be. She knew she belonged and she knew that she wanted to help students one day—to ensure that she would be there to encourage them when something went wrong, to highlight their achievements and share her nursing stories with them, to tell them about the possibilities, to feel proud and wanted, and to belong to the nursing profession.
Chapter 7: Implications and Recommendations of Findings

7.1 Introduction

The CSP for registered nurses was developed and implemented as a strategy to meet the national agenda requirements outlined by HWA for health professional education. This specifically related to the role of the clinical supervisor of health care professional students while on clinical placement (HWA, 2010). This program was specifically developed for registered nurses who supervise nursing students.

The findings of this research project have demonstrated that a positive effect on participants’ knowledge and attitudes can be achieved with a dedicated study day program. The participants endorsed the CSP as an education strategy that could provide nurses with the necessary knowledge, skills and attitudes to facilitate positive clinical supervision placements.

Findings from the research also suggested that the ongoing success of the program on participants’ effective implementation of the role could not be guaranteed without ongoing organisational support and commitment to the role. Participants felt that more support from the health care facilities and education providers was required, including greater recognition of the role, responsibilities, barriers and time requirements.

The implications of these findings are an important take-home message for hospital executive staff, educational institutions and clinical supervisors who want to improve their organisational culture and the role of the clinical supervisor. These findings suggest that the success of the clinical supervision relationship between nursing students and registered nurses is co-dependent on all of these factors. Health care facilities and education providers need to consider these findings and their implications for future policy and strategy development. The implications of the research project are summarised in Figure 7.1.
Figure 7.1: Implications of the findings of the CSP research project

Health care facilities are strongly recommended to develop strategies that are not only education specific. The literature advocates a number of strategies that can be implemented to support staff who supervise students. These include, but are not limited to, awards recognising staffs’ efforts, including the clinical supervisor role within organisations’ value statements and objectives, supporting student placements with dedicated staff to manage placements, providing orientation programs for students and supporting staff to support students with appropriate workloads.

Each implication will now be discussed in relation to the clinical, education and research recommendations from this research.

7.2 Clinical Implications

Providing nursing students with clinical placements that will allow them to apply their theory to practice and develop the essential attributes of the nursing profession requires commitment from both the health care facilities and education providers. Health care facilities need to ensure that their workplace cultures and organisational structures support students and staff during these clinical placements. Education providers need to ensure an ongoing commitment
to health care facilities to provide support to both nursing staff and students. The important role of the nursing clinical supervisor should not be underestimated by either organisation due to its fundamental ability to promote the success of students’ clinical placements.

The role of registered nurses is complex, and it cannot be taken for granted that staff intuitively understand their role in the supervision of nursing students. Being a student does not prepare them for the role of supervising a student. The clinical supervisor role is complex, and staff have articulated through this study that they require specific education and support to understand the importance of the role, its effect and its function in the clinical setting.

This study has described that a negative workplace culture and a lack of support provided to participants has affected their ability to function in this role. The study has also described the effect of the program on participants’ knowledge and attitude scores, as well as their changes in supervisor practice. Participants described that they would like more staff to attend clinical supervision education in order to provide a greater understanding of the role in the workplace and to improve the workplace culture.

7.3 Education Implications

The implementation of the CSP has demonstrated that it can meet the educational needs of registered nurses who supervise nursing students. The implementation of the program must be carefully considered by any health care facility choosing to implement it.

7.3.1 Considerations

1. To effect organisational culture change, education must be strongly encouraged and supported by management for all staff to attend.
2. The teaching delivery method for the program was identified in the findings as a significant contribution to its success. The role of the facilitator and her skills was a significant implication for this research. While the teaching plan incorporated the theories of learning and principles of adult learning, without a skilled facilitator to introduce these teaching plans, the positive result of the program cannot be guaranteed. The future implementation of the CSP must therefore carefully consider
who the facilitators of the program should be, and the education and support they require to present the program to its full benefit.

3. Health care facilities implementing the program cannot afford to do this as a stand-alone strategy. Consideration must be given to staff support and culture change from a whole-organisation perspective.

4. Dedicated policies and support mechanisms must be implemented to support the management of student placements. This ensures appropriate student orientation and welcoming to the health care facility, ongoing communication between education providers and health care facilities, and a support role for clinical supervisors.

7.4 Research Implications

The CSP, now called ‘The Art of Clinical Supervision’, has been recommended to HWA by the Western Australian DoH as a program that can meet the educational requirements of the nursing workforce in Western Australia to support nursing students. Both HWA and the Western Australian DoH (personal communications with researcher, 2012, 2013) have requested the researcher to facilitate the program not only for registered nurses, but for all health care professionals.

This change in the program’s intended audience is currently being reviewed, with consideration for future research requirements to determine the program’s ability to provide effective education for a multidisciplinary audience.

Further research in regards to the effect of belongingness is also recommended. This concept was strongly supported by nursing staff as a simple strategy to improve workplace culture and students’ learning experiences. Further research from the perspective of nursing clinical staff, nurse managers, nurse educators and clinical facilitators could provide further clarification of its full potential and effects.
7.5 Recommendations

Recommendations from the CSP research project stem from these clinical, education and research implications. As the program was presented in Western Australia, these recommendations relate to the Western Australia health care sector; however, the researcher believes these recommendations may be applicable to all states and territories in Australia. The researcher makes the following recommendations:

- A state-wide implementation strategy for clinical supervision education to be made available to all nurses engaged in the role, and to support clinical supervisors.
- The development and implementation of a state-wide policy articulating the minimum education requirements for clinical supervision. The purpose of this is to promote a culture of staff training and education in the area of clinical supervision.
- The incorporation of the clinical supervisor role as a formalised component of registered nurses’ job descriptions as both an accreditation requirement with the NMBA and in local job descriptions.
- The inclusion of clinical supervision in the mission statement of health care facilities. This may be promoted in terms of fostering and developing the next generation of nurses.
- Further research regarding the benefits of this program for those in the fields of midwifery, medicine, allied health and health science professions, and across all state and territory jurisdictions in Australia.
- Further research regarding the implications of belongingness as a concept to promote a positive workplace culture for students, new staff and all employees.
- Greater corroboration between education providers and health care facilities to determine and confirm the role and expectations of the clinical supervisor and clinical facilitator in order to facilitate course accreditation requirements for clinical placement learning and assessment.

7.6 Conclusion

This descriptive research study has articulated the development, implementation and evaluation of the CSP for registered nurses in Western Australia. Its findings have provided
positive confirmation of the importance of clinical supervision education and its effects on participants.

The research participants have endorsed the CSP as a valuable resource to support their professional development as clinical supervisors. The improved survey scores in the post program knowledge and attitude surveys support these views.

However, the CSP is one part of the equation. Ongoing support by health care organisations and education providers is essential to achieve cultural change in organisations and consolidation of the clinical supervisor role. Without this, the knowledge and attitude changes achieved by participants cannot be guaranteed to result in long-term role change by participants.
Epilogue

Twenty years later, I remain a registered nurse who is proud of my profession and achievements. My experiences as a student, as articulated through my story in this thesis, guided me towards nursing education, and today I help prepare and guide students through their clinical placements and teach nurses ‘The Art of Clinical Supervision’. I also remain an employee of the same hospital; those first impressions have led me to stay attached to this wonderful organisation, even though my professional journey has taken me into a more academic role.

Throughout this 20-year learning journey, I have learnt many things. My take-home points as an educator are to:

- keep it simple, practical, meaningful, achievable and beneficial
- inspire confidence, professionalism and passion
- practice what you teach.

Thus, my facilitation today—of teaching registered nurses how to supervise students on their clinical placements—is very different to when I started as a junior educator. Today, the theory is there, but in the background. My sessions flow throughout the day, building upon each other and providing strategies for staff. Does it matter if a clinician cannot define andragogy? No, I do not think so. Does it matter if the nurse does not follow the principles of andragogy? Absolutely. Thus, in teaching the theory, I make it practical and give it meaning and understanding to the context of the clinical world. Our clinicians are clinically competent professionals and experts. Supervising and educating the next generation is an expected part of the role that they undertake, but they are not trained to be educators. Thus, as an educator, I must guide them, let them be experts in their clinical practice and give them the strategies to share their knowledge, skills and attitudes in order to assist with the development of the next generation of clinicians.
References


Western Australian Country Health Service. (2013). *Scoping study of clinical supervision education in WA*. Government of Western Australia, WA.


Appendix 1: Ethics and Research Committee Approval Letters and Approval from the Department of Health

14 March 2012

Kylie Russell
78 Alcester Street
East Fremantle WA 6158

Dear Kylie

The School of Nursing and Midwifery Research Committee has met to consider your research proposal and independent Reader reports, and has recommended you be permitted to move to full candidacy in your doctoral studies.

The Research Office congratulates you on this achievement and wishes you well for your research program. Please do not hesitate to contact the Research Office or your Supervisor if you have any questions about your candidacy.

Yours sincerely

[Signature]

Professor Richard Berlach
Acting Pro Vice Chancellor - Research

cc Professor Selma Aliex, Dean, School of Nursing and Midwifery
Dr Adrian Morgan, Chair, SRC
Dr Heather Gilyas, Supervisor
17 April 2012

Ms Kylie Russell
7B Alcester Street
East Fremantle WA 6158

Reference Number: 012019F

Dear Kylie,

I am writing to you in regards to your Low Risk Application for Ethics Clearance for your proposed research, to be undertaken as a student project at The University of Notre Dame Australia. The title of the project is: "The effect of clinical supervision training on registered nurses’ attitude and knowledge."

Your proposal has been reviewed by the University’s Human Research Ethics Committee, and based on the information provided has been assessed as meeting all the requirements as mentioned in the National Statement on Ethical Conduct in Human Research (2007). I am therefore pleased to advise that ethical clearance has been granted for this proposed study.

All research projects are approved subject to standard conditions of approval. Please read the attached document for details of these conditions.

On behalf of the Human Research Ethics Committee, I wish you well with what promises to be a most interesting and valuable study.

Yours sincerely,

Dr Natalie Giles
Executive Officer, Human Research Ethic Committee
Research Office

cc: Prof Selma Alles, Dean, School of Medicine;
Prof Adrian Morgan, SRC Chair, School of Nursing.
Dear Ann,

Many thanks for confirming access to these sites.
Kind regards

Kylie

---

Kylie Russell

PhD Candidate
School of Nursing and Midwifery
Fremantle Campus
The University of Notre Dame, Australia

---

HI Kylie
Just confirming that you have access to [Geraldton, Albany and Rockingham/Kwinana Hospital](mailto:Ann.Hobson@health.wa.gov.au) for your PhD project. All areas have approved your participation in the project. Please forward your university research committee and ethics approval for our records and to these hospital sites.
We are looking forward to having your input and evaluation.
Regards
Ann

Ann Hobson
Project Coordinator /Clinical Supervision Project
Department of Health
189 Royal Street
East Perth WA 6000
Phone 08 92222187
Email [ann.hobson@health.wa.gov.au](mailto:ann.hobson@health.wa.gov.au)
Mobile 0413902141
11 April 2012

Ms Kylie Russell
PhD Student, School of Nursing & Midwifery
University of Notre Dame
PO Box 1225
FREMANTLE WA 6959

Dear Ms Russell

Re: The Effect of Clinical Supervision Training on Registered Nurses’ Attitude and Knowledge (Our ref No: 533)

Thank you for forwarding the above project for review by the St John of God Health Care Ethics Committee (“the Committee”).

I am in agreement with the assessment of your project as “low risk.” It has been reviewed by a sub-group of Committee members out of session and no ethical issues have been identified. I also acknowledge that your project has the prior approval of Notre Dame University Human Research Ethics Committee.

Accordingly, I am pleased to advise that ethical approval of your project has been granted under an expedited review process, as per section 5.1.7 of the National Health and Medical Research Council’s National Statement on Ethical Conduct in Human Research (NHMRC, 2007) (“the National Statement”). Your project will be tabled for the information of the full Committee, at its next scheduled meeting on 9 May 2012. Please find attached a signed and dated Committee membership list.

MercyCare will now write to you directly to confirm final study approval and authorise the commencement of your research on their site. You are reminded that this letter constitutes ethical approval only. You must not commence this research study at MercyCare until separate authorisation from MercyCare has been obtained.

The Committee is a Human Research Ethics Committee (HREC) that is constituted and operates in accordance with the National Statement. In line with the National Statement requirements, researchers need to keep the Committee and the institution (specifically, the participating site: MercyCare) promptly and regularly informed on the progress of their approved research including:

1. any serious, and suspected, unexpected serious adverse events, any unforeseen events, any significant protocol deviations or violations, any withholding or withdrawal of study approval by another HREC/institution, and any allegation or suspicion of research misconduct, that may affect continued ethical approval of the study.
2. any proposed changes to the research/research documentation as previously approved by the Committee, including any proposed study extensions.
3. when the study is completed, abandoned, terminated, suspended or withdrawn.

The Committee and the participating site (ie MercyCare) would also appreciate receiving at a minimum an annual study progress report as well as a final report on the study results and/or any subsequent publications.

I wish you well with your study.

Yours sincerely

Professor Con Michael
Chairman, St John of God Health Care Ethics Committee
Appendix 2: Clinical Supervision Program—Study Day Agenda

The Clinical Supervision Program
for Registered Nurses

Study Day Program

<table>
<thead>
<tr>
<th>Program</th>
<th>File Chapter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registration &amp; Housekeeping</td>
<td>-</td>
</tr>
<tr>
<td>The Big Picture</td>
<td>-</td>
</tr>
<tr>
<td>Clinical Supervision</td>
<td>1</td>
</tr>
<tr>
<td>Roles of the Clinical Supervisor</td>
<td>2</td>
</tr>
<tr>
<td>Benefits and Barriers</td>
<td>3</td>
</tr>
<tr>
<td>Morning Tea</td>
<td>-</td>
</tr>
<tr>
<td>Adult Learning and Learning Styles</td>
<td>4</td>
</tr>
<tr>
<td>Critical Thinking, Clinical Reasoning and Reflection</td>
<td>5</td>
</tr>
<tr>
<td>Lunch</td>
<td>-</td>
</tr>
<tr>
<td>Belongingness</td>
<td>6</td>
</tr>
<tr>
<td>Competency and Assessment</td>
<td>7</td>
</tr>
<tr>
<td>Afternoon Tea</td>
<td>-</td>
</tr>
<tr>
<td>Provision of Feedback</td>
<td>8</td>
</tr>
<tr>
<td>Summary and Close</td>
<td>9</td>
</tr>
</tbody>
</table>

You will find material for each section within your work-file.
Appendix 3: Clinical Supervision Program, Teaching Plan

TEACHING PLAN: CLINICAL SUPERVISION SEMINAR FOR REGISTERED NURSES

Administrative Details
Duration: 8 hours
Date: TBC
Time: 0800 – 1630
Room: Seminar or Classroom
Equipment: PowerPoint presentation facilities
Resources: White Board/pens/butcher paper

Additional notes are provided on the Power Point presentation on the notes pages.

0800 - 0810 Registration
0800 - 0830 Pre Program Knowledge and Attitude survey to be completed
0830 - 0845 Introduction
0845 - 1545 Days lectures, per attachments
1545 - 1600 Summary and Close
1600 - 1630 Post Program Knowledge and Attitude surveys to be completed
**SESSION ONE: INTRODUCTION**

**Administrative Details**
- Duration: 15 minutes
- Time: 0830 – 0845
- Resources: Power Point

**Session Plan**

<table>
<thead>
<tr>
<th>Heading</th>
<th>Time</th>
<th>Learning Resources</th>
<th>Content/Learning Process</th>
</tr>
</thead>
</table>
| Introduction | 15 mins | 1. Slide 1  
2. Slide 2  
3. Slide 3 | 1. Introduce the program title and welcome everyone to the study day. Briefly introduce self as the facilitator of the program. Outline any OS&H requirements.  
2. Ask each person in the room to briefly introduce themselves, including their current involvement with students, why they choose to attend, and what they would like to achieve in today's program (that is their learning objectives). Then introduce self, and experience with students to gain participants creditability with the program contents  
3. Outline the days contents, including break times and finish time. These can be fluid depending on the group discussions. **Remind group that any examples provided in the session are for learning and must be respected and treated as confidential.** |
SESSION TWO: BIG PICTURE

Administrative Details
Duration: 30 minutes
Time: 0845 – 0915
Resources: Power Point

Learning Objectives
By the end of this session it is anticipated that the learner will be better able to:
1. Explain, in class discussion, the role of the clinical supervisor according to the national guidelines for supervision by the Nurses Board of Australia and Health Workforce Australia
2. Outline their own role in the current national strategies for clinical supervisors and student placements
3. Understand the current national policy on student placement requirements

Session Plan

<table>
<thead>
<tr>
<th>Heading</th>
<th>Time</th>
<th>Learning Resources</th>
<th>Content/Learning Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bigger Picture</td>
<td>20 mins</td>
<td>1. Slide 4</td>
<td>1. Read and discuss slide points</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Ensure you have a thorough understanding of HWA and their role, relate this to what</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>the national strategies are and how these impact on clinicians</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Explain who CTN are in WA and their role</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- The impact on current recruitment and retention policies</td>
</tr>
</tbody>
</table>
SESSION THREE: CLINICAL SUPERVISION/ROLES OF THE CLINICAL SUPERVISOR/BENEFITS AND BARRIERS

Administrative Details
Duration: 45 minutes
Time: 0915 - 1000
Resources: Power Point, White Board/pens, Professional documents (in Work-file)

Learning Objectives
By the end of this session it is anticipated that the learner will be better able to:
1. Understand the differences between the terms Clinical Facilitator and Clinical Supervisor
2. Define the role of the clinical supervisor according to the national guidelines for supervision by Health Workforce Australia
3. Explain the relevant professional codes of practice that govern clinical supervision
4. Apply the principles of secondary mentorship to the clinical supervision relationship
5. Identify the roles of the clinical supervisor
6. Apply the roles of the clinical supervisor to the work environment
7. Determine the role of the clinical supervisor to assist students to become workforce ready graduates
8. Identify the barriers in the workplace in relation to clinical supervision
9. Identify strategies to overcome the barriers to clinical supervision in the workplace

Session Plan

<table>
<thead>
<tr>
<th>Heading</th>
<th>Time</th>
<th>Learning Resources</th>
<th>Content/Learning Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Supervision</td>
<td>5 mins</td>
<td>1. Slide 5</td>
<td>1. New section slide</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Slide 6</td>
<td>2. Read the definition of clinical supervision. Note that there is a lot of different terms currently used, however this is the HWA preferred terminology that WA has agreed to accept.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Slide 7</td>
<td>3. These are the current terms used in health to describe the role of a clinical supervisor or a clinical facilitator. Confirm that a clinical facilitator is an employee of an education provider responsible for providing a link between them and the health care facility. They may or may not be involved with supervising students directly during their clinical placement.</td>
</tr>
<tr>
<td>Heading</td>
<td>Time</td>
<td>Learning Resources</td>
<td>Content/Learning Process</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>------</td>
<td>------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Terminology                 | 5 mins | 1. Slide 8 & 9  
2. Slide 10                                                                 | 1. Define mentorship, and relate how clinical supervisors, whilst not mentors, can use some of the qualities of mentorship to provide a richer more meaningful clinical placement for students. Secondary Mentorship relates to a short term relationship, this principle can be applied to clinical supervision  
2. Preceptorship, is in particular a nursing term and used by some allied health professions. It is now used more commonly to describe the support of a first year nurse or new nurse to an area, then a model for supporting students. |
| Application                  | 5 mins | 1. Slide 11                                                                         | 1. Encourage participants to think about who they supervise in the workplace: RN students from the different education providers both from within and outside of WA, EN students, AIN students, medical students and allied health. Use this opportunity to determine the groups understanding of these different programs, and briefly outline them. Outline the national standards for RN and EN training.  
- RN 800 clinical hours = 20 weeks  
- EN 400 clinical hours = 10 weeks  
- Placements often 2 weeks. What is the aim of these placements? What can we expect a student to learn in 2-3 weeks? Are you overteaching… setting expectations too high?  
- **This begins to explain the student journey** |
| Role of the Clinical Supervisor | 15    | 1. Slide 12  
2. Slide 13  
3. Slide 14, 15, 16, 17, 18 and Professional documents included in work-file  
4. Slide 19 – activity 1  
5. Slide 20 | 1. New section slide  
2. Read out slide, link the students learning to life long learning as a health professional. This also means we can have students anywhere on this continuum.  
3. Discuss each of the roles – role model, educator, assessor, social agent. Use this time when discussing these to refer participants to the ANMAC and AHPRA documentation included in the work-file: Domains of Practice, Competency standards etc.  
4. White board what the participants’ expectations are of their graduates (first year nurses), then reverse this, and ask what is their role to ensure students gain this knowledge, skill and attitude when with them on clinical placement. Provoke them to think about what they currently do, and what could they be doing better.  
5. Summarise the different roles and responsibilities of those involved in a students |
placeplacement
– Health care facility: has a positive culture to accept and support students
– Provision of a clinical facilitator to provide clinical supervisors with support to meet the learning requirements of the education provider. Assist with barriers to learning, student performance management, documentation etc.
– Permission from the family for the student to practice, often taken for granted
– Clinical Supervisor, a pivotal role in the success of the placement. A clinician who provides appropriate learning and reflection opportunities for students to assist them meet their learning objectives in a safe and supportive environment

<table>
<thead>
<tr>
<th>Heading</th>
<th>Time</th>
<th>Learning Resources</th>
<th>Content/Learning Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefits and Barriers</td>
<td>25</td>
<td>Slide 21</td>
<td>1. New section slide</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Slide 22</td>
<td>2. Ask the participants to present to the group their current barrier, and as a facilitator and group offer potential strategies to overcome these.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Slide 23</td>
<td>3. Read the benefits to the clinical supervisor, give examples to the dot points</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Slide 24</td>
<td>4. Read the benefits to the students, provide examples of student feedback</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Slide 25</td>
<td>5. Highlight the resources available, remembering this is a team approach to clinical supervision</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Slide 26</td>
<td>6. Summarise the morning sessions</td>
</tr>
</tbody>
</table>

Slide 27, Morning Tea: 15-20 minutes
SESSION FOUR: ADULT LEARNING AND LEARNING STYLES

Administrative Details
Duration: 50 minutes
Time: 1020 – 1110
Resources: Power Point, Learning Style Survey handouts (in work-file)

Learning Objectives
By the end of this session it is anticipated that the learner will be better able to:
1. Define the principles of adult learning
2. Identify the different styles of adult learning
3. Explain how different learning styles can be incorporated into clinical teaching
4. Identify different teaching styles that can be incorporated into the clinical environment
5. Explain the importance for clinical supervisors to adapt their teaching to assist students learning in the clinical environment
6. Describe the principles of workplace learning and the challenges that this creates for students and their supervisors
7. Identify strategies to assist supervisors and students to overcome the challenges of workplace learning

Session Plan

<table>
<thead>
<tr>
<th>Heading</th>
<th>Time</th>
<th>Learning Resources</th>
<th>Content/Learning Process</th>
</tr>
</thead>
</table>
| The Cup that is Full | 5 mins | 1. Slide 28, 2. Slide 29 | 1. New section slide  
2. Story of Zen - Read from work file and discuss its meaning. Then relate this to the principle of the leaking bucket - the importance of life long learning (will later link in to critical thinking) we must let go of the old and take in the new. Also as RNs we need to understand the bigger picture as this influences nursing delivery e.g., state and federal polices, budgets etc. We need to encourage our students to take note of the role of health care in our society, and our consumers expectations. Therefore it is not just about teaching the role of the RN, but about the health care industry |
<p>| Adult Learners   | 5 mins | 1. Slide 30 | 1. Read and discuss slide, provide examples |</p>
<table>
<thead>
<tr>
<th>Heading</th>
<th>Time</th>
<th>Learning Resources</th>
<th>Content/Learning Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning Styles</td>
<td>40mins</td>
<td>1. Slide 31 &amp; Work-file for learning survey</td>
<td>1. Participants to complete the learning style survey in the work-file (less than 5 minutes to complete). Explain to the participants how to do this.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Slide 32</td>
<td>– Once completed, divide the participants into groups according to their results.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Slide 33</td>
<td>– Ask each group to write on the butcher paper their preferred ways to learn, and what about these strategies makes them feel comfortable in their learning, and that their learning is correct and safe, allocate 15 minutes. Then read each groups characteristics according to the learning survey, and ask them to read to the group their comments.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2. Summarise the groups’ findings, highlighting that just like the picture, we all have different ways that we approach learning, and participate in learning, and makes us feel secure in our learning. What are the implications for clinical supervisors? Prompt the group to determine that we need to adjust our teaching style, and ask our students how they like to learn.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>3. Summarise the section, and relate to next section of critical thinking, clinical reasoning and reflection as strategies to assist with student learning.</td>
</tr>
</tbody>
</table>
SESSION FIVE: CRITICAL THINKING, CLINICAL REASONING AND REFLECTION

Administrative Details
Duration: 1 hour
Time: 1110 – 1210
Resources: Power Point, Work-file article ‘clinical reasoning instructor resources’

Learning Objectives
By the end of this session it is anticipated that the learner will be better able to:
1. Describe the principles of critical thinking, clinical reasoning and reflection
2. Relate the role of critical thinking, clinical reasoning and reflection to assist students to develop their professional practice
3. Apply the principles of critical thinking, clinical reasoning and reflection to teaching in the work place to assist students clinical development

Session Plan

<table>
<thead>
<tr>
<th>Heading</th>
<th>Time</th>
<th>Learning Resources</th>
<th>Content/Learning Process</th>
</tr>
</thead>
</table>
| Definitions and application of critical thinking and clinical reasoning | 30 mins| 1. Slide 34  
2. Slide 35  
3. Slide 36  
4. Slide 37  
5. Slide 38  
6. Slide 39  
Work-file for Article: | 1. New section slide  
2. Read slide points  
3. Read slide points  
4. Explain and apply the clinical reasoning process using an example of your own, or ask for an episode of care example from a participant. Refer participants to the Teaching Clinical Reasoning, teacher resource, found in the work file. Use the table 1 example if uncomfortable using your own example.  
5. Summarise the definitions again. Suggest to participants to read the article in detail after the study day for practical suggestions to teaching clinical reasoning.  
6. Strategies for teaching clinical thinking and clinical reasoning also include the use of case studies and reflection. Education facilities use case studies in written form and simulations. In the clinical placement supervisors should encourage reflection of patient cases. |
<table>
<thead>
<tr>
<th>Heading</th>
<th>Time</th>
<th>Learning Resources</th>
<th>Content/Learning Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reflection</td>
<td>30 mins</td>
<td>1. Slide 40, 41</td>
<td>1. Definition - Read and discuss slide. Reflection can be used for enhancing clinical reasoning, and also as a debrief tool for students after experiencing confronting episodes of patient care, or any time where a student feels overwhelmed/depowered etc.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Slide 42</td>
<td>2. Group activity, read slide and ask participants how they would respond to this. Remind the group about the resources available to them, and follow up care for students once they leave the health care facility (Education provider counselling services and academic staff).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Slide 43</td>
<td>3. Discuss Gibb’s model of reflection, there are many different models, this is just one that participants may like to use as a guide to ensuring that the reflection process is effective. Use the previous example to go through the application of the Gibbs reflection, and for general application to patient care to enhance clinical reasoning.</td>
</tr>
</tbody>
</table>

Slide 44, Lunch: 40 minutes
SESSION SIX: BELONGINGNESS

Administrative Details
Duration: 1 hour 10 minutes
Time: 1250 – 1400
Resources: Power Point, ‘Belongingness’ articles from work-file, butcher paper and marker pens

Learning Objectives
By the end of this session it is anticipated that the learner will be better able to:
1. Define the term ‘Belongingness’
2. Explain the importance of ‘Belongingness’
3. Outline how ‘Belongingness’ can be promoted in the clinical arena for students

Session Plan

<table>
<thead>
<tr>
<th>Heading</th>
<th>Time</th>
<th>Learning Resources</th>
<th>Content/Learning Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belongingness</td>
<td>1 hour 10 minutes</td>
<td>1. Slide 45</td>
<td>1. New section slide</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Slide 46 and articles from work-file on belongingness</td>
<td>2. Complete Belongingness activity:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>– Divide the group into smaller groups (max 4-5 per group), 3-4 groups required.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>– Allocate each group a journal article related to Belongingness from the work-file</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>– Ask each participant to read their allocated article and highlight the 5 main points. Write these in the allocated space in their work-file. Then in their groups agree to the 5 main points and write these down on butcher paper (allocate 40 minutes)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>– Using a white board, ask each group to give a summary of their article, and read out their 5 main points, write these on the white board (allocate 10 minutes)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>– Then ask the whole group as to how they can incorporate belongingness into their workplace. Write these down on a butcher paper/another white board (allocate 10 minutes)</td>
</tr>
</tbody>
</table>

Slide 47, Afternoon Tea: 10 minutes
# Session Seven: Competency and Assessment

## Administrative Details
- **Duration:** 50 minutes
- **Time:** 1410 - 1500
- **Resources:** Power Point

## Learning Objectives
By the end of this session it is anticipated that the learner will be better able to:

1. Explain the term ‘Competence’
2. Outline the principles of Bloom’s Taxonomy of Learning
3. Apply the principles of the Conscious Competent Learning Model
4. Define the term ‘Assessment’
5. Understand the Delegation Framework
6. Explain the application of competence to student evaluation tools

## Session Plan

<table>
<thead>
<tr>
<th>Heading</th>
<th>Time</th>
<th>Learning Resources</th>
<th>Content/Learning Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competency</td>
<td>15 mins</td>
<td>1. Slide 48 2. Slide 49</td>
<td>1. New section slide 2. Definition of competency</td>
</tr>
</tbody>
</table>
SESSION EIGHT: PROVISION OF FEEDBACK

Administrative Details
Duration: 45 mins
Time: 1500 - 1545
Resources: Power Point

Learning Objectives
By the end of this session it is anticipated that the learner will be better able to:
1. Describe the process of providing feedback to students in the clinical arena
2. Relate the importance of providing students with clinical and professional feedback
3. Outline strategies for managing feedback in difficult situations
4. Explain the process of managing the struggling and/or failing student

Session Plan

<table>
<thead>
<tr>
<th>Heading</th>
<th>Time</th>
<th>Learning Resources</th>
<th>Content/Learning Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision of Feedback</td>
<td>45 mins</td>
<td>1. Slide 57</td>
<td>1. New section slide</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Slide 58</td>
<td>2. Types of feedback, define these according to the slide</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Slide 59</td>
<td>3. Considerations when giving feedback</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Slide 60</td>
<td>4. Responding to students in difficult circumstances. Ask members of the group to provide examples that were difficult for them, and use these as examples to provide future strategies for.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. Slide 61</td>
<td>5. Tips and Tactics for giving feedback</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6. Slide 62</td>
<td>6. Remember to document and consider feeding back to the Education Provider</td>
</tr>
</tbody>
</table>


SESSION NINE: SUMMARY AND CONCLUSION

Administrative Details
Duration: 15 mins
Time: 1545 - 1600
Resources: Power Point

Learning Objectives
By the end of this session it is anticipated that the learner will be better able to:
1. Describe, in class discussion, the application of supervision principles to the workplace

Session Plan

<table>
<thead>
<tr>
<th>Heading</th>
<th>Time</th>
<th>Learning Resources</th>
<th>Content/Learning Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Summary</td>
<td>10 mins</td>
<td>1. Slide 63</td>
<td>1. Read and discuss slide</td>
</tr>
</tbody>
</table>
Appendix 4: Attitude Survey—Stagg

RESEARCH SURVEY – Stagg’s attitude survey
Clinical Supervision Program for Registered Nurses

ID: ________________________________________________

Dear participant

Thank you for taking the time to complete the following survey. You will be asked to complete this survey on three occasions. Please tick the relevant box for this survey:

Please tick:
- Pre program survey
- Immediate post program survey
- Eight-week post program survey

Instructions

Please circle the most appropriate response to each question, e.g.

SA A Undecided D SD

If you make an error, place a cross X through the error, and circle your answer, e.g.

SA A Undecided D SD
<table>
<thead>
<tr>
<th></th>
<th>Please circle the response which best describes how you feel about each question as it relates to nursing students</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I believe nursing students respect nurses as practitioners</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>2.</td>
<td>Nurses consider nursing students as part of the nursing team</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>3.</td>
<td>The nursing students are too friendly with their instructors</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>4.</td>
<td>With nursing students who are new on the unit, nurses have time to do other things.</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>5.</td>
<td>Nursing students accept constructive criticism</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>6.</td>
<td>With nursing students who are familiar with the unit, nurses have time to do other things.</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>7.</td>
<td>We were all students once, so we should be nice to nursing students</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>8.</td>
<td>You cannot tell nursing students anything because they know everything</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>9.</td>
<td>Nursing students willingly help nurses to get things done</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>10.</td>
<td>Nurses should not have to do the teaching that clinical instructors are paid to do</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>11.</td>
<td>Nursing students become overwhelmed if they have to care for more than 1 or 2 patients</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>12.</td>
<td>There is too much to do to have to worry about students</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>13.</td>
<td>Nursing students ask too many questions</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>14.</td>
<td>Nursing students rely on their instructor more than the ward nurses</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>15.</td>
<td>Nursing students are too dependent on the ward nurses</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>16.</td>
<td>Nursing students are too chummy with the doctors</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>17.</td>
<td>Nursing students help other students to get things done</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>18.</td>
<td>Nursing students do not have enough confidence in themselves</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td></td>
<td>Statement</td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Undecided</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------------------------------</td>
<td>----------------</td>
<td>-------</td>
<td>-----------</td>
<td>----------</td>
<td>-------------------</td>
</tr>
<tr>
<td>19.</td>
<td>When I was in nursing school, I had more clinical experience than the nursing students do now.</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>20.</td>
<td>I enjoy working with nursing students</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>21.</td>
<td>Nurses learn new information from nursing students.</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>22.</td>
<td>I had it tough in nursing school, so nursing students of today should too.</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>23.</td>
<td>Nursing student's questions stimulate new ways of doing things</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>24.</td>
<td>Today's nursing schools provide quality education</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>25.</td>
<td>Overall, nursing students provide good patient care</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>26.</td>
<td>Decisions are made too hastily by nursing students</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>27.</td>
<td>I would never have dreamed of calling my instructors by their first name</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>28.</td>
<td>Nursing students ask good questions</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>29.</td>
<td>Nursing students are more trouble than they are worth</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>30.</td>
<td>I would not have to spend extra time with nursing students, if the instructor would supervise the nursing students.</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>31.</td>
<td>Nursing students look professional</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>32.</td>
<td>Nursing students have time to attend to patients needs</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>33.</td>
<td>Nursing students are eager to learn</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>34.</td>
<td>Nursing students do only what they are assigned</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>35.</td>
<td>Nursing students lack in common sense</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>36.</td>
<td>Nursing students admit when they do not know something</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>37.</td>
<td>It is about time instructors eased up on the nursing students</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>38.</td>
<td>Nursing students practice assertiveness</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>39.</td>
<td>Nursing students do not get enough clinical experience</td>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
</tbody>
</table>
Appendix 5: Permission from Stagg to Use Survey

From: Sharon Stagg <sstagg@shorehealth.org>
Subject: RE: request to use survey tool - attitude towards nursing students
Date: 2 February 2012 10:54:36 PM AWST
To: Kylie Russell <kylie.russell@nd.edu.au>

Kylie,
Your study sounds very interesting. You have my permission to use the survey. I would be interested in your finding when you complete your study.
Best of luck.
-Sharon

Sharon Stagg, RN, DNP, MPH, FNP-BC, | Director | Shore Wellness Partners
Shore Health System | University of Maryland Medical System
505 Byrn Street | Cambridge, Maryland 21613
☎ 410-228-5511 ext. 8162 | ☭ sstagg@shorehealth.org
“An Magnet Recognized Organization”

From: Kylie Russell [mailto:kylie.russell@nd.edu.au]
Sent: Tuesday, January 31, 2012 10:20 PM
To: Sharon Stagg
Subject: request to use survey tool - attitude towards nursing students

Dear Dr Stagg,

I am writing to you regarding your Master’s thesis on Staff Nurses attitudes toward nursing students in 1992. I am currently enrolled in my PhD at the University of Notre Dame, Australia and would like to use your survey tool used in this study. My PhD proposal is currently with the School of Nursing and Midwifery ethics committee for approval. I will be implementing a new education program for registered nurses titled the ‘Undergraduate Clinical Supervision Program for Registered Nurses’. This program aims to improve the attitude of nurses who precept/supervise nursing students in the clinical area. The program includes content related to the principles of adult learning, critical thinking, clinical reason, reflection, clinical teaching, providing feedback etc, however the undertone of the day through workshops and other activities is to also promote participants to reflect on their attitude towards students and use the strategies presented and discussed during the day to improve this. Work in Australia by Tracey Levett-Jones links a sense of student belongingness to improved student placements, and I hope to achieve this. I would like to use your survey both immediately pre and post the program and at 8 weeks post program. There will be another survey related to the content of day, an online reflective feedback tool for 8 weeks, and for those willing a short interview at 10 weeks. I hope to use your tool in conjunction with these other data methods to determine if there is any impact of the program on the attitude of the participants towards nursing students. The program will be presented on 10 occasions with between 20-25 participants. This program has now also been accepted by the Department of Health in Western Australia, and will be presented statewide over the year. I hope that you will be able to support me in this project by consenting to the use of your tool. Of course it will be referenced and acknowledged. Only two questions will be removed due to Australia having only one program for registration as a RN (not bachelor and diploma as referred to in the tool). I am happy to send you my candidacy statement when I receive it, which hopefully will be the end of next month.
I look forward to your response.

Kind regards

Kylie Russell
Appendix 6: Pre-program Knowledge Survey

RESEARCH SURVEY – PRE ATTENDENCE TO PROGRAM
Clinical Supervision Program for Registered Nurses

I.D NUMBER: ____________________________________________________________

1. Which category best describes your current role/area of practice?
   *(Please list all areas of employment if employed in more than one area)*

<table>
<thead>
<tr>
<th>Category</th>
<th>Please</th>
<th>Full time or Part time</th>
<th>Length of service</th>
<th>Level (e.g. RN, CN, SRN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community/Clinic/GP practice/Surgicentre/Diagnostic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical/Surgical/DPU</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Theatres/Recovery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Critical Care/HDU</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paediatrics/Maternity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Units</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educator/Staff Development Nurse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agency/Casual Call</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Are you employed in regional Western Australia *(please circle correct response):* Yes/No

3. Are you employed in private or public health care *(for you main position)*?

4. How long have you worked as a registered nurse?
5. **Please circle your age group**

- A 20-30
- B 31-40
- C 41-50
- D 51-60
- E 61-70
- F 71-80

6. **What was your reason/s for attending this program?**

   ____________________________________________________________

   ____________________________________________________________

   ____________________________________________________________

7. **Have you attended any education for supervising students in the past, if yes please describe. Did you find this useful? Have you been able to apply what you learnt?**

   ____________________________________________________________

   ____________________________________________________________

   ____________________________________________________________

   ____________________________________________________________

   ____________________________________________________________

   ____________________________________________________________

   ____________________________________________________________

   ____________________________________________________________

   ____________________________________________________________

   ____________________________________________________________

   ____________________________________________________________
8. On average, how frequently have you worked with a student in the last six months (please circle the most accurate response)?

A Most days (more than 50% of your weekly shifts)
B Some days (less than 50% of your weekly shifts)
C Infrequently (on occasions each month)
D Rarely (once or twice in the last six months)
E Not at all

The following questions relate to the content of this study day. This is designed to provide a pre attendance knowledge level of the group.

1. What do you understand by the term Secondary mentorship?
(Please circle your chosen response)

A The relationship between two staff of the same organisation at a senior management level designed to assist with career progression
B The relationship between two staff at a senior management level designed to assist with career progression
C A short term relationship between two individuals, one the mentor the other the mentee, to assist with professional growth and development
D A short term relationship between two individuals designed to assist with career progression

2. What do you understand by the term Critical Thinking?
(Please circle your chosen response)

A Involves the ongoing commitment of the individual to examine any belief or knowledge in the light of the evidence that supports it
B Involves forming conclusions, making decisions drawing inferences and reflecting
C Is based on experience and pattern recognition processed at a subconscious level
D Involves accurately solving problems

How do you apply critical thinking in the clinical setting with students?
3. **What do you understand by the term Clinical Reasoning**

(Please circle your chosen response)

A  A health professional implementing Best Practice for the clinical care of a patient
B  The thought processes that occur when a health professional engages in clinical problem solving
C  The thought process used by health professionals to analyse data
D  The thought process used by health professionals to plan patient care

How do you apply Clinical Reasoning with students?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

4. **What does the term Reflection mean to you?**

(Please circle your chosen response)

A  An individual reviewing past experiences
B  A process in which we analyse a situation
C  Developing a new framework for future practice
D  How we explore our actions

How do you apply the principles of Reflection with students?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
5. Can you explain the following terms?

<table>
<thead>
<tr>
<th>Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educator</td>
</tr>
<tr>
<td>Socialiser</td>
</tr>
<tr>
<td>Advocate</td>
</tr>
<tr>
<td>Assessor</td>
</tr>
<tr>
<td>Role Model</td>
</tr>
<tr>
<td>Belongingness</td>
</tr>
</tbody>
</table>

6. How do you currently provide feedback to your students?

<table>
<thead>
<tr>
<th>Category</th>
<th>Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive:</td>
<td></td>
</tr>
<tr>
<td>Negative:</td>
<td></td>
</tr>
</tbody>
</table>

7. Define the term Competence?

<table>
<thead>
<tr>
<th>Definition</th>
</tr>
</thead>
</table>

THANK YOU FOR COMPLETING THIS SURVEY
Clinical Supervision Program for Registered Nurses

RESEARCH PROJECT SURVEY – POST ATTENDENCE TO PROGRAM

I.D: ______________________________________________

Please tick:

Immediate post survey  □
Eight-week survey  □

Have you supervised RN students since attendance to the program:

Yes/No (please circle)

1. Did the program meet your expectations (please circle)? Yes  No
   Why?
   ___________________________________________________
   ___________________________________________________
   ___________________________________________________

2. Would you recommend this program (please circle)? Yes  No
   Why?
   ___________________________________________________
   ___________________________________________________
   ___________________________________________________

3. What did you like the most about the program?
   ___________________________________________________
   ___________________________________________________
4. What, if any, changes would you recommend?

5. What do you understand by the term Secondary mentorship?
   (Please circle your chosen response)
   A. The relationship between two staff of the same organisation at a senior management level designed to assist with career progression
   B. The relationship between two staff at a senior management level designed to assist with career progression
   C. A short term relationship between two individuals, one the mentor, the other the mentee, to assist with professional growth and development
   D. A short term relationship between two individuals designed to assist with career progression

6. What do you understand by the term Critical Thinking?
   (Please circle your chosen response)
   A. Involves the ongoing commitment of the individual to examine any belief or knowledge in the light of the evidence that supports it.
   B. Involves forming conclusions, making decisions, drawing inferences and reflecting on the evidence or knowledge in the light of the evidence that supports it.
   C. Is based on experience and pattern recognition processed at a subconscious level.
   D. Involves accurately solving problems.

How do you apply critical thinking in the clinical setting with students?
7. What do you understand by the term Clinical Reasoning?  
(Please circle your chosen response)

A. A health professional implementing Best Practice for the clinical care of a patient
B. The thought processes that occur when a health professional engages in clinical problem solving
C. The thought process used by health professionals to analyse data
D. The thought process used by health professionals to plan patient care

How do you apply Clinical Reasoning with students?

8. What does the term Reflection mean to you?  
(Please circle your chosen response)

A. An individual reviewing past experiences
B. A process in which we analyse a situation
C. Developing a new framework for future practice
D. How we explore our actions

How do you apply the principles of Reflection with students?
9. Can you explain the following terms?

<table>
<thead>
<tr>
<th>Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educator</td>
</tr>
<tr>
<td>Socialiser</td>
</tr>
<tr>
<td>Advocate</td>
</tr>
<tr>
<td>Assessor</td>
</tr>
<tr>
<td>Role Model</td>
</tr>
<tr>
<td>Belongingness</td>
</tr>
</tbody>
</table>

10. How do you currently provide feedback to your students?

<table>
<thead>
<tr>
<th>Feedback Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
</tr>
<tr>
<td>Negative</td>
</tr>
</tbody>
</table>

11. Define the term Competence?

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________
Has this program resulted in a change of how you believe you will supervise students in the workplace? In what way?

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

12. Can you please provide feedback in regards to the different teaching methods used during the program, did you find these teaching methods helpful in understanding the content?

<table>
<thead>
<tr>
<th>White board</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Group discussion</td>
<td></td>
</tr>
<tr>
<td>Case study/examples</td>
<td></td>
</tr>
<tr>
<td>Role Play</td>
<td></td>
</tr>
<tr>
<td>Power point slides</td>
<td></td>
</tr>
<tr>
<td>Workbook</td>
<td></td>
</tr>
<tr>
<td>Articles (wk 8 only)</td>
<td></td>
</tr>
</tbody>
</table>

13. Would you be willing to participate in a one to one interview?
I welcome any further comments you would like to make

THANK YOU FOR COMPLETING THIS SURVEY
Appendix 8: Online Reflection Feedback Instructions for Research Participants

Clinical Supervision Program

ON-LINE REFLECTIVE FEEDBACK INSTRUCTIONS

Dear Participant,

If you are willing to be involved in the ongoing on-line reflective feedback following this program for eight weeks please place your name and email address on the ‘Consent to participate in the Clinical Supervision Program On-Line Reflective Feedback’. This will be passed around at completion of the Clinical Supervision Program study day.

You will be contacted by email to confirm your participation in the on-line reflective feedback process. Participants will then be contacted each week, for eight weeks, by email from Kylie Russell, the program facilitator and PhD student.

The following points are a guide for you to follow when sending an on-line reflection.

- Write a narrative of your interactions with students. This may be a summary of a shift or a particular instance of teaching, providing feedback, interactions with student and/or other staff.
- You may wish to relate these experiences to your personal growth and development as a supervisor, and/or what you would like to know more about.
- The more detail of the event/experience provided will assist the researcher to understand the moment/event.
- Please use full sentences and minimise abbreviations to assist the researcher to understand your intent.
- Do not include names or the student's university details.
- Reflections can only be received by email.

Thank you for considering being a part of the On-line Reflective process, and for attending the Clinical Supervision Program.

Kylie Russell
Program Facilitator, and PhD Candidate
School of Nursing and Midwifery
The University of Notre Dame, Australia
Appendix 9: Interview Questions for Research Project Participants

Clinical Supervision Program, Research Project: Interview Questions

Research by Kylie Russell, PhD Candidate

Facilitator: Kylie Russell
Participant: ______________________________________
Date: ______________________________________
Venue: ______________________________________

Prior to commencement confirm:

O Informed consent received and confirmed

O Consent to audiotape confirmed

Post interview

O Participants preferred format of data for review (circle)

    Email    Post    Meeting
1. Welcome and thank the interviewee for participating in the surveys and interview
2. Explain the interview process

Interview Questions

1. What experiences in your career have you had being a mentor/preceptor/buddy to nursing students?
2. Can you comment on your experiences supervising students since attending the program?

Examples of Probing Questions

- Has this improved your understanding of the clinical supervisor role?
- Has this helped you understand how to provide the optimum learning environment for students?
- Has this helped you to promote reflective practice/critical thinking/clinical reasoning/belonging/feedback
- Can you tell me a bit more about the last time you experienced that or felt that way?
- Can you give me an example of ....?
- Do you feel that way?
- Is that something you have experienced?
- Can you tell me more?
- Can you explain your answer?

(Notes pages attached)
Appendix 10: Information Sheet for Research Expert Group, Validation of Program, Participants

Clinical Supervision Program, Research Project

Dear Colleague,

Thank you for agreeing to participate as a member of the expert group for this PhD research project: **The impact on the knowledge and attitude of Registered Nurses who attend the ‘Clinical Supervision Program’**.

The intent of this research is to design, implement and evaluate the impact of a new education program for nursing staff that will assist them to develop the necessary knowledge and attitude to meet the requirements of a clinical supervisor to nursing students. The Clinical Supervision Support Paper (2010, p. 15) report discusses that supervisors require the core skills of:

1. Clinical skills and knowledge
2. Adult teaching and learning skills
3. Ability to give and receive feedback
4. Communication
5. Appraisal and assessment
6. Remediation of poorly performing students; and
7. Interpersonal skills.

The cores skill, point 1, regarding the development of clinical skills and knowledge is provided through clinical workshops, seminars and in-service already provided within the health care facilities unique to each area of practice. This will not be addressed in this research project.

The Clinical Supervision Program study day was designed to meet points two through to seven. After an extensive review of the literature, and from the personal experiences of the researcher, the researcher determined that the program will provide participants with these core skills through the underlying philosophy of secondary mentorship. The sessions will incorporate, through the principles of adult learning, the relevant core skills, in a practical approach to provide examples of practice.
To master each of the areas included in the Clinical Supervision Program and outlined by the CSSP (2010) would require extensive education. It is therefore the intent of this program to provide participants with a foundation level of information that they can use to improve their clinical supervision. The program will utilise case studies, discussion, storytelling and reflection to promote experiential learning (Kolb, 1984). These stories and cases then provide resources/real examples for participants to relate to. It is envisaged that this information will assist nurses to provide a positive learning experience in which students feel supported in their learning, as the nurses relate their clinical care to theory and provide opportunities for reflection and feedback.

The program will utilise the work of Tracey Levett-Jones and her research on Belongingness (2007, 2008 & 2009). The importance of belongingness and its impact on student learning in this research has highlighted that the attitude of the clinical supervisor has a significant impact on the ratings of clinical placement satisfaction by students. The intent of this program and research is not only to improve the knowledge of participants regarding the requirements of supervision, but to have an impact on the attitude of the participants.

This concept of belongingness will be applied through the principles of secondary mentorship. Secondary Mentorship is the development of a short-term relationship designed to assist with the professional development of an individual. It focuses on the development of a positive relationship aimed at assisting the professional growth and development of the student (Johnson, 2002).

It is envisaged that the content and delivery method of this program will assist nursing staff to develop the knowledge and attitude to work effectively in the role of a clinical supervisor. This is the desired “impact” of the program; it refers to a change in knowledge and practice (Moon, 2004, p. 4). To meet industry demands for succinct education in a climate where staff can be released from the workplace for a limited time, the program will consist of an intensive one-day program and resource manual.

The program will incorporate a number of teaching strategies based on the principles of adult learning. The program will assist participants to gain insight into their current supervision behaviour and attitude, and explore avenues for potential change and growth (Moon, 2004). Program attendance will be no greater than 20 participants to promote group interaction and discussion.

To achieve this the program will incorporate a number of learning activities. This involves a combination of theory and then its application through role-play, case studies,
group discussion and group activities. These are designed to assist nursing staff to understand the role of the clinical supervisor and how to apply this to their practice.

Consumer input into the development of the program will be sought (through you). This will be through the development of the expert groups for content validity, a review of the literature, as well as augmented by the experience of the author who has extensive experience in this area evidenced by completion of Masters in Health Science, Education (including mentorship, principles of adult learning, clinical reasoning, clinical teaching and supervision), previous experience in preceptorship and mentorship education (Coordinator of Preceptorship Program Fremantle Hospital and Health Service (FHHS) 2006-2008, Coordinator of Undergraduate Mentorship Training Program, School of Nursing, University of Notre Dame Australia, Fremantle 2009 – 2013) and completion of previous Team Leader Model for Clinical Supervision research project 2006-2009 (in conjunction with FHHS and Curtin University of Technology, Perth WA), presented at three international conferences and published (The Australian Journal of Advanced Nursing, March 2011).

Kylie Russell

PhD Candidate
The School of Nursing and Midwifery
The University of Notre Dame, Australia
EXPERT GROUP FEEDBACK FORM

Thank you for agreeing to participate as an expert member for the review of the Clinical Supervision Program for Registered Nurses. Please use this form to provide your feedback. Please email to – kylie.russell@nd.edu.au or fax (08) 9433 0227

If you have any questions, please do not hesitate to contact Kylie Russell on (08)9433 0183 or email kylie.russell@nd.edu.au

PROGRAM REVIEW (e.g. do you believe the contents will meet the CSSP core skills, is there anything you would add or remove, are time frames appropriate?)

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

SURVEY TOOL FEEDBACK (please consider the clarity of the tool, was it easy to comprehend, was it unambiguous, did you find it easy to answer)

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Time taken to complete the survey: ____________________________
Do you believe the pre and post implementation survey tool will answer the research questions?

1. What is the knowledge of nursing staff pre program in relation to the principles of clinical supervision?
2. Is there a change in knowledge related to the principles of supervision after attending the program? If so, what is the perceived change of participants?
3. What nursing staff perceive on completion of the program about their knowledge and attitude towards providing effective student supervision has changed?
4. Do participants perceive a different impact from this program compared to other clinical supervision education? If so why, if not why not?
5. Do nursing staff believe that the program assisted them to undertake this role more effectively? If so why, if not why not?
6. Do participants perceive that they have changed their attitude towards nursing students after attending the program?
7. Is there a change in the participants’ attitude towards nursing students after attending the program?

Thank you for your time and expertise in assisting with this research.
## EXPERT GROUP FEEDBACK

<table>
<thead>
<tr>
<th>Question</th>
<th>Program Feedback</th>
<th>Action taken</th>
</tr>
</thead>
</table>
| 1        | 1. The program is comprehensive, well written and logically sequenced. There appears to be ample time for lecture content and discussion groups. This allows for the adult learner to acquire new skills according to their needs. The program not only meets but it exceeds the core skills as the program allows group interaction and discussion which will open interesting discussion topics and perhaps new concepts.  
2. A comprehensive Program that covers CSSP core skills and utilises a range of teaching/learning methods. Time frames appear to be appropriate. It is great that longer times have been allocated for group discussions and role play etc. X1 typo in outline highlighter.  
3. The program addresses all the requirements to address the core skills as discussed in the CSSP. The slides all display clear information. They address all core skills in a clear and concise manner. The format will suit the needs of both experienced and novice nurses.  
4. The program seems extensive and appears to meet core content and skills required. Session length is appropriate and teaching strategies vary to keep participants engaged. Learning objectives for each session are measurable and achievable. The progression of the topics throughout the day seems logical and I like the idea of the final session to bring everything together and summarise. Content and presentation of PowerPoint slides is professional and accurate. Looks good!  
5. The content is appropriate and relevant to all nursing staff regardless of level. The frequency of activities is good and will aid with engagement. In relation to the slides: I would prefer less words/slide. | Nil required  
Correction made to typed error  
Nil required  
Nil required  
Nil required  
Nil required |
| 2        | 1. Would recommend numbering questions  
More lines needed for positive/negative feedback.  
2. easy to answer. X1 typo circled. Perhaps include further questions about feedback, e.g. what are some points to consider when giving feedback.  
3. The feedback tool was very clear in what the participants were asked. There was no underlying ambiguity and the participants can easily follow what is needed.  
4. The survey tools were easy to complete and understand. It was good having a mix of MCQ and short answer questions. I also thought it good that you are asking them to relate the theory to practice, by asking how they apply the concepts. All the content questions asked are clearly covered in the content for the day, which is good.  
5. The tool was easy to use and follow. Sequence of questions made sense. Q: Is it mandatory for people to add their names. Maybe comment on how this information will be used. Is it anonymous? | Questions numbered and more space provided  
Feedback addressed in question 12.  
Nil required  
Nil required  
Names not use, participants will be allocated a ID. |
<p>| 3        | 1. 20 minutes |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>Not answered</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Not answered</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>10 minutes for each survey</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Not answered</td>
<td></td>
</tr>
</tbody>
</table>

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>I believe the survey tool meets all of the above criteria 1-5. Unsure how 6 can be answered from the questionnaire</td>
<td>Question 6 answered via attitude survey, online reflection and interview</td>
</tr>
<tr>
<td>2.</td>
<td>Yes</td>
<td>Nil required</td>
</tr>
<tr>
<td>3.</td>
<td>Yes the participants should be able to display pre and post knowledge clearly. The questions above are very clear in what is required from the program.</td>
<td>Nil required</td>
</tr>
<tr>
<td>4.</td>
<td>Yes I feel the pre and post implementation survey tool will allow the research questions to be answered. In relation to numbers 5 &amp; 6, No 5 is addressed by the question in the post survey asking them if they have changed how they believe they will supervise students and question 6 I assume will be evaluated by the researcher comparing their pre and post surveys answers to all questions.</td>
<td>Nil required</td>
</tr>
<tr>
<td>5.</td>
<td>Not sure that your question is comparing to other programs? Q5&amp;6: not sure if you can see a change in attitude? Otherwise yes to all questions</td>
<td>Attitude is assessed by alternative data collection.</td>
</tr>
</tbody>
</table>
Appendix 11: Attachments for Validation Expert Group

Please refer to Appendix One for the program outline and Appendix Three for the teaching plan.

Due to the size of this PowerPoint it has been supplied on Thumb Drive. If you would prefer a hard copy please contact the researcher or supervisors for this to be arranged.
Appendix 12: Clinical Supervision Program Work File

Due to the size of this document it has been supplied on Thumb Drive. If you would prefer a hard copy please contact the researcher or supervisors for this to be arranged.
Appendix 13: Expert Group for Program Validation, Participants’ Details

1. Lecturer, The University of Notre Dame, Australia and facilitator of the undergraduate nursing mentorship program

2. Director of Staff Development, WA South Metropolitan Area Health Service, with previous experience as the Nursing Graduate Program Coordinator, and presenter of clinical supervision education at the hospital preceptorship program

3. Project Manager for WA HWA clinical supervision training project, seconded from: Undergraduate Program Coordinator, WA South Metropolitan Area Health Service & coordinator of the hospital preceptorship and clinical training program

4. A/Undergraduate Program Coordinator, WA South Metropolitan Area Health Service, and committee member for HWA clinical supervision program regional health online learning package

5. Assistant Professor/Lecturer, University of Western Australia – facilitator of Teaching on the Run program
Dear Colleague,

My name is Kylie Russell and I am a current research student at the University of Notre Dame, Australia within the School of Nursing and Midwifery. My research relates to my current work role of Clinical Coordinator, in which I am responsible for all aspects of the School of Nursing and Midwifery Clinical Practicum Program. My project is the introduction of a new education program for registered nurses to assist in the supervision of student nurses.

As an attendee at today’s program I would appreciate any feedback you would like to provide regarding the content and presentation style of the day. This information will be utilised to review the programs teaching plans prior to further presentation. This information will be utilised and referred to in the research thesis purely as feedback regarding the program in this initial stages. No identifying information is required from you.

Kylie Russell, PhD Candidate, The University of Notre Dame, Australia

If participants have any complaint regarding the manner in which a research project is conducted, it should be directed to the Executive Officer of the Human Research Ethics Committee, Research Office, The University of Notre Dame Australia, PO Box 1225 Fremantle WA 6959, phone (08) 9433 0943.
## Appendix 15: Pilot Project Participants’ Feedback

Pilot Program, 23 participants: 20 nursing, 3 Occupational Therapists

<table>
<thead>
<tr>
<th>FEEDBACK FROM EACH PARTICIPANT</th>
<th>ACTION TAKEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Good varied style</td>
<td></td>
</tr>
<tr>
<td>• Would be better if workbook flowed presentations</td>
<td>Workbooks have been reformatted into a file</td>
</tr>
<tr>
<td>• Content good, also applicable to junior staff</td>
<td></td>
</tr>
</tbody>
</table>

The challenge in Geraldton is that we have many students at the same time and not enough nurses to precept on an ongoing basis – the staff get very tired of teaching and fatigue quickly decreasing their own motivation in the workplace. Increased study days for supervisors/mentors/preceptors would increase motivation and excellent practice with their students

<table>
<thead>
<tr>
<th>FEEDBACK FROM EACH PARTICIPANT</th>
<th>ACTION TAKEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>• I found the day and course content very easy to follow and it followed a formal and practical process.</td>
<td>N/A</td>
</tr>
<tr>
<td>• Excellent content and very informative and gave realistic solutions to perceived issues and problems to workplace assessment</td>
<td>N/A</td>
</tr>
<tr>
<td>• Well presented, good use of work situations to make people think</td>
<td>N/A</td>
</tr>
<tr>
<td>• Good concepts of teaching students and grads</td>
<td>N/A</td>
</tr>
</tbody>
</table>

I would appreciate maybe a pre-reading material. I do not generally deal with students in my area of work but post graduates are who are deal with mostly. But I found this study day beneficial as the info I got also works with post graduates. The facilitator and the teaching aids used today were very good and helpful, thank you.

<table>
<thead>
<tr>
<th>FEEDBACK FROM EACH PARTICIPANT</th>
<th>ACTION TAKEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>• I believe the sessions were very relevant and well delivered by presenter</td>
<td>N/A</td>
</tr>
<tr>
<td>• The clinical reasoning tool and conscious competent learning model were a great source of information or educations tools that can be used in my area of nursing and delivering nursing education to students, graduates and all nurses.</td>
<td>N/A</td>
</tr>
<tr>
<td>• Thank you for the enthusiasm shown, it has helped me look at our roles as nurses and what our performance and how our attitudes and performances reflect on our nursing students, thank you</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Lovely relaxed atmosphere which highlighted that we do a good job. We just need to make sure someone is doing it. Very comfortable, many thanks

<table>
<thead>
<tr>
<th>FEEDBACK FROM EACH PARTICIPANT</th>
<th>ACTION TAKEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Use of recent resource articles/journals. High aspect of reflective examples/ increase knowledge</td>
<td>N/A</td>
</tr>
<tr>
<td>• Enthusiastic</td>
<td>N/A</td>
</tr>
<tr>
<td>• Thank you for reinforcing how important clinical placement is and how much impact we have on future workforce.</td>
<td>N/A</td>
</tr>
</tbody>
</table>

I have only been nursing for just over 12 months and i found this session to be very reassuring. I did not feel confident in my ability to mentor a student as my knowledge and skills as far as I was concerned was not adequate enough to enhance the development of the students. However today’s session has given me the confidence and courage to work with students in the future, thank you.

<table>
<thead>
<tr>
<th>FEEDBACK FROM EACH PARTICIPANT</th>
<th>ACTION TAKEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Work stations/group work was helpful, except the role play</td>
<td>N/A</td>
</tr>
<tr>
<td>• Highlighting points in articles was very informative</td>
<td>OT</td>
</tr>
<tr>
<td>• Great all round feedback on student supervision. Very knowledge presenter who was able to adopt presentation to make relevant for all health professionals</td>
<td></td>
</tr>
</tbody>
</table>
- Specific examples very helpful and easily applied to practice
- Very interactive. Helpful workbook/informative/great resource

| OT | Presented very effectively  |
|    | Enjoyed the practical sessions, lots of them which broke up the day |
|    | Presenter knew lots on clinical supervision, sharing experiences with us |
|    | Good resources to take away, readings etc |

| OT | Good use of activities and participation to reinforce learning |
|    | Workshop structure flowed well. |
|    | Enjoyed have journal articles incorporated |
|    | Very much appreciated that it wasn’t nursing only, felt included by the presenter seeking OT examples, highly relevant to allied health professionals |

Found today really helpful and great discussion. The information on feedback, clinical reasoning were relevant and great as can be put into current practice. Great presentation

| N/A | I think that what was covered today was very comprehensive and useful. |
|     | It outlined in a logical way what RNs should be more aware of and work towards when being part of clinical supervision |

| N/A | I found the program effective in the sense that it applies practically to current issues around clinical placements and as the role of mentors, preceptors in the ward |
|     | I have a better understanding of the competency framework actually referring and replacing the previously used scope of practice. |
|     | Thank you for sharing your knowledge, insight and time |

| N/A | I found the day very useful. Going through the clinical reasoning cycle has been excellent as it reminds me that this needs to be highlighted each time contact with student supervision is made. |
|     | As a clinical instructor over the past few years I have found the standard of student RNs has been outstanding. They are professional, passionate and use imitative and critical thinking |
|     | Thanks for the good insights. |

| N/A | Well presented, non threatening environment |
|     | Would be suitable for staff who have not had much previous education |

The book resource provided is excellent and comprehensive however I would like it up front as pre reading 1 week prior

Thank you for a very informative day and the amount of resource you are giving out. I particularly enjoyed the information of preceptorship and insights into forming well educated and competent students. I am sure we will adopt some of the ideas presented and some may lead to new ideas that will work for us, or not, thank you again

Registered nurses need more preparation to become effective preceptors. Most of the time the RNs refuse to have students as they consider the student as a burden, they feel that they can’t finish their talks in time and they don’t want to involve student in the important aspects of care. Most of the time RN are good care fivers but they are not good preceptors, student should up in the hands of good models and should be accepted, motivated and should get the sense of belonging.
Appendix 16: Request to Participate in Reliability Expert Group

Dear Colleague,

My name is Kylie Russell and I am a current research student at the University of Notre Dame, Australia within the School of Nursing and Midwifery. My research relates to my current work role of Clinical Coordinator, in which I am responsible for all aspects of the School of Nursing and Midwifery Clinical Practicum Program. My project is the introduction of a new education program for registered nurses to assist in the supervision of student nurses.

As a part of this research I will be asking participants that attend the study day program to complete a survey based on their knowledge and understanding of clinical supervision. This will be completed before and after participants attend the study day.

As this is a new survey that I have developed, I need to determine that participants can easily understand the survey, and that the survey gathers the information that will assist with answering my research questions.

In order to determine this, I require 30 nurses to complete this tool on two occasions, at least two weeks apart. I then mark the survey and give it a score. I then compare these scores to see if the survey was successful in gaining the same level of information from you at two different periods of time. I would also be appreciative of any comments you might like to make about the survey.

If you are happy to be involved, you will find attached the first survey. Please complete this and return. I will take this as your consent to be involved in completing the form again after two weeks. I will forward the second form to at this time.

Please note at no time will you be individually referred to in this research. You do not need to use your name on the survey; I just need to able to link your two surveys. You may therefore choose to place a nickname, or a number, that you will remember when completing the tool for the second time. When you have completed the survey, can you please either:

- Scan and email the completed survey to: kylie.russell@nd.edu.au  
- Fax to: Attention Kylie Russell – (08) 9433 0227  
- Or if at [ ] Hospital, please leave in the yellow envelope placed at the ward clerks desk on the [ ] and I will call in to collection these.

Thank you for taking the time the time to read this request.

Kind Regards  
Kylie Russell  
PhD Candidate  
The School of Nursing and Midwifery  
The University of Notre Dame, Australia
EXPERT GROUP FEEDBACK FORM
Thank you for agreeing to participate as an expert member for the reliability testing of the knowledge survey for participants of the Clinical Supervision Program for Registered Nurses.

Attached to this form is the first of the two copies of the knowledge survey that you are asked to complete. You will complete these two surveys two weeks apart. After completing the first survey please do not refer to the survey or research any of the contents. After two weeks I will forward the survey again. Please email or fax to Kylie Russell at – kylie.russell@nd.edu.au or fax (08) 9433 0227.

The first form you will be given has a number ‘1’ in the right top hand corner, and the second form will have a number ‘2’, this is so I can identify the forms on their return.

If you have any questions, please do not hesitate to contact Kylie Russell on (08) 9433 0183 or email kylie.russell@nd.edu.au

SURVEY TOOL FEEDBACK (please consider the clarity of the tool, was it easy to comprehend, was it unambiguous, did you find it easy to answer)

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Time taken to complete the surveys: 1:___________  2:____________

Thank you for your time and expertise in assisting with this research.
Appendix 18: Email to Expert Group, Reliability of Knowledge Survey, to Complete Second Survey for Reliability Testing

From: Kylie Russell <kylie.russell@nd.edu.au>
Subject: expert group survey part 2 - Kylie Russell
Cc: Kylie Russell <kylie.russell@nd.edu.au>
Bcc: removed for confidentiality

Dear Colleague,

Thank you for participating as a member of the reliability expert group. It is now been two weeks since I forwarded the first email, and I would kindly ask that you could complete the survey attached again. Please forward through via email or fax as per the instructions below.

Many thanks for your time and participation in this project, without your support the project could not have been possible.

Kind Regards
Kylie

Kylie Russell

PhD Candidate
School of Nursing and Midwifery
Fremantle Campus
The University of Notre Dame, Australia
Kylie.russell@nd.edu.au

(NB. Original email request also attached to email)
## Appendix 19: Reliability Testing Results, Feedback and Participants’ Details

<table>
<thead>
<tr>
<th>Participant</th>
<th>Survey Tool Feedback</th>
<th>Time to complete</th>
<th>ACTION TAKEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>• Questions would be easier to follow if numbers</td>
<td>20mins 20mins</td>
<td>1. Numbering added</td>
</tr>
<tr>
<td></td>
<td>• Question 3 should be broken into each question (3Qs in one paragraph)</td>
<td></td>
<td>2. Q3 reworded</td>
</tr>
<tr>
<td></td>
<td>• More space required for feedback re +ve and −ve (last page)</td>
<td></td>
<td>3. More space provided for feedback</td>
</tr>
<tr>
<td></td>
<td>• Questions relate to the topic very well</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Did not return</td>
<td>40 30</td>
<td>Verbal feedback in person regarding time</td>
</tr>
<tr>
<td>3</td>
<td>Multiply choice really tricky. This tool made me think whether I really knew the</td>
<td>25 25</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>differences between clinical reasoning and critical thinking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>• Did not like completing the form before the training, unsure if answers are right,</td>
<td>25 15</td>
<td></td>
</tr>
<tr>
<td></td>
<td>will be easier to complete after training.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Had to think too much about the questions,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>the first time to clarify what my understanding of the questions were. Would</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>have been easier to say critical thinking is this...(definition). How do you apply</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>this students in the clinical setting. But that may not be testing the</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>effectiveness of the pre course questionnaire.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>• Easy to follow</td>
<td>5 5</td>
<td>Check formatting for online completion</td>
</tr>
<tr>
<td></td>
<td>• Difficult to mark all areas of practice if practicing across several areas</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Text boxes changed font at times</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>• Overall, I found it easy enough to understand and didn’t find it ambiguous.</td>
<td>20 15</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>• The only point I found a little confusing was the secondary mentorship MCQ. This</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>may be because I wasn’t entirely sure of the answer given. There seemed lot</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>similarities between options.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>• I felt that the tool was clear and unambiguous. As I work at UNDA as a tutor and</td>
<td>20 30</td>
<td>All information is de-identified. This was</td>
</tr>
<tr>
<td></td>
<td>am currently doing research involving nurse education it may have been easier for</td>
<td></td>
<td>outlined in the initial email inviting participants</td>
</tr>
<tr>
<td></td>
<td>me to answer the questions quickly and feel more comfortable with the tool</td>
<td></td>
<td>to partake in the expert group. This email was</td>
</tr>
<tr>
<td></td>
<td>• I appreciated that enough time had passed that I could not remember what I had</td>
<td></td>
<td>attached the reminder email.</td>
</tr>
<tr>
<td></td>
<td>written on the last survey</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• I felt a slight discomfort at the thought they I may have been incorrect in my</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>definitions and the effect that could have on my</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

358
reputation as an educator. It was very tempting to look up a dictionary.
- As a researcher I appreciated the confidentiality of the information and that with large quantities of information that is de-identified my reputation is not affected. I am sure if this was expressed clearly to participants in the first survey. It wasn’t in the second one.

<table>
<thead>
<tr>
<th>No</th>
<th>Clarity</th>
<th>Very straight forward to use – quick and easy to answer although it would be simple to Google some of the responses in order to get right answers</th>
<th>10</th>
<th>7</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Biggest difficulty was completing form as a clinical supervisor who had not attended the study day program. The tool focuses on at beginning. I felt at times due this I may have been ‘stabbing in the dark’ with some of my answers.</td>
<td>20</td>
<td>15</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Not completed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>The tool was easy to use and answer</td>
<td>40</td>
<td>10</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Not returned</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Not returned</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Not returned</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>No comment</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>No comment</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>No comment</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>No comment</td>
<td>20</td>
<td>10</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>No comment</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>No comment</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>No comment</td>
<td>60</td>
<td>30</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>No comment</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>No comment</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>No comment</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>I have not formally read or learnt about many of the terms used. I used my knowledge and experience to describe my understanding of them.</td>
<td>15</td>
<td>15</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Difficult to use if haven’t done course/study but tried to answer from experience</td>
<td>10</td>
<td>15</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>No comment</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Felt like an exam I hadn’t studied for. Time consuming</td>
<td>-</td>
<td>-</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>
### TOOL RELIABILITY – participant scores and time to complete the survey

<table>
<thead>
<tr>
<th></th>
<th>SCORE 1</th>
<th>SCORE 2</th>
<th>DIFFERENCE</th>
<th>TIME 1</th>
<th>TIME 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>20.5</td>
<td>19.5</td>
<td>-0.1</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>2.</td>
<td>8.5</td>
<td>8.5</td>
<td>0</td>
<td>40</td>
<td>30</td>
</tr>
<tr>
<td>3.</td>
<td>15.5</td>
<td>16.5</td>
<td>+1</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>4.</td>
<td>12.5</td>
<td>12.5</td>
<td>0</td>
<td>25</td>
<td>15</td>
</tr>
<tr>
<td>5.</td>
<td>10.5</td>
<td>10.5</td>
<td>0</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>6.</td>
<td>15.5</td>
<td>15</td>
<td>-0.5</td>
<td>20</td>
<td>15</td>
</tr>
<tr>
<td>7.</td>
<td>6.5</td>
<td>7</td>
<td>+0.5</td>
<td>20</td>
<td>30</td>
</tr>
<tr>
<td>8.</td>
<td>12</td>
<td>12</td>
<td>0</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>9.</td>
<td>11</td>
<td>11</td>
<td>0</td>
<td>20</td>
<td>15</td>
</tr>
<tr>
<td>10.</td>
<td>7.5</td>
<td>8.5</td>
<td>+1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>11.</td>
<td>19</td>
<td>19</td>
<td>0</td>
<td>40</td>
<td>1</td>
</tr>
<tr>
<td>12.</td>
<td>14</td>
<td>10</td>
<td>-4</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>13.</td>
<td>16</td>
<td>17</td>
<td>+1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>14.</td>
<td>7</td>
<td>10.5</td>
<td>+3.5</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>15.</td>
<td>12</td>
<td>11.5</td>
<td>-0.5</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>16.</td>
<td>9</td>
<td>8</td>
<td>-1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>17.</td>
<td>14.5</td>
<td>14.5</td>
<td>0</td>
<td>15</td>
<td>20</td>
</tr>
<tr>
<td>18.</td>
<td>5.5</td>
<td>2</td>
<td>-3.5</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>19.</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>20.</td>
<td>17</td>
<td>17</td>
<td>0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>21.</td>
<td>8.5</td>
<td>8.5</td>
<td>0</td>
<td>60</td>
<td>30</td>
</tr>
<tr>
<td>22.</td>
<td>8</td>
<td>6.5</td>
<td>-1.5</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>23.</td>
<td>2</td>
<td>0</td>
<td>-2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>24.</td>
<td>5</td>
<td>5.5</td>
<td>+0.5</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>25.</td>
<td>4</td>
<td>3.5</td>
<td>-0.5</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>26.</td>
<td>14.5</td>
<td>11.5</td>
<td>-3</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>27.</td>
<td>10</td>
<td>6</td>
<td>-4</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>28.</td>
<td>12.5</td>
<td>11.5</td>
<td>-1</td>
<td>25</td>
<td>5</td>
</tr>
<tr>
<td>29.</td>
<td>21</td>
<td>18.5</td>
<td>-1.5</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>30.</td>
<td>18</td>
<td>18</td>
<td>0</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
## Participant List

<table>
<thead>
<tr>
<th></th>
<th>Position</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Lecturer and clinical facilitator</td>
<td>16 RN &amp; TAFE lecturer</td>
</tr>
<tr>
<td>2</td>
<td>Clinical Facilitator</td>
<td>17 RN</td>
</tr>
<tr>
<td>3</td>
<td>Lecturer and Clinical Facilitator</td>
<td>18 RN</td>
</tr>
<tr>
<td>4</td>
<td>Clinical Facilitator</td>
<td>19 Clinical Nurse</td>
</tr>
<tr>
<td>5</td>
<td>Director of Nursing, private sector</td>
<td>20 RN</td>
</tr>
<tr>
<td>6</td>
<td>Lecturer and Clinical Facilitator</td>
<td>21 RN</td>
</tr>
<tr>
<td>7</td>
<td>Clinical Facilitator</td>
<td>22 CN</td>
</tr>
<tr>
<td>8</td>
<td>Lecturer and Clinical Facilitator</td>
<td>23 RN</td>
</tr>
<tr>
<td>9</td>
<td>Clinical Facilitator</td>
<td>24 RN</td>
</tr>
<tr>
<td>10</td>
<td>Lecturer and Clinical Facilitator</td>
<td>25 A/Clinical Nurse</td>
</tr>
<tr>
<td>11</td>
<td>Lecturer and Clinical RN</td>
<td>26 RN</td>
</tr>
<tr>
<td>12</td>
<td>Clinical Nurse</td>
<td>27 RN</td>
</tr>
<tr>
<td>13</td>
<td>Staff Development Educator</td>
<td>28 RN</td>
</tr>
<tr>
<td>14</td>
<td>Staff Development Educator</td>
<td>29 RN</td>
</tr>
<tr>
<td>15</td>
<td>RN</td>
<td>30 RN</td>
</tr>
</tbody>
</table>
Appendix 20: Marking Tool for Knowledge Surveys

MARKING TOOL FOR KNOWLEDGE SURVEY

- **Multi-choice:** Correct questions have been highlighted
- All other questions have a marking guide criteria included within this form
- Allocation of marks included within text boxes
- Total score of 24

**What do you understand by the term Secondary mentorship?**

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>The relationship between two staff of the same organisation at a senior management level designed to assist with career progression</td>
</tr>
<tr>
<td>B</td>
<td>The relationship between two staff at a senior management level designed to assist with career progression</td>
</tr>
<tr>
<td>C</td>
<td>A short term relationship between two individuals, one the mentor the other the mentee, to assist with professional growth and development</td>
</tr>
<tr>
<td>D</td>
<td>A short term relationship between two individuals designed to assist with career progression</td>
</tr>
</tbody>
</table>

**What do understand by the term Critical Thinking?**

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Involves the ongoing commitment of the individual to examine any belief or knowledge in the light of the evidence that supports it.</td>
</tr>
<tr>
<td>B</td>
<td>Involves forming conclusions, making decisions drawing inferences and reflecting</td>
</tr>
<tr>
<td>C</td>
<td>Is based on experience and pattern recognition processed at a subconscious level</td>
</tr>
<tr>
<td>D</td>
<td>Involves accurately solving problems</td>
</tr>
</tbody>
</table>

**How do you apply critical thinking in the clinical setting with students?**

*Encouraging Self Reflection of known knowledge, what are the gaps*

<table>
<thead>
<tr>
<th>Activity</th>
<th>Marking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Study analysis/patient care analysis</td>
<td>½ mark</td>
</tr>
<tr>
<td>Review current literature/policies/procedure manuals</td>
<td>1 mark</td>
</tr>
<tr>
<td>Encourage students to discuss ideas in small groups, or review journals/policies etc.</td>
<td>2 marks</td>
</tr>
<tr>
<td>Critical incident debrief/analysis question care delivered, why?</td>
<td>½ mark for each point, max mark of 2</td>
</tr>
</tbody>
</table>
What do you understand by the term Clinical Reasoning?

A A health professional implementing Best Practice for the clinical care of a patient
B The thought processes that occur when a health professional engages in clinical problem solving
C The thought process used by health professionals to analyse data
D The thought process used by health professionals to plan patient care

How do you apply Clinical Reasoning with students?

Encouraging Self Reflection of the information
Case Study analysis and/or patient simulation
Review current context and relate known information
Discuss concept/care with student

What does the term Reflection mean to you?

A An individual reviewing past experiences
B A process in which we analyse a situation
C Developing a new framework for future practice
D How we explore our actions

How do you apply the principles of Reflection with students?

Guided reflection – supervisor with student
Encouraging the student to right down their thoughts and actions and explain these
Discussing an episode of patient care with the student
Reflection in action, as well as reflection on action
Guided reflection – supervisor with student
14. Can you explain the following terms?  

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educator</td>
<td>A person who teaches or educates</td>
</tr>
<tr>
<td></td>
<td>A person who passes on knowledge and/or skills</td>
</tr>
<tr>
<td></td>
<td>A person with a qualification, able to teach others</td>
</tr>
<tr>
<td>Socialiser</td>
<td>Providing an individual with the knowledge and skills to participate within a group</td>
</tr>
<tr>
<td></td>
<td>Invite, welcome, involve an individual into a team</td>
</tr>
<tr>
<td>Advocate</td>
<td>A supporter or a defender</td>
</tr>
<tr>
<td></td>
<td>One that argues for another</td>
</tr>
<tr>
<td>Assessor</td>
<td>A person who evaluates performance</td>
</tr>
<tr>
<td></td>
<td>A person who provides feedback regarding performance</td>
</tr>
<tr>
<td>Role Model</td>
<td>A person regarded by others</td>
</tr>
<tr>
<td></td>
<td>A good example to follow, model of excellence,</td>
</tr>
<tr>
<td></td>
<td>A person who inspires</td>
</tr>
<tr>
<td></td>
<td>A guide</td>
</tr>
<tr>
<td>Belongingness</td>
<td>Belongingness relates to the relationship between a student nurse and the nurse supervising their practice and the ward's level of support. A positive sense of belongingness provides motivation, confidence, promotes self-direction and questioning</td>
</tr>
</tbody>
</table>

15. How do you currently provide feedback to your students?

Positive: *immediately/as soon as possible*, allow opportunity for *reflection* to assist the student to realise the *positive features* of their practice and *how to continue to improve* and develop as a professional.

**Improvement Required:**

- **Why:** are you giving it
- **When:** are you giving it
- **What:** are you going to say
- **How:** are you going to say it
- **Who:** is going to be present
- **Where:** are you going to say it
- **Documentation**

Set objectives and strategies for future practice

*Will the university/TAFE be informed*

16. Define the term Competence?

The essential *knowledge, skill* and *attitudes* required for effective performance at the *required level*
Appendix 21: Reliability of Knowledge Survey Results

From: Max Bulsara
To: Kylie Russell
Subject: RE: PhD reliability testing of survey

Reliability Statistics

<table>
<thead>
<tr>
<th>Cronbach's Alpha</th>
<th>N of Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>.976</td>
<td>2</td>
</tr>
</tbody>
</table>

Intraclass Correlation Coefficient

<table>
<thead>
<tr>
<th></th>
<th>95% Confidence Interval</th>
<th>F Test with True Value 0</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lower Bound</td>
<td>Upper Bound</td>
</tr>
<tr>
<td>Single Measures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Measures</td>
<td>.976</td>
<td>.949</td>
</tr>
</tbody>
</table>

Two-way random effects model where both people effects and measures effects are random.
a. The estimator is the same, whether the interaction effect is present or not.
b. Type C intraclass correlation coefficients using a consistency definition—the between-measure variance is excluded from the denominator variance.

Professor Max K. Bulsara, PhD, MSc, BSc(Hons)
Chair in Biostatistics
(Adjunct Professor UWA School of Population Health
Visiting Professor University College London)
Institute of Health and Rehabilitation Research,
University of Notre Dame,
19 Mouat Street,
P.O Box 1225, Fremantle, WA 6959
Tel: (08) 9433 0297
Fax: (08) 9433 0210
Email: max.bulsara@nd.edu.au
CRICOS code: 01032F
Appendix 22: Email to Health Care Facilities to Promote the Clinical Supervision Program for Registered Nurses

Dear colleagues,

As you may be aware I am completing my PhD, which involves the introduction of a new education program titled ‘The Clinical Supervision Program for Registered Nurses’

This study day program will be available for free on campus at Notre Dame on the 8th and 9th May and the 5th of June. If you have any staff that would like to attend the day can you please either ask them to complete the attached application form, or alternatively forward their name and email address to me.

Participants will be given a certificate of attendance from the university and provided with morning and afternoon tea.

The day is particularly for registered nurses and staff development nurses. The aim of the day is provide staff with the essential knowledge and attitudes to supervise students in the workplace.

The study day contents include:

· Clinical supervision
· Principles of adult learning
· Application of critical thinking and clinical reasoning
· Belongingness
· Competency and assessment
· Provision of feedback.

The day does involve a research component, and I have attached the information sheet and consent that participants will be asked to sign on the day.

I am also currently working with the DoH and presenting this day at Hospital, Hospital and Hospital. This is therefore an opportunity for staff to attend this day outside of these sites.

PROGRAM DETAILS: 0800-1600

<table>
<thead>
<tr>
<th>Date</th>
<th>Room</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuesday 8th May</td>
<td>ND43/301</td>
</tr>
<tr>
<td>Wednesday 9th May</td>
<td>ND36/102</td>
</tr>
<tr>
<td>Tuesday 5th June</td>
<td>ND 43/201</td>
</tr>
</tbody>
</table>

(I have attached a map of the university also for the room details.)

I appreciate your assistance with forwarding this information on to interested staff.

Kind Regards

Kylie

Kylie Russell, PhD Candidate
School of Nursing and Midwifery, Fremantle Campus, The University of Notre Dame,

Attachments: Participant Information Sheet – Appendix 27, Participant Consent – Appendix 28, Application flyer – included, Application form – included, Map of University – not included
THE CLINICAL SUPERVISION PROGRAM FOR REGISTERED NURSES

The Clinical Coordinator for the School of Nursing and Midwifery at Notre Dame University as a part of a research study will be presenting programs in 2012 for REGISTERED NURSES working within the hospital or community care sector who provide direct supervision to RN students.

This 1-day program is designed to assist nursing staff to undertake the role of clinical supervision with student nurses in the workplace.

For further information and enrolment please contact: Kylie Russell RN

Kylie.russell@nd.edu.au
or call 9433 0183

These sessions will be presented at the University of Notre Dame, School of Nursing and Midwifery, Fremantle Campus.

2012 Dates
- Tuesday 8th May
- Wednesday 9th May
- Tuesday 5th June
Course Registration Form

The Clinical Supervision Program for Registered Nurses

Please print clearly and fully complete.

Registration confirmation will be forwarded to applicants within 2 weeks of registration received. If you do not receive confirmation please contact Kylie Russell on 9433 0183 or email kylie.russell@nd.edu.au

| APPLICANT DETAILS |
|-------------------|-----------------|
| Family Name:      | Given Name:     |
| Employer:         | Area:           |
| Contact Number:   | Contact email:  |
| Years of Nursing experience: |

**DATE PREFERENCE** *(Please tick preferred date, or both if available for either)*

- Seminar 1 May 8th
- Seminar 2 May 9th
- Seminar 3 June 5th

- All seminars will be presented at the School of Nursing and Midwifery at the University of Notre Dame Australia – Mouat Street Fremantle.
- This study day is involved in a research project conducted by Kylie Russell RN. An Information Sheet and Consent form will be sent to you on application. Please read these carefully.
- If you have any queries please contact Kylie Russell on 9433 0183, or email kylie.russell@nd.edu.au
- The program will run between 0800 to 1630.

Please ensure that you apply to your employer for any necessary leave requirements to attend this program.

**Please send completed form to:**

**EMAIL** (scanned form)  
kylie.russell@nd.edu.au

**FAX**  
(08) 9433 0227

**POST**  
Kylie Russell  
School of Nursing and Midwifery  
The University of Notre Dame, Australia  
PO Box 1225  
Fremantle WA 6959
Dear Colleague,

Your health care facility has agreed to the presentation of the Clinical Supervision Program. This one day study day program has been designed to assist staff acquire the necessary knowledge and attitudes to supervise a nursing student.

This program is a part of a research project, and as such participants will be asked to consent to the projects data collection methods. Can I please ask that you forward to participants a copy of the research project consent and information sheet (attached). My details are included within these fact sheets if participants have any queries or concerns. The research approval and ethics approval have been forwarded to the Director of Staff Development.

Session Details:

Date:

Time: 0800 – 1630

Requirements:

- Seminar Room with tables for 20 participants
- Multimedia projector
- White Board

Lollies, morning and afternoon tea will be provided. I will also bring butcher paper, highlighters, pen and the participants work files. Certificates for the participants will be posted at a later date. Participants will need to provide their own lunch.

Can I please ask that you send me a copy of the flyer for the program, and that this includes information about the research component of this day.

Thank you for your assistance with organising the study day.

Kind Regards

Kylie Russell

Kylie.russell@nd.edu.au

0407386102
Appendix 24: Participants’ Consent for Online Reflections

CONSENT FOR ON-LINE REFLECTIVE FEEDBACK PARTICIPATION

Dear Participant,

If you are willing to be involved in the ongoing on-line reflective feedback following this program for eight weeks please place your name and email address below.

You will be contacted by email to confirm your participation and the on-line reflective feedback process.

In summary, participants will be contacted each week, for eight weeks, by email from the program presenter. The following dot points are a guide for you to follow when sending an email.

- Write a narrative of your interactions with students. This may be a summary of a shift or a particular instance of teaching, providing feedback, interactions with student and/or other staff.
- You may wish to relate these experiences to your personal growth and development as a supervisor, and/or what you would like to know more about.
- The more detail of the event/experience provided will assist the researcher to understand the moment/event.
- Please use full sentences and minimise abbreviations to assist the researcher to understand your intent.
- Do not include names or the student’s university details.

<table>
<thead>
<tr>
<th>NAME</th>
<th>EMAIL ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 25: Example of Weekly Email for Online Reflection Participants

From: Kylie Russell <kylie.russell@nd.edu.au>
Subject: On line reflective feedback - week one
Date: 30 July 2012 11:06:11 AM AWST

Dear participant,

Thank you for agreeing to participate in the on-line reflective feedback sessions after attending the study day “Clinical Supervision Program for Registered Nurses”.

Your feedback will assist with the evaluation of the impact of the study day, and therefore assist us to ensure that we provide quality education that supports registered nurses in their role of supervisor to student nurses.

If you wish to provide any feedback for this week 1, of the eight-week reflective feedback cycle, all you need to do is click the ‘reply’ button, and my email address will be there for you.

Remember your involvement with the supervision of students may be as the result of you supervising a student (even for a few hours), you witnessing another colleague supervising a student, as a coordinator allocating students or as a resource person (Staff Development Nurse/Manager) assisting others supervising a student.

When addressing your feedback, I have listed some suggestions for you as to how you may write your thoughts.

- Write a narrative of your interactions with students
- This may be a summary of a shift or a particular instance of teaching, providing feedback, interactions with student and/or other staff.
- You may wish to relate these experiences to your personal growth and development as a supervisor, and/or what you would like to know more about.
- The more detail of the event provided will assist the researcher to understand the moment/event.
- Please minimize abbreviations to assist the researcher to understand your intent. The researcher will email participants for clarification if the reflection entry is not understood.
- Do not include names or the student’s university details.

All feedback will be confidential, and your personal details (name, email address) will be removed prior to the data being used for the research project.

If you have any queries or would like to be removed from this email distribution list please do not hesitate to contact me via email or phone 9433 0183.

Again thank you for your commitment to this research.

Kind Regards

Kylie Russell
PhD Candidate
School of Nursing and Midwifery, Fremantle Campus
The University of Notre Dame, Australia
19 Mouat Street, Fremantle WA 6959
Appendix 26: Letter of Appreciation for Research Program Participants

*DATE*

Dear ______

RE: Clinical Supervision Program for Registered Nurses

I would like to take this opportunity to thank you for your time and sharing of your thoughts and ideas in relation to the Clinical Supervision Program for Registered Nurses. This research project would have not been possible without the support of nurses like yourself who were willing to donate their time in completing the surveys, online reflections and speaking to me for the research interviews.

I am now in the final stages of analyzing the research data, and I believe that the findings of this research have the potential to have an significant impact on the delivery of clinical supervision education in Western Australia.

As promised at the study day, I will let all participants know when the project is fully completed and a summary of the findings will be forwarded by email.

Again thank you for volunteering, and I wish you all the best in your nursing career and clinical supervision experiences.

Kind Regards

Kylie Russell

PhD Candidate
School of Nursing and Midwifery
Fremantle Campus
The University of Notre Dame, Australia
19 Mouat Street, Fremantle WA 6959
Dear Colleague,

My name is Kylie Russell and I am a current research student at the University of Notre Dame, Australia within the School of Nursing and Midwifery. My research relates to my current work role of Clinical Coordinator, in which I am responsible for all aspects of the School of Nursing and Midwifery Clinical Practicum Program. My project is the introduction of a new education program for registered nurses to assist in the supervision of student nurses.

You are receiving this information because you have registered your interest to attend this new education program

WHY INTRODUCE THIS PROGRAM.

The HealthWorkforce Australia, Clinical Supervisor Support Program-Discussion Paper (2010) has called upon hospitals and universities for all health professions to review the current education and support provided to health professionals working with students. The paper has suggested the creation of a multidisciplinary package for all staff followed by profession specific education. This program has been designed to provide nursing staff with the information required for the clinical supervision of students.

THE PROGRAM

The program has been designed from my experience in managing both graduate and undergraduate programs within the hospital and university sector and the literature.
**What does this research involve?**

You are invited to participate in the research project evaluation. This will involve the completion of:

1. **A pre survey questionnaire** – completed on the day of the program
2. **2 post survey questionnaires** - completed on the day of the program and at eight weeks later (by post or email)
3. **Provide regular feedback for eight weeks outlining your experiences supervising after the program** - via email
4. **And the possibility of an interview** – 2 to 3 months post the program day. This interview will be taped and converted into written text

It is anticipated that the questionnaires will take between 5-10 minutes to complete. You will be contacted by phone or email (per your preference) regarding the dates and times for interviews. These will take place at the University (or your workplace if preferred, depending on meeting space availability) and at regional centres for regional presentations, this will take approximately 1 hour to complete.

**Voluntary Participation and Withdrawal from the Study**

Participation in this study is purely voluntary. If you choose to participate and then wish to withdraw from this study at any time, you may do so for whatever reason.

**Privacy, Confidentiality and Disclosure information**

If you agree to participate in the research study, any information collected will only be used by the researcher and will not be disclosed to anyone else. No information that might identify you will be used in either the analysis or any publication. All information will be stored at the University in a locked cabinet, and will be destroyed 5 years after completion.

**If you have any further questions concerning the study contact Kylie Russell: 9433 0183**

Thank you for your consideration.

Kylie Russell, PhD Candidate

<table>
<thead>
<tr>
<th>PARTICIPANT’S SIGNATURE:</th>
<th>DATE:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>RESEARCHER’S FULL NAME:</th>
<th>KYLIE RUSSELL</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>RESEARCHER’S SIGNATURE:</th>
<th>DATE:</th>
</tr>
</thead>
</table>

*If participants have any complaint regarding the manner in which a research project is conducted, it should be directed to the Executive Officer of the Human Research Ethics Committee, Research Office, The University of Notre Dame Australia, PO Box 1225 Fremantle WA 6959, phone (08) 9433 0943.*
Appendix 28: Research Program Participants’ Consent

<table>
<thead>
<tr>
<th>PARTICIPANT’S SIGNATURE:</th>
<th>DATE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>RESEARCHER’S FULL NAME:</th>
<th>KYLIE RUSSELL</th>
</tr>
</thead>
<tbody>
<tr>
<td>RESEARCHER’S SIGNATURE:</td>
<td>DATE</td>
</tr>
</tbody>
</table>

If participants have any complaint regarding the manner in which a research project is conducted, it should be directed to the Executive Officer of the Human Research Ethics Committee, Research Office, The University of Notre Dame Australia, PO Box 1225 Fremantle WA 6959, phone (08) 9433 0943.
Appendix 29: Letter Sent to Program Participants with Eight-week Survey and Certificate

Dear colleague,

Please find enclosed your certificate of attendance to the ‘Clinical Supervision Program for Registered Nurses’. I hope that you found the study day rewarding and it assisted you in your role as a clinical supervisor to students.

You will also find enclosed two follow up surveys. These are designed to determine if the study day has had a longer term impact in regards to participants understanding of the supervisor role. I would be very grateful if you could take the time to complete this and return. I have placed on the form your unique id code. Once this final stage is completed your name will be removed from all data sources linking you to this code.

If you wish to indicate on the form that you are happy to be interviewed for a part of this research, can you please ensure that you write your preferred contact details on this letter and return by either:

- Fax – 9433 0227
- Scan and email – kylie.russell@nd.edu.au
- Or use the reply paid envelope.

Thank you for your time and effort in assisting with this project.

Kind Regards

Kylie Russell, PhD Candidate,
The University of Notre Dame, Australia

I am happy to be interviewed for this research project,
Name: __________________________________________
Preferred contact: __________________________________________
Insert name

attended
The Clinical Supervision Program for Registered Nurses (8 hours), and
participated in the adjoined research project (2 hours)
Appendix 30: Conference Presentations of Research Project

- **Accepted for Australasian Nurse Educators conference Wellington, October 2013**
  - The Art of Clinical Supervision, The implementation and evaluation of a clinical supervision program for registered nurses in Western Australia
- **ANZAHPE June, 2013**
  - Poster: The Art of Clinical Supervision, its impact on nursing staff knowledge and attitude
- **‘14th National Nurse Education’ conference Perth, March 2012**
  - The development of the ‘Clinical Supervision Program for Registered Nurses’
Appendix 31: The Art of Clinical Supervision Advertising Poster

The students of today will be our leaders of tomorrow. Our future health professionals are in your hands.

The program includes discussion and activities on:
- Clinical Supervisor Roles
- Adult Learning
- Belongingness
- Assessment and Feedback
- Critical Thinking and Clinical Reasoning
- Reflective Practice
- Supporting Students
- Implementation Into Practice
- Putting the heart back into learning

For further information and applications, please contact your Ward/Unit Manager

Our students, our future

This project was made possible due to funding made available by Health Workforce Australia