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The art of Clinical Supervision Program for registered nurses

Kylie P. Russell
The University of Notre Dame, Australia

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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 corroboration of 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
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.

| Phase 1 | • Development of the program  
| | • Development of the research tools |
| Phase 2 | • Feedback from expert group regarding program  
| | • Validity and reliability testing of knowledge survey tool by expert group |
| Phase 3 | • Modify program and/or tools as a result of phase 2 |
| Phase 4 | • Implementation of the program  
| | • Completion of the pre-survey by participants to establish a baseline of knowledge/attitude, and demographic data of the sample population  
| | • Completion of the immediate post-survey by participants |
| Phase 5 | • On-line reflective feedback: Weekly emails to participants seeking feedback/reflection of experiences supervising/interacting with students  
| | • Post-seminar survey at eight weeks |
| Phase 6 | • Interviews |

**Figure 3.4: Phases of the research process**

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.

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 Levet-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
• Roles of the Clinical Supervisor
• Benefits and Barriers
• Adult Learning and Learning Styles
• Critical Thinking, Clinical Reasoning and Reflection
• Belongingness
• Competency and Assessment
• Communication and the Provision of Feedback
• Summary and Close.

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><strong>The need to know</strong></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><strong>The learner’s self-concept</strong></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 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><strong>The role of experience</strong></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><strong>Pedagogy (P)</strong></td>
<td><strong>Andragogy (A)</strong></td>
<td><strong>Application—A or P</strong></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>A: 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>P: 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. A: Application of information is then achieved through group discussion, case studies and group activities to give a real-life practical approach to the topic.</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>P: The facilitator acts as a role model to the group, rewarding the group through positive feedback. A: 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.</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>Positive</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>Indifferent:</td>
<td>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>
</tr>
<tr>
<td>Negative:</td>
<td>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>
</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.
**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.

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**Figure 3.7: Theories and principles of learning and attitude applied to the CSP**
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>
</table>
| What is the pre-program knowledge of nursing staff in relation to the principles of clinical supervision? | A score to determine the level of knowledge of the participants | • Multi-choice questions  
• Short-answer questions, score allocated according to marking sheet | Quantitative |
| 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? | A score to determine the level of knowledge of the participants  
• Participant words, written and spoken, related to their perceptions of change | • Multi-choice questions and short-answer questions, score allocated according to marking sheet  
• Short-answer questions for participants to articulate their self-perception of learning | Quantitative  
Qualitative |
| Upon completion of the program, what do nursing staff perceive has changed about their knowledge and attitudes towards providing effective student supervision? | Participant words, written and spoken, related to their perceptions of knowledge and attitude change | • Short-answer questions for participants to articulate their self-perception of learning  
• Online reflective feedback  
• Interview | Qualitative |
| Do participants perceive a different effect from this program compared to other clinical supervision education? If so, why? If not, why not? | Participant words, written and spoken, related to their perceptions of knowledge and attitude change | • Short-answer questions for participants to articulate their self-perception of learning  
• Online reflective feedback  
• Interview | Qualitative |
| Do nursing staff believe that the program assisted them to undertake this role more effectively? If so, why? If not, why not? | Participant words, written and spoken, related to their perceptions of knowledge and attitude change | • Short-answer questions for participants to articulate their self-perception of learning  
• Online reflective feedback  
• Interview | Qualitative |
| Do participants perceive that they have changed their attitudes towards nursing students after attending the program? | Participant words, written and spoken, related to their perceptions of knowledge and attitude change | • Short-answer questions for participants to articulate their self-perception of learning  
• Online reflective feedback  
• Interview | Qualitative |
| Is there a change in participants’ attitudes towards nursing students after attending the program? | A score to determine the attitude of the participants | • Five-point Likert scale attitude survey by Stagg (1992) | Quantitative |

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.

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>
<tr>
<td>No. of Items</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>Intraclass Correlation Coefficient</td>
</tr>
<tr>
<td>------------------------------------</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Single Measures</td>
</tr>
<tr>
<td>Average Measures</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.

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.
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.

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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.