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## Promoting student belongingness: The development, implementation and evaluation of a toolkit for nurses

Christine King

*The University of Notre Dame Australia*

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# **Promoting Student Belongingness**

The Development, Implementation and Evaluation of a  
Toolkit for Nurses

**Christine King**

**20143858**

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

School of Nursing and Midwifery  
The University of Notre Dame, Australia

2018

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## List of Abbreviations

ABF	Activity-based funding
ACS	Art of Clinical Supervision
AHPRA	Australian Health Professional Registration Authority
ANMC	Australian Nursing and Midwifery Council
ANMAC	Australian Nursing and Midwifery Accreditation Council
CF	Clinical facilitator
CINAHL	Cumulative Index to Nursing and Allied Health Literature
CN	Clinical nurse
COAG	Council of Australian Governments
CPD	Continuing professional development
CS	Clinical supervisor
CSSP	Clinical Supervisor Support Program
DOF	Depth of Field: Exploring Ageing
DoH	Department of Health
EN	Enrolled nurse
ENB	English National Board
FTE	Full-time equivalent
HREC	Human Research Ethics Committee
HWA	Health Workforce Australia
ICU	Intensive care unit
IHPA	Independent Hospital Pricing Authority
LMS	Learning management system
NHMRC	National Health and Medical Research Council

NMBA	Nursing and Midwifery Board of Australia
NMC	Nursing and Midwifery Council (UK)
NPA	National Partnership Agreement
NSCCA	Nursing Students Contributions to Clinical Agencies
NSQHS	National Safety and Quality Health Service
NSW	New South Wales
PsycINFO	PsycINFO (American Psychological Association Database)
QSR NVivo	Qualitative Software for Research
QUAL	Qualitative
QUANT	Quantitative
RAND	Research and development
RN	Registered nurse
SCORM	Shared Content Object Reference Model
TTR	Teaching, training and research
UK	United Kingdom
UKCC	United Kingdom Central Council
WHO	World Health Organization

## Abstract

The literature suggests that the need to belong to a community influences health and wellbeing, which in turn affects behavioural, and cognitive responses. However, student nurses are often in a vulnerable position of being excluded intentionally or otherwise from ward/unit activities. This can lead to feelings of isolation and poor achievement.

The aim of this project was to design and develop a toolkit for nurses in an e-learning format using reflective learning to promote a sense of belonging and inclusion of student nurses in the clinical team. Upon completion of the development of the e-learning program, distribution commenced to selected clinical areas for use by nurses before periods of clinical practicum for students. The e-learning program can be accessed at <https://wanted.moodle.school/login/index.php> (see Appendix 12 for e-learning instructions to register).

A sequential mixed method design was used, which employed the results of the initial qualitative phase to inform the following quantitative phase. The qualitative phase consisted of three rounds of open questionnaires using the Delphi panel method with 18 participants. Themes emerged and were expanded upon during the process to inform the design of the framework for the toolkit. The quantitative data that were subsequently collected reported on the evaluation of the toolkit's applicability, usefulness and sustainability.

An e-learning package entitled WANTED was subsequently developed to address the major themes of Welcome, Attitude, Nurture, Team, Encourage (autonomy) and Delight (in success of student inclusion). The interactive program, which included pre- and

post-questionnaires based on Stagg's attitude survey (1992), was offered to a random selection of nurses in Western Australia to participate in the activity and comment on the usability of the tool. Twenty-three completed programs identified that attitude change towards student nurses could be improved and that the e-learning format gave excellent information that reflected and supported traditional training.

Addressing issues of student integration into the nursing team and creating a belongingness environment with the use of practical tools will encourage and enable a fundamental shift in attitude towards students. This project has considered individual personal values and characteristics, the effect of the direct environment and the need to belong in order to create a learning environment.

## **Statement of Candidate Contribution**

### **Declaration of Authorship**

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

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

---

Christine Louise King

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Date

This is dedicated to my dear friend, Chris Andrew,  
who for many years welcomed and supported  
hundreds of students and graduates in her administrative role  
in the Education Department at Fremantle Hospital.  
Her kindness and dedication made their journey easier.



## Acknowledgements

My heartfelt thanks must go to my Principal and Co-Supervisor, Associate Professors Kylie Russell and Caroline Bulsara. Their belief in me being able to complete this project has been outstanding, and their continual support throughout this process has been unwavering. Without them, I do not think I would ever have completed my long-held aspiration.

To my patient husband Colin: without his technical and moral support, I would not have been able to overcome some of the hurdles along the way. He has helped me to believe that anything is possible, even when it does not look that way. You just have to have the courage to keep at it!

Thanks to all those who participated in the Delphi panel. It was very encouraging that you returned for each of the three rounds of questions, and your input was invaluable when I needed varying viewpoints and insights to develop the WANTED toolkit.

My thanks to all those who undertook the e-learning program. Your participation was essential for the completion of this project.

Thanks also to the Western Australian Nursing and Midwifery Office for their support by awarding the grant that enabled me to obtain essential software, produce video material and write the e-learning program and additional information for this project.

To all the students, lecturers, volunteers from the University of Notre Dame Australia and my work colleagues who kindly acted in all of the videos, I want to say a big thank you for bringing the stories to life. You were all truly professional.

Thank you to Mark Sutton, who patiently photographed, edited and produced all of the videos in the e-learning package, and to my friend Glennis, who meticulously read my drafts and checked for the inevitable typos.

Finally, to my terrific children and lovely grandchildren, thank you for believing that I could do this, and I hope that you all succeed in your dreams.

## Awards, Conference Presentations and Publications

### Awards

- Nursing & Midwifery Office Fellowship—2017  
Academic Support Grant Award
- Nursing & Midwifery Office Fellowship—2015  
Academic Research Grant Award

### Conference Presentations

- Australia and New Zealand Association for Health Professional Educators  
Conference 2013—Melbourne
- Nursing & Midwifery Leadership Conference 2015—Perth
- Getting to the Heart of Nursing and Midwifery Research (UNDA, Fremantle)  
2016
- International Conference of Innovative Nursing 2016—Perth
- 6<sup>th</sup> World Nursing and Healthcare Conference 2016—London, UK
- 12<sup>th</sup> National Nurses Education Conference 2018—Melbourne

### Publication

King, C., Russell, K., & Bulsara, C. (2017). Promoting student belongingness: 'WANTED'—The development, implementation and evaluation of a toolkit for nurses. *Australian Journal of Advanced Nursing*, 34(3), 48–53. Retrieved from [http://www.ajan.com.au/ajan\\_34.3.html](http://www.ajan.com.au/ajan_34.3.html) (see Appendix 29)

## Prologue

For many years, I have been involved in the education of student nurses, graduates, nurses and interdisciplinary clinicians. Much of my experience has entailed working alongside students in the clinical setting and listening to their stories, as well as advising on working parties with the intention of improving clinical placements. Early in my career, I gained a strong belief that it is extremely important to support students both clinically and psychologically; however, nurses have very little training for this role.

Having trained in the hospital system, I am aware of how critical it is for nurses to be educated to a level that meets the needs of increasingly complex healthcare. I undertook a Teaching and Assessing qualification and then an Honours Degree in Nursing Education in the United Kingdom to ensure that I could deliver the standard of education necessary for all students. At this time, I met a very enthusiastic lecturer who was passionate about undergraduate education and extremely knowledgeable. She encouraged me to use my nursing skills as tools for teaching and training, which started my journey towards this study.

My involvement with students and graduates continued upon arrival in Australia. As a student and graduate coordinator, I became aware of the many issues surrounding clinical placements and the pressure placed on nursing staff. I joined a working party that was a collaboration between health services and education facilities to explore the redesign of the models of clinical placement with a view to beginning a process of change. During this time, I became aware of the work being done by Dr Kylie Russell and Anne Hobson at a tertiary hospital to improve clinical supervision. Subsequently, I was engaged to be part of the team as an educator for the Clinical Supervision Program, which focused on a team approach and the attitude of staff to

embrace students to create a proactive learning environment. When delivering the program, I realised the importance of workplace culture, and I perceived that many who undertook the program made positive changes to their attitudes as well as those of their colleagues.

For the past few years I have continued my career in education as a Unit Coordinator for an interdisciplinary training centre for sub-acute care. This diverse role supports education for clinicians and students across the state and focuses on team building, compassionate care for self and others, goal setting and person-centred care in the clinical setting. During this time, the use of technology has become an important part of delivering education. I have encouraged, supported and developed the use of videos and e-learning as part of the blended learning programs because I believe they are valuable tools for the future (see Appendix 25).

I reflected on this work and saw an opportunity to expand education and training in supervision for nurses. Upon commencing my study, I sought nurse clinicians' opinions to develop strategies for enhancing student belongingness and wellbeing and to create a toolkit to meet this need.

As a result, I have contributed to supporting supervising nurses using modern technology. The use of e-learning will enable them to understand how to change clinical placements for the better. Although time is an issue for many healthcare workers, education is still paramount if standards are to be maintained. New methods for delivering important messages must be found, supported and progressed.

## Chapter 1: Introduction

*Belongingness is intrinsic in humans with the need to belong and be accepted by their social group, a fundamental element in social interactions.* (Block, 2008)

This chapter will provide a background to the research context and reflect on the considerable body of literature that maintains that clinical placements are essential for professional socialisation. Adapting to this professional culture, nursing students are influenced by nurses who are compelling role models for how to think, feel and act. To emulate the core values of the nursing profession, which are essentially compassion, empathy and caring for others' wellbeing (Curtin, Horton, & Smith, 2012), students need to gain a sense belonging to their chosen profession. The inclusive behaviour of a clinical team can exert a powerful influence on cognitive processes and behavioural responses, but the absence of meaningful interpersonal relationships can result in failure to develop holistically (Ali & Panther, 2008). To reflect on the social and cultural norms, this study will provide a description of the clinical learning environment, the preparedness and willingness of nurses to support student learning and how belongingness can support learning and be embedded in the clinical environment. This will be followed by the research questions of this project and a description of the theses chapters to follow.

### 1.1 Background

'Where are we going to put them all?' (Morrison & Brennaman, 2016) is a common phrase heard not only from clinical coordinators of universities, but also from nurse managers, supervisors and nursing staff. The increase in nursing students across the globe to meet continuing workforce demands (World Health Organization [WHO], 2010) requires the clinical environment to provide an authentic context for nursing students to acquire essential skills, including values and attitudes of the nursing

profession (Levett-Jones, 2012). However, in contrast with these needs, experiential and anecdotal evidence suggests that nursing students on clinical placements often experience antipathy, which can adversely affect their sense of belonging in the clinical setting and ultimately their decision to remain in the profession (Gilbert & Brown, 2015). Somers (1999, p. 16) defined belongingness as the 'need to be' and perceptions of being involved with others at differing interpersonal levels, which contributes to one's sense of connectedness. This thesis intends to conceptualise a study that identifies knowledge gaps in nursing preparation for student supervision. These gaps ultimately influence the success of clinical placements; therefore, alternative options for models of clinical supervision and education need to be developed for the future of nursing. By examining the literature and collecting data from nurses working with students, the researcher intends to address these longstanding and multidimensional issues. The researcher's experience working in both the United Kingdom (UK) and Australia has influenced the direction of the study, and comparisons have been made to identify best practice in each country.

In the early 1970's it was first proposed that health professional education should be separated from the needs of the health service (Borneuf & Haigh, 2010). Australia moved nursing education from hospital-based nursing schools with an apprentice-type system to the tertiary sector, which generated a transition from being a staff member on the ward to a supernumerary student requiring a clinical experience placement. This was a radical change in thinking, and by the 1980s, many schools of nursing in smaller, regional and rural hospitals had closed because they did not have the capacity to meet the stringent educational requirements of the then state-based nursing registration boards. Additionally, there was a rapid increase in technology in the health sector in the 1980s, which in turn placed demands on all health professionals to expand

their scope of practice. As a result, the nursing curriculum increased from 1,000 to 1,200 hours over the three-year training period (Health Workforce Australia, 2011).

In addition, in the late 1980s, the UK proposed the Project 2000 program in response to the perceived inadequacy of nurse education. Project 2000 was designed to reflect the fact that medical treatments and clinical care were becoming more sophisticated. Nurses had to have a full intellectual grasp of the increasingly complex treatments they were delivering, and the best place to gain this education was deemed to be in a university classroom. This education transformation was accelerated by technological and rapid social change, which placed greater pressure on nursing to take an increasingly complex role that required in-depth knowledge beyond meeting basic patient needs to involve critical thinking and clinical reasoning (Hamshire, Willgoss, & Wibberley, 2013).

This change in educational preparation resulted in the creation of a clinical placement allocation system, whereby students were allocated placements by their education provider across various health services. This significant change created a divide between health services and education providers because students no longer 'belonged' to a health service, but were labelled as trainees. University students who visited various health services were seen as 'outsiders' and were viewed by many in the profession as a threat. The researcher experienced this change in workplace dynamics, and many nurses found the new system threatening to their knowledge base because of the increased academic profile of a university qualification.

The implementation of these new programs consequently affected nurses' attitudes and their willingness to support student nurses because they were no longer considered part of the workforce. The sense of belonging to the hospital team was in question, and many students felt that they were 'outsiders or interlopers' (Levett-Jones,



2007). Additionally, these changes introduced new ways of teaching and assessing students during clinical placement, and many nurses felt unprepared to supervise nurses who were engaged in a different form of education that was both unknown and threatening to them. Bradshaw and Merriman (2008) identified in a position paper that there has been widespread uncertainty about the required educational level in the UK in both students and those practitioners who were supposed to assess them. From 1923 – 1977 mandatory nursing syllabuses had emphasised the acquisition of certain specific clinical skills which were rigorously tested to an explicit standard set by the UK General Nursing Council. They maintain that subsequently, the change from this system resulted in many training institutions introducing clinical skills laboratories, simulation of practice and the Objective Structured Clinical Examination to meet expectations of ensuring all nurse training produced safe nurses.

However, Bradshaw and Merriman (2008) followed up two of their previous papers published in 1997 and 1998 on student competence in which they expressed concern about the perception of students still not being fit for practice 10 years on and that nurse training still had no uniform or mandatory system in place to ensure all registered nurses were clinically competent and safe to practice. They noted that educational policy across the globe had moved away from hierarchy, prescriptions, rules and examinations towards a collegiate, self-reliant, flexible and self-directed method of learning. Individual nurses were now expected to be self-developing, self-actualising learners and assume responsibility for their own educational standards and development.

Although similar change also occurred in Australia in the late 1980s (Grealish & Trevitt, 2005), there is still ongoing concern about the delivery of teaching and assessment of students on clinical placement. Many entry to practice education options

are now provided within the higher education sector for eligible registration as a registered nurse. Traditional nursing entry to practice courses have evolved significantly to include diverse transition programs such as enrolled nurses (ENs) (Certificate IV, Tier 2 nurse, Diploma Courses in NSW for ENs) to registered nurses (RNs), international nurse bridging courses and a two-year conversion course to Master of Nursing for students with a degree in any area. A number of universities also offer double degree courses in areas such as midwifery and health promotion (reference). Given that all of these students require the same level of teaching and assessment support in the clinical environment, this research will involve all of these student categories, and they will be referred to in this document as nursing students.

The potential significance of this research lies in the outcome of the data to inform the design of a relevant and practical ‘belongingness’ toolkit, articulated by Levett Jones, Lathlean, Maguire and McMillan (2007) as the foundation for clinical placement learning. A toolkit as defined in the Collins English Dictionary is a personal set of resources, abilities and skills used together for a particular purpose. This toolkit may support nurses working with students in the clinical practice setting. The research supports its development through data collection, analysis and interpretation of issues, perceived problems and potential possibilities that directly affect both the student’s and clinical workforce’s ability to encapsulate the sense of belonging.

The aim of the toolkit is to provide educational support to nurses in terms of reflective learning, prompting a self-review of their clinical supervision practice and that of the people they work with, while also supporting participants’ development through the sharing of practical strategies. Students’ sense of belonging and social wellbeing are consistently recorded as being influenced by nurses’ attitudes and competence to supervise. Therefore, through self-reflection, the toolkit may be a vital

component in preparing nurses as skilled supervisors who positively enable students to direct their attention and energies towards learning through compassionate care (Levett-Jones, 2007).

### **1.1.1 Challenges of providing a skilled, flexible and innovative health workforce for the future**

The challenges confronting the Australian healthcare system include an ageing population and workforce with a constricting labour market (Segal & Bolton, 2009). The literature has identified that a lack of trained healthcare personnel, more advanced technical and medical possibilities and limited financial resources are emerging global trends that will require more changes in healthcare practice and professional education within the sector (Batalden & Davidoff, 2007; Howarth, Holland, & Grant, 2006; WHO, 2010). Nursing models must therefore evolve to meet the demand; however, the identified problem of attrition in nursing student programs has raised international anxiety regarding the future and workforce development targets to meet healthcare needs (Boychuk, 2016; Hamshire, Willgoss, & Wibberley, 2013; Health Workforce Australia [HWA], 2010; Mellor & Gregoric, 2016).

HWA was established in 2009 as a federal government initiative to address the challenges of providing a skilled, flexible and innovative health workforce to meet the needs of the Australian community; however, it was dissolved in August 2014 because of a change in government. As one of its functions, the HWA provided support for the delivery of clinical training to the health workforce (*HWA WA Act*, 2009). The Clinical Supervisor Support Program Discussion Paper for Health Professionals (HWA, 2010) confirmed that while health and education establishments were endeavouring to provide appropriate clinical placements, there was confusion regarding the role of the clinical supervisor (CS). In some cases, this led to a less than acceptable learning and teaching

environment (Elliot, 2002; Henderson, Happell, & Martin, 2007; Courtney-Pratt et al., 2012; Henderson, Ossenberg, & Taylor, 2015).

Numbers of students undertaking clinical placements continues to increase almost doubling in recent years requiring additional growth of placements in areas of community, rural and residential care (Courtney-Pratt, Ford & Marlow, 2015). These areas, particularly rural placements are often less accessible for educational support for clinical supervision. Therefore, additional time and resources are required on an ongoing basis. The Quality Clinical Placement Evaluation (QCPE) research group has over recent years collaborated between tertiary and public sector health care providers to develop a flexible framework for use in practice settings. While the clinical placement is predominantly designed to meet the need of students, the effect of having students as supernumerary within the clinical areas impacts on individuals, cultural and site-specific workforce issues. The work of the QCPE research group has focused on these factors and has identified approaches that enable opportunities for health care and education providers to interact, share experiences and collaboratively develop plans for ongoing support to both undergraduates and those who work with them (Courtney-Pratt, Ford & Marlow, 2015).

To improve this clinical environment, a proposed initiative for improvement has been the implementation of effective supervision through support and education for staff within the clinical setting. However, hospitals are complex, sociologically rich places that are hard to read and even harder to change, and reports on cultural change and organisational learning processes are only occasionally detailed in empirical case studies (Rowley, 2006). Despite these challenges, it is important to change these environments to support student placements by developing supportive learning relationships to establish supportive work settings and workplaces in which people want

to stay (Henderson, Ossenberg, & Tyler, 2015; Mills, Francis, & Bonner, 2005) . These relationships include not only the supervisor–supervisee relationship, but also a sense of belonging within the clinical environment (Russell, 2016). Findings from focus group interviews in the literature suggest that students who are supported in the clinical environment with a positive attitude by those working with them are able to support each other, leading to reduced feelings of social isolation and unskillfulness, and creating a heightened sense of readiness to learn in order to support the achievement of competency (Christiansen & Bell, 2010).

Conversely, students with negative placement experiences identified a sense of alienation as a result of not knowing what they should be doing, not being included in ward/unit activities and feeling that they were in the way (Henderson, Happell, & Martin, 2007). Therefore, the need to belong or be part of a group or team exerts a powerful influence on cognitive processes and behavioural responses. Failure to satisfy this need can have devastating consequences for the future of nursing and patient care (Levett-Jones & Lathlean, 2009), with attrition remaining high within the first two years after graduation (Borrott, Day, Sedgewick, & Levett-Jones, 2016). However, the need to belong has wider implications for communities than just for learning. The relationship between nursing students' belongingness and workplace satisfaction was identified by Borrott et al., (2016) through a cross-national longitudinal study in which participants felt they needed to know there were people to turn to and to feel accepted by them. Students' desire to be accepted as part of the clinical team influenced satisfaction with their future role as a registered nurse. Social capital theory refers to the ways in which people are more productive through social networks and connections that value and provide both personal and collective benefits (Levett-Jones, Lathlean, Maguire & McMillan, 2007).

Furthermore, the absence of meaningful interpersonal relationships can lead to an increase in associated behaviours such as unquestioning agreement with another's clinical decision, resulting in failure to develop clinical reasoning and critical thinking skills to manage patient care safely (Russell, 2016). In a phenomenological study, Andrews and Roberts (2003) identified that despite rehearsing interpersonal skills in the classroom, students were often unable to replicate what they had learned once confronted by the actuality of the clinical workplace.

When moving from the safe environment of the classroom to clinical practice, there is considerable evidence that many students experience poor clinical placements because they do not establish a rapport with the clinical team and are treated disrespectfully (Borrott et al., 2016; Hamshire et al., 2013). Successful clinical placement experiences depend on a number of factors, including the development of effective interpersonal relationships between all stakeholders involved (Knight et al., 2012; Levett-Jones, 2007) and the competence and willingness of nurses to provide guidance to others (Berggren & Sevverinsson, 2006; Morrison & Brennaman, 2016). The Nursing and Midwifery Board of Australia's (NMBA, 2008) supervision requirements for nurses and midwives appear straightforward in that supervision of a student on clinical placement is regarded as the responsibility and role of all registered nurses regardless of experience or expertise. However, supervision is in fact a complex part of the nursing role because considerable interpersonal skills are required to promote a sense of belonging and alleviate anxiety and disengagement during the clinical placement.

To further complicate matters, role definition has created misperceptions and misunderstandings for students and nursing staff. For example, HWA (2011) stated that a CS is involved in the oversight of either direct or indirect supervision of professional

procedures and/or processes performed by a student on a one-to-one basis. In contrast, a clinical facilitator (CF) is a supernumerary supervisor typically responsible for a group of nursing students (usually around eight) on clinical placement and is the liaison between the health facility and the educational facility. However, some universities use these titles interchangeably. For the purpose of this study, HWA's definitions will be used.

## **1.2 Clinical Environment**

The clinical environment in Australia can be found in a variety of hospital-based or community settings, including mental health, aged care, acute and sub-acute care areas. It covers inpatients, outpatients, community, school health, clinics and general practice medical centres. Student placements across Australia are varied as the accreditation standards of the Australian Nursing and Midwifery Accreditation Council (ANMAC, 2012) dictate total course hours, rather than hours per semester or year., or by speciality area of practice. As such, students may attend clinical placements of various lengths at different times across the programs offered. Many commence with a residential care placement in semester one, with varying time frames between 1–5 weeks. Whilst final year students may attend for up to five weeks or longer during their last practicum. An average placement will involve the student nurse being on shift for two to three weeks (HWA, 2011).

Clinical placements in these environments should provide opportunities for professional socialisation, a process which encourages nursing students to experience how nurses interact, communicate and value the role (Levett-Jones, Lathlean, Higgins, & McMillan, 2008), as well as observing role models for how to think, feel and act. Professional socialisation is the development of a person's behaviour, skills and knowledge to embrace the expected ideals and values required to become a member of a

professional group. This broadly relates to the social learning theory defined by Bandura (1977), whereby if individuals do certain things, they are entitled to specified rewards and privileges. Much of an individual's life is spent in the working environment; therefore, the recognition of good work and values encourages the environment to become more positive, and it enriches those who engage within it. In a study conducted by O'Luanaigh (2015), the researcher identified that significant themes pertaining to a positive clinical environment would inform the research undertaken in the present study. O'Luanaigh (2015) used a case study methodology based on previous research to understand nursing students' experiences. He focused on how learning occurs by analysing the students' recall of their clinical experiences.

O'Luanaigh (2015) noted that the clinical environment is more than a workplace; it is an opportunity for nursing students to gain and develop fundamental nursing skills and attributes, and to begin their professional socialisation. He identified four important themes that affect the learning environment. The first theme acknowledges that the clinical environment is unique and that students cannot learn the profession without this exposure. To facilitate this learning, CSs should respond to students' learning needs. In addition, they should support an environment of belonging which will ultimately influence students' professional identity development.

Each of these themes is explored in further detail below.

#### *Clinical environment*

The first theme from O'Luanaigh (2015) examined student nurses' experiences to identify how knowledge and learning in the clinical environment are influenced and developed (see Figure 1.1a). The subthemes suggest that learning opportunities in the clinical environment differ from those in the university. O'Luanaigh (2015) maintained that rather than being an extension of the classroom, in which the student demonstrates



and applies theoretical knowledge and skills they have previously learned, the clinical environment is a chance for learning that cannot be facilitated elsewhere. This is significant when exploring options for developing education for nursing supervision because there must be a realisation that there is minimal time and opportunity for students to gain valuable practical experience.

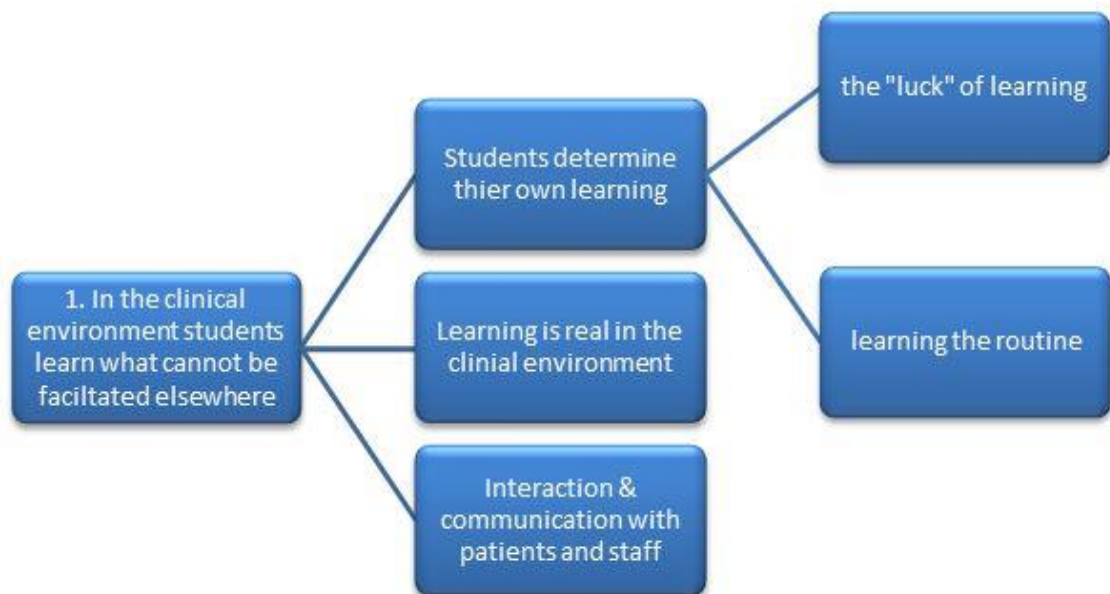
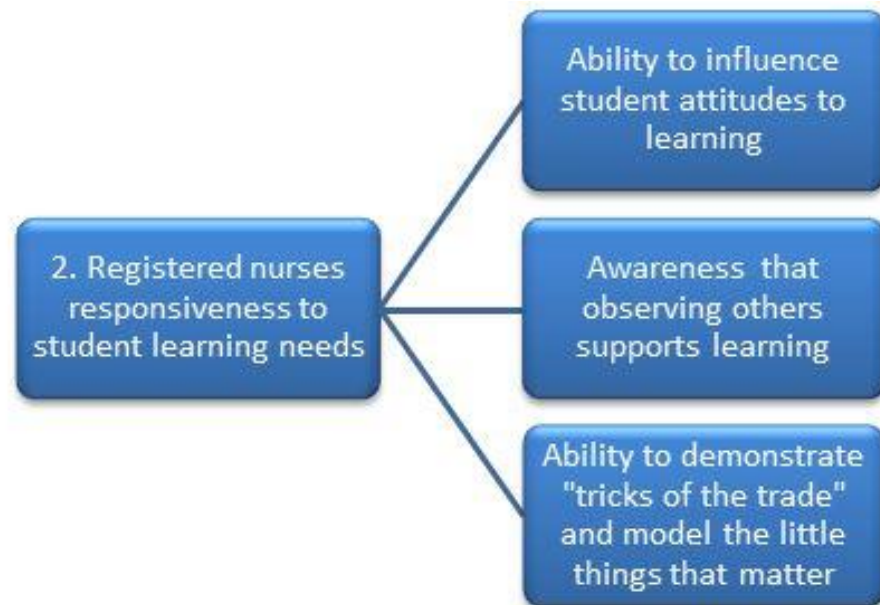


Figure 1.1a. Clinical environment (O’Luanaigh, 2015).

#### *Responsiveness to students’ learning needs*

The second theme relates to nurses showing an interest in students’ learning by actively supporting and facilitating learning opportunities (O’Luanaigh, 2015; see Figure 1.1b). Students’ active participation in the clinical environment develops their competence and confidence; however, this involvement depends on nurses’ ability and confidence to delegate responsibility. The role of the nurse supervisor as a positive role model cannot be underestimated as an influence and motivation to learn for many nursing students. The support and willingness of nurses to undertake this role can be dictated by their understanding of the teaching role and their confidence in being

responsive to student nurses' needs (Hegenbath et al., 2015). An important part of this study involves developing tools to support nurses' ability to respond to students' needs.



*Figure 1.1b.* Registered nurses' responsiveness (O'Luanaigh, 2015).

### *Belongingness*

The third theme identified from the students' feedback was that being valued and engaged with the clinical team gave them a sense of belonging to that clinical environment and team, which had a positive effect on their learning (O'Luanaigh, 2015; see Figure 1.1c). The need to be included, trusted and given responsibility is important for everyone. A supporting thematic analysis of a study at nine institutions in the North West of England conducted by Hamshire, Willgoss and Wibberley (2012) identified problems related to clinical placements. It was evident when student nurses were treated with a lack of respect by not being addressed by their name, they did not establish a rapport with the clinical team. Education for clinical supervision should support nurses to learn how to deliver education using positive elements to improve the clinical environment. Creating a sense of belonging affects professional identity development (Rebeiro, Edward, Chapman, & Evans, 2015).



Figure 1.1c. Sense of belonging (O’Luanaigh, 2015).

#### *Professional identity*

The final theme identified that good nursing role models help shape the perceptions of the kind of nurse the students wanted to emulate (see Figure 1.1d). RNs who participated in a subsequent focus group identified that positive outcomes for student learning should be supported by exemplary and respected clinicians.

Professional modelling and competence are essential for student learning (O’Luanaigh, 2015).



Figure 1.1d. Professional identity development (O’Luanaigh, 2015).

The findings generated from this study will help the researcher develop activities that can be incorporated into everyday practice. Related to O’Luanaigh’s (2015) study, in which participants described nursing as caring, Hegenbath et al. (2015) researched beliefs about the ideal clinical learning environment. The findings revealed two core themes: *influencing* factors and a *willingness* to invest in students alongside the form that the investment takes. Three subthemes of willingness emerged:

- *openness*: being welcoming and helping students become part of the team
- *taking them under a wing*: providing protection and preventing exposure to an unwelcoming environment
- *structuring to meet goals*: facilitation and exchange of information, and exposure fitting to students’ level.

Despite substantial past research into student clinical learning environments, few studies have been conducted from the psychological educational perspective (Bradbury-Jones, Sambrook, & Irvine, 2011). Many researchers agree that more needs to be done than simply justifying the key attributes of a good clinical learning environment (Chan, 2001). Midgley (2006) used a quantitative approach and found a statistically significant difference ( $p < 0.001$ ) between the students’ idealised perception of clinical placement before commencing in the clinical setting and their actual clinical placement experience. Personal welfare (identified as interaction with members of nursing team—a sense of belonging) was perceived as the most important domain.

### **1.2.1 Preparedness and willingness of nurses to supervise and support students**

This study relates to the preparedness and willingness of nurses to provide an atmosphere of belongingness in the working clinical environment that will enable students to achieve competence more readily, as outlined by Levett-Jones et al. (2008). Levett-Jones et al.’s (2008) findings from several sites with differing healthcare and

education systems identified that staff–student relationships have the greatest influence and are the key to students’ sense of belonging and learning. The authors noted that more research is required to explore methods to support and recognise the supervision role of RNs, and that belongingness should be proactively fostered to prevent potentially valuable and prospective members of the healthcare community from being lost to other professions (Levett-Jones et al., 2008). While there is an awareness of accountability and responsibility for students by nurses generally, the role appears to be understood in varying degrees; therefore, tools and activities to support further cognition will enhance supervision outcomes (Bittner & Gravlin, 2009).

Levett-Jones et al.’s (2008) findings are supported by research dating back three decades, when three significant studies examined the clinical environment (Fretwell, 1980; Ogier, 1981; Orton, 1981). Significantly, the studies identified that attitude characteristics of nursing staff—particularly ward managers—had a significant effect on encouraging learning in the clinical environment (Midgley, 2006; Saarikoski & Leino-Kilpi, 2002). The pressures of managing a ward are complex; however, the motivation to encourage staff to welcome student nurses upon arrival to a ward or clinical area lies with the senior staff. Allaying the fears and apprehension of student nurses creates an optimal environment for learning.

Students arriving at their clinical placement initially want to familiarise themselves with the staff and the workplace routine and develop relationships with the nursing team. Nonetheless, without support and guidance to learn the routines, language, values, practices and dynamics that are specific to the ward, little becomes familiar or comfortable during the course of the placement. Levett-Jones (2007) recounted the following student’s experience:

The friendliest placement I've had and where I think they really planned for me to come and where I was really accepted, was my placement in renal dialysis ... They gave me a book explaining what they do there, journal articles, quite a lot of question-and-answer things, books and references that you could use to see what they do there ... The nurse unit manager introduced me, showed me around and made sure I was okay. (Levett-Jones, 2007, p. 92–93, 100–102, 131–132)

For this student, it indicated a state of readiness and receptiveness to students, thereby enhancing their feeling of belonging.

### **1.3 Establishing Belongingness**

To function effectively, a sense of belongingness is a prerequisite of successful professional and clinical development (O'Lunaigh, 2015; Russell, 2016). However, the focus of this study is not to establish if belongingness is necessary for learning to take place, because this has been extensively identified and documented (Levett-Jones et al., 2007, 2008, 2009a; Midgley, 2005; Russell, 2012; Somers, 1999). Notably, from the perspective of health professionals, belongingness is not clearly understood. Research by Hamshire et al. (2013) explored the experiences of students on clinical practicums and found that a significant number described problems related to their placements, including not establishing rapport with the team:

I was treated like a second-class citizen ... The Student isn't my name but people referred to you as that out of lack of respect. (Hamshire et al., 2013)

I felt I was not progressing in my learning and nobody cared. (Hamshire et al., 2013)

Part of the problem of not initially establishing rapport is the ambiguity of the students' role in the healthcare team, which inhibits their ability to engage as members

of the team. An atmosphere of condescension by staff towards students and non-participation in students' education negatively affects their perceptions of clinical learning experiences (Nishioka, Coe, Hanita, & Moscato, 2014; Rowbotham & Owen, 2015; Sundler et al., 2014). Henderson et al. (2007) maintained that despite the literature consistently reporting this finding globally, only one study had evaluated an intervention designed to improve staff engagement in student learning and develop best practices in clinical education. This study by Henderson et al. (2007) found that a staff development intervention designed to improve the supervisory relationship between nurse supervisors and students improved students' perceptions of learning in the clinical learning environment. This evidence demonstrates that the overall atmosphere of the clinical environment and the capacity of nurses to build and nurture relationships can be modified with behavioural interventions. Jessee (2016) proposed that future studies should advance from description to experimental or quasi-experimental design to modify and improve the overall sociocultural atmosphere. Moving on from description requires lateral thinking to offer an approach that engages both nurses and students.

To gain a greater understanding of nurses' approach to nursing students and the gaps they identified in supervision education, the following research questions were developed. The qualitative questions were first addressed to a Delphi panel, and the quantitative questions were addressed to nursing staff who provide clinical supervision.

#### **1.4 Research Questions**

The overarching purpose of this study is to explore underlying assumptions and information concerning the concept of belongingness for student nurses in the clinical learning environment and to correlate information from both the literature and a group of experts (Delphi panel). The findings of the Delphi panel provide a framework to develop a toolkit (Wilkes, Mohan, Luck, & Jackson, 2010) to support nursing staff in

developing and improving students' sense of belonging to the clinical team and ultimately enhancing the students' learning.

The methodology for the design draws from the expert knowledge of nurses either with recent previous experience or currently involved with student supervision. This grounded approach is in response to understanding contemporary clinical learning environment cultures to produce a program designed from "coalface" experiences rather than an educationalist perspective. Hamshire et al., (2013) identified dissatisfaction with degree level study was associated with university campus based learning and the transition to the clinical placement environment; therefore for this program design to succeed it should be responsive to actual clinical environment cultures.

The questions are as follows:

***Qualitative: Delphi panel***

1. What attitudes and patterns of behaviour from nursing staff influence the creation and maintenance of a learning culture for students?
2. Who or what are the major contributors for actions and behaviours influencing an inclusive working environment and a sense of belonging?
3. What nursing practice and decision-making is required to create belongingness within a professional team in a clinical learning environment?

***Quantitative: Nursing staff***

1. What are the pre-program attitudes, behaviours, knowledge and skills of nurses towards students' requirements for an effective clinical learning environment embracing belongingness?
2. Do nurses perceive that they have changed their attitudes and approach to nursing students within the clinical learning environment after completing the program using the toolkit?



3. Has the toolkit using strategies, resources and processes for key activities been identified as an enabler to encourage belongingness within the clinical environment?

The data obtained from the initial Delphi panel questions informed the design of the toolkit, and the quantitative data were used to gauge the changes brought about by using the toolkit.

## **1.5 Rationale**

Smedley and Morey (2010) stated that the success of clinical placements in engaging student learning is somewhat dependent on the quality of the clinical supervision provided by the RN. However, the literature articulates that both practical and psychological improvements to the clinical supervision environment are required. This links to the international concern that student nurses are not being adequately prepared to meet the demands of contemporary healthcare. This is coupled with increasing demands on nurses to provide target-driven and economically constrained practice, which increases workplace stress and reduces their ability to demonstrate compassionate practice (Curtis, 2013). Of similar concern, the literature shows that students feel vulnerable to dissonance between learned professional ideals and the reality of RNs' practice (Curtis, Horton, & Smith, 2012). These ideals are challenged by the pressures of workload, poor organisational support and lack of compassion, despite a focus on promoting compassion in nursing over the past 10 years.

Recent literature shows that little has radically changed in relation to compassion and negative attitudes and behaviours that threaten students' progression and retention in the nursing profession (Hampshire, Willgoss, & Wibberley, 2013). Studies indicate that three important elements influence nursing students' progress and empowerment: 'being valued as a learner; a team member and a person' (Bradbury-

Jones et al., 2011). These elements sit within the concept of professional socialisation, which involves an acceptance of values and working in partnership. However, when student nurses receive ineffective learning opportunities, their caring behaviour has been shown to diminish as they near the end of their education (Curtis, Horton, & Smith, 2012). This is a concern for the future delivery of patient care and must be addressed by both healthcare providers and university educators.

Although the cessation of HWA in 2014 removed a national voice that identified that Australia is at risk of ineffective clinical learning opportunities (Russell, 2016), the literature continues to argue that new educational programs and strategies must be implemented to promote effective clinical supervision (Webster, Bowron, Matthew-Maich, & Patterson, 2016). However, to bring about change, research has brought to light new challenges, technologies and opportunities that widen the horizon of the educational landscape when traditional methods are no longer viable in a pressured environment (Kop & Fournier, 2011). To increase support for self-directed learning, reflection and implementation, there is greater reliance on the accumulation of information and informal education through technology (i.e., e-learning, social media), which now provides access to understanding globally delivered creative collaboration. Therefore, to advance previous work and equip the current workforce with the essential attributes to embrace student learning, it is important to present the toolkit with a modern, flexible and user-friendly approach.

## **1.6 Summary**

The overall consensus from literature, collegial discussion and anecdotal feedback is that understanding, support and attitude towards nursing students is essential to meet learning needs. Change must continue to ensure a future for an efficient, effective and motivated workforce. The provision of a structured and

interactive education program that engages nurses will promote critical thinking and capability (Anderson, Linden, Allen, & Gibbs, 2009). Further, clinical workplace environments that readily assimilate students through placements contribute to their successful integration into the profession (Henderson, Ossenberg, & Tyler, 2015).

This thesis will detail the course taken by the researcher to develop a toolkit not only as a reflective learning program, but also as a practical guide with resources to enhance the clinical supervision of students. Through the following chapters, it is anticipated that, as stated by Chan (2001, p.626), ‘more has been done than just justify the key attributes of a good clinical learning environment’.

Chapter 1 provides an overview of the background of this project, including the historical influences that have shaped the clinical environment for nurses and students. In addition, it briefly touches on the different phases undertaken to bring this program together, as well as the rationale behind it. Chapter 2 examines the literature in relation to this research and the development of the tools. The primary focus is on interpersonal relationships, belongingness, the role of nurses in supporting students and the learning environment in which opportunities for technology are provided. Chapter 3 focuses on the methodology and describes the sequential mixed method chosen, including its application in two separate phases. Connecting two sources of data will deliver a better knowledge base to provide a resolution to the problem. The first source encompasses the qualitative approach by using the Delphi technique to achieve convergence of opinion to develop the tool. This method is suitable for interpreting the meanings of individuals’ experiences because it encourages participants to express their feelings in their own words, thereby producing rich, in-depth information that is essential in understanding the situation (Denzin, 2010; Liamputtong, 2013). Chapter 4 presents the process and findings from the qualitative phase that captures the rich data, which

ultimately leads to developing practical applications for promoting student belongingness through a functional framework for the toolkit. Chapter 5 presents aspects of the design process of the toolkit used to stimulate reflection and incorporate interactive participation, creating a more powerful teaching and learning toolkit. Chapter 6 details the process and findings for the second phase of the project, the piloting of the program and the quantitative data collection and analysis. Chapter 7 compares nurses' reflective learning and their subsequent thoughts on improving existing clinical circumstances with current literature relating to student belongingness in the clinical environment. Chapter 8 appraises the future for the role of the nurse–student relationship incorporating a sense of belonging, and it considers the implications of using alternative educational tools to assist in the improvement of this complex sociological undertaking.

## Chapter 2: Literature Review

*Thoughtfulness is needed when considering how we welcome strangers into our daily way of being together.* (Block, 2008)

### 2.1 Introduction

Diverse preparation is necessary for students to reach the requisite standard to register as a nurse and pursue a career in the nursing workforce. Although participation in learning experiences in a variety of health settings to familiarise oneself with everyday practices is likely to be highly variable, in a phenomenological study by Kelly & Ahern, (2009) it was identified that the provision of guidance and assistance is nonetheless essential for effective integration into the profession. In association with this premise, research undertaken by Morrison & Brennaman, (2016) during their descriptive study continues to focus on the students' perspective of clinical placement and pays limited attention to practice implications for a busy ward or clinical setting. In addition, it is often assumed that attitudes, values and beliefs underpinning professional behaviours will be acquired by students through clinical interactions, with an emphasis placed on the more cognitive and psychomotor skills (Plack, 2006). However, little research is available that examines the effect of students on nursing staff during clinical rotations, and there is even less research concerning support frameworks for nursing staff to create an inclusive clinical learning environment for students.

Of some concern, Henderson, Ossenburg and Tyler (2015) found that when measuring organisation learning using the Clinical Organisational Culture Survey (CLOCS), at the commencement of clinical practicums, students consistently highlighted feelings of uncertainty and isolation. Thus, unless support is provided, it is difficult to successfully integrate inexperienced student nurses into the system to enable them to become effective team participants. Jewell (2013) noted in a review of the

literature that support during the socialisation process can substantially influence changes to isolation and poor performance. Organisations that encourage compassionate learning environments assist in the integration and assimilation of staff and students. They demonstrate certain qualities, such as rewarding and recognising staff and exhibiting sharing behaviours, and they are open to new ideas (Henderson et al., 2010).

This chapter will examine role theory, interpersonal relationships, belongingness, delegation and supervision to better understand what nursing staff require to create an inclusive community in their workplace. The literature review will explore research that examines the relationships between students and the various levels (roles) of RNs. It will also examine previous research into the attitudes of staff towards students to gain an understanding of the lived experiences of RNs working with students.

High demand for clinical placements means that nurses are continually supervising different students for weeks at a time without a break, potentially leading to 'student fatigue' (Walker, Cooke, & McAllister, 2008). Strengthening the fabric of any community is a collective effort that starts with a shift in mindsets about the sense of connectedness to others within the community. Therefore, this review will also explore previous research including the paper by Chan (2001) discussing the Clinical Learning Environment Inventory, to identify the development of models and tools used to help create a more conducive workplace.

In addition, part of this literature review will appraise types of learning, including face-to-face learning, self-directed learning and e-learning. In particular, e-learning is increasingly becoming an integral part of learning support in improving capability to cope with workplace challenges. For time-poor professionals, time for education is becoming more difficult and competitive. The review aims to provide

insights into the perceived advantages and disadvantages of each learning method and to discuss success factors for application. However, the final toolkit will be developed according to the outcome of the Delphi panel. Although consideration of each type of learning method is important, given the complexities of the teaching and learning environment, the researcher is aware of the importance of being open to using e-learning technology versus traditional modes of education. A discussion paper by Al-Shorbaji et al., (2015) observed that healthcare organisations worldwide are seeking innovative methods of teaching and learning to respond to the needs of busy health workers.

## **2.2 Search Strategy**

An initial search of the literature to understand the concept of belonging involved examining written works from the disciplines of psychology and the social sciences. The search was not originally restricted to studies relating to nursing and health professionals, but also included information from non-health professions. The key words used were ‘community’, ‘belonging’, ‘behaviour’, ‘acceptance’, ‘participation in a group’, ‘culture’, ‘social learning’ and ‘social positions’. The terms ‘nurses’, ‘nurse manager’, ‘delegation’ ‘supervision’ and ‘compassion in nursing’ refined the search and showed literature that expanded on the extensive skills and attitudes required by nurses when supervising students.

Reference books, journal articles and scholarly papers were identified through the electronic databases of MEDLINE, Cumulative Index to Nursing and Allied Health Literature (CINAHL), ProQuest, OVID and PsycINFO. The dates for published papers were mainly from 2000 onwards; however, seminal works were used from as far back as 1943. Although articles originated from various countries with similar standards of nursing education and practice (e.g., United States, Canada, UK and Scandinavia), all

articles were written in English or translated into English and were reviewed and critically appraised for quality of methodology. All references were entered into the reference management software tool Endnote, and papers were organised into themes to assist in the development of the questionnaire for the first round of the Delphi process.

To more clearly understand the effect of students' presence in the clinical setting, the terms 'nursing students', 'preceptorship', 'clinical environment' and 'clinical placement' were added, which revealed that most of the literature focused on students' perceptions of the learning environment and the role of the preceptor. Few researchers have examined the effect of students on RNs and implications for practice. The relevant literature which include literature reviews from Ali, P. A and Panther, W. (2008); Gilbert, J., & Brown, L. (2015) largely describes a negative response from nursing staff consisting of condescending or judgemental behaviour (Aghamohammadi-Kalkhoran, M., Karimollahi, M., & Abdi, R. 2011; Anderson, C., Moxham, L., & Broadbent, M. 2016). Conversely, some observational studies indicated that the effect of nursing students on nursing staff is beneficial for quality of patient care and nurses' professional development. Using a sample of 253 nurses, Morrison and Brennaman (2016) discovered that approximately 60% of the staff felt that student participation challenged them to remain proficient, and that working with students aided the development and refinement of their skills. In addition, participants noted that working with students stimulated them intellectually and exposed them to different perspectives. Therefore, it is evident that much needs to be done to increase potential through educational support for nurses to be able to understand and develop interpersonal relationships that will improve the learning environment and students' sense of belonging.



## **2.3 Interpersonal Relationships**

### **2.3.1 Role theory**

Role theory is defined as a perspective on the ‘acting out’ of socially defined categories alongside characteristic patterns in most everyday activities and how individuals behave in social situations. It clarifies roles by maintaining the premise that people are members of social positions and hold expectations and beliefs regarding their own status and that of others. They are aware of their participation in a group, which has a social structure that arises from repeated interaction among the members (Brehm & Kassim, 1993). This is often influenced by how these behaviours are perceived by others, and the roles are then based on social learning and interpretation.

Nurses’ perceptions of their roles can be prejudiced by peer pressure and attitudes, trends in professional issues and government policy, leading to expectations about the roles that they and others will play within the workplace context. This is evident in a study in which many students reported that they did not establish rapport and felt that being labelled ‘the student’ rather than being referred to by name showed a lack of respect (Hamshire, Willgoss, & Wibberley, 2013). The act of labelling can diminish the capacity of people to fulfil their potential as identified in a phenomenological study by Knight et al. (2012). In addition, people subtly encourage others to act within the role expectations they have for them, and similarly, they will act in the roles they adopt. Categorisation or labelling is a way of organising or setting apart from the main group, but alongside these groupings is a set of suppositions or predictions (Handy, 1999) for example, ‘students are time consuming’. However, Handy (1999) also maintained that although stereotyping can be inaccurate, people appear to readily accept generalisations rather than make their own individual assessments.

Within this social context, culture is understood to be the patterned processes of people making sense of their world, including the conscious and unconscious assumptions, expectations, knowledge and practices they call upon (Pasick et al., 2009). This can limit the opportunities of nursing staff to change themselves and the environment in which they work. Examples influenced by predictions of stereotyping (e.g., gang behaviour) have shown how people react differently to the same behaviour. There is also the risk of a strong tendency to conform to others' perceptions of them.

However, within this context, and potentially more positively, the opportunity to educate and be educated by peers can result in a perceived increase in self-confidence in both more and less experienced students (Gidman, McIntosh, Melling, & Smith, 2011). Feeling less intimidated when learning from their peers, being offered the opportunity to exchange information and knowing that they are part of a group gives a sense of belonging, and support from peers can be pivotal in facilitating students' continuation when students consider leaving (Hamshire et al., 2013; Knight et al., 2012). Nursing staff could take advantage of this by facilitating such opportunities within the clinical environment, which would also enhance their own education (Morrison & Brennaman, 2016).

### **2.3.2 Social learning theory**

Figure 2.1 demonstrates how people endeavour to enhance their self-esteem—of which there are two components (personal identity and various social identities derived from the groups to which they belong)—by encouraging in-group favouritism and derogating out-groups (Brehm & Kassim, 1993). For example, Levett-Jones & Lathlean, (2009b) profiled a cross national case study in which it was identified that the 'in-group' of established nurses may show favouritism to a student who does not 'rock the boat', whereas a student who endeavours to bring new evidence-based

information and practice may be seen as threatening, and derogatory or belittling tactics may be used to put them into an ‘out-group’, therefore excluding them from the team and portraying a sense of superiority.

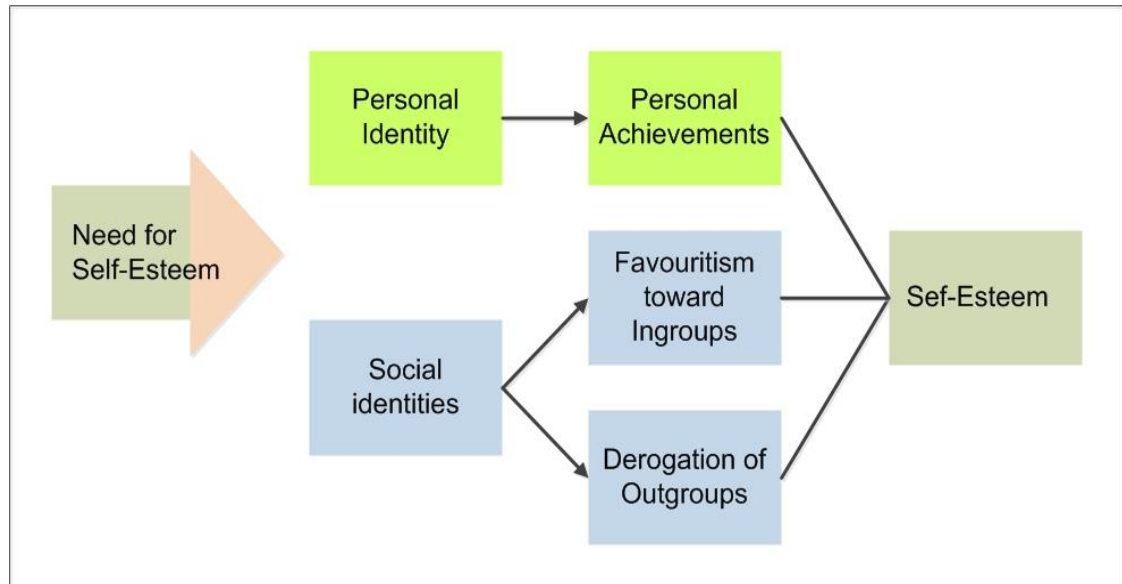
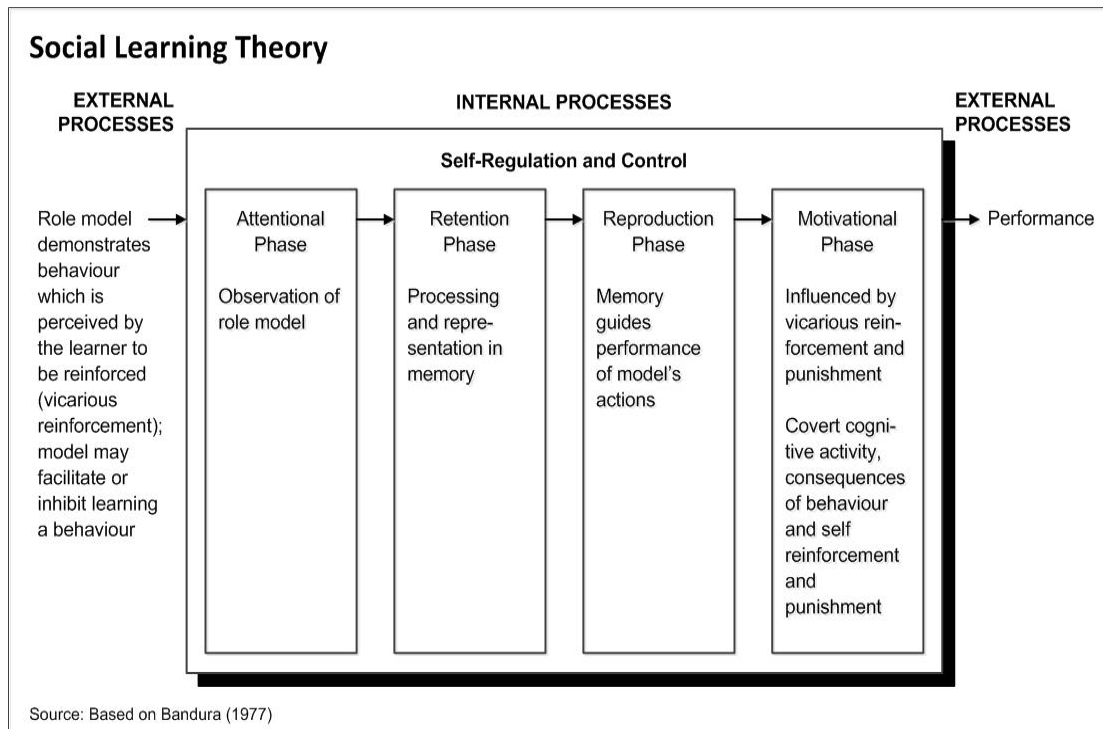


Figure 2.1. Social identity theory (Brehm & Kassim, 1993).

### 2.3.2.1 Bandura

Bandura (1977) specialised in social modelling or role modelling, which involved the learner observing the behaviour of another while also monitoring the consequences of that behaviour. For example, if rejection is the consequence of inappropriate behaviour, a learner is unlikely to copy that behaviour; however, if the consequence is rewarding, the learner will endeavour to copy that behaviour. According to Bandura’s (1977) social learning theory:

The action of others can also serve as social cues that influence how others will behave at any given time...In social learning theory, human functioning relies on three regulatory processes; stimulus, cognitive and reinforcement control.



*Figure 2.2.* Social learning theory (Bandura, 1977).

Bandura (1977) used social learning theory to explain why people behave as they do (see Figure 2.2). He proposed that most human behaviour occurs under aversive stimulus control, and it is in this form of emotional learning that persons, places and events become significantly important in engendering apprehension. To minimise this anxiety, a primal function of anticipatory behaviour is to provide protection against potential threats, but while many emotional responses are learned through direct involvement, most human learning occurs through communicated conditioning.

This concept is of particular importance when developing positive attitudes through education because emotional responses of another person conveyed through facial, verbal and postural expressions can arouse strong emotional reactions in the observer. People are not only affected by the experiences created by their own actions; they also regulate their behaviour to some extent on the basis of observed consequences.

Later in 2001, Bandura discusses the capacity to exercise control over the nature and control of one's life. Core features of this human agency enable people to play a

part in their self-development, adaptation and self-renewal with changing times. Goals rooted in a value system and a sense of personal identity invest activities with meaning and purpose. Conversely, people retract from behaviours that give rise to self-devaluation and self-censure. An atmosphere of 'not belonging' is often created by a facial or postural expression of 'I don't have time for students, I don't want her' (Levett-Jones, Lathlean, McMillan, & Higgins, 2007). Non-verbal message traffic between humans is 'overwhelmingly more copious' than verbal message traffic (Freese & Burke, 1994), but nonetheless just as significant in its effect. Contextual factors and interpersonal dynamics have a substantial bearing on students' experiences and a significant effect on their self-concept and professional role and identity (Levett-Jones et al., 2007). An affiliation to the professional role can only be achieved through a sense of belonging to that professional body (Block, 2008); therefore, nurses need to be made aware of the negative effect of harsh facial or postural expressions. Developing an educational tool such as a video would enable them to observe this response through the eyes of others and reflect on this action and the barrier created to students' belongingness. Therefore, the next section of the literature review will focus on the concept of belongingness and its application to workplace learning and the development of professional socialisation.

## **2.4 Belongingness**

As previously stated Somers (1999, p. 16) defined belongingness as the 'need to be' and perceptions of being involved with others at differing interpersonal levels, which contributes to one's sense of connectedness. However, student nurses have enormous expectations to connect placed upon them, and they are expected to integrate into the clinical environment with little disruption to the daily routine of the workplace setting.

The literature shows that students are often overwhelmed by the magnitude of their surroundings in the healthcare setting, but they are compelled to assimilate and belong. However, this often proves difficult and affects their ability to become competent (Levett-Jones et al., 2008). From the perspective of health professionals, belongingness is not clearly understood, and this is demonstrated in the practice of orientation before the start of a clinical placement. Much time and effort are placed on the orientation process in many organisations; however, this process is often based around the physical environment and not the emotional and psychosocial situation of enhancing belonging to the organisation.

Hospitality is associated with culture and is a social practice and a more personal quality to be admired. Nonetheless, in Western culture, individualism and the need to feel safe and secure in a perceived hostile environment seem to translate into work as exclusion and fear of involvement. Thoughtfulness is needed when considering how strangers (students) are welcomed into our daily way of being together (Block, 2008). Further, Block (2008, p.9) maintained that 'community building is so complex that it occurs in an infinite number of small steps'. Block (2008) proposed that the core concept of social capital theory or quality of relationships relies on social networks having value, which provides personal and collective benefits. While many academics in the literature consider experience the basis for learning with a focus on the individual, Plack (2006) conducted a qualitative multicase study to identify that it is the interaction between the newcomer and the community of practice that develops the student. When the mentor and community are receptive to newcomers, they share information and make the newcomers comfortable and welcome, which reduces stress and opens the lines of communication. However, a community that lacks empathy or is too busy can be interpreted as a hostile environment, which limits learning and the development of

professional identity through a sense of belonging (Wenger, 1998). Wenger's (1998, p. 5) framework for a social theory of learning is articulated in Figure 2.3. He identified that four essential elements provide platforms of learning when creating a learning environment: community, identity, meaning and practice. People learn to belong through community, and they become part of that community by learning; that is, they gain identity. Wenger (1998) asserted that practical application is essential for learning because learning through experience gives meaning to practice. The four learning elements remain a core feature in contemporary research because each component is interconnected, mutually defining and interchangeable.



*Figure 2.3.* Components of a social theory of learning: an initial inventory (Wenger, 1998).

Wenger-Trayner et al., in 2015 presented a more elaborate perspective on learning in communities of practice. They move on from the premise that learning is an inherent dimension of everyday life, a social process, but can be viewed more of a

journey of straddling boundaries between the academic and the workplace. There are well-known challenges of resilience and tensions towards boundaries as students work their way through courses of learning in communities of practice they occupy. Wenger-Trayner et al., (2015) discuss pushing the traditional boundaries whether in person or via technology to develop meaningful relationships that enables learning with and from each other.

The art of creating belonging in the clinical environment is to discover the means and new possibilities for staff to bring about changes for students to enable them to be part of the community or team.

#### **2.4.1 Workplace belongingness**

According to Cockshaw, Shochet and Obst (2013), workplace belongingness can be defined as the extent to which an individual feels personally accepted, respected, included and supported by others in the organisational environment. The authors of that descriptive study suggested that if a person perceives that the organisation cares about them, it creates a sense of belongingness in the workplace. Responsive commitment and workplace belongingness are linked because they relate to the relationship between the person and the work environment. Students' feelings of acceptance and belongingness support their professional socialisation in the workplace. This is a process by which a person acquires the skills, knowledge and identity that are characteristic of a member of their professional group (Curtis et al., 2012). However, a number of factors influence professional socialisation and thereby affect students' morale and attitudes, including a lack of informed education or training in clinical supervision for nursing staff (Russell, 2011), as well as poor support and performance from university CFs, including a lack of governance and suitability for the role (Health Workforce Australia, 2010).



In addition, staffing and acuity issues, such as efficiency and cost containment measures, affect workplace belongingness (Hartigan-Rodgers, Cobbett, Amirault, & Muise-Davis, 2007; Rowley, 2006). This affects nurses' capacity to engage in responsive commitment and create a sense of workplace belongingness. Other factors that affect professional socialisation are highlighted by Cockshaw et al. (2013), who presented evidence from a seminal review by Baumeister and Leary (1995) that referred to the fundamental human need to belong. Baumeister and Leary (1995, p. 506) concluded that 'real, potential or imagined changes in one's belongingness status will produce emotional responses with positive effect linked to increases in belongingness and negative effect linked to decreases in it'.

An impression of not being valued is consciously experienced as reduced self-esteem and leaves the individual with doubts about their self-worth and an increased need for validation (Leary & Cox, 2008). Reduced support for staff and negative appraisals that include criticism, rejection and disinterest can lead to depressive reactions. However, Senge (1992, p. 12) maintained that 'Harmony and collaborativeness and personal mastery enable individuals to have the drive to continually learn and see how their actions affect the world'.

#### **2.4.2 Professional socialisation**

As previously stated, professional socialisation is the development of a person's behaviour, skills and knowledge to embrace the expected ideals and values required to become a member of a professional group. However, students feel vulnerable to disharmony between professional idealism and practice realism (Curtis, Horton, & Smith, 2012). Mooney's (2007) grounded theory study identified effective socialisation as a key factor related to the prevention of the costly attrition of not only qualified nurses, but also students. The philosophical approach of Marcellus (2005) viewed

individuals as being interactive components of their environment and who take meaning from experiences shared with others. Student nurses are exposed to several different social environments, including university and various clinical placements, and assimilating to each environment requires a different approach.

Bradshaw and Merriman (2008) in a position paper observed that students' ability to challenge the reality of practice limitations while maintaining professional idealism was affected by their need to fit in with the team, become an accepted team member and feel that they belonged. However, to support students in their socialisation to maintain compassionate care, those facilitating practice placements must embrace the need to work collaboratively, encourage leadership for learning (O'Driscoll, Allan, & Smith, 2010) and assist students in the presentation of professional ideals (Maben, Cornwell, & Sweeney, 2010). Acknowledgement of the important role that nursing staff play in the development of students' socialisation, skills and attitudes requires managerial and organisational vision.

It is important to identify and recognise the role for supporting students. To support continuing educational advances for nurses to maintain and improve their supervision and leadership skills, a balance must be reached that responds to the accountability and responsibilities of an RN.

This next section of the literature review will focus on the role of nurses in supporting students' learning during clinical placements. In particular, terminology is used to describe the support provided and the effect of supervising nurses on the nurse–student relationship, as well as consequential learning, emotional vulnerability and the importance of compassion. This will be followed by nursing education in clinical supervision and the possible models of education applicable to this research.

## 2.5 Nurses' Role in Supporting Students

The literature has established that RNs' attitudes can significantly affect the socialisation, competence and confidence needed by student nurses to develop professionally (Bradbury-Jones, Sambrook, & Irvine, 2011). Supporting students to learn is an important role of both educators and practitioners, and a variety of models of practice learning exist around the globe. For example, in contrast to Australia, where as previously described clinical practice allocations are relatively short and vary according to educational facilities from a starting point of potentially as little as one week in residential care in the first years extending to longer placements in the final year; the clinical practice in the UK accounts for approximately 50% of the student nurse program. However, similar to Australia, the format of the practicum is ill-defined, with a range of models being applied (Andrews & Roberts, 2003).

Therefore, a global consensus has not been reached on the definition of clinical supervision; however, the National Clinical Supervision Support Framework (HWA, 2001, p. 4) stated that:

it involves the oversight either direct or indirect by a clinical supervisor of professional procedures and/or processes performed by a student or group of students within a clinical placement for the purpose of guiding, providing feedback on and accessing personal professional and educational development in the context of each student's experience of providing safe appropriate and high-quality patient care.

HWA (2010) identified that a lack of national consistency in training CSs is a concern. The role of the CS, who is usually an onsite clinician, requires:

an appropriately qualified and recognised professional who guides students' education and training during clinical placements. The clinical supervisor's role

may encompass educational, support and managerial functions. The clinical supervisor is responsible for ensuring safe appropriate and high-quality patient care. (HWA, 2011, p. 4)

CFs are usually supernumerary supervisors from the educational provider who undertake responsibility for 8–10 students for assessment over a period of 1–4 weeks. When students are subsequently allocated a CS (for whom various definitions are listed below), the CF will visit all students on a regular basis and observe them undertaking procedures and skills. CSs would expect to receive educational support from the CF.

In comparison, nurses who supervise students in the UK are expected to have been on the register for at least 12 months and completed a Nursing and Midwifery Council (NMC) approved mentor preparation course (Ali & Panther, 2008). However, there appears to be little consensus in the literature around the definition of support in this context. Research at two universities in Southeast England by Andrews et al. (2006) highlighted diverse experiences within models despite a more structured framework for supervision. While a considerable number of studies have identified specific issues for clinical education, including a lack of resources (Walker, Cooke, & McAllister, 2008; Webster et al., 2016), there has been a paucity of literature that provides effective frameworks to guide the development of effective clinical placements.

The next section will further explore the role of nurses in supervising students. It will begin with a review of the varied terminology used to describe the role of the supervisor, followed by a description of the supervisor–supervisee relationship. This will be followed by a review of the influence of the supervising nurse on the clinical learning experience and the importance of compassionate care and its influence on nursing students' socialisation and development as compassionate nurses.

### 2.5.1 Terminology

In comparing the models of supervision both nationally and internationally, it is evident that the terms that are used vary considerably, adding further confusion for many staff and students (Gleeson, 2008). In the literature, the clinical supervision role can often be interchanged with the terms ‘mentor’, ‘preceptor’ and ‘buddy’ (Smedley & Morey, 2010); however, each term has its own definition. The following definitions describe each term used.

#### 2.5.1.1 Mentorship

In defining the term ‘mentor’, Homer’s *Odyssey* talks of the role of mentor as the trusted teacher, guide, friend and protector—a more experienced person (Russell, Allix, & Gluyas, 2016). A mentorship involves giving the mentee encouragement, reassurance and guidance in learning and assessment of practice. This primary relationship is enduring and trusting. The mentor–student relationship passes through various phases (see Figure 2.4).

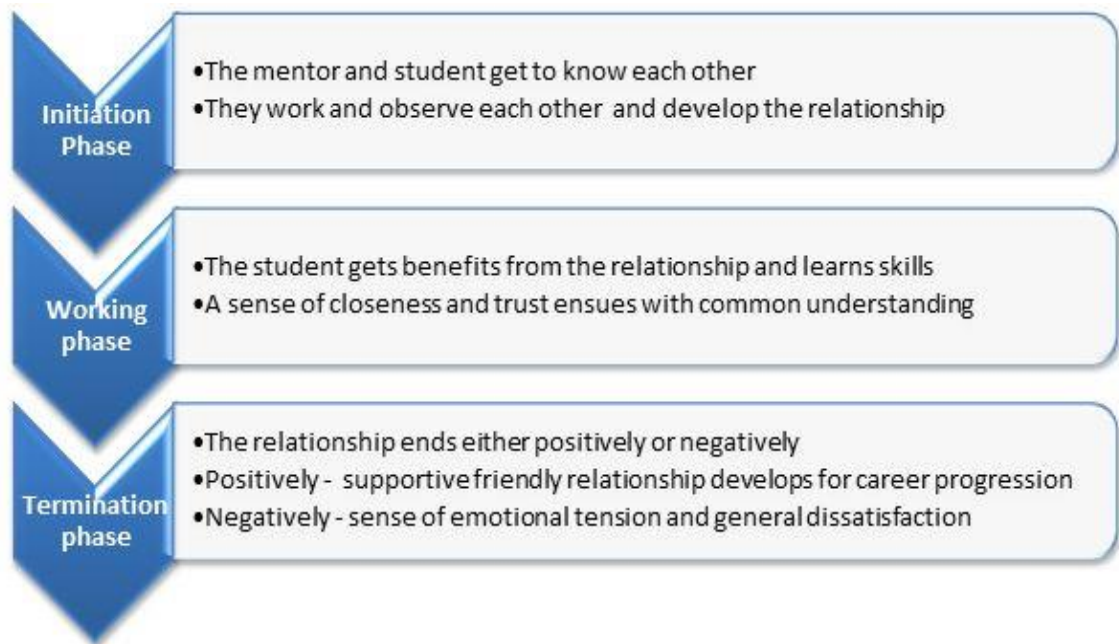


Figure 2.4. Professional development and the role of mentorship (Ali & Panther, 2008).

As shown above, this style of mentorship is often a short but critical period for students on clinical placement. It has been referred to as secondary mentorship assisting the mentee through a particular period of professional development (Russell, 2012). Mentorship programs are widely used overseas—particularly in the UK, where the NMC provides guidelines and protocols (Ali & Panther, 2008) for undergraduate nursing. In contrast, the term ‘preceptorship’ in the UK is used in connection with newly qualified nurses.

### ***2.5.1.2 Preceptorship***

While undertaking the role of preceptor of a student/newly qualified nurse, the supervising nurse’s priority is to deliver safe patient care, which enables the supervisee to identify learning opportunities. The challenge is to manage heavy work assignments and divide the time between teaching and providing feedback and direct patient care (Henderson & Eaton, 2013).

Role modelling that encourages critical thinking, communication, clinical reasoning and problem-solving gives the student a template on which to base their practice. Students view the preceptor relationship as an opportunity to bring together the various components of their education (Yonge et al., 2002).

### ***2.5.1.3 Registered nurse buddy***

The RN buddy is an RN who is often previously unknown to students and is assigned by nurse managers or shift coordinators to work with a student for one shift at a time. RNs are usually chosen randomly from staff working on the required shift; thus, an RN buddy can have a different student during each shift (Walker et al., 2008). The buddy role was previously mandated by the Australian Nursing and Midwifery Council (ANMC, 2007) and although informal, it carried important responsibilities and challenges. Unlike the role of the ‘mentor’ in the UK context (or ‘preceptor’ in the

Republic of Ireland) and ‘preceptor’ in the US context, the RN buddy is not formally prepared or qualified to directly assess the student (Carrigan, 2012; Leners, Sitzman, & Hessler, 2006).

The CF will often seek summative feedback from the RN buddy that is succinct yet meaningful concerning the student’s performance. However, Walker et al. (2008) noted that as a result of poor preparation and lack of recognition of the buddy, there is often little concept of the role; consequently, an emotive, inarticulate and incomplete response is presented, leaving the student confused and unsatisfied.

As previously stated, the purpose of this study is to develop, implement and evaluate a toolkit for nurses in their role of supporting students’ learning in the clinical environment. Despite the various titles used by education providers and health services, for the purpose of this study, all of the above titles fit within the umbrella of CS and therefore form part of the end user group. However, for this study, as stated by HWA (2011), the term ‘clinical supervisor’, or ‘supervisor’, will be used to identify nurses who provide a learning and teaching environment for students on clinical placement. The next section will further explore the role of the supervisor and supervisee.

### **2.5.2 Supervisor and supervisee**

The influence of a welcoming, positive, supportive person guiding the learning experience is identified as an important contribution to students’ wellbeing and cannot be underestimated (Happell & Charleston, 2006). Support and responsibility for students to learn from ‘real world’ clinical situations are delegated to clinicians who may be in the difficult position of supervising a variety of different students from different education facilities on a continual basis, without the opportunity to establish a relationship or seek respite to refresh their own interests (Bergjan & Hertal, 2013). It should therefore be recognised that there is a need for managerial and institutional

support, relevant training and higher education opportunities to equip nurses with up-to-date knowledge (Wilkes, 2006).

However, a literature review by Girot (2000) examined the role of RNs as mentors and identified that they are likely to have minimal experience as assessors compared with educationalists, which may contribute to the opinion that practice-based competencies are less valued than university-based assessments. This could place RNs in the position of not being valued by the student, or they may develop feelings of low self-esteem, anxiety, stress and guilt at not properly providing either quality care for patients or an effective learning experience for students (Walker et al., 2008; Yonge, Krahn, Trojan, Reid, & Haase, 2002). Nevertheless, nursing education continues to evolve and is a dynamic backdrop to providing safe, person-centred caregivers and practitioners to healthcare systems (Rebiero, Edward, Chapman, & Evans, 2015). However, little information appears to have been recorded regarding the far-reaching changes in nursing education on interpersonal relations that occur between the mentor and mentee, although the relationship between the supervisor and supervisee has been identified as the single most important factor affecting successful clinical placements (Hall, McFarlane, & Mulholland, 2012; Kilminster & Jolly, 2000; Levett-Jones, Lathlean, Higgins, & McMillan, 2008).

To promote student involvement in the workplace, the role played by the RN must be one of a role model, educator, assessor, advocate and socialiser (Russell, 2012). Quality supervision is the key, but it is challenging for many because, although they may have many years of clinical expertise, they may have very little or no teaching experience to be able to appropriately support the student (Carrigan, 2012). The role requires RNs to initiate students into clinical practice involving tasks of patient care and socialisation with the team. Continuing to maintain learning on a day-to-day basis is



designed to be reinforcing and requires questioning, feedback, guidance, shared discussion and problem-solving.

Increased time and energy spent in the initial development of students produces positive long-term benefits to clinical areas and the profession. Preferential job uptake by graduates has been linked to successful clinical practicums, satisfactory learning environments and quality supervision (HWA, 2011). There are limits to maintaining these effective clinical environments for students, but by supporting supervisors with quality education and tools to improve their initiative, skills and job satisfaction, further enrolment of other members of staff to become CSs may occur (HWA, 2011).

Providing support and education to nurses to enable them to conduct students' education in the clinical setting reinforces organisational value to the role of the RN (Rebeiro et al., 2015). Graduating nurses have consistently stated that their first choice of place of employment is where they had a positive experience (Courtney-Pratt, FitzGerald, Ford, Marsden, & Marlow, 2012), whereas negative experiences lead to student and graduate attrition (Yonge et al., 2002). Opportunity or time to reflect on their performance as a student supervisor is not seen as important during a clinical shift; however, the effect of a nurse's relationship with the student has many implications for safe practice (Moonaghi, Mirhaghi, Oladi, & Zeydi, 2015). Raising nurses' awareness of these factors is essential to improve the clinical learning environment.

### **2.5.3 Effect of nursing staff on student learning in the clinical setting**

Thomas and Burk (2009) searched the literature on nursing staff and student relationships and found a persistent issue of non-physical violence. A continual theme in the literature is that interactions in the form of bullying, harassment and refusing to work with or ignoring an individual, cause students to feel intimidated, threatened and upset (Johnston, Phantharath, & Jackson, 2009; Morrison & Brennaman, 2016). This

has potential implications for patient safety and the preparation of students for professional practice. Consequences for nurse retention and recruitment lie in the decisions made by students to remain in the profession. They are often influenced by nursing staff who either have an enabling or hindering effect or actively discourage students from pursuing this career (Webster, Bowran, Matthew-Maich, & Patterson, 2016).

The findings in 2016 of Webster et al.'s study using a qualitative description approach indicated that nurses' actions, attitudes and enthusiasm towards teaching are crucial factors for learning and socialisation to nursing. Hindering experiences were found to have resulted in students feeling neither wanted, comfortable nor safe asking for assistance. In addition, instances of valuable learning opportunities were missed. However, enabling attitudes promoted feelings of comfort and confidence, and students appreciated engaging in appropriate tasks for their skill levels.

To understand the relationship between nurses and students, Haitana and Bland (2011) conducted a descriptive phenomenological study capturing the experiences of five RNs. Semi-structured, audio-taped interviews from this purposive sample developed the following themes:

- getting to know the student
- developing trust
- letting go (so students can develop autonomy)
- the importance of connecting
- obtaining feedback from student nurses.

Although this was a very small study and the limitations identified that it did not cover a variety of clinical settings, the significance of the findings for this research

study is the importance of building relationships between the supervising nurse and the student.

Following on from Haitana and Bland (2011), Morrison and Brennaman (2016) identified factors that caused satisfaction and dissatisfaction for RNs as clinical role models and student preceptors. The larger response of 391 participants to the Nursing Students' Contributions to Clinical Agencies (NSCCA) survey clarified 'satisfiers' and 'dissatisfiers'. While positive perceptions were consistent with findings from previous studies, they were dependent on nurses' years of experience (less than 10 years were most positive) and clinical setting (perinatal was less positive than medical).

Responding to what would be an appropriate reward, the nurses felt that acknowledgement on their personnel file would diminish some of the dissatisfaction. Education and educational resources were also listed as important to them, with participation in student presentations highlighted as getting to know the student's workload. However, the survey indicated that these techniques were infrequently implemented. Recognition of staff efforts is highlighted throughout the literature as being of paramount importance (Morrison & Brennaman, 2016).

Global recognition of the wellbeing of staff has also been highlighted as a 'satisfier', with the need for resources to be implemented to change the culture to become more inclusive and self-caring. The Department of Health in the UK (2013) recognised a serious deficit in compassionate care alongside the attrition of dissatisfied nurses and the effect on students. As a result, a mandate was delivered to health education bodies in England to deliver high-quality, effective and compassionate care, and to develop the right people with the right skills and values. This incentive has motivated educators to develop the right resources to enable staff to be proactive. The most significant UK study relating to compassion was conducted in Scotland (Adamson

et al., 2012 cited in Curtis et al., 2016) and had four strands: the establishment of beacon wards to ‘showcase excellence in compassionate care’, the facilitation of leadership skills in ‘key individuals’, influencing the undergraduate curriculum by ‘embedding relationship-centred compassionate practice’ for nurses and midwives, and providing support for newly qualified nurses (Curtis et al., 2016). It is noteworthy that there is an opportunity to educate nurses in relationship-centred practice to create a positive effect on the nurse–student relationship. Compassionate care is important to both nursing practice and the nursing curriculum, and it will influence the next generation in adopting safe and effective self-care (Mills & Chapman, 2016).

#### **2.5.4 Emotional vulnerability and self-compassion in the supporting role**

Self-compassion has been defined as:

being open to and moved by one’s own suffering, experiencing feelings of caring and kindness toward oneself, taking an understanding, non-judgemental attitude toward one’s inadequacies and failures, and recognizing that one’s own experience is part of the common human experience (Neff, 2003, p. 224).

Nurses seldom talk about psychological and emotional vulnerability or the influence of values on their interactions—many of which were developed during nursing training (Maben, Latter, & Macleod Clark, 2007). Studies acknowledge that personal values can influence emotional wellbeing and professional behaviour, and that there are benefits from understanding these values, including an increased sense of teamwork and culture (Tillott, Walsh, & Moxham, 2013). As health professionals, nurses are deeply immersed in a culture that inhibits compassion—particularly for self—and they use coping strategies to reduce anxiety by depersonalising themselves to others, including both students and patients. However, recent research suggests that compassion is a predictor of psychological health and wellbeing, with a positive effect

of social connectedness and kindness on oneself and others (Jazaieri et al., 2014; Pace et al., 2010). Curtis et al. (2012) maintained that those involved in supervising student nurses' education in the clinical and university settings need to collaborate to improve socialisation in compassionate practice to ensure that future generations have experiences that perpetuate compassion for self and others.

Training programs are now emerging internationally that define how best to cultivate compassion. Nonetheless, it has been suggested in the literature that individuals may 'actively resist in engaging in compassionate experience or behaviours' (Gilbert, McEwan, Matos, & Ravis, 2010, p. 252) because it may expose their vulnerability. They suggest that this fear of extending compassion towards others may feel threatening to one's own interests or the interests of one's identified group. Consequently, this affects the nurse–student relationship and nurses' capacity to engage successfully with students. The value of training in self-compassion for both clinical and student populations cannot be underestimated; however, the literature notes that studies are yet to determine the extent to which formal training in compassionate care will improve self-compassion and lead to a cultural change (Jazaieri et al., 2012; Mayhew & Gilbert, 2008). Nevertheless, there are increasing opportunities for learning in this area, and nurses can aspire to professional ideals for student supervision through education while experiencing dissonance with practice reality. To change existing realities because of a lack of preparation requires a new initiative that combines clinical and educational expertise.

The next section will review the current programs available in clinical supervision. The aim of this study is to complement current programs and build upon the contemporary needs of the workforce rather than recreate what is already available. Thus, a review of the current literature is undertaken to support all phases of the study.

An understanding of the current programs that support the Delphi process provides an understanding of the current gaps and ensures that a new and innovative approach is adopted in developing the toolkit.

## **2.6 Review of Current Education Programs in Australia**

In Australia, there is currently no single education program that is nationally accepted as essential learning for supervising a student. However, programs such as the Art of Clinical Supervision (Russell, 2012) have been extensively used, particularly in Western Australia (WA), to meet the needs of nurses supervising students. This program has a face-to-face format and is delivered through workshops. Healthcare facilities have supported educational staff to attend these sessions and then hold toolbox sessions at their facility prior to students arriving in the clinical area. Programs delivered through universities such as the University of Western Australia and the University of Notre Dame have provided interprofessional postgraduate courses on clinical supervision that enable clinicians to gain a broader perspective in their learning and understanding of what clinical supervision entails. However, because of the length and costs associated with postgraduate study, enrolments in these programs are restricted to a small number of the profession.

In New South Wales (NSW), the Health Education and Training Institute (HETI) is a leading provider of high-quality training and education to support more than 110,000 clinical and non-clinical staff, trainers, managers and leaders across the NSW health system. They also provide courses such as workshops and state-wide programs to support rural and remote locations, as well as e-learning modules to enable them to reach many of their clinicians. However, these programs are not mandatory training for nurses undertaking clinical supervision of nursing students.

Similarly, across Australia, the Teaching on the Run program has been a successful program adopted by medical and nursing educators. The program is a staff development package that includes six foundation workshops designed to enable participants to apply sound teaching and learning principles in their workplace. Teaching on the Run started in 2004 and remains a popular and versatile professional development program. It includes a suite of workshops for improving the skills of health professionals involved in clinical teaching, supervision and assessment. The programs are delivered in a blended learning format (online preparation: ¾–1 hour and a 1–2 hour workshop), which gives more flexibility for time management and self-directed learning by combining e-learning and face-to-face programs. The success of this program is a valuable indicator of the way forward for programs being developed using blended learning.

The next section will review a variety of educational teaching and learning styles that may support the development of the toolkit for CSs. This will include a review of face-to-face, self-directed and e-learning.

## **2.7 An Educational Tool to Support the Nurse's Role**

The literature overwhelmingly supports the premise that clinical education is a complex and dynamic process in which students gain experience within the clinical environment, which is in itself a complex setting for joining theoretical knowledge and clinical care (Elliot, 2002; Moonaghi, Mirhaghi, Oladi, & Zeydi, 2015). The skills for student supervision are often lacking in nursing staff because preparation is not adequately managed.

Cooperation and coordination between hospitals and universities for improved preparation and organisational support of staff is required to improve the student experience; therefore, there is a continuing need for research into educational support

(Mackay, Brown, Joyce-McCoach and Smith, 2014). This is mainly because student supervision is predominantly an educational activity, and while nurses may be expert clinicians, they are not experts in teaching and learning (HWA, 2010).

The current model of clinical placements adopted in many clinical settings does not readily promote critical thinking or clinical reasoning for students, and it does not support knowledge, skills, attitudes and satisfaction for nurses in their supervisory role (Moonaghi et al., 2015, Courtney-Pratt et al., 2015). To support the development of a toolkit for this research, a variety of teaching and learning methodologies were reviewed, including traditional face-to-face learning, self-directed learning and e-learning. A review of these models of learning will support the interpretation of the Delphi panel findings into an appropriate toolkit format. The toolkit must be accessible and support nurses' understanding of teaching and learning in the clinical context. Further, it must help nurses to promote an environment in which critical thinking and clinical reasoning form the foundations of clinical practice.

### **2.7.1 Face-to-face learning**

Face-to-face learning can be described as an interrelated process between teacher and learners whereby a variety of teaching strategies progressing from teacher-centred to learner-centred may be used (Carlson, Wann-Hansson, & Pilhammar, 2009). This variation can be achieved using different approaches, including didactical and teacher-centred (e.g., lectures, workshops, presentations) or facilitative, with teachers directing towards problem-solving techniques using adult learning to help students reflect on and articulate what they know. This type of learning is restricted to the schedule of the teacher and an allocated place and time.



### 2.7.2 Self-directed learning

Unlike face-to-face learning, researchers view learner autonomy as an important component of self-directed learning (Kop & Fournier, 2010). Determining factors for successful self-directed learning include the learning environment, learning context and the connections that people make during their learning (Kop & Fournier, 2010). However, self-directed learning implies there is no teacher on hand, and on-demand learning is conducted at a pace that is managed or controlled by the learner.

Nevertheless, discussion around self-directed learning highlights that it should be positioned more for social and political action rather than individual learning. Kop & Fournier, (2010) argue that although new structures and environments such as the internet and the Web provide access to a vast range of information, creating a plethora of opportunities and change in the educational landscape, the effectiveness of learning autonomously is questionable. These technologies however, do provide the opportunity of global creative collaborative learning with others outside educational structures. Therefore, the provision of resources, learning tools, motivation and encouragement are essential to ensure success (Rana, Ardichvili, & Polesello, 2016).

A toolkit in whatever form whether paper based or delivered through technology should be viewed as an independent resource which provides guidance on how to use learning tools to improve practice through self-directed learning. The design and development of a toolkit that supports the process of planning and reflection, impacts both in terms of changing practice and developing a critical awareness of the issues (Cook & Oliver, 2002). Toolkits are used, for example, in higher education, industry and the provision of performance based contracting for health services and often draw on real-life examples to give an effective and realistic approach to meeting the needs of the learner.

### 2.7.3 E-learning

Through self-directed learning, e-learning offers the opportunity for clinicians to take charge of improving their own performance as supervisors and to develop the potential of their clinical area to be an effective learning environment. Continuous quality improvements in clinical education require nurses to evaluate the strengths and weaknesses of learning and teaching processes in clinical areas.

As previously stated, there has been much discussion around the mismatch and transferability of academic learning to practical skills and attitudes. Choules (2007) identified a possible solution, stating that by adopting and using existing well-defined adult learning principles, e-learning can effectively engage learners to acquire knowledge, skills, attitudes and behaviours. These acquisitions in the area of clinical supervision are vital if nurses are to build an area of belonging and clinical learning.

E-learning is defined as:

an approach to teaching and learning representing all or part of the educational model applied that is based on the use of electronic media as tools for improving access to training, communication and interaction and that facilitates the adoption of new ways of understanding and developing learning. (Sangrà, Vlachopoulos, & Cabrera, 2012, p. 5)

Globalisation of healthcare and advancements in technology have seen e-learning being increasingly used in health education. In recent research reported by the Imperial College London and the WHO (2015) on potential advantages and disadvantages of e-learning, ease of access and flexibility were shown as being particularly useful in relation to being able to undertake learning at a time and place of

the learner's choosing. Similarly, for those in remote areas, e-learning provides availability of access.

The relationship between technology and content knowledge is crucial for the successful use of this approach to education. In recent literature concerning developments in e-learning, digital game-based learning has emerged as the application of game principles and mechanics to engage users in solving problems and improving engagement, attitudes, motivation and knowledge. This technology is advancing rapidly, and specialised software are being developed for the healthcare industry to enable individuals to be self-directed learners (Rana, Ardichvili, & Polesello, 2016).

#### *Benefits of self-directed learning*

In more recent years as an educator, the researcher has observed that initiatives such as e-learning in today's climate of limited education time and restricted financial support are proving to be a cost-effective way of delivering education to meet the needs of many clinicians at their own pace. However, studies have recognised that flexible approaches that integrate technology and reduce the delivery of traditional training require a more self-directed attitude towards learning. According to Rana et al. (2016), many authors have acknowledged that within the workplace, self-directed learning should have a position of importance and should be encouraged to promote initiatives in different ways of learning.

#### *Obstacles to self-directed learning*

Chang and Lee (2007) maintained that self-development, job satisfaction and growth, which are promoted by self-directed learning, do not develop in isolation. Instead, teamwork in a cooperative, collaborative and supportive environment is essential, and without the encouragement and leadership of senior staff and

management, opportunities to deliver new learnings and insights alongside fresh approaches to ways of handling a problem are lost.

Davis and Daley (2008) argued that for learners to be self-directed, encouragement must be given through leadership to create an environment for ownership and motivating their own activities. Offering training to staff using digital tools and other learning technologies such as e-learning should be seen as reinforcement of self-directed learning in an environment that is tailored to improving access and ease of use. For example, educational programs for nurses with limited opportunities for travel and time for study can now use online tools that are customised to meet their needs.

However, recognising the importance of digital tools can be hampered by the lack of resources, free spaces and organisational culture (Karakas & Manisaligil, 2012). Thus, a change in culture to one that rewards personal growth and emphasises initiatives in collaboration, interaction, learning and development should be encouraged at the highest level. Organisational and managerial support are continually highlighted in the literature, and management intervention that challenges a shortfall in both resources and behaviours is a positive basis for restructuring a learning environment (Hegenbarth et al., 2015).

This section of the literature review has provided a comprehensive overview of the nurses' role in the clinical supervision of students on clinical placement, including the terminology used to describe the student–nurse relationship, the psychological effect of clinical placement and the importance of compassion, the role of education in supporting nurses to be effective CSs, and the different types of teaching and learning styles available in the health sector to support the development of the proposed toolkit.

The next section of the literature review will examine the learning environment that is the clinical workplace. It will include an overview of the student learning process, the role of nurse delegation and supervision to allow student nurses to safely practice within their scope of practice, and how this supports students' ascent to competence.

## **2.8 Learning Environment**

It has been suggested in the literature that the length of clinical placement affects students' sense of belongingness because it affects their ability to become immersed in the team culture (Levett-Jones et al., 2007). However, regardless of the length of the clinical placement, the crucial factors appear to be guidance and support given in a well-supported placement, which gives the student a sense of belonging (Henderson & Eaton, 2013).

### **2.8.1 Model of student learning**

Figure 2.5 displays a model of learning through participation in clinical practice, which the authors developed and validated using an evaluation questionnaire (Sheehan et al., 2008). From a sample of approximately 120 students, 84 respondents identified four main factors for effective learning environments: supervisor relationship, team environment, orientation and development of professional skills. The model demonstrates the complexity of the relationships, detailing the involvement of the team, the supervisor and the student working together to create an environment of belongingness and ultimately the acquisition of knowledge and skills. There are two critical components in the initiation stage: 1) the task of providing patient care and 2) engagement with the team. The student's involvement in patient care is crucial because it encourages them to feel invited to participate and engage with the team, which in turn stimulates a sense of belonging, trust and capability. This process follows many stages,

including initially being welcomed into the team, acknowledging the student's right to be there and respecting their input to the team.

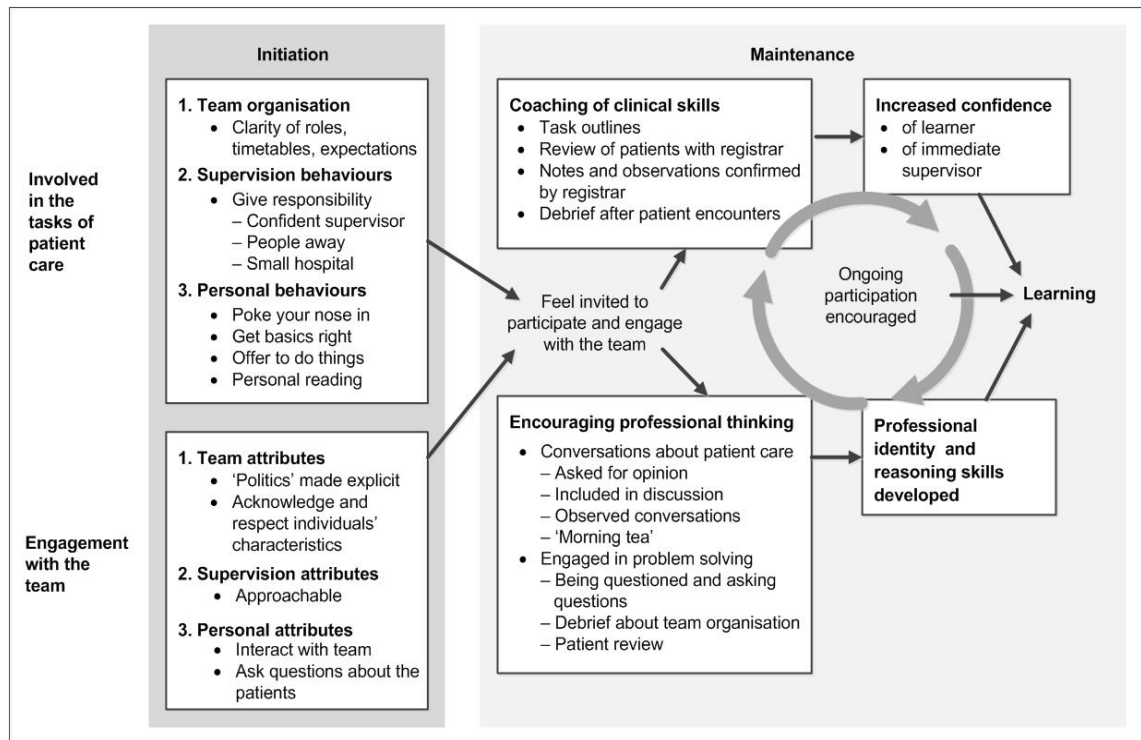


Figure 2.5. Learning through participation in clinical practice (Sheehan, Wilkinson, & Paltridge, 2008).

Sheehan et al. (2008) identified that this pathway will inform the development of the toolkit. For example, it is important to understand 'Team Organisation'—in which roles, timetables and expectations are clarified, along with the politics of the area through orientation—to enable students to feel safe and secure in the knowledge that they understand the dynamics of the area and can act appropriately to engage with the team. Orientation to an area is often poorly conducted, missing many introductions to the community itself and only offering an introduction to the physical environment. Levett-Jones et al.'s (2008) recommendations for practice identified the need for comprehensive orientation and socialisation to the clinical environment for students as preparation for learning. However, inconsistencies in the clinical setting as a learning

environment and varying processes in planning, communication and delegation affect the essential criteria being met for adequate supervision.

It is within the power of the nurse to delegate care, and it is through this action alone that students are able to practice in the clinical environment. Therefore, it is vital for both the supervising nurse and the student to understand their 'scope of practice' and the use of a delegation framework to enable student practice while directly or indirectly supervised by the RN.

### **2.8.2 Delegation, supervision and scope of practice**

As regulated health professionals, RNs are responsible and accountable to the NMBA. As part of practice, RNs are also responsible and accountable for supervision and the delegation of nursing activity. The NMBA (2016, p. 6) defined delegation as:

the relationship that exists when a RN delegates aspects of their nursing practice to another person such as an enrolled nurse, a student nurse or a person who is not a nurse...In some instances, delegation may be preceded by teaching and competence assessment.

As previously stated, it is important for the supervising nurse to be aware of their own and the student nurse's scope of practice when providing opportunities for practice. The scope of practice of an individual nurse or midwife is broadly defined by their profession's scope of practice, in which:

the individual has been educated, authorised and deemed competent to perform. It is influenced by the wider environment, the specific setting, legislation, policy, education, standards and the health needs of the population. (ANMC, 2007, p. 2)

The nursing profession is Australia's largest regulated health workforce; however, its practice boundaries are poorly understood (Scanlon, Cashin, Bryce, Kelly,

& Buckely, 2016). The ambiguity surrounding the practice scope of nurses limits the profession's ability to fully respond to Australia's current and emerging health system challenges. That is, the full extent of the nurse's role in the delivery of healthcare is under constant scrutiny as requirements for practice are challenged and extended. Currently, the role is often bound by hospital policy rather than legislation, which adds another dimension to clinical placement experience. Students can experience different levels of nursing practice within different health services or areas of practice.

Further, a key strategy to deliver essential healthcare nationally in the future has been to increase workforce numbers. HWA was an initiative of the Council of Australian Governments (COAG) and was established following the National Partnership Agreement (NPA) in 2008 to devise solutions through education and training to meet the needs of planning, reform and development of new models of healthcare delivery. This resulted in an increase in educational places for health professions at the degree and diploma levels, followed by ever-increasing demand for clinical placements in health institutions across all health professions (HWA, 2011). As a result, HWA (2011) recommended that clinical supervision in the context of entry to practice nursing education be recognised as the relationship between the student nurse and the RN responsible for their practice on clinical placement. This relationship is protected by the practices of delegation and scope of practice, yet remains confusing for both nurses and students. Gone are the days of student lists provided by state boards to be completed on placement; instead, CSs are expected to consider each patient care situation and determine whether the student can undertake the care required.

Additionally, while delegation and supervision have been considered fundamental components of the professional nurse role, staff shortages, the increasing complexity of patients, demand for services and reduced resources have all curtailed the



preparation of nursing staff and CSs to support students—our future workforce—in this era of change. This has affected the ability and readiness of nursing staff to undertake the additional role of CS for the unrelenting growth and unmet demand of clinical placements.

There is a lack of research on the extent to which RNs are prepared for students' learning in today's practice settings and how their preparation may have been obtained serendipitously or intentionally (Andrews et al., 2006). As a CF and educator, the researcher has obtained empirical and anecdotal evidence suggesting that nursing students' clinical experiences are often fraught with problems, leading to even greater confusion by nursing staff regarding the role of the supervisor (Levett-Jones et al., 2008). Literature suggests that a lack of trust often arises when there is poor understanding of one another's skills and competency (Gillen & Graffen, 2010; Weydt, 2010). Nurses may hesitate to delegate care when they are unsure of the student nurses' knowledge, skills and ability—particularly when asked to supervise students for short periods. This hesitation to delegate and the perceived lack of trust of the student, combined with the teaching skills deficit of some nursing staff, contributes to the constraints on student learning and inadequate ideals of working relationships in clinical settings (Levett-Jones & Lathlean, 2009a).

Controversially, key findings of a recent report on delegation and supervision conducted by the Department of Health in Victoria (2014) identified that RNs will require access to education that is specifically designed to develop knowledge and skills in this area. The recommendations included access to a range of educational learning tools to ensure effective and safe delegation and supervision, including enhancing opportunities to prepare pre-registration students for their role as potential supervisors. However, commentators on the report responded that there is no current framework to

develop these skills, and that the culture of the unit will inevitably affect its ability to provide an environment conducive to learning (Department of Health, Victoria, 2014). This report appears to be in line with work produced by HWA (2010). Many different student supervision models operate in Australia, but there is a need for a clearer role and function definition of CSs. The paper also acknowledges that service delivery, teaching and reporting compete with priorities such as client service. The health services' interests of delivering cost-effective client care may conflict with the needs of the education provider, whose main priority is training and education. However, there is a synergy between the desired outcomes to improve both the quality of health and education.

### **2.8.3 Clinical placements**

Clinical placements are structured around the academic learning that takes place at educational institutions. As discussed in the literature, they vary in suitability, duration and opportunity, which means that nursing students are occasionally placed in areas that are unsuitable for the stage reached in their academic studies, and often for limited periods, thereby curtailing their learning opportunities.

As previously discussed, CFs are responsible for 8–10 nursing students' learning during the clinical placement; however, the student placement itself is varied in both length and structure. An average placement will involve the student nurse being on shift for two weeks. To accommodate the number of students, health facilities expect students from year 2 onwards to be able to work a full-time shift rotation, including night duty. This has caused a mismatch in some cases between the CF's availability and the rotation undertaken by the student, leaving the educational responsibility entirely with the CS (Carrigan, 2012).

Although research identifies that experience in the clinical setting is important for the outcome of student nurses' education (Hegenbath et al., 2015), and that 'the creation of a positive learning environment and a nurturing environment for mentoring is of crucial importance' (Matsumura et al., 2004, p. 302), the aforementioned limitations continue and diverse experiences are documented, some resulting in poor behaviours by both staff and students.

Smedley and Morey (2010) reported that in this situation, students are strongly affected by the attitude and communication of staff, which will intensify their feelings of exposure and vulnerability. Andrews et al. (2006) maintained that clinical placements should provide learning through a real-life experience of practice, which should not be the worst of experiences. The culture of the clinical area has been highlighted in the literature for many years, and negative aspects of nursing (e.g., bullying) continue to be experienced. Huntington et al. (2010) identified that the tension between expected quantity of care in poorly resourced settings that lack educational opportunities and the need to maintain quality to meet professional standards and expectations results in nurses describing their work as unpleasant and destructive, with a climate of 'nurses eating their young', which often includes students. Inconsistencies in the clinical learning environment should present a concern; however, little is known about what nurses themselves perceive as a conducive learning relationship with students, which ultimately encourages involvement with the team. Education in team building enables nurses to implement strategies for involvement, thereby changing the culture of the environment.

Access to formal and informal activities encourages students to feel part of the team. Involvement in informal gatherings such as shared lunchtimes can increase comfort levels, engagement in dialogue and questioning with other staff and students,

which will in turn validate students' experience (Plack, 2006; Sheehan et al., 2008). However, the researcher's experience as a CF and an undergraduate coordinator shows that students are often not included in such activities. Students report that placement experiences are significantly affected by the attitudes of senior nurses such as ward managers. Numerous studies have identified that staff attitudes, actions and quality of teaching are directly influenced by ward managers' attitude towards student education (Andrews et al., 2006); however, role modelling starts at the top and prejudices the behaviour of staff (Courtney-Pratt et al., 2012).

A conceptual framework developed by Levett-Jones and Lathlean (2009a) applied a modified version of Maslow's (1954) hierarchy of needs to the clinical placement experiences of undergraduates and maintained that there is a clarity and simplicity that resonates with lived experiences. This framework can be seen as a progressive tool that provides practical, structured and research-based guidelines that, when applied to clinical placement supervision, will develop and facilitate the requirements for an environment that best addresses undergraduates' needs. A multiple case study by Hegenbarth et al. (2015) disclosed culture has a significant effect on attitudes in valuing students' input to become part of the team, this is consistent with Levett-Jones et al.'s (2009) perspective of students seeking belongingness. Positive dynamics within the team can provide a safe environment, whereas negative approaches can destroy confidence. This is congruent with Maslow's model, whereby individuals' self-esteem and confidence are precursors to self-actualisation.

#### **2.8.4 Ascent to competence**

To understand what motivates people, Maslow depicted their needs as hierarchical levels of a pyramid (see Figure 2.6). He maintained that the lower levels of basic needs such as food, water, warmth, security, shelter, family, friends and

community need to be satisfied before progress can be made towards the higher growth levels of self-esteem and self-actualisation. He also proposed that everyone has the capability and desire to reach the top level (Maslow, 1954).



*Figure 2.6.* Maslow's hierarchy of needs (1954).

Maslow's (1954) hierarchy of needs proposed that by developing practices that acknowledge the whole needs of the individual, such as food, shelter, family and recognition, an optimal level of functioning can be achieved. By applying Maslow's theory to student clinical placements, an understanding evolves of what is required to create a learning environment. However, the duration and structure of clinical placements pose a challenge to the feelings of safety and security for students because they are on clinical practicums for a short time and therefore cannot establish a long-term relationship within the community of nurses. The recommendation of the development of a model of fewer placements for a longer period—similar to some allied health undergraduates—will increase socialisation. Levett-Jones, Gilligan, Lapkin and Hoffman (2012) raised this controversial concern; however, there are some innovative education models in place that attempt to address these issues (Carrigan, 2012).

Acknowledging this, Levett-Jones and Lathlean (2009a) demonstrated that, as with Maslow's original hierarchy, this conceptual framework has five levels that provide a system of interrelated concepts (see Figure 2.7). Each theme is a concept in its own right, but the divisions between the levels are less distinct. A pyramid rather than a triangle is thought to be a clearer representation of the ascent to competence because of the multidimensional aspects of both the concepts and students' individualism (Levett-Jones & Lathlean, 2009a). However, for any student to succeed, all components must be fulfilled. Failure ensues when support from staff is not maintained because of a lack of understanding of what is required of them.

Levett-Jones and Lathlean (2009a) identified this range of needs and proposed recommendations for practice. They maintained that the key role for clinical leaders is to create a belonging environment and positively influence the attitude of other staff towards students to promote dialogue and debate on professional issues. For these to become the benchmark of best practice (NSQHS standard 13.4), a structured process is required to help nurses understand the types of organisational values, structures, practices and behaviours that better prepare and create an environment that is conducive to learning.

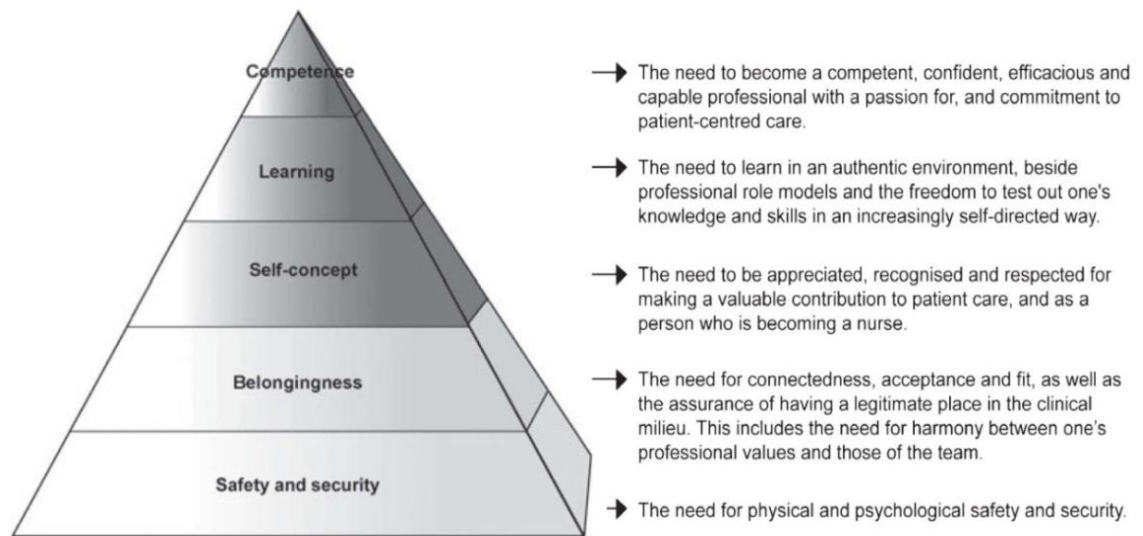


Figure 1 Ascent to Competence conceptual framework (adapted from Maslow's Hierarchy of Needs, 1987).

*Figure 2.7. Ascent to competence (Levett-Jones & Lathlean, 2009a).*

Recommendations for practice (Levett-Jones & Lathlean, 2009a) provide an alternative perspective on methods for improving students' experiences. They provide a guide using the concept of belongingness to influence any decision-making for future clinical placement models to be more meaningful and of practical significance. Supporting this perspective, Sheehan et al. (2008) identified four factors for participation in clinical practice, with each factor fitting within and supporting the learning model, and the evaluation tool provided results for further support. The designed constructs containing activities would support busy staff with the aim of creating a student-friendly culture and enhanced satisfaction and morale (Cleary & Walter, 2010).

This review of the learning environment has highlighted the essential role of the supervising nurse in providing an environment in which students are supported to practice through the delegation of care that sits within their scope of practice. The opportunity to practice supports students' progression through the ascent to competence framework and their ability to meet the RNs' standards of practice.

The literature review has shown that there needs to be an advancement in supporting nurses to not only understand the concept of belongingness, but also to embrace learning, which could influence a cultural change in the clinical learning environment to support nursing students. Recent changes to the provision of healthcare throughout the world's health services have left many nurses disenchanting and disenfranchised. However, if nursing is to continue as a progressive, competent profession, leadership must be shown in changing how the next generation can benefit from clinical placements. The literature shows that the profession has long been aware that improvements need to be made. Gathering the opinions of experts to make practical changes may go some way to making the necessary adjustments for staff and students to gain satisfaction from this relationship and experience. Further, to gain expert opinions in the field of nursing, a methodology used with success in recent times is the Delphi method (de Meyrick, 2003), which elicits opinions that produce qualitative data.

## **2.9 Delphi Method**

The researcher sought confirmation that the Delphi method would be suitable for extracting data to inform the development of the toolkit. To this end, a review of the literature revealed that Skulmoski, Hartman and Krahn (2007) recommended the Delphi method as attractive for graduate students completing Masters- and PhD-level research. It is a structured process that can be matched to the abilities and aptitudes of graduate students. The flexible technique is an iterative process for collecting and distilling anonymous judgements of experts when there is incomplete knowledge. The aim is to improve the understanding of the problem and the possible opportunities or solutions available.

A search of the literature in the CINAHL, ProQuest, OVID and Google Scholar databases using the keywords 'Delphi', 'research', 'medical', 'nursing' and 'experts'



revealed that the conventional Delphi method was developed for technological forecasting and attributed to Dalkey and Helmer of the RAND Corporation, who aptly named it after the oracle of Delphi. Although this method has been adopted for more than 1,000 published research projects since its inception in the 1950s (Baker, Lovell, & Harris, 2006; de Meyrick, 2003; Hasson, Keeney, & McKenna, 2000; Loo, 2002), the search was limited to research examples for use in the area of clinical practice. According to published papers from 2000 onwards, it is particularly well suited for informing health education and has been extensively used in medical, nursing and health services research (de Meyrick, 2003; Hasson et al., 2000). Most notably, a significant number of papers were from the UK, where the Delphi method is widely used for gathering data from a panel of experts and commonly employed to make decisions or allocate resources in the health service.

While much of the literature states that the Delphi method is typically used as a quantitative technique, researchers can nonetheless use qualitative techniques with the Delphi method. While there are many varieties of Delphi, common to all are design considerations that need to be decided upon, including sample composition, sample size, methodological orientation (qualitative and/or quantitative), the number of Delphi rounds and the mode of interaction (Skulmoski, Hartman, & Krahn, 2007).

### **2.9.1 Sampling and the use of experts**

A critical review of the Delphi technique as a research methodology for nursing by Hasson, Keeney and McKenna (2000) showed that there are many differing forms of Delphi in existence. Their critique of the method identified that Delphi does not use a random sample that is representative of the target population, but instead employs 'experts'. However, they reflected that simply because individuals may have knowledge of a particular topic, it does not necessarily mean that they are experts. In fact, they

stated that ‘those who are willing to engage in discussion are more likely to be affected directly by the outcome of the process and are also more likely to become and stay involved in the Delphi’ (Hasson, Keeney, & McKenna, 2000, p. 1010).

Skulmoski et al. (2007) described the Delphi method as being used in research to develop, identify, forecast and validate a wide variety of research areas. A Delphi method round consists of a questionnaire sent to a panel of experts, and the anonymous responses are aggregated to inform the next questionnaire for the next round. Typically, a three-round Delphi survey is conducted; however, single- and double-round Delphi studies have also been completed, and the sample size varies from four to 171 ‘experts’. Therefore, there is no ‘typical’ Delphi; rather, the method is modified to suit the circumstances and research question.

Skulmoski et al. (2007, p. 9) illustrated and included examples of the various ways in which the Delphi method can be used:

1. methodological choices, such as a qualitative, quantitative or mixed methods approach
2. initial question degree of focus, whether it be broad or narrowly focused
3. expertise criteria such as technical knowledge and experience, capacity and willingness to participate, sufficient time, and communication skills
4. number of participants in the heterogeneous or homogeneous sample
5. number of Delphi rounds varying from one to six
6. mode of interaction, such as through email, online surveys or groupware
7. methodological rigour and a research audit trail
8. results analysis
9. further verification through triangulation or with another sample
10. publication of the results.

A sample of theses from 1985 to 2005 is shown in Table A.1 (see Appendix 1), which presents an overview of the focus of each study undertaken, as well as the numbers of rounds and sample sizes. When reviewing the methodology for the development of the framework for the toolkit, the researcher identified similarities to these studies in terms of focus and techniques.

In addition, according to the review of studies in the area of healthcare by Sulmoski et al. (2007), these have been undertaken to include GPs' information requirements in a Welsh health authority in 1999, identifying the content and context of nurses' continuing professional development needs in 1998, and nursing policy and administration in 1990, 1994 and 1998. It is interesting to note from the literature review that none of these studies used the Delphi method in the same way. From the literature, it can be concluded that the Delphi method has advantages over common survey methods, but they must be evaluated against the proposed study (Skulmoski et al., 2007).

In the first stage of this study, the researcher planned to use the data effectively to develop the next stage of the study, and then to develop a purpose-built toolkit.

To support the development of the toolkit, this literature review has articulated that the attitude of nursing staff towards the role of the CS affects their engagement with students. Therefore, in developing the toolkit, it is essential that the contents not only provide a framework for teaching and learning, but also deliver a persuasive message of providing an environment that encapsulates the concept of belonging. Therefore, the next section will provide an overview of the concept of attitude, how to influence attitude and, to ensure beneficial evaluation of the toolkit, the measurement of attitude.

## **2.10 Persuasion and Attitude Theories**

While developing the toolkit from the data collected from the Delphi panel in stage one, the researcher needed to understand the theories of persuasion and how attitudes are developed. The researcher identified that if the toolkit is to deliver the intended change of attitude towards student nurses, a clear idea of positive persuasion techniques was required. Thus, the researcher examined the literature in relation to both negative and positive theories and the motivation for changing attitudes using persuasive messaging.

### **2.10.1 Persuasion**

Persuasion is a common function of communication that is intended to influence another while giving the freedom of choice (O’Keefe, 2016). A number of different theoretical approaches have elaborated on the theory of persuasion, including social judgement theory, the elaboration likelihood model, reasoned action theory and cognitive dissonance theory. Research has identified various factors that influence persuasive outcomes, including communicator characteristics (e.g., credibility, liking, similarity), message properties (e.g., different kinds of arguments, narratives, fear appeals) and recipient characteristics (e.g., moods, defensive reactions, personality traits) (O’Keefe, 2016).

One recurring theme is the importance of adapting persuasive messages to recipients. When individuals can choose to process or not process information, individual and situational factors can determine whether people attend to and scrutinise a message carefully (Brinola, Ruckerb, & Petty, 2015). People who associate persuasion with something positive might think that persuasion is something to which one should pay attention. This ideal would allow educators to use positive messaging to assist in the promotion of ideas to change attitudes. Similarly, those who associate persuasion with

something positive may believe detailed scrutiny is not needed because persuasion is safe.

However, people who associate persuasion with something negative might think that it is something that should be ignored. The power to influence these people lies in the communicator's ability to build rapport. Alternatively, associating persuasion with something negative might lead individuals to think persuasive attempts need to be guarded against and scrutinised carefully (Brinola, Ruckerb, & Petty, 2015). People have become warier with the common use of social media; therefore, integrity is essential to encourage positive reactions.

To influence the change of attitude through persuasion to a positive ideal, the researcher was required to encourage participants of the program to actively participate in the designed activities. Reflection on the messages portrayed by both the tools and the characters in the videos was important to inform practice for the future. Examples of reflective practice used in e-learning are detailed in later chapters. The success of this approach to changing attitudes relies on a quality product.

A principle outcome of this research was to determine whether the toolkit could illicit a change in attitude that would affect supervision behaviour and improve relationships between RNs and nursing students. To determine whether this outcome was achieved, a measurement of attitude was sought in the literature, with O'Keefe (2016) maintaining that attitude is the precursor to behaviour.

### **2.10.2 Attitude measurement**

To determine participants' attitudes, the researcher sought to identify developed and presented attitude scales. Cutcliffe and Hyrkas (2006) noted that social psychology contains extensive literature that examines attitudes, and within nursing research, it is not uncommon given the theoretical and conceptual congruence. However, attitude is an

ill-defined phenomenon, and variability often occurs, with mood, personality and emotion affecting evaluation. Despite this, useful data may be elicited to inform future research studies.

Upon further review of the literature, Stagg's (1992) attitude survey was sourced from her nursing master's thesis, which had also been used by Russell (2012) and Parvin et al. (2015). However, Russell (2012) noted that the survey did not directly relate to nurses' attitudes towards clinical supervision, but instead towards students, and supervision questions were embedded in the tool. Subsequent research of the literature shows that two separate clinical supervision programs produced positive results in influencing attitudes and raising participants' awareness about effective supervision strategies (Russell, 2012). Although these were self-reported findings, Smedley and Morey (2010) revealed a logical link between appreciation of the supervision role and attitudes towards nursing students. While conducting a preceptorship program that involved promoting group interaction and problem-solving, they were able to obtain data that suggested that positively influencing attitudes towards students improved the confidence and communication abilities of the nurses undertaking the clinical supervision course.

Russell (2012) therefore determined that the attitude survey designed by Stagg (1992) could be used as a measure of attitudes towards clinical supervision. Further, the researcher concluded that this particular survey could deliver the data required for this study.

### **2.11 Stagg's Attitude Survey**

The design and validation of Stagg's attitude survey was implemented in two hospitals as part of her master research thesis. The results portrayed a poor or low attitude by nurses towards students. Using the Likert scale, Stagg (1992) developed a

themed questionnaire to collect data; the survey has since been used by several researchers. Parvin et al. (2016) rated Stagg's attitude scale highly in terms of simplicity, relevance and validity. The reliability of this questionnaire was determined at 89% on Cronbach's alpha coefficient.

The methodology of this research study presents a second quantitative stage that involves using Stagg's attitude survey (1992). This particular survey was chosen by the researcher because Russell (2012) and Parvin et al. (2016) previously used this method of data collection to explore nurses' attitudes towards students. This enabled the researcher to compare previous data with the results from this study using a pre-tested reliable tool that incorporated the Likert scale.

### **2.11.1 Likert scale**

Stagg's attitude survey (1992) uses a five-point Likert scale. The Likert scale is applied as one of the most fundamental and frequently used psychometric tools in educational and social sciences research. Likert's survey presents items on a scale to enable participants to choose clearly opposed alternatives (Joshi, Kale, Chandel, & Pal, 2015). The Likert scale used in this survey combines the participants' responses to groups of questions that relate to one area or a variable. The purpose of the research is to understand the opinions and perceptions of the participants that relate to a single variable or phenomenon of interest (Joshi et al., 2015). The variables of this survey include professional issues, personal issues, time, motivation, the instructor–student relationship and background comparisons (Stagg, 1992, p. 36).

The Likert scale included the choices of 'Strongly Agree', 'Agree', 'Undecided', 'Disagree' and 'Strongly Disagree'. Each question had a preferred response, as supported by Stagg's research.

## 2.12 Summary of the Literature

This literature review focused on previous research that identified the need for belongingness in an authentic clinical setting for student nurses to be able to gain confidence and competence. More significantly, it focused on the ability, capacity, attitudes and effects on student learning of nursing staff in providing a well-supported placement that offers student nurses a sense of belonging (Smedley & Morey, 2010; Webster et al., 2016).

While reviewing the literature from the different perspectives of interpersonal relationships, including role and social learning theories, the review underlined the difficulties for both students and nurses in establishing a meaningful relationship and embracing the expected ideals and values required to become members of a professional group (Moonaghi et al., 2015; Sheehan et al., 2008). However, the literature is disproportionately greater in volume when discussing the student nurse perspective, while the body of knowledge that addresses the views and perceptions of nurses is considerably smaller, offering a disjointed overview of what works and what does not.

Nevertheless, a significant quantity of the literature highlights the lack of preparation and education given to nurses in terms of the facilitation of student learning, which results in valuable learning opportunities being missed and socialisation hindered (Carrigan, 2012). In addition, the culture, which is part of the social fabric of nursing, affects professional behaviour and influences both positive and negative coping strategies, which in turn does or does not stimulate a sense of belonging, trust and capability (Hall et al., 2012).

Notably, the literature identifies and supports the need for a practical, structured process that uses developed educational resources and technology to increase the potential to educate, and that uses expertise from within the profession to guide the



process (Sheehan et al., 2008) as previously discussed in 2.8.1 Model of student learning. The literature also identifies that this positively influences the attitude of nurses to build stronger relationships with students, thereby enabling them to truly 'belong' and become an integral part of the team (Gidman et al., 2011). This study draws on this expertise by forming a Delphi panel to develop a toolkit to create an environment of belonging and ultimately learning (de Meyrick, 2003).

Following on from the development of the toolkit, participants using the toolkit were asked to show change according to their level of agreement on a metric scale. The literature identifies that although attitudes, perceptions and opinions are qualitative attributes, they are amenable to quantitative transformation. Qualitative research techniques depict the complexity of human thoughts, feelings and outlooks, but quantification of these traits can be measured using psychometric techniques (Joshi et al., 2015). The use of Stagg's attitude scale employing the Likert scale revealed specific dimensions of the attitudes towards students.

## Chapter 3: Methodology

*The key to success is realising that our big goals aren't going to happen overnight. (Anon)*

### 3.1 Introduction

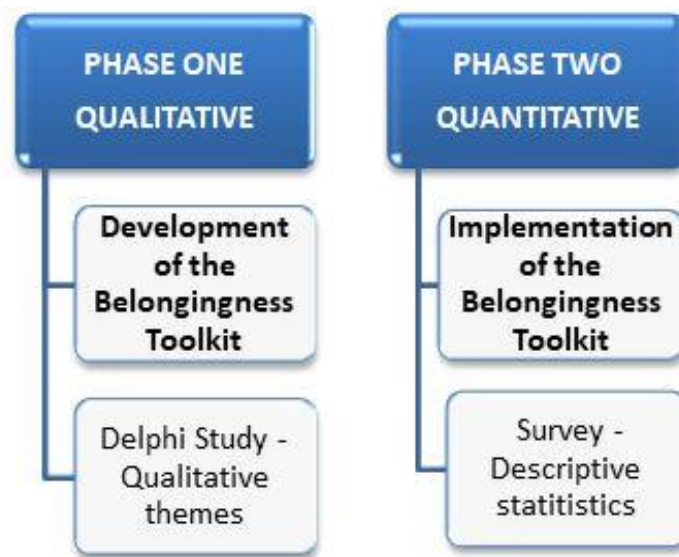
The overall aim of research in social science is to capture the non-tangible attributes of human behaviour and performance and to qualify and quantify that which cannot be measured through conventional measurement techniques (Joshi et al., 2015). In searching for the patterns to answer the research questions, the researcher needed to choose a method of research that would entail more than the collection of two datasets. The approach needed to examine data from different viewpoints to add breadth and depth to inform the development of the toolkit.

In this study the qualitative data would be necessary to inform the next stage of obtaining quantitative data because the factors that underpin the phenomenon of belongingness are far from definitive (Levett-Jones, 2007). The researcher examined alternative mixed method research design such as case studies using in-depth structured interviews with interest in the case or phenomenon as used by Levett- Jones in her thesis on *Belonging in 2007*. In addition a descriptive methodology involving the collection and analysis of quantitative and qualitative data using a triangulation approach as undertaken by Russell (2012) in her thesis on *Belongingness* was considered.

However, in seeking to reach as many experts as possible in this field both state-wide and nationally to initiate the first stage, the researcher concluded that in-depth interviews conducted by both of the other researchers would not be a practicable solution. Using a pluralistic approach would give the participants the opportunity to best address the questions. This strategy would enable examination of data from the different viewpoints to add breadth and depth and to inform the development of the toolkit using

the participant's understanding of the contemporary clinical learning environment cultures. The researcher concluded that the Delphi panel methodology offered the opportunity to drill down through continual rounds to understand the research problem using an alternative method to interviewing.

This chapter outlines the chosen research method. The study used a sequential mixed method that consists of both qualitative and quantitative phases (QUAL+QUANT), as demonstrated in Figure 3.1. This identifies that the purpose of phase one is the development of the toolkit using a Delphi study to inform the content. Phase two is the implementation of the toolkit and subsequent survey using descriptive statistics to determine the intervention's outcome.



*Figure 3.1.* Sequential mixed methods design (Creswell et al., 2011).

The sequential mixed method model aims to use the results of the initial phase to inform the design and implementation of the subsequent phase (Creswell, Plano Clark, & Clegg Smith, 2011). The use of both qualitative and quantitative research offers contrasting methods, and multiple data sources have merit when studying a complex phenomenon of sociocultural context. Further, this methodology combines not only

methods, but also assumptions, concepts and values; therefore, it can be appropriately considered a mixed paradigm.

Paradigms are an approach to common interests, beliefs, practices and positions that tend to be shared and ultimately guide researchers (Liamputtong, 2013; Morgan, 2007). They are ‘assumptions made about the nature of social reality and the way in which we can come to know this reality’ (Blaikie, 2010, p. 8). Denscombe (2008, p. 272) maintained that the basis for a research paradigm is that it: (a) is consistent with the pragmatist underpinnings of the mixed methods approach, (b) accommodates a level of diversity and (c) has good potential for understanding the methodological choices made by those conducting mixed methods research. Methodological quality relates to the choices and ultimately the construct of trustworthiness and how biases are minimised (Hong & Pluye, 2018).

A paradigm that has become increasingly popular with health researchers is pragmatism, whereby it is argued that knowledge is based on the reality and experience of the world we live in. Knowledge is gained not only through natural and physical realities, but also through psychological and social realities (Liamputtong, 2013). With this in mind, the researcher initially used the Delphi technique. A description is given of the recruitment and participation of the panel, the data sources and how the data were collected to inform the development, implementation and evaluation of the toolkit.

### **3.2 Theoretical Perspective**

The application of frameworks enables feasibility of a study while adhering to the theoretical and conceptual frameworks upon which the study is founded (Creswell et al., 2011).

The researcher’s choice of a paradigm that embraces pragmatism was influenced by existing literature from the scientific community of social science and psychology.

Within this scientific community, belongingness is seen as a complex human phenomenon and an influence on personal experiences of the world. A pragmatic approach using experiences from realities to derive knowledge about problems is the methodology that will encourage the researcher to move beyond the constraints of a single paradigm towards practical possibilities.

Levett-Jones (2007, p. 7) noted that the tenets of pragmatism are ‘commitment to what works in practice, appreciation of plurality and a desire for integrated results’. The interest in this paradigm is growing, and a previous example of this methodology was successfully demonstrated in a study by Levett-Jones and Lathlean (2009), who used a mixed method design to obtain quantitative data from an anonymous online survey (Belongingness Scale—Clinical Placement Experience) completed by 362 nursing students in Australia and the UK, as well as subsequent qualitative data obtained from in-depth, semi-structured interviews with a subsample of students. They identified a natural appeal to the need for belongingness, and their qualitative approach provided a rich data source from the students. A number of theorists have presented findings on social networking and the need to belong through the field of psychology. Block (2008) proposed that the core concept of social capital theory or quality of relationships relies on social networks having value, which gives personal and collective benefits. Therefore, to understand human behaviour within the clinical community, a panel comprising individuals involved in many levels of care delivery will assist in finding patterns and themes to support those collective benefits.

However, the challenge is to successfully synthesise the different forms of data. Qualitative exploration is beneficial and improves understanding by investigating the underlying complexity of the phenomenon of belongingness before the development of the toolkit. When a quantitative phase follows a qualitative phase, the intent can be to

develop an intervention (in this case, a toolkit) informed by qualitative findings (Creswell et al., 2011). Following the introduction of the intervention, the effectiveness of the toolkit can be examined using quantitative methods to gather data from comparison groups to describe its usability and sustainability in objective terms. This approach also enables the testing of the toolkit to be replicable to measure or identify the same thing in many alternative areas.

### **3.3 Methodology of the Research Project**

In undertaking this project, the researcher's aim was to examine the literature, personal experiences of qualified and student nurses and opinions from experts in the field to determine the components required to develop a framework for a toolkit to support an environment of belongingness.

The chosen methodology of sequential mixed methods ultimately supported the design of a relevant and practical toolkit based on data collection, analysis and interpretation of issues, perceived problems and potential possibilities that directly affected the ability of students and the clinical workforce to encapsulate the sense of belonging.

#### **3.3.1 Sequential mixed methods**

The sequential mixed method model uses the results of the initial data collection and analysis phase to inform the design and implement subsequent data collection phase(s) (Creswell et al., 2011). Mixed methods research allows for the study approach to be both comprehensive and analytical in a holistic way using a combination of methods (Pasick et al., 2009), thereby providing a better understanding of a specific phenomenon. Qualitative and quantitative research offers contrasting methods because both have different strengths that can be capitalised upon. Similarly, weaknesses can be

minimised with alternative strategies (Patton, 1990). Creswell et al. (2011, p. 31)

suggested that to complete a mixed methods study, the researcher needs to:

- collect both quantitative and qualitative data
- employ rigorous procedures in the methods of data collection and analysis
- integrate or mix (merge, embed or connect) the two sources of data so that their combined use provides a better understanding of the research problem than one source or the other
- use a mixed methods research design and integrate all features of the study with the design
- convey research terms consistent with those being used in the mixed method field.

By exploring and defining underlying assumptions and information concerning the concept of belongingness for student nurses and correlating informed decisions from the literature, nurses and a group of experts (Delphi panel), a framework for the development of a toolkit becomes achievable (Wilkes, Mohan, Luck, & Jackson, 2010).

### ***3.3.1.1 Qualitative***

Qualitative research focuses on narratives collected by the researcher and is centred on the subjective experiences of people and their world (Liamputtong, 2013). These narratives, which are obtained through social inquiry, highlight many levels of interaction and interpretation that influence a given problem within groups, communities or organisations. A significant strength of qualitative research is the focus on contexts and the meaning of human lives and experiences for the purpose of inductive or theory development. It ascertains previously unknown practices—that is, ‘explanations of why and how phenomena occur and the range of their effects’ (Pasick et al., 2009, p. 17). Qualitative design focuses on a holistic view of the lived experience

and is more flexible and fluid in its approach because our understanding of reality can alter in different social contexts. However, it is more suited to researchers' and participants' interpretation of meanings attributed to individuals' experiences, because this method encourages subjective expression of individual feelings in participants' own words (Denzin, 2010; Liamputtong, 2013).

A qualitative approach provides detailed information about environment and context, and it emphasises the voices of the participants (Liamputtong, 2013). It also facilitates the collection of data when quantitative measures do not exist or are not appropriate, and it provides a depth of understanding of concepts. It is a systematic and rigorous form of inquiry that uses methods of data collection such as in-depth interviews and reviews of documents or a multiple iteration survey technique that uses a systematic refinement of expert opinions or 'pooled intelligence'—the Delphi technique (Creswell et al., 2011; de Villiers, de Villiers, & Kent, 2005). This technique is discussed in more detail below.

The qualitative research approach produces rich, in-depth information from individuals, a group or groups of people, thereby increasing the understanding of situations that require investigation from a number of diverse perspectives (Liamputtong, 2013). Collection methods may use unstructured or semi-structured data collection techniques to uncover themes in thoughts and opinions, thereby allowing the researcher to identify issues from the perspective of the study participants. In this case, the Delphi panel give their interpretations of behaviours and events by responding to questionnaires.

### ***3.3.1.2 Quantitative***

Quantitative research is a mode of enquiry that collects descriptive information, tests theories and hypotheses, and examines relationships between variables using a



deductive process (Creswell et al., 2011). This mode of research is used to enumerate a problem by way of generating numerical data that can be converted into useable statistics. Often using a larger sample than qualitative research, it employs strategies to collect numerical factors to describe a given situation in objective terms. It is more structured and will quantify defined variables (i.e., behaviours, attitudes, opinions) to formulate facts and uncover patterns through surveys and systematic observations. The use of quantitative techniques to measure the reactions of many people produces broad, generalisable data that provide a snapshot at that point in time. This is a more suitable approach for stage two of this project because it facilitates comparisons and statistical evidence to test the usability and sustainability of the toolkit (Morgan, 2007; Pasick et al., 2009).

### **3.3.2 Application of sequential mixed method research**

In this study, the researcher used both qualitative and quantitative methods and therefore engaged a pragmatic methodology using a mixed method approach, which will provide a more holistic and multifaceted means of answering the research questions. Employing a pragmatic approach allows the research design to be determined by the questions asked before either the selection of the method or paradigm (Punch & Oancea, 2014). A pragmatic perspective uses diverse data collection approaches to discover what is optimal for answering the research questions, and it values both objective and subjective knowledge (Morgan, 2007).

The appeal of the mixed method approach for this project is that it provides a wider exploration of the social, philosophical and ethical issues related to belongingness in clinical placements, and it encourages the researcher to use one type of investigation to inform the subsequent development of another.

However, the challenge is to successfully integrate the different forms of data at the appropriate point within the research design timeframe. Qualitative exploration can be beneficial in investigating the underlying complex phenomenon of belongingness before any development of a conceptual framework to inform the quantitative phase of the study. Both Chan (2001) and Levett-Jones et al.'s (2009) research on the learning environment concluded that attainment of competence is only achieved when previous needs of belongingness, safety, security, healthy self-concept and learning have been met. These rich research data are valuable when considering the design of the next quantitative stage of providing a framework of key principles to produce a practical instrument.

### ***3.3.2.1 Phase one***

The qualitative data collection phase consisted of a qualitative approach that used the Delphi technique to engage in participant recruitment, the collection of data sources and identified the process regarding how the data were to be collected.

The researcher examined the literature on the key issues of the phenomenon of belongingness (Levett-Jones & Lathlean, 2009, p. 2877), including recommendations for practice, to create a solid foundation on which to develop an initial questionnaire to distribute to a panel of experts. This approach was appropriate for the initial stage of this study in which the Delphi technique was employed to obtain experts' opinions to refine assumptions, options and supporting evidence in given areas (Wilkes et al., 2010). The aim was to achieve convergence of opinion for tool development and then attempt to address what could/should be used to create an environment of belongingness.

### 3.3.2.1.1 Delphi method

The Delphi method is a well-established consensus method that gathers data from a panel of experts within their domain of expertise. It is well suited to building consensus opinion on real-world issues that require insights from subject matter experts using a group communication process (Hsu & Sandford, 2007). Further, it is appropriate for researching complex issues that require an initial range of opinions with the aim of reaching consensus on the topic of focus. Although it does not offer the rigour of clinical hypothesis testing, it is developed to facilitate deliberation on a problem while providing scientific rigour to aggregate informed opinions (Grisham, 2009).

In many areas, the Delphi method is used to estimate the likelihood and outcome of future events. It is an opportunity for a group of experts to exchange views anonymously by providing estimates and assumptions to a facilitator who reviews the data to determine information that may generate consensus. Consensus methods, including Delphi panel surveys that use an iterative multistage process, are being employed within healthcare to transform opinions into group consensus (Hasson, Keeney, & McKenna, 2000).

The Delphi technique has previously been used for the development of assessment tools in health (Biondo, Nekolaichuk, Stiles, Fainsinger, & Hagen, 2008). Löfmark and Thorell-Ekstrand (2004) used this process to obtain opinions from an expert panel about an assessment form and possible changes to it. The open-ended questions and space given for comments allowed new ideas and new content to be suggested. While de Meyrick (2003) noted that this method might be less attractive to some researchers from qualitative and quantitative disciplines, Linstone and Turoff (2002) argued that there is a need to employ the Delphi method if the problem does not lend itself to precise analytical techniques, and benefits can be gained from subjective or

informed personal judgements on a collective basis. In addition, recent research regarding modified Delphi has illustrated acceptability and the potential for more widespread use by stakeholders in developing health service performance measures (Khodyakov et al., 2016). Belongingness is neither a 'precise art' nor a tangible or directly observable construct, and the Delphi technique provides a method of enquiry (Kennedy, 2004) that has gained popularity for its benefits in the nursing field (Grisham, 2009).

#### 3.3.2.1.2 Delphi process

The conventional Delphi method uses a series of questionnaires to aggregate knowledgeable opinions anonymously from selected experts over a series of rounds.

Hsu and Sandford (2007) described guidelines for up to four iterations of the Delphi process as a data collection technique. The rounds can be continuously iterated until consensus is determined to have been achieved. Although it appears from the literature that three iterations are often sufficient to collect the needed information, there is no universal agreement; rather, it will depend on the objectives and circumstances of the research (Biondo et al., 2008; Hasson et al., 2000).

In the first round, a questionnaire with open-ended questions (see Appendix 6) was devised using reviews from the literature and reliable previous anecdotal information concerning the main problem (i.e., from CSs and coordinators). The questionnaire was then used to obtain information on the topic of interest and to collect expert opinions to refine assumptions, options and supporting evidence within the given area (Wilkes et al., 2010). For round two, upon receiving the initial responses from the experts, information emerged that needed to be constructed by the researcher into a survey for the second round of data collection. The panel members were asked to respond to each question that had been based on answers received in the first round. As

a result of round two, 'themes' became more identifiable and rationales supported priorities. For the third round, the panellists were asked to rate or rank questions, which gave them an opportunity to clarify the importance of the emerging themes.

#### 3.3.2.1.3 Selection of the Delphi panel

When selecting panel members, Grisham (2008) identified that some studies have as many as 60 experts, while others have as few as 15. He noted that panel experts need to show interest in the subject, but also understand that this will not bias thinking and that there will be impartiality and a balance of opinion in their responses. Previous studies have chosen individuals based on their specialist knowledge in a specific area (Hasson et al., 2000). This supports de Meyrick's (2003) suggestion that these participants can contribute additional information that is relevant to the question.

For this study, the selection of the Delphi panel required a number of subject matter experts (Loo, 2002) and criteria for deciding who would be most appropriate given their knowledge of the subject and their personal experiences with students on practicum. An inclusion criteria checklist was created to identify potential experts for the Delphi panel both nationally and internationally (with an understanding of Australian education and healthcare practices). Professionals from the field of nursing management, nursing education, clinical nurse (CN) specialists and practitioners were sought. Further details of the checklist can be found in Appendix 2. Given the researcher's extensive background as a senior professional nurse and educator, a purposeful sample was obtained using professional networking and past professional liaisons. As Loo (2002) explained, arbitrary selection may not be appropriate because there may be limited experts within the research area. This may require a more prescriptive choice of individuals who have knowledge that will provide an accessible

source of information that can be developed promptly to obtain contemporary opinions (Baker, Lovell, & Harris, 2006).

The Delphi method requires commitment from panel members both to participate and to maintain continual involvement until consensus is reached. It is therefore essential that consideration is given to the preparation of selection; otherwise, response rates during the continuing rounds may be unfavourable. Grisham (2009) identified the importance of informing the selected experts what is expected of them. This information includes the purpose of the research, the input required from them, an accurate draft timetable (including how much of their time is required) and how the information will inform the project. Although many of the participants were known to each other outside the study, none of them were aware of who else was participating in the research. The researcher ensured that all respondents were anonymous to each other and only identifiable to the researcher.

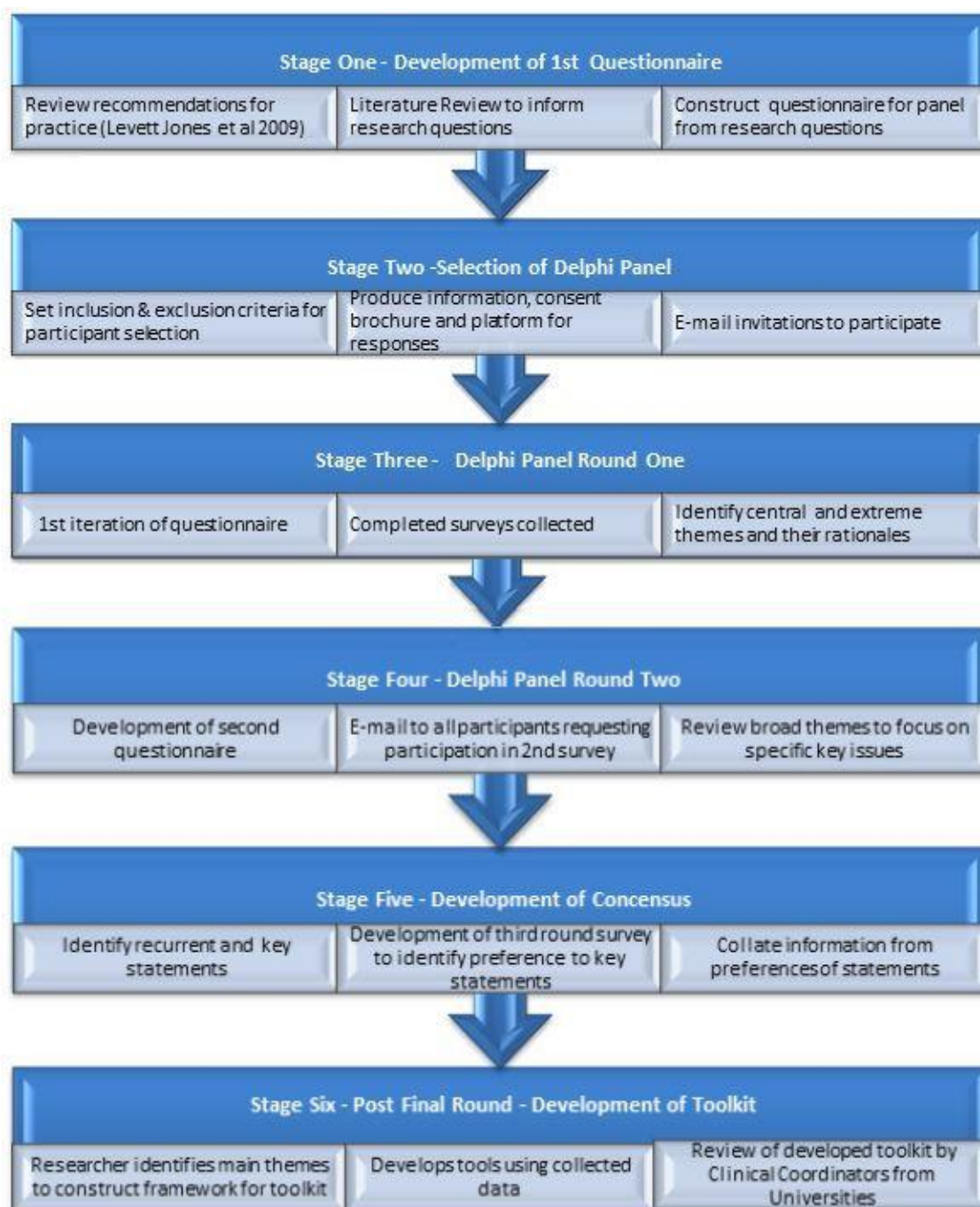
#### 3.3.2.1.4 Application of the Delphi method

The process for this part of the project included six stages (see Figure 3.2). This was planned to enable the researcher to logically follow the format of using the Delphi method. It proceeded as follows:

1. development of the first questionnaire
2. selection of the Delphi panel
3. commencement and completion of round one
4. commencement and completion of round two
5. development of consensus
6. development of toolkit.

A personalised email was sent to 23 experts to request their participation in the Delphi panel. Attachments in the email included an Invitation to Participate in Research

(see Appendix 3), a University of Notre Dame Participant Sheet (see Appendix 4) and a consent form (to be returned before the study commenced) (see Appendix 5). Once the consent forms were returned, each participant was sent a link to the Survey Monkey survey tool, which contained 13 questions (see Appendix 6). The questionnaire was developed by peer-recognised experts with published research on staff attitudes and nursing students' experiences (Hamshire, Willgoss, & Wibberley, 2013; Midgley, 2006; Smedley & Morey, 2010). The questionnaire was developed for the initial Delphi round to provoke thought and comment from the chosen expert panel. Refinement of the questionnaire occurred in consultation with the researcher's supervisors to test questions for ambiguity, time and appropriateness of responses. By reviewing and implementing their comments and recommendations, the researcher ensured that the questions were useful in terms of achieving the objective of the study, and that they would maintain the interest of the Delphi panel to commit for several rounds.



*Figure 3.2.* Stages of the research process for Phase One.

Twenty replies were received from the original 23 requests (a response rate of 87%) between 2 February 2016 and 22 March 2016, although most replies were received within the two-week timeframe given at the onset (see Graph 3.1).





*Graph 3.1.* Timeframe of responses.

According to the survey data, most participants took an hour to complete the questionnaire (as indicated in the original participation request). For this descriptive study, thematic analysis was used to produce a description of participants' experiences and reality as well as their meanings. The questionnaire produced rich data in which major topics were highlighted. Thematic analysis identifies, analyses and reports patterns within the data (Braun & Clarke, 2006). This technique is discussed in greater detail in Chapter 4. Using the QSR NVivo software package to manage the data for analysis, some common themes emerged across the range of questions asked. The researcher considered some of these themes important enough to be applied in several different contexts (e.g., welcome: answers consistently alluded to the need to feel welcome and the importance of creating a welcoming environment). Anecdotal feedback from several participants for the first round indicated that the questions were thought-provoking and interesting to answer. This was supported by the detailed and noteworthy answers to the questions. For example, one question asked: 'How do you

envisage a toolkit promoting belongingness in the clinical environment?' The respondent replied:

Maybe modulated so that clarification of belongingness and how it is articulated in practice is highlighted, needs to include clinical leadership and vignettes from students both positive and negative on the effects they have experienced. Format wise, blended with usage of e-learning, workshops and tutorials, and toolbox sessions is a suggestion. It needs to be a resource that is easily accessed by individuals and health organisations with choice of formats that suits. Therefore, I would envisage that funding and resources for the development of a toolkit would be required. Plus, ongoing funding and support to ensure the toolkit is sustainable and accessible in the long term. (R1p8)

The second round of questions was developed from the responses received in the first round. Specifically, and in keeping with the Delphi technique, key themes from the first round were coded and grouped to inform the development of the second questionnaire, which consisted of 16 questions (see Appendix 7). An email was sent to all previous participants to inform them that the structure of the next questionnaire was based on their input from the first round and would follow on from key findings from that initial Delphi round (see Appendix 8).

Eighteen replies were received from the second round. On this occasion, the emerging themes became more evident (attitude, culture, leadership, welcome, patient participation, learning environment, time). Subsequently, the third survey (see Appendix 9) was constructed using these themes. However, the third questionnaire was presented differently. Specifically, there were seven questions, but each question contained five common statements taken from the previous answers, and the

participants were asked to rank them 1–5, with 1 being the most important. Again, 18 responses were received from the participants.

The responses provided the participants' ideas for types of tools and activities, which the researcher was able to expand upon for the development of the toolkit. This will be discussed in the chapter that addresses the findings.

#### 3.3.2.1.5 Development of toolkit (stage 6)

The aim of this sequential mixed method research is to develop a series of tools to enable nurses to better support students and create an environment of belongingness to the clinical team. The ranking of the statements from the Delphi panel using Survey Monkey and QSR NVivo enabled the researcher to focus on the major topics and ideas to create a framework for the development of the toolkit.

From this framework, an original collection of five tools was designed with the aim of conducting a pilot study on three wards at a public tertiary teaching hospital. The toolkit consisted of:

- two posters
- a video
- a Nurse Support Notebook (Appendix 20)
- a Welcome Notepad for students (Appendix 17)
- video clips were produced, each with a storyline that involved students acting in scenarios that were developed from anecdotal evidence and qualitative data depicting both enabling and hindering behaviour (Webster et al., 2016).

Subsequently, the tools in the toolkit were adapted to an e-learning format to reach a wider cohort of participants (see Chapter 5). The video was successively divided into vignettes to work as introductions to each section of the WANTED e-learning program. The acronym WANTED evolved from the common themes which emerged

from across the range of questions asked of the Delphi panel. Each letter identifies an important topic heading within the e-learning program. A more detailed description of the framework will be discussed in later chapters.

W – Welcome

A – Attitude

N – Nurture

T – Team

E – Encourage (autonomy)

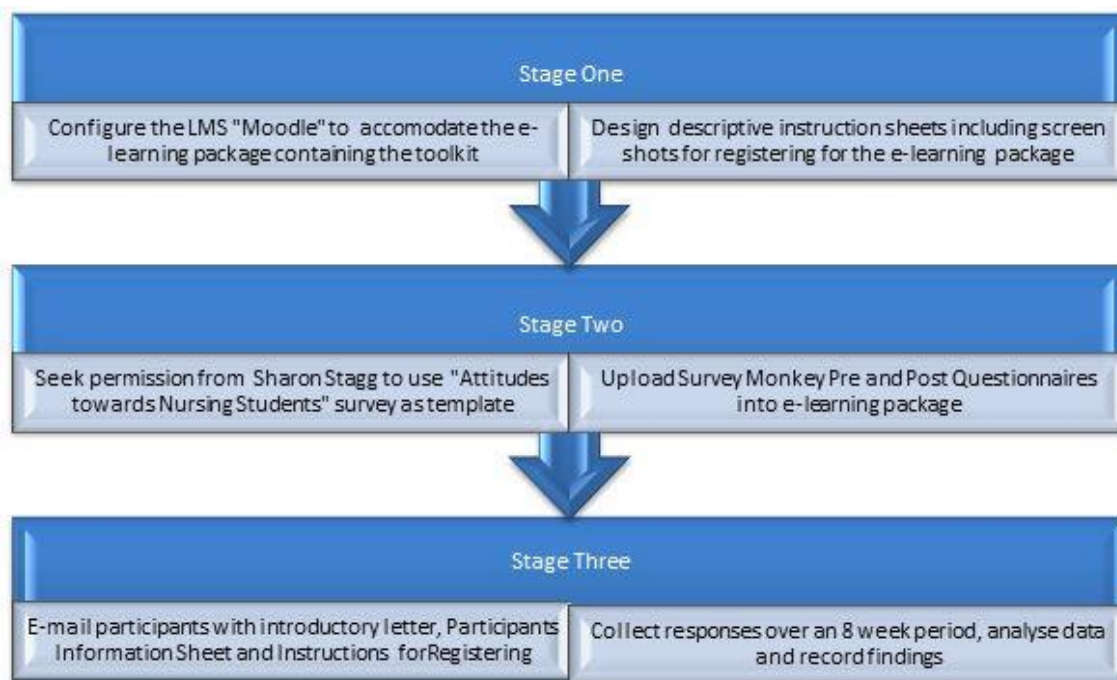
D – Delight (in success)

The principal sections within the Nurse Support Notebook were also embedded into the program, and the two posters and Welcome Notepad became resources accessed from the comprehensive ‘Resources’ page within the e-learning package. It was envisaged that this medium would enable the tools to be more easily accessible and user friendly in the future to reach a wider audience.

### ***3.3.2.2 Phase two***

A pragmatic viewpoint draws on the perception of ‘what works’ using varied strategies, and it values both objective and subjective knowledge (Morgan, 2007). The second phase of this research is presented in Figure 3.3. Based on the researcher’s previous experience with presenting educational tools, the stages were as follows:

1. configure a learning management system and design instruction sheets
2. preparation for pre- and post-questionnaires
3. collect, analyse and record data.



*Figure 3.3.* Stages of the research process for Phase Two.

This involved the collection of quantitative data to record the effect of the content and the usability and sustainability of the toolkit developed from the qualitative research in phase one. The data collected had to provide measurable evidence for potential replication and generalisation. A commonly employed methodology in health research is to explore the rich sources of data in the qualitative collection phase to provide a better understanding of the problem or theory, and to use the findings to design a quantitative method of administration to a sample population (Creswell et al., 2011) The findings from phase one were used to inform the development of the toolkit; subsequently, a quantitative instrument in the form of questionnaires was implemented in phase two to assess the new factors associated with the use of the e-learning program.

The pre-questionnaire included demographic items such as age, sex, designation (EN/RN/CN), years of nursing and nursing education (university/hospital-based). This provided further analysis of findings against these demographic parameters, which may provide interesting findings and ramifications for the future and support the successful

expansion of the toolkit into other clinical areas. Stagg's (1992) attitude survey composed the second part of the pre-questionnaire (see Appendix 13).

#### 3.3.2.2.1 Participants

The most suitable participants to undertake the e-learning program were ENs, RNs CNs and ward managers. The choice to include ENs was made as although the majority of nursing students are undertaking RN courses, the reality is that on many wards sufficient numbers of RNs are often not available to supervise the number of students on a ward. In addition it is considered that the experienced EN has many "hands on" clinical skills that the 1<sup>st</sup> year students would benefit from learning. The designations in Australia differ from some countries overseas. ENs are no longer trained in the UK; however, in Australia, they complete a two-year or equivalent Diploma of Nursing within the vocational education training (VET) sector. RNs complete three years or equivalent of tertiary study in a Bachelor of Nursing degree. CNs are essentially RNs who have usually completed additional study in a particular area of nursing and have gained experience in that area for several years. As a result, they take on additional roles such as education, leadership, portfolio work and quality activities, and they act as a resource person to other RNs in the area.

The sample was a convenience sample of participants selected by the researcher because of the understanding that they may provide information relevant to the attitudes being explored; however, it was not a requirement that they had previously supervised a nursing student as all participants would have encountered students at their workplace. Their attitude towards students whether supervising or not, would have an impact on the clinical environment Morgan (2007) stated that researchers choose what is important and appropriate, and this is influenced by aspects of their personal history, social background and cultural assumptions.

The sample numbers for this quantitative phase differed from the selection of participants for the Delphi panel in phase one. Creswell et al. (2011) noted that there are several reasons for using mixed methods; it delivers data that gathers information on a macro level (e.g., knowledge of clinical placements across health systems), and it adds information about individuals (e.g., nurses' experiences supervising students).

Therefore, different population selections and numbers were sourced for each phase:

The great strength of this pragmatic approach (mixed methods) to social science research methodology is its emphasis on the connection between epistemological concerns about the nature of knowledge that we produce and technical concerns about the methods that we use to generate that knowledge. (Morgan, 2007, p. 73)

Consequently, the strategies used to recruit the participants for phase two differed from phase one and were employed as follows:

1. a letter of request to join the research project (see Appendix 10) was sent to persons, including clinical coordinators, who had expressed an interest in the program after a conference presentation given by the researcher
2. a similar letter of request was sent to postgraduates at the University of Notre Dame Australia School of Nursing and Midwifery Alumni
3. a similar letter of request was sent to nurses belonging to the Honor Society of Nursing Sigma Theta Tau International, Chapter Psi Alpha at-Large
4. a similar letter of request was sent to nurses belonging to the Australian Rehabilitation Nurses Association.

Attached to this letter was a 'Participant's Information Sheet' (see Appendix 11) and instructions on how to enrol in the learning management system (see Appendix 12) to commence the program. Embedded in the e-learning program was a consent question.

This question, together with the Participant Information Sheet, provided a summary of the program and the processes undertaken once consent was given. By answering the consent question, the participant agreed (or not) to be part of the research process. Using Survey Monkey to extract the data, the researcher was able to take advantage of the embedded security within the software program to ensure anonymity and reassure participants that they were able to leave the program at any time without consequence.

#### 3.3.2.2.2 Pilot presentation

The aim of delivering the program ‘live’ online was to reach as many participants as possible without the need for dedicated time or travel to access the education. The objective was to provide the researcher with feedback from those who were in a position to give constructive criticism concerning the interpretation of their own and nursing students’ experiences as relayed by the content of the e-learning package and toolkit. The learning management system of ‘Moodle’ was employed to allow participants to enrol in the course. ‘Moodle’ is an internet-based learning platform that allows educators of any discipline to create a private space online that is filled with tools that easily create courses and activities, all optimised for collaborative learning. It was created by Martin Dougiamas as part of his PhD research in 1999 at Curtin University and has more than 100,000,000 subscribers globally. It gives participants an opportunity to engage in online learning at a time and place convenient to them. The researcher had previous experience using this learning platform and therefore knew that it would be suitable to use for the program. The WANTED e-learning program was loaded onto the internet-based platform, and a detailed e-learning instruction sheet was designed to guide the applicants first to register and then to complete the Survey Monkey pre-questionnaire (see Appendix 13). The pre-questions were taken directly from research by Stagg (1992). A request was sent to Stagg seeking permission to use



the attitude scale—Attitudes towards Nursing Students (Stagg, 1992; see Appendices 14a and 14b). As described in the previous chapter, this survey has been used or adapted on previous occasions (Parvin et al., 2016; Russell, 2012), and the researcher felt that this would be a robust tool to illicit the information required from the participants. A similar set of questions was used for the post-questionnaire (see Appendix 15) to enable a comparison of attitudes towards students during a clinical placement. A four-week period was set in which to receive the responses from the questionnaires.

Before opening the program to the nurse participants, the toolkit and additional survey was tested for face validity, which refers to the degree to which an assessment or test subjectively appears to measure the variable or construct that it is supposed to measure. Participants testing for face validity included the two research supervisors and the SONM Clinical Coordinator. Feedback highlighted that the toolkit was easy to understand and flowed logically. The design of the e-learning program was deemed to be interesting and held the attention of the participants throughout. The five questions evaluating the e-learning program were developed from a survey evaluating e-learning programs that had been previously designed by the researcher in her work as an educator using a five-point Likert scale. Given that these questions had previously been successfully used to gain the required data, the researcher was confident in using them for this program. This was confirmed by the two supervisors and clinical coordinator; as a result, no changes were made to the questions or the layout of the survey.

### **3.4 Data Analysis**

The method undertaken for the qualitative analysis of this research was used by Braun and Clarke (2006), who identified that there are different ways to approach thematic analysis. They defined thematic analysis as a ‘method for identifying, analysing and reporting patterns within data. The “realist” method reports experiences,

meanings and the reality of the participants' (Braun & Clark, 2006, p. 79). They noted that to give a more comprehensive breakdown, coding and theme development are directed by the content of the data. This process of determining the most important issues by devising a coding system was recommended to track responses and to continue the building process towards further rounds (de Meyrick, 2003). No additional items were added, and the participants' original wording continued in listing items for round two without the inappropriate involvement of the researcher.

Descriptive statistics were the preferred method for analysing the quantitative data. They describe the features of the data and provide simple summaries about the sample and measures. The Likert scale was applied as one of the most fundamental and frequently used psychometric tools in educational and social sciences research. Before applying any statistical tests, the data were tested for normality of distribution, while measures of variability were applied using skewness and kurtosis. Both parametric and non-parametric tests were applied to the mean ratings for all 18 questions to compare the pre- and post-data. This will be discussed in greater detail in Chapter 6.

### **3.5 Ethical Considerations**

The ability to judge the ethical acceptability of various aspects of a research proposal requires a thorough understanding of the community's customs and traditions—in this case, the nursing community. There are several reasons why it is important to adhere to ethical norms in research (Resnik & Elmore, 2016), including providing a safeguard for data and personal information that may be considered private or sensitive. However, individual interpretation can be influenced by life experiences and values, and deciding how to act involves examining ethical values and principles. In this project, consideration has been given to confidentiality, consent, data security and protection of human subjects.

The National Health and Medical Research Council (NHMRC) is responsible for the regulatory requirements of health and human research and provides leadership and policy in Australia. The National Statement on Ethical Conduct in Human Research (2007) was updated in May 2015 and consists of a series of guidelines made in accordance with the *NHMRC Act* 1992. Standard conditions of approval from the Human Research Ethics Committee (HREC) at the University of Notre Dame Australia state that failure to comply with the National Statement (2015) may result in suspension or withdrawal of approval.

The HREC is responsible for ensuring that all research involving human participants complies with state and federal government standards and is conducted with the highest possible ethical integrity. The National Statement on Ethical Conduct in Human Research provides a scientific and ethical review of proposed human research projects, taking into consideration:

- the scientific design and proposed conduct of the project
- how participants will be recruited, including the means of obtaining consent
- care and protection from harm of research participants
- protection of research participants' confidentiality.

The HREC works to protect research participants and the community at large and protects the reputation of the university and its researchers. By commenting on a project from a variety of perspectives, it provides a resource for researchers to suggest ways in which projects may be modified to improve research and prevent possible difficulties (HREC University of Notre Dame, 2018).

### **3.5.1 Ethics approval**

Ethics approval from the University of Notre Dame Australia was received on 16 February 2016 (Reference No. 016015F) (see Appendix 16) after submitting an

‘Application for Low Risk Review of a Project Involving Human Participants’.

Approval was obtained for both phases 1 and 2 of the study and included the outline of the project, the method of recruiting participants, survey tools and all described methods of collecting data.

The original collection of four paper-based tools and video clips of the resource pack were to be delivered to three wards of a tertiary hospital with the consent of the executive board. However, mindful of changes that took place within the healthcare sector that particularly affected the governing structure of the hospital of choice, the researcher decided that a broader cross-section of the nursing population would be of greater value. Consequently, still covered by the HREC’s approval, the recruitment of nurses was undertaken by emailing practising clinicians from a wide variety of facilities. This resulted in a ‘snowball’ effect that allowed participants to recommend others to the program, thereby enabling the researcher to increase the number of participants.

### **3.5.2 Informed consent, privacy and confidentiality**

The email sent to all potential participants (see Appendix 10) contained a ‘Participant Information Sheet’ (see Appendix 11). This provided details concerning the research and clarified that their engagement with the program was voluntary and that they could withdraw at any time without consequence. Ten participants did not complete the program, but without consequence to themselves. No details were given by the participants of why they did not wish to complete the program. The university policy concerning the protection of privacy and confidentiality was explained, and contact details were made available for enquiries or complaints. No complaints were received concerning the program at any time. In addition, before students accessed the toolkit, they completed a pre-survey using Survey Monkey and were required to give

consent in the survey before gaining access to the program. The software package has built-in options to ensure that anonymity is maintained in relation to who is responding to the questionnaires, thereby maintaining confidentiality of the research data.

As the results of the study supported the use of an e-learning package that required participants to register in the LMS Moodle, complete anonymity could not be provided by the researcher. Further, given that a 'snowball' approach was used, there was a probability that nurses would be known to each other. No reference was made to either individuals or places of work in any public documentation.

### **3.6 Chapter Summary**

This chapter charted the research strategy and the stages of a sequential mixed method design that consisted of two distinct phases: qualitative and quantitative research. The process of this methodology was to employ a Delphi panel to obtain qualitative data extracted from iterative rounds of questions to inform the design of the toolkit. Subsequently, quantitative data were obtained to discover the effect of the toolkit and e-learning package on encouraging and enabling a fundamental shift in attitudes towards students.

Each stage demonstrated the researcher's understanding and ability to process the research questions of this project and adhere to the principles of research when seeking to develop an innovative approach to encourage belongingness.

This chapter noted the implications associated with ethics approval and clarified the regulatory requirements of health and human research when conducting data extraction through less well-known systems such as the Delphi method. These considerations for both phases were outlined and discussed to identify that participants were not at undue risk.

The data analysis from the first phase of this project involving the Delphi process described above will now be investigated and reported upon in the next chapter.

## Chapter 4: Findings from the Qualitative Phase

*'Teachers' attitudes toward students, rather than their professional abilities', were the crucial difference between effective and ineffective teachers. (Sweet & Broadbent, 2017)*

### 4.1 Introduction

The literature indicates that clinical placements for nursing students in clinical settings are becoming increasingly limited, partly because increased numbers of students need to be educated to meet future workforce demand. However, alongside this is the reduction in numbers of qualified nurses available for supervising (Morrison & Brennaman, 2016). Assessing relationships and addressing concerns between RNs and nursing students can have direct implications for the overall quality of students' clinical experiences and learning environments because many nursing staff consciously or subconsciously discourage students from joining the profession (Boychuk, 2016), resulting in graduates being less interested in remaining in nursing.

This mismatch has been a problem for many years, and more so since the nursing students' position became supernumerary. Therefore, it is essential that nurses act as role models for students and implement a zero-tolerance policy to toxic work environments (Hinchberger, 2009).

This chapter will provide details of the qualitative data collection, including the selection of the Delphi panel. In addition, the development of the round one questionnaire and the data subsequently collected will be discussed. The process of extracting themes and subthemes using coding is detailed, which then informs the second-round questionnaire and subsequently the third-round questionnaire. Finally, details will be provided of the process that resulted in the framework for the toolkit being developed.

## **4.2 Qualitative Data Collection**

The conversion of raw data into ‘a clear understandable, insightful, trustworthy and even original analysis’ (Gibbs, 2007, p. 1) is a valuable experience. The richness, thoroughness and detail provided by the participating Delphi panel of experts allows the researcher to gain a broader understanding of the issues, thus enabling information to be prepared that is clear, articulate and convincing (Rubin & Rubin, 2012, p. 190).

### **4.2.1 Selection of the Delphi panel**

For this study, the selection of the panel for the Delphi method required a number of subject matter experts (Loo, 2002). The criteria for deciding who would be most appropriate not only rested on knowledge of the subject, but also on personal experiences with students on practicum. The Delphi system is built on the assumption that a group of informed people are less likely to arrive at an erroneous decision than any one individual (Hasson et al., 2000).

In accordance with Adler and Ziglio (1996), Delphi participants should meet four ‘expertise’ requirements:

- knowledge and experience with the issues under investigation
- capacity and willingness to participate
- sufficient time to participate in the Delphi
- effective communication skills.

For this study, an inclusion criteria checklist was created to identify potential experts for the Delphi panel both nationally and internationally (requiring an understanding of Australian education and healthcare practices). Twenty-five professionals were sought from the field of nursing management, nursing education, CN specialists and practitioners. An email was sent to request their participation and detail the purpose of the study, along with an information leaflet, consent form and ethics



approval. Given the researcher's extensive background as a senior professional nurse and educator, a purposeful sample was obtained through professional networks and past professional liaisons.

#### **4.2.2 Development of the round one questionnaire**

The first questionnaire was initially informed by the research of others with extensive, peer-reviewed and published knowledge of students' perceptions of nursing staffs' attitudes towards nursing students (Hamshire et al., 2013; Midgley, 2006; Smedley & Morey, 2010b) and the influence of nursing staff on student learning (Morrison & Brennaman, 2016; O'Luanaigh, 2015; Webster et al., 2016). Although initial questions are typically broad and require more time-consuming analysis by the Delphi panel participants during the initial stage, a more focused and structured approach can be employed to guide the participants while categorising the questions for each round. If the goal is to understand subtleties (a goal in qualitative research) and the sample is homogeneous, then fewer than three rounds may be sufficient to reach consensus or theoretical saturation, or to uncover sufficient information (Skulmoski, et al., 2007).

Appropriate research questions were developed by extensively reviewing the literature and examining recommendations for practice to overcome the barriers leading to an improved clinical learning environment. Previous questions in the literature identified key features of the topic. One example identified by the researcher as highly relevant was a descriptive qualitative research study by Moonaghi, Mirhagi, Oladi & Zeydi in 2015 which asked students to complete two open ended questions: How do you describe the present status of clinical education? What are the facilitators and barriers for your learning in clinical education? Write your experience in detail. Two expert researchers sorted the questionnaires for comprehensiveness and richness. From this a

more detailed questionnaire was developed. The data from their study proved useful for the researcher in developing the first round questions for the experts in this thesis. The three main themes that emerged in the Moonaghi et al., (2015) study were “being a promoter”; “too hungry to learn” (motivation and acquiring self-confidence) and “unwelcoming field”. The relevance of these themes to the key features of this study’s objectives proved advantageous when developing the first round questionnaire. All were based on a clear understanding of the study’s objectives informed by the literature and researcher’s extensive professional involvement with student and graduate nurses. By using these research questions as a baseline and sourcing the research of others whose knowledge on attitudes towards nursing students is well documented (Hamshire et al., 2013; Midgley, 2006; Smedley & Morey, 2010b), the questionnaire for the first round of the Delphi panel was developed to provoke thought and comment from a chosen expert panel.

Loo (2002) suggested that by using open-ended questions, panellists can elaborate to include information and data not restricted by closed questioning. Refinement of the questionnaire before distribution occurred in consultation with the researcher’s supervisors to test questions for ambiguity, time and appropriateness of responses. The supervisors ensured that the questions were useful in terms of achieving the objective of the study.

## **4.3 Qualitative Data Analysis**

### **4.3.1 Round one questionnaire**

Survey Monkey was used to create and distribute the first survey in an electronic format. Identification and details of each panel member were made available to the researcher for tracking purposes between each Delphi round. However, all participants remained anonymous to each other. The questionnaire contained 13 questions and took

each of the 20 Delphi panel members approximately one hour to complete. The raw data collected from this initial round were read and reread by the researcher to identify significant phrases or words that could be grouped under major headings or themes (Wilkes, 2010). Braun and Clarke (2006) identified that there are different ways in which thematic analysis can be approached; however, inductive, semantic and realist approaches tend to cluster together, giving a more comprehensive data breakdown. Coding and theme development a) are directed by the content of the data; b) reflect the explicit content of the data and c) focus on reporting an assumed reality that is evident in the data.

This process of determining the most important issues by devising a coding system was recommended to track responses and to continue the building process towards further rounds (de Meyrick, 2003). Further, Green, Jones, Hughes and Williams (1999) recommended that no additional items be added, and that original participant wording continue in listing items for round two without the inappropriate involvement of the researcher.

#### ***4.3.1.1 Allocation of codes***

Coding commenced with the aim of sorting and organising the data so that further analysis could take place (Liamputtong, 2013). A more focused coding or familiarisation involved reading and rereading the data to synthesise the codes and determine relationships about which the researcher made basic notes as the categories began to emerge. The researcher used Braun and Clarke's (2006, p. 87) stages of thematic analysis as guidelines to commence the analysis and employed the software package QSR NVivo (Version 10) to generate initial codes. The stages of thematic analysis are:

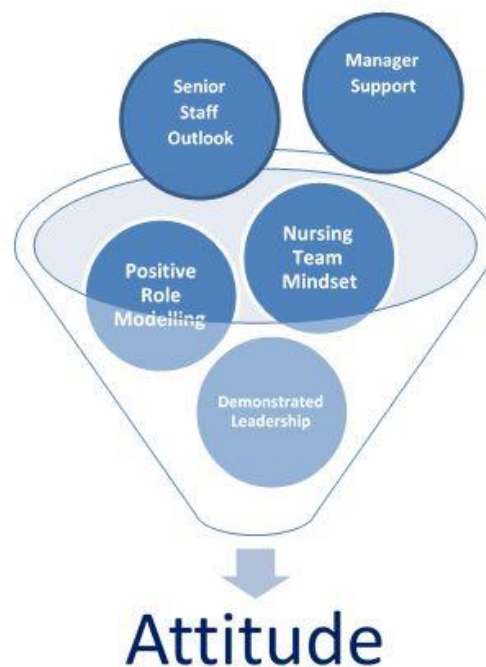
- coding

- searching for themes
- reviewing themes
- defining and naming themes
- writing up.

Using the management system of nodes and tree nodes in the software package to organise the subthemes, this process continued after several readings of the survey answers until no new nodes could be added.

The subthemes identified important issues (see Figure 4.1):

- management support
- senior staff outlook
- nursing team mindset
- positive role modelling
- demonstrated leadership.



*Figure 4.1.* Development of subthemes to themes.

The researcher was mindful of the research questions when reading and rereading the data that supplied the themes and subthemes. As demonstrated above, it was necessary to merge some codes to achieve a more precise list. Similarly, significant statements that portrayed a clear understanding of the clinical experience were coded appropriately. For example:

Invitations to join staff in lunch or break rooms for morning/afternoon tea and lunch breaks. Nursing staff asking students how they are going and involving them in social conversations during break time. Provision of a recognised place e.g. position at a desk for students contributes to their sense of belonging.

Importantly students should be made to feel welcomed and accepted by the nursing team (and other medical and allied health staff on the ward). (R1p13)

- **Attitude:** accepted by the nursing team (and other medical and allied health staff on the ward).
- **Belongingness:** invitations to join staff in lunch or break rooms for morning/afternoon tea and lunch breaks. Nursing staff asking students how they are going and involving them in social conversations during break time. Provision of a recognised place (e.g., position at a desk) for students contributes to their sense of belonging.

Similarly, a second statement was coded:

The successful clinical supervision of students often relies heavily on the individual ward nurse's desire to supervise students and their own knowledge of teaching principles in the clinical setting. Their ability to welcome others into the team, make students feel comfortable in asking questions and ability to communicate with students and remember what it is like to be a student (empathise) are important characteristics. Some nursing staff have these skills

(either existing or learned through mentorship courses in the workplace), but often the ability to supervise students across all staff varies in standard across the health environment. (R1p1)

- **Attitude:** often relies heavily on the individual ward nurse's desire to supervise students.
- **Welcome:** ability to welcome others into the team.
- **Skills for supervision:** often the ability to supervise students across all staff varies in standard across the health environment.

With this process, the subthemes were refined into the themes listed below:

- attitudes
- belongingness
- culture and the team
- learning environment and student supervision
- leadership
- welcome.

Figure 4.2 presents three examples of the emerging themes that were identified from the answers to the 13 questions in round one.

Q3 What do you consider are the important social elements required to create a sense of belongingness in any community?

Cultural<sub>Team</sub> Sense of Belonging Listening  
 Welcoming Interest Inclusion<sub>Shared</sub>  
 Community<sub>Valued</sub> Staff

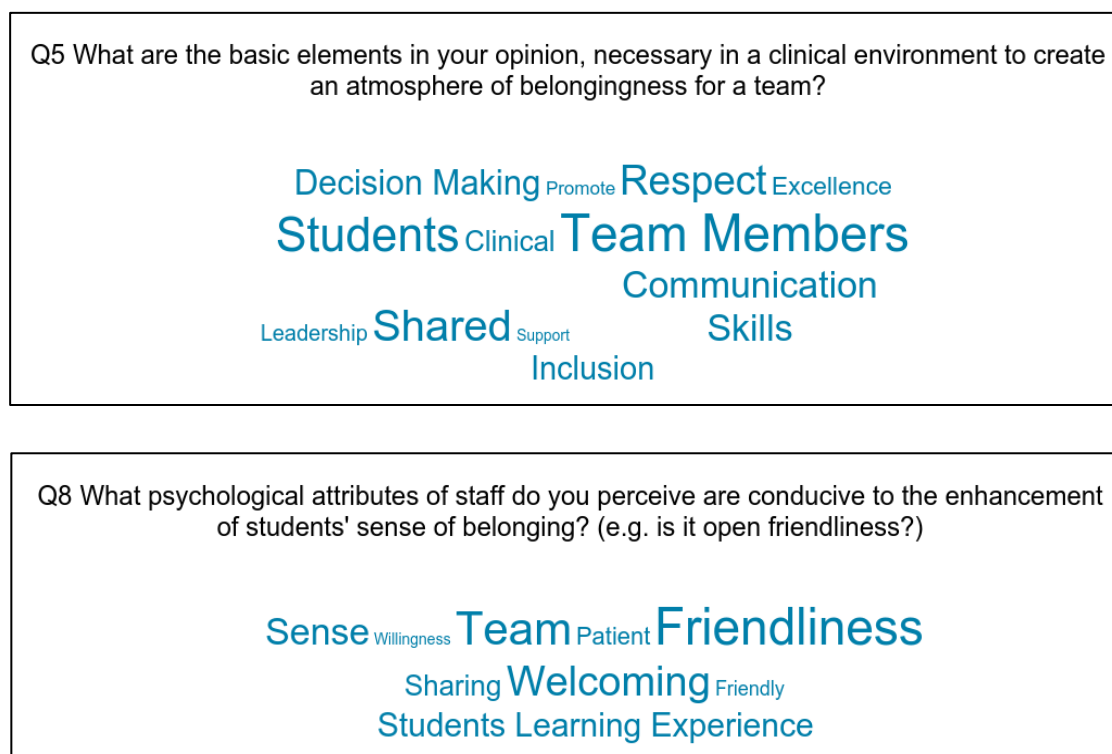


Figure 4.2. Examples of the word clouds for questions three, five and eight.

These subthemes will be discussed in greater detail in relation to how they evolved and what they covered (see Section 4.3.2).

The researcher felt that while some of the subthemes were repeated within several different themes, the list should remain comprehensive to give the panel an opportunity to expand on their round one responses. At this point, it was not felt necessary to merge or collapse the themes any further.

To identify each data source, the following codes were allocated

R1: round 1 (13 questions)                      p1–p18: respondent numbers

R2: round 2 (16 questions)

R3: round 3 (7 questions)

#### 4.3.2 Second round questionnaire

An email was sent to thank the participants for their participation in the first round and to outline the outcomes that would inform the second round. Eighteen of the original 20 participants continued with the process. The round one responses obtained from the opinions of the Delphi panel were the basis upon which the round two

questions were developed. This second round expanded on the responses of the first round by examining specific subthemes within the themes that were identified as major topics by most of the panel. The answers demonstrated the participants' thoughts more clearly because they were able to give comprehensive statements to address the questions. Lecklitner (1984) used a sample of 345 informed and involved individuals from six general stakeholder groups of interest to his study. Six subgroups were formed and were asked to complete two rounds of questionnaires. Lecklitner (1984) did not strive for consensus, but rather to understand what the subgroups thought about the research questions. This is a further dimension to the Delphi method, which offers an opportunity to gain a broader and richer picture than with consensus alone (Skulmoski et al., 2007).

With this in mind, the researcher had to identify the data that would assist in developing the next round and that would subsequently start shaping the framework for the toolkit. An example of this rich data was R2p15's answer to question three (How do we improve an understanding of belongingness?)

This is difficult; however, I feel key to learning in workplaces. There is a lot of literature around that talks to a sense of belongingness during work placements—this includes welcoming students by name when they arrive on placement, giving them a secure place to keep their belongings, inviting them to staff lunch rooms and morning tea rooms, giving them meaningful tasks to complete and so on. This understanding of belongingness could form part of workplace learning supervisor/preceptor training sessions/modules whether face to face or online. This information could also be included in placement guidelines that are sent out to sites prior to students commencing.



There was consensus with other participants' answers in stating that 'belongingness' is the key to learning in the workplace, but the participant also enriched the answer with further suggestions for improvement and implementation.

The key to the development of the toolkit described in the next chapter was the following subheadings that emerged from the allocation of codes (previously discussed) when collating the data using the software package QSR NVivo (Version 10). The following sections present a more detailed analysis of these themes to demonstrate the understanding of the Delphi panel participants and, in some cases, offer a problem-solving pathway to underpin the development of the toolkit.

#### ***4.3.2.1 Attitudes***

It was evident from the answers that many factors, including past and present experiences, contribute to attitudes that are adopted by nurses towards the learning environment and students. Some participants felt that attitudes are difficult to change, 'particularly in the hurly burley of every day work' (R2p15). However, in wanting to change negative attitudes, many recognised that the organisational culture needs to more readily value and recognise the work of supervisors. It was proposed that incentives and support for nurses to be educated would be useful motivators.

Greater understanding of students' expectations and needs through the provision of additional skillsets, resources and time would enable staff to take more ownership of students' education and wellbeing. R2p5 indicated that 'nurses on the floor who work in a supported area and feel part of a team are more positive and open to students'.

However, on a personal level, it was felt that nurturing was a commendable quality because 'we were all students and beginners initially' (R2p16), and that nurses needed to lift expectations beyond a reward system to intrinsically ask 'why wouldn't you want a student?' (R2p14), thereby acknowledging that the future of nursing lies

with new nurses. Further, participants agreed that students need to be part of the ward team, and that the effect of belonging or not belonging is reliant on nurses' attitudes.

#### **4.3.2.2 *Belongingness***

Participants of the Delphi panel identified the importance of education, communication and role modelling in fostering a sense of belonging in all staff. These elements are significant because have been discussed in the literature concerning social learning theory. Bandura (1977) maintained that human functioning relies on three regulatory processes: stimulus, cognitive and reinforcement control. It is important to stimulate education, while communication and role modelling reinforce attitudes and behaviours. R2p8 proposed 'staff education about belongingness (relative to all of us) and how to create a workplace that is proactive about fostering a sense of belonging in all staff'.

When asked how to improve an understanding of belongingness, R2p9 commented that we initially need to 'ensure that staff actually know what belongingness is', while R2p14 stated that 'this needs a top down approach with role modelling from leaders', as well as 'education and training sessions for clinical staff and management' (R2p17).

Suggested strategies varied to improve belongingness in the clinical environment, but there were common themes of inclusion and recognising each other's part in the ward workforce. R2p16 supported this 'by including the students into meetings, education sessions and decision making'. Practical suggestions revolved around the sharing of students' experiences and attendance at ward meetings, while R2p11 suggested a visual cue such as 'a poster on belongingness being put up in ward staff rooms'.

To ensure students are recognised as part of the ward workforce, other participants recommended that designated lockers, induction into the social nature of the workplace and alerting students to special interest group activities would improve their sense of belonging. Interestingly, one participant suggested ‘holding seminars by students who have had negative experiences of registered nurses intimidating them’ (R2p10). The idea to expose nurses to how students feel in this situation was the catalyst for the researcher to develop a video simulating these types of situations and using them as part of the toolkit to educate nurses to understand the need for positive rather than negative action.

#### ***4.3.2.3 Culture and the team***

The development of a positive clinical learning environment was consistently regarded as being influenced by the culture of the ward: ‘A positive team culture and inclusiveness will enhance the students learning experiences’ (R2p16).

Several panel members suggested encouraging a culture that respects education and is kept up to date with improvements in practice to provide inspiration to the team. R2p15 succinctly conveyed this when proposing a practice that would challenge many nursing staff, but that would ultimately change the culture to be more open and motivated:

A type of partnership where students can challenge the contemporary practice of nursing staff and nursing staff can challenge and enhance educational practice of students; staff will move toward a culture that respects education and its capability to enhance and challenge clinical practice. (R2p1)

A positive team culture that embraces inclusiveness and staff involvement was repeatedly expressed as enhancing students’ learning experience. R2p7 proposed ‘working as a team with senior staff supporting junior staff to give them an opportunity

to preceptor a student successfully'. Similarly, R2p17 suggested that 'providing staff with education on how to include students and showing the benefits to clinical practice would impact on their long-term workforce and team morale'. Similarly, it was highlighted that there is a need to see the value of what students bring to the profession by having open discussions on inclusion and team membership. R2p5 responded: 'allow students and staff to take part constructively in all discussion. The staff and students should be able to appreciate each other's point view. Improve knowledge of both the staff and students by listening to them'.

Comments linking leadership and role modelling to culture were noted within this theme. Several participants alluded to ownership being required at the executive level, whereby strategic planning is developed to improve workplace cultures and provide leadership that views education as integral to moving forward as a team:

We need to encourage and ensure our teams are kept up to date with changes and improvements in practice in their own work environment; this will develop a culture that is much more open to change. (R2p2)

#### ***4.3.2.4 Learning environment and student supervision***

For students to learn the 'art of caring', it was generally felt that a culture that values hospital-wide education values student learning and has a strong commitment to social or role modelling within that hospital, thereby positively contributing to a sense of involvement for students. Knowles et al. (2011) believed that there are positive influences on educational outcomes when education is focused on attitude, beliefs and performance skills.

Support from nursing staff and opportunities for students to develop was a recurring theme that was addressed when discussing improving the learning environment and a sense of belongingness:

Students are graduating without skills in time management, prioritisation and recognition of the deteriorating patient...students need to participate and not just observe to consolidate their learning and develop their skills. (R2p7)

Debriefing and feedback with and about students were referred to by some of the participants in relation to how to manage students effectively and positively. R2p7 suggested: 'Obtain feedback from staff and students to improve the learning environment. It is the staff and students work environment provide them with an opportunity to have input into the team vision'.

Several respondents recommended the creation of champions or 'buddies' to advocate for students' inclusion into teams and to have equal access, encouraging an expectation of staff to 'stand back' and allow students to think critically of their next step (R2p4). Consequently, most participants identified that teams that work well together must understand each other's strengths and perspectives (including those of students), and must work on these to provide a positive environment (R2p5, R2p6, R2p11): 'If empathy and compassion have been embedded in the culture, staff will want to ensure they are up to the minute in their practice and will want to attend education' (R2p6).

Participants R2p11, R2p13 and R2p7 further considered that staff and students need to be able to share feedback, experiences and reflections to understand each other's perspectives. This would enable them to formulate strategies that, with the aid of developed tools, would contribute to improved learning and ultimately a sense of belongingness. Some of the strategies discussed were 'recognising and rewarding positive values and achievements in the workplace' (R2p17) or "'Star of the Week"—small notes/ tokens of appreciation by staff to others to let them know their positive behaviours have been appreciated and make them feel they are working together as a

good team' (R2p4). Being supportive of students through effective communication and inclusion in activities in the work environment (e.g., ward meetings), as well as being open to ideas to improve their learning experience, was also strongly recommended by several panel members.

However, to encourage all staff to improve the learning environment, it was felt that 'incorporating a fun factor in the training and involving students in active participation, possibly using simulation or simulated scenarios as an ideal teaching and learning modality, would be a way to support clinicians and students to learn together' (R2p5, R2p10). By learning how to use the student and increase learning as a way of completing work and gaining knowledge and experience, R2p11 felt that this would benefit both the nurse and the student.

Patient participation and involvement in the learning environment was identified as a useful but not fully utilised resource for integrating students into the clinical environment. To make more of these opportunities, it was suggested that nurses 'provide opportunities for patients to provide informal and formal feedback on the students' performance from the patient's perspective' (R2p7) or give 'feedback as to how they felt during the care administered by the students' (R2p5). This feedback could then be used by nurses to complete assessments on students' performance. R2p15 felt that the nurse's responsibility involved 'always introducing students to patients, even if they are observing, in a positive way, emphasising the contribution the students make to the smooth running of the ward. Avoid any negative student stereotypes when talking to patients about students'.

Practical suggestions from several of the panel recommended an inclusion in patient information packs stating that 'students will be part of their stay on the unit and that they have an opportunity to help develop the nursing team of the future by allowing

students to have learning opportunities and to provide care where possible' (R2p2) or simply develop a brochure/leaflet/poster informing patients of students' involvement (R2p1). This could be undertaken by the students as part of their contribution to demonstrate integration into the ward environment. R2p15 maintained that 'bolstering patient confidence in students is likely to encourage participation and also increases student confidence which often results in improved performance'.

#### **4.3.2.5 Leadership**

Management and leadership appeared to be a major theme in the participants' comments. It was suggested that feeling supported by managers and senior staff and being part of a positive team environment can improve the situation in which the attitude of 'why wouldn't you want a student?' becomes the norm. Several participants felt that managers and leaders should provide information and tools to build a team vision for the learning environment to create a positive atmosphere and a focus of daily practice. R2p6 commented that 'teams working well together have to understand each other's strengths and work on these to enhance the whole team. Negativity should be quickly dealt with'.

The provision of education and interactive programs was highlighted by several participants. R2p6 maintained that 'teaching leaderships skills—learning about oneself—mindfulness training for all staff' was important, while R2p7 wrote that 'education on how to include students into the team and assist them in the development of required skills would require the time for staff to attend education sessions'.

Developing 'in-house' leaders within the clinical workplace was thought to be essential for the sustainability of an effective learning environment. To gain a more robust model of supervision, R2p2 proposed developing staff to undertake more of a leadership role in improving the clinical learning environment, stating that:

Support would need to be provided that allowed the champions to engage with the students so that they can establish how students would like to be represented and included in the clinical environment. The champions could also find ways to facilitate a process where students were practical and within scope and able to care for patients independently to develop confidence but also so that the team would have tangible evidence that student involvement is a positive process.

The toolkit would need to give nurses the necessary skills to improve their own practice and take a leadership role to encourage others to change their attitudes towards students' belongingness to the team.

#### **4.3.2.6 Welcome**

The perception of 'welcome' and 'feeling welcome' was a dominant theme in the responses given by the Delphi panel. This is consistent with the literature on social learning, in which attention is focused on encouraging a desired outcome through the reinforcement of behaviours by arranging the surrounding environment (Knowles et al., 2011).

Comprehensive answers covered many aspects of this theme; however, throughout the replies, there was seen to be a need for having an organised, timely and standardised approach across the organisation. Consistency across all clinical areas and making staff aware of their obligations and expectations was found to be important in making students feel more welcome and adding value to the clinical environment.

R2p15 commented:

Perhaps establish an education bulletin that alerts all staff to student schedules and when students will be present in workplace so that staff are aware that when students will be on site so extra care can be taken to make students feel



welcome. Staff would also need professional development around understanding the importance of welcoming students on placement.

Links to leadership, communication and culture were identified by R2p14 'when the ward takes ownership of the students as part of a team or unit', and R2p7 saw 'orientation to the work environment as a team responsibility'. R2p5 felt that there should be 'proper communication about the student coming to do the placement and a proper package put together to enhance the learning experience of the student'. Generally, it was believed that an expectation should be made of the team that the welcoming of students should be considered 'the norm'. Further, ward orientation should be positive and emphasise the welcome. Practical suggestions were made by R2p2:

Having information relating to the team available such as team photos, team vision and values displayed on the unit so that the student is able to determine what is important to the team, this will give them the opportunity to take an interest and become involved.

R2p17 felt that 'encouraging staff to welcome new students into the team (modelled from management down) with "Welcome" packs as well as orientation material' was important, and that 'orientation should be a shared job amongst all staff' (R2p11). This was supported by others, who suggested welcome signs, banners or a 'visitor book' with comments and tips from previous students that may be helpful to new students.

R2p15 pointed out that 'staff would also need professional development around understanding the importance of welcoming students on placement', and R2p7 reinforced 'the education of all staff in clinical supervision to promote optimal support'.

The tools identified as being practical would give nurses the necessary skills to improve their own practice and take a leadership role to encourage others to change their attitudes towards students' belongingness to the team.

After reading and rereading these rich data, the researcher identified significant recurring statements within these themes that were then collated to develop a third round to be presented to the Delphi panel.

### **4.3.3 Third round**

The processes of ranking and rating statements from the previous rounds is commonly used in the Delphi method (Schmidt, 1997). Therefore, for the third round, the researcher focused more on the specifics as identified in the recurring themes within the statements. An email was sent to the entire panel who had completed round two to thank them for their input and advise that this would be the final round in which they could review the statements and rank them from 1 to 5 (1 being the most important) in each of the seven questions. There was an opportunity to make further comments after reviewing the statements; however, none were made. All remaining 18 members of the panel participated in this round. Figure 4.3 presents an example (Question 1) of the results in a ranking format.

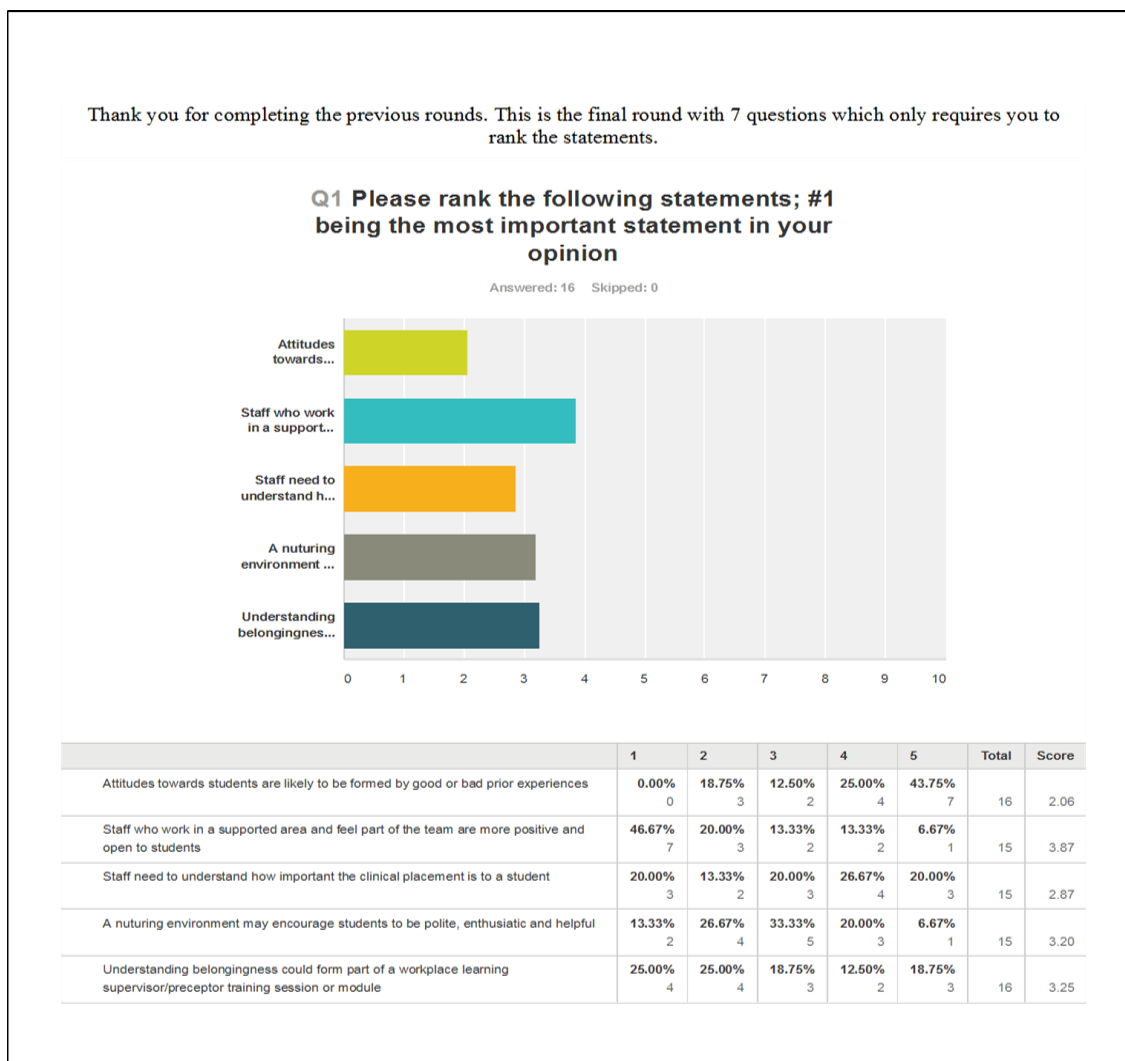


Figure 4.3. Example: question one.

The process was completed for each of the seven questions. It highlighted that almost 47% of respondents felt that staff who work in a supported area and feel part of the team are more positive and open to students, and that 25% realised that to achieve this understanding, belongingness should be part of workplace learning.

As the common statements from round two were ranked, it became increasingly clear that support by way of education for nursing staff is crucial if they are to understand how to create a positive environment of belongingness. To improve the situation, raising the student profile by welcoming them openly as contributing members of the team is a high priority. Encouraging staff, patients and students to share

their ward experiences and reflections and openly voice their ideas was seen to be essential to optimise care and increase student learning. This is in line with Block (2008), who maintained that the core concept of social capital theory relies on making and maintaining social networks that give personal and collective benefits. Further, the interaction between the newcomer and the community of practice develops the newcomer (Plack, 2006). The panel members felt that allowing more autonomy within supportive surroundings would contribute to students' sense of belonging. The support and influence of managers and senior staff was considered fundamental to the promotion of belongingness, with 12 out of 18 (66.67%) respondents ranking this as a number 1 statement: 'Managers/leaders need to provide a positive environment; negativity should be quickly dealt with'.

Finally, there was seen to be a need in the work environment for persons advocating for students and supporting inclusion in the team. This was not for an official position, but more of a voluntary 'buddy' role.

#### **4.4 Summary of the Qualitative Findings**

The three rounds of the Delphi method uncovered sufficient information (Skulmoski et al., 2007) to confidently comprehend and articulate experts' opinions that would shape the creation of a framework. It was clearly identified that the initial welcome students receive when entering a new environment has a profound effect on their ability to integrate into the environment. The attitude of all staff dictates both the atmosphere of the area and the effectiveness of the team. As previously identified by Jewell (2013), the socialisation process can influence changes to isolation and poor performance. The response to nurturing students and encouraging greater participation among givers and receivers of care highlights the strong influence of collaboration considered necessary for a fully inclusive and functioning team. This is supported by

the literature, which finds that if organisations encourage compassionate learning environments, the integration and assimilation of staff improves exponentially (Henderson et al., 2010; Jewell, 2013). For many of the experts who agreed to be part of the Delphi panel, these issues have been very familiar during their careers; therefore, their opinions are generated from first-hand experience.

The researcher decided that to capture these rich data and apply them to promote belongingness, a framework was required to convincingly endorse the data. The framework came together from the findings as ‘WANTED’—Welcome, Attitude, Nurture, Team, Encourage, Delight.

- **Welcome:** legitimisation of the student role
- **Attitude:** compassion for self and students
- **Nurture:** encourage sociable exchange
- **Team:** involve everybody in ward activity
- **Encourage:** show leadership and encourage autonomy
- **Delight:** in a supportive relationship and success.

The researcher decided to use the acronym WANTED because it identified with and incorporated all of the main themes highlighted in the qualitative research process. It also created an easily identifiable framework and course of action to be undertaken using the e-learning package discussed in the next chapter.

## Chapter 5: Developing the E-Learning Toolkit

*The scope and magnitude of the health workforce challenges we face require greater investment and more effective and strategic use of available resources, it becomes necessary to fully exploit the potential of innovative approaches and new technologies. (WHO, 2015)*

This chapter will provide an overview of the options that the researcher considered to provide a useable and effective learning toolkit. It details the different perspectives of learning and presents the various conceptual models and the influences of the styles of teaching on the learning process.

### 5.1 Background and Context

The process of developing the toolkit through the literature review, Delphi panel technique and data analysis thereof resulted in an original collection of four paper-based tools (see Appendices 17–20) and a video with the intention of conducting a pilot study using these tools on three wards. Pedagogic toolkits which embrace technologies have been promoted as ideal resources for educators to become more engaged with new, challenging areas of teaching. Toolkits assume a ‘just-in-time’ approach and generally promote flexible engagement by the user, in contrast to more traditional, linear-structured manuals (Conole & Oliver, 2002). They maintain that the specification for the learning toolkit design should be easy-to-use and to support practitioners’ flexible use. Elements of the toolkit, such as the survey tool and online course, can easily be adapted by an institution to fit the user’s context e.g. professional education, mentoring, reflection and should model change rather than replicate existing patterns and modes of behaviour.

As stated in Section 3.3.2.1.5, the toolkit consisted of:

- two posters
- a video

- a Nurse Support Notebook
- a Welcome Notepad for students

These items were put together as a resource pack to be delivered to the nurses through either CFs from the educational facilities or ward managers.

Before running the pilot studies, the researcher wanted to obtain feedback from clinical educators and ward managers—some of whom had been on the Delphi panel. Subsequently, two meetings were held: one with clinical educators from universities in Perth, WA, and the second with local ward managers. A resource pack was given to each person, and the researcher explained the content and purpose of the individual tools and their intended use. At the end of the sessions, a questionnaire (see Appendix 21) was provided for the participants to take away, complete and then return to the researcher.

The feedback was very positive concerning the overall content of the toolkit; however, a recurrent theme was that it was felt that the mode of delivery would not work because it would not be viable to keep printing the Nurse Support Notebook, and nurses would probably not always refer to them:

I like the toolkit 'booklet' but do worry it will end up on a shelf as staff are too busy (Clinical Coordinator).

My nurses are more likely to take this resource onboard as an educational learning experience such as e-learning, which they can do either at work or alternatively in their own time (Ward Manager).

At this point, the researcher considered that the second comment proposed an opportunity to examine alternative methods of delivering the toolkit. It also gave the prospect of being able to record this learning on a learning management system (LMS), which would be an added incentive for nurses when engaging in continuing professional

development (CPD) using this resource. LMSs are used by health services to record employees' education and competency achievements. Given that nurses in Australia are required to complete a minimum of 20 hours of CPD each year for nursing registration, this electronic record of completion not only provides health services with an immediate indication of staff training, but it also supports nurses in any reporting requirements requested by the NMBA.

Recent research has shown that the scope and applications of e-learning provide new possibilities in the delivery of flexible education using information and communication technologies to add to the teaching toolbox (Choules, 2007). Flexible learning facilitates a range of options within the learning experience, including time, instructional approach and delivery. In addition, it increases access and availability to education by breaking down geographical barriers.

## **5.2 Self-Directed Learning**

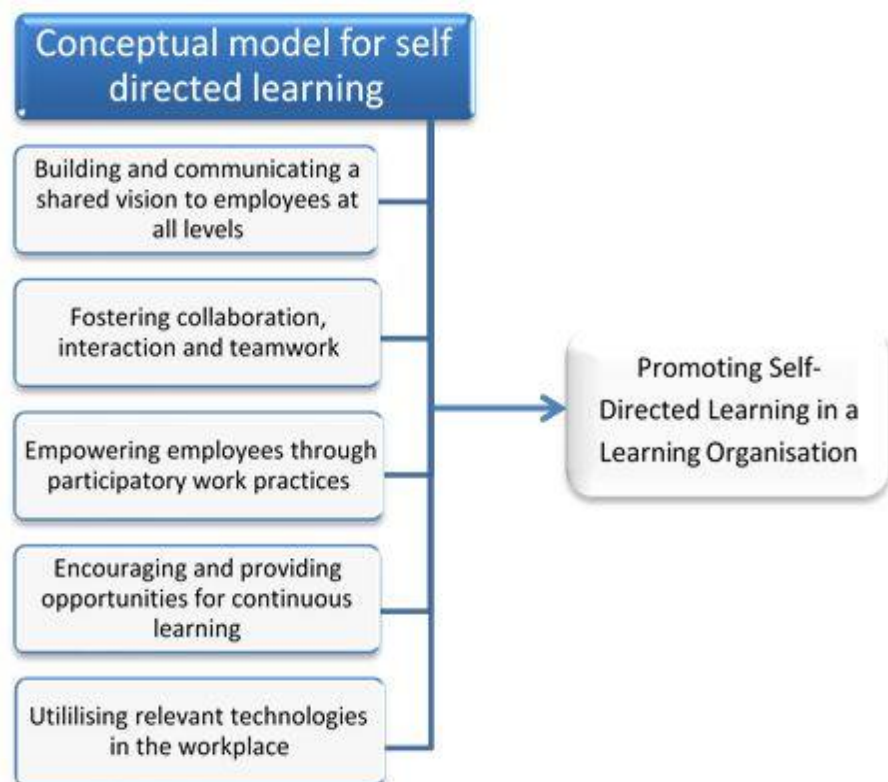
As previously mentioned, there is accelerating change in society as a result of ever-growing demand for knowledgeable and employable graduates. As a result, the delivery of clinical education is becoming more challenging for health organisations. Therefore, it is crucial for organisations to explore supportive ways to encourage staff to take more responsibility for their own learning and development using both formal and informal learning. Many successful external industries have embraced the concept of a learning organisation because it has been proven that the ability to innovate, improve efficiencies and create value is reliant upon people's capability to learn (Davis & Daley, 2008). The learning organisation concept was defined by Senge (1992, p. 126) as 'a company that facilitates the learning of its members and continuously transforms itself'. However, the expectation that the learner will work in isolation is unrealistic for most adults. Thus, by creating resources that facilitate self-direction, there is the opportunity



to share ‘what and how’ and to monitor personal progress (Rana, Ardichvili, & Polesello, 2016).

McNamara (2008) contested that there is an increase in effectiveness from learning through self-experiences, which will improve development. By providing practical and appropriate materials and accommodating respective learning styles, this improvement can then be applied to the workplace. In addition, it can be more cost-effective than paid courses, which are not necessarily tailored to meet employees’ needs, and which can be costly to the organisation (McNamara, 2008).

Rana et al. (2016, p. 478) proposed the conceptual model in Figure 5.1, which identifies five practices and processes that are necessary to successfully create appropriate conditions for self-directed learning.



*Figure 5.1.* Conceptual model for self-directed learning (Rana et al., 2016, p. 478).

Using relevant technologies in the workplace is an effective enabler, and e-learning has an underexploited potential to empower clinicians to take charge of their own competency development and ability to act as change agents (Al Shorbaji et al., 2015).

### **5.2.1 Reflective learning**

With an increasing focus on learning processes throughout health services to improve critical analysis, reflective learning of both experience and knowledge is essential to ensure future health professionals are self-aware and engage in self-monitoring of their ongoing professional practice (Lahti, Kontio, Pitkänen, & Välimäki, 2014). ‘Preflection’ offers the opportunity to consider possible outcomes and anticipate experience before the event (Brand et al., 2016); however, despite its educational importance, there is limited published literature on educational innovations or teaching tools that aim to raise learners’ awareness to attitudes and bias in clinical practice. Using relevant technologies can be a powerful practice, as demonstrated by the Depth of Field: Exploring Ageing (DOF) (Brand et al., 2016) reflective learning resource that explores the use of photo-elicitation techniques to enhance reflective learning experiences by surfacing unconscious bias in health professional students’ perceptions of older adults. Following the DOF session, there was a significant overall positive shift in responses on the post-questionnaire than on the pre-questionnaire. A number of students displayed awareness that they were using their assumptions and stereotypes to fill in the gaps: ‘It is easy to make assumptions when you don’t have much information to work with’.

The researcher investigated and reflected on the many possibilities for using relevant technologies to enrich teaching tools, which would provide a valuable learning experience through a reflective learning methodology. Wear and Aultman (2005)

termed the phrase ‘pedagogy of discomfort’, which actively prompts learners to identify, question and address any unconscious bias or prejudices. Brand et al. (2016) when developing her program “Depth of Field” emphasised the importance of facilitating learning opportunities for reflection and creating a safe space to become aware of prejudice and bias.

#### ***5.2.1.1 ‘Pedagogy of discomfort’***

Pedagogy is a style of teaching that may not encourage inquiry, but rather adopt a course of when, how and what is learned. With limited knowledge or experience to guide the learner, they are dependent on teachers to provide knowledge and motivation in much the same way as children are taught. Many nursing staff have limited experience and education in teaching or reflective practice; therefore, they often display unconscious bias or prejudicial attitudes towards students. However, Wear and Altman (2005) challenged learners to move away from the ‘comfort’ of pedagogy and adopt an adult learning style using andragogy principles.

Andragogy encourages inquisitive thinking and independent learning that focuses on learning from experience rather than a teacher, which culminates in personal growth. However, Knowles et al. (2011) identified that a basic body of knowledge, skills and attitudes must be established before adopting an andragogy style of learning. Similar to Brand et al. (2016), the researcher accepts the importance of learning opportunities that offer a safe learning environment to reflect and reform attitudes. The creation of the toolkit using e-learning techniques and technology with information and resources, but within a safe environment, seemed ideally suited for the developmental process of becoming aware of the influence of nursing staff on creating an environment of belongingness.

This section has discussed self-directed learning and the merits of reflective learning, as well as the various learning styles that should be taken into consideration when delivering education using either pedagogical or androgl styles of teaching.

The next section will cover key pedagogical theories associated with e-learning, including behaviourism, cognitivism and constructivism.

### **5.3 Aspects of E-Learning**

E-learning is a process that integrates the use of technology into teaching and learning. Content knowledge combined with the application of educational technology and appropriate pedagogical principles is the basis for the development and delivery of e-learning content (Ruiz, Mintzer, & Issenberg, 2006). Using pedagogy (the art and science of teaching) to provide necessary intrinsic motivation in the complex process of education, e-learning can effectively enable participants to attain attitudes, behaviours, knowledge and skills (Choules, 2007). As with traditional learning, pedagogy as applied to adult learners with limited knowledge or experience of a specific area or task is an important consideration in the process of e-learning. Key pedagogical theories associated with e-learning include behaviourism, cognitivism and constructivism.

#### **5.3.1 Behaviourism**

Learning occurs through the transference of information from the teacher to the student. The teacher is fundamental to the approach of reinforcement as the student listens, observes, memorises and responds to the environment that then shapes their behaviour accordingly (Knowles, Holton, & Swan, 2011). As mentioned in previous chapters, the behaviourism work of Bandura (1913) involved the learner's behavioural processes of observing, memorising and responding. This concept is of particular significance to the development of an e-learning tool (a simulation of the teacher and environment) and exposure in a safe learning situation to desirable and undesirable

behaviours, thereby enabling the student to observe and attain desirable attitudes and behaviours.

### **5.3.2 Cognitivism**

Cognitive theorists maintain that learning is not solely a response to stimuli, but also the application of knowledge and active participation (Al Shorbaji et al., 2015).

Learners with increased insights draw upon previous experience and existing knowledge to develop new knowledge (Jackson, 2009). Bloom's revised taxonomy model (see Figure 5.2; Anderson et al., 2002) identified six cognitive domains, from simple recall to the more complex evaluation and creation of innovative ideas.

Innovation as demonstrated by e-learning techniques offers potential for creative future learning methods incorporating six key stages:

- remembering
- understanding
- applying
- analysing
- evaluating
- creating.

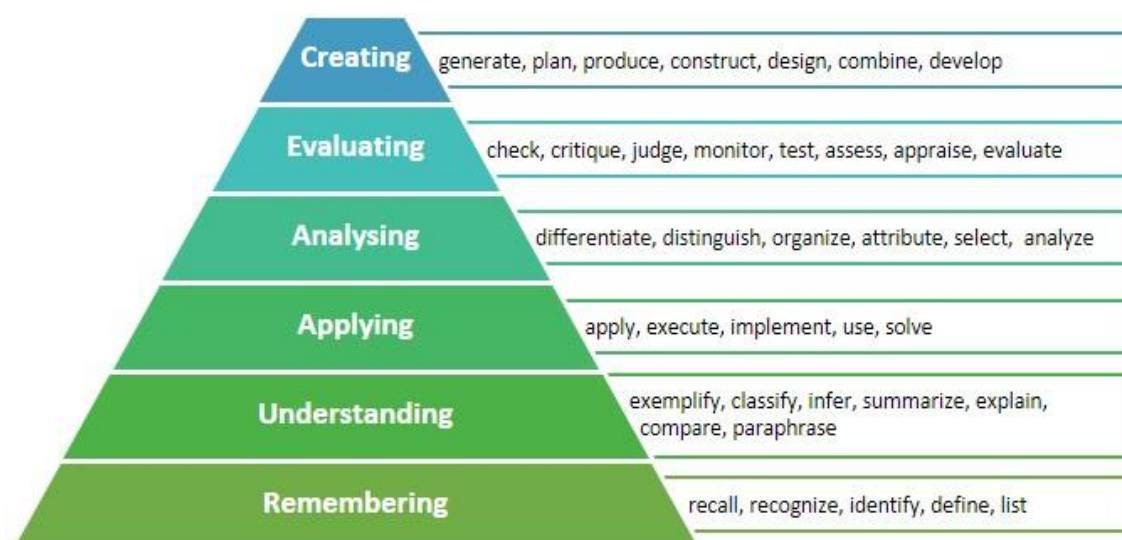


Figure 5.2. Bloom's six cognitive domains (Anderson et al., 2002).

### 5.3.3 Constructivism

Constructivism refers to the process of constructing new knowledge based on previously acquired knowledge. The term refers to the idea that learners construct knowledge for themselves and that each participant individually (and socially) constructs meaning as they learn (Masters & Ellaway, 2008). Learners are actively engaged in problem-based learning to construct new knowledge, and e-learning provides opportunities to construct new knowledge using case studies, simulation and scenarios that provide examples for participants to apply knowledge, reflect on outcomes and apply newly learned knowledge in a safe environment.

Huitt (2003) maintained that if we accept the constructivist position, we are inevitably required to follow a pedagogy that contends that learners must be given the opportunity to interact with sensory data and construct their own world.

This section has covered behaviourism involving Bandura's behavioural processes. Bloom's six cognitive domains were also identified, and the construction of new knowledge was discussed, along with its implications for e-learning.

The next section will reflect on the types of e-learning that are now available, as well as the quality control perspectives, using Kirkpatrick's model, which should be

taken into consideration when deciding on the delivery and evaluation of e-learning content. The concept of blended learning will also be discussed, along with its implication for the e-learning program.

## **5.4 Types of E-Learning**

The researcher investigated the different e-learning interventions being employed in areas of health education and compared their modalities. These included modalities such as ‘passive’ modes, which involve reading a slideshow on a computer, and ‘active’ modes, which include not only reading a slideshow, but also actively participating and interacting with the scenarios and completing multiple choice questions. Active participation, feedback and the ability to self-pace are key contributors. Further, interactivity offered by e-learning is believed to encourage deeper learning experiences because learners are active participants rather than passive receivers of information (Davis & Daley, 2008). E-learning is seen as changing the emphasis from instructor/teacher-centred learning to learner-centred learning (Gerdprasert et al., 2011), which enables self-directed learning.

### **5.4.1 Quality of an e-learning resource**

E-learning material must be developed to target the desired learning outcomes for which it is designed. While the material may be of good quality in other settings, the composition should be functional for this medium (Al Shorbaji et al., 2015). The researcher discovered that although clinical educators and ward managers commended the paper-based toolkit for its content, upon reflection, the layout and presentation were not suited for delivery as an e-learning package. Upon further investigation, the researcher established that by using an e-learning authoring tool software package such as Storyline (by Articulate) or Captivate (by Adobe), it would be possible to build content more appropriate to the medium of e-learning.

The Shared Content Object Reference Model (SCORM) criteria are a set of related technology standards, specifications and guidelines for the use, exchange, management and tracking of learning content (Ruiz et al., 2006). The SCORM criteria are the e-learning industry's current standards to be achieved by developers. Further, a commonly used taxonomy for assessing the quality of e-learning at the level of the learning process is Kirkpatrick's evaluation taxonomy (Pandey, 2018; see Figure 5.3). While Kirkpatrick's model is not the only one of its type, it serves the purposes of most industrial and commercial applications, and his theory is arguably the most widely used and popular model for the evaluation of training and learning. Kirkpatrick's four-level model is now considered an industry standard across training communities. The attraction of using technology to deliver knowledge results from the immediate benefits associated with it. Consequently, there is a need to identify accurate evaluation measures for e-learning programs, and learning evaluation is therefore a widely researched area because the subject is fundamental to the existence and performance of education around the world (Pappas, 2016).

The researcher considered employing this model of evaluation when formulating feedback forms and questionnaires to assess the quality of the program. Kitchen (2012) maintained that it is important to assess the reaction of the learner because their motivation drives learning. The researcher therefore decided to build the original paper-based feedback forms and surveys into the e-learning package using the Survey Monkey tool to determine the reactions of the participating nurses.



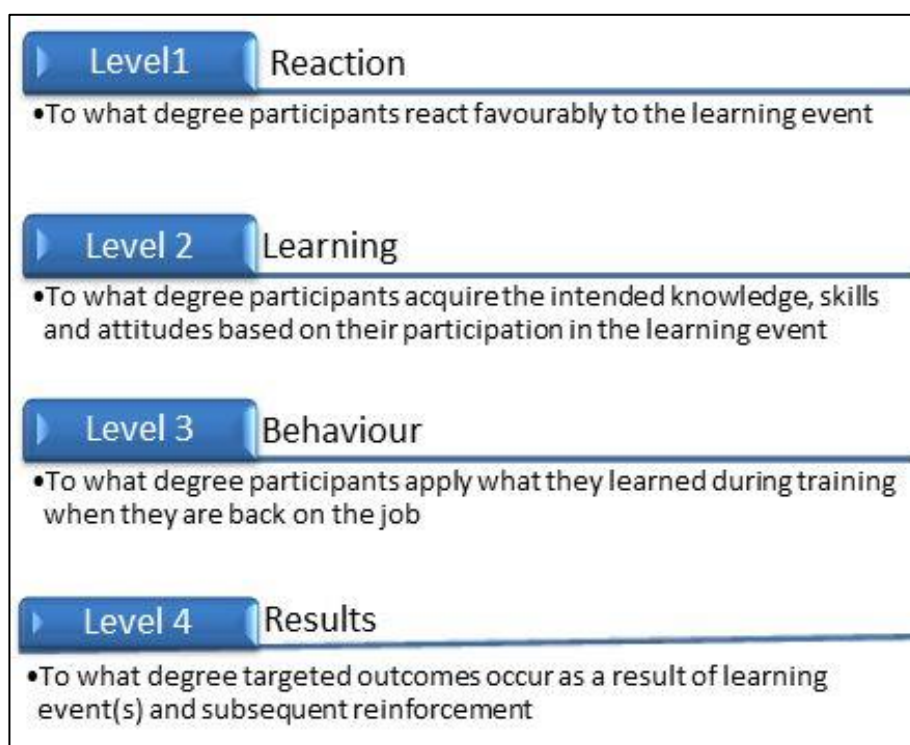
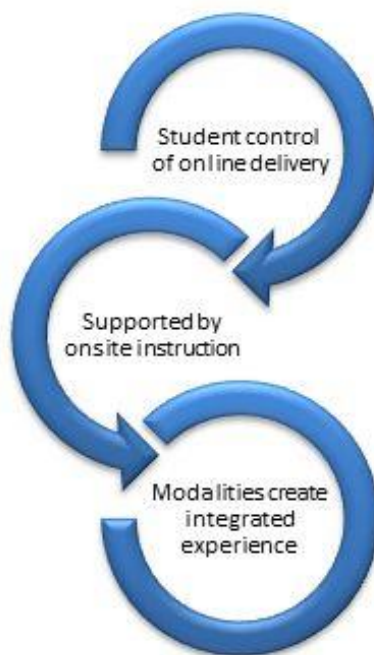


Figure 5.3. Kirkpatrick model.

#### 5.4.2 Blended learning

In the current climate of diminishing opportunities for education, a common feature of health professional education has been to develop a strategy of blended learning. Blended learning combines teaching and learning methods such as face-to-face, mobile and online learning, and it includes elements of both synchronous and asynchronous online learning options (Ramakrisnan, Yahya, Hasrol, & Aziz, 2012). According to Singh (2003, p. 53), ‘the concept of blended learning is rooted in the idea that learning is not just a one-time event—learning is a continuous process. Blending provides various benefits over using any single learning delivery medium alone’.



*Figure 5.4.* Concept of blended learning (Singh, 2003).

While the researcher identified the evolution of e-learning technologies as a major shift in delivering education, which was ideal for reaching a wider audience, it was felt that the toolkit should also be a combination of computer technology and traditional materials. A variety of factors are required to create a meaningful learning experience (Singh, 2003). The use of posters and a ‘Welcome’ notepad for students was considered beneficial by clinical educators who reviewed the toolkit contents. Learners could then decide when and where to access the program, but would be supported with onsite resources, which would create an integrated experience (see Figure 5.4). The aim of using blended learning was to make available as many different types of resources as could be conveniently accessed in a busy workplace. This idea was reinforced with feedback from clinical coordinators: ‘The student notebook is fantastic and an excellent resource! Posters will also be great for quick reference on busy wards...they will be an important prompt’.

This section has provided an overview of self-directed and reflective learning processes, and it has detailed the learning concepts that need to be incorporated when

developing educational tools. It has also discussed the requirements of quality control when offering the concept of blended learning, which combines teaching and learning methods from face-to-face and self-directed modes of delivery.

The next section will provide an overview of the design process for the package.

## **5.5 Design Process of the E-Learning Package**

Designing for learning is a complex task that requires a holistic approach with an emphasis on the importance of carefully selecting the learning and teaching activities and using systematic and easy-to-use frameworks (Al Shorbaji et al., 2015).

The original idea for the ‘Nurse Support Notebook’ was created from the themes that arose from the Delphi panel responses. Using the WANTED framework and identifying the gaps in knowledge and skills that exist in preceptoring students, clear objectives emerged for the design of the e-learning package. Transforming this material and data was the next stage of the process, and mind mapping (see Figure 5.5) was used to create the concept design to illustrate how to navigate the course, the content outline, the structure of the information and activities, and the screen-by-screen storyboard (see Appendix 22). In developing the program using a purpose-built software package, the researcher was required to design a format so that there was logical progression through the process.

The storyboard development used real life scenarios to produce videos. These scenarios were developed from situations the researcher had observed during her clinical career both as a clinician and a supervisor and which had been recorded in a personal reflective diary kept as part of a professional portfolio. Production of the videos and the writing of the program using the software tool Articulate took approximately four months to complete to a satisfactory standard. This timeline should

be given consideration if further developments are to be made to extending the program in the future.

From the initial feedback received from the clinical educators and nurse managers, the researcher identified that presenting a video alone would not be an effective or efficient way of conveying the issues and themes identified by the Delphi panel. The integration of the video scenarios into the e-learning package gave a better blended learning approach because each situation was used to identify common problems encountered by both nurses and students, and it gave nurses the opportunity to reflect on the issues that arise, thereby enabling them to take part in solving the problem.

An exact time to complete the e-learning program was not given as it was designed to be flexible to work with the participants available time i.e. it did not need to be completed all in one session if this was not practical. However, the estimated time taken on average to complete would be between half and three-quarters of an hour.

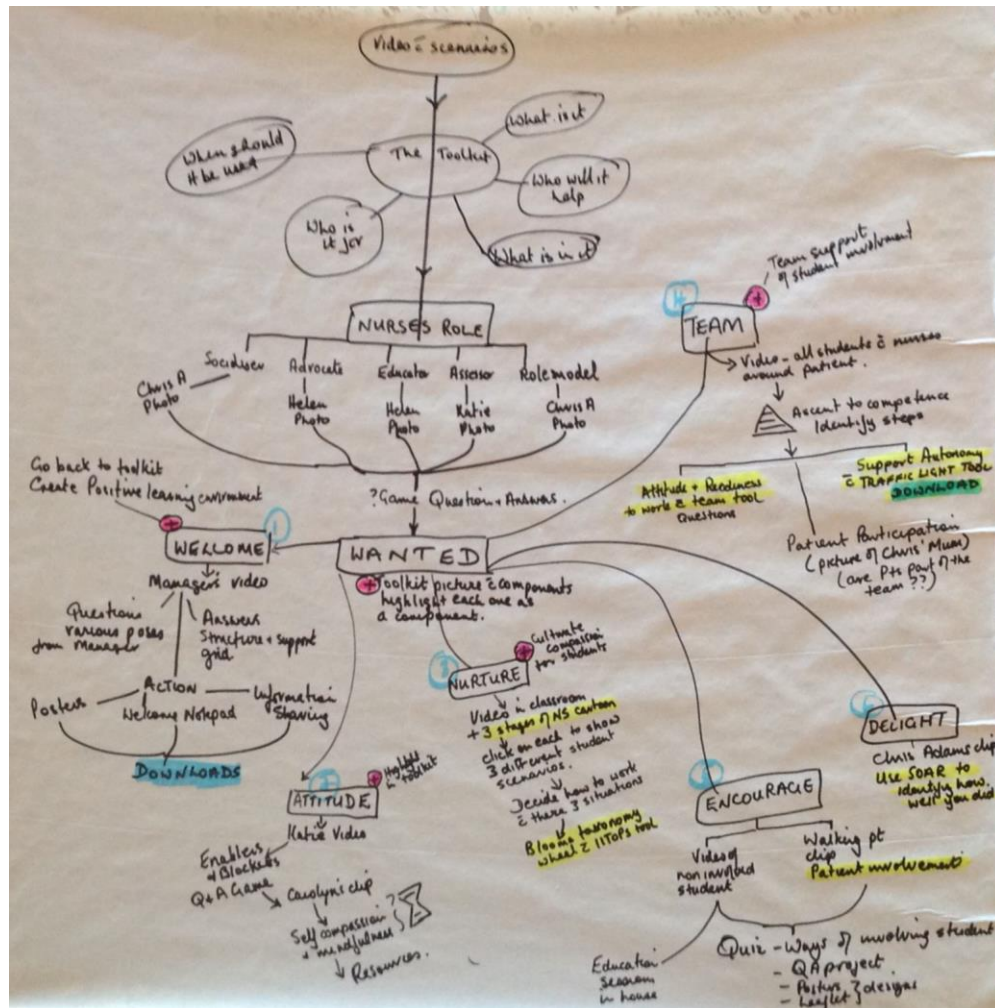


Figure 5.5. Mind map for the concept design.

### 5.5.1 Format of the e-learning program

The entire e-learning program was based on the WANTED framework, and its creation was described in the previous chapter. An examination of existing e-learning programs and their subsequent critiquing and feedback was undertaken to avoid common errors of poor presentation. For example, it is recommended that the writer of a program take advantage of all that e-learning has to offer by building interactions that invite the learner to participate in the information (David Anderson, Director, Customer Training at Articulate). By introducing videos to the program to stimulate reflection, and by incorporating interactive participation, the researcher was able to create a

teaching and learning tool that was more influential than a PowerPoint presentation. It also had the advantage of being accessible for nurses at their convenience.

Gagné (1977) suggested that for knowledge absorption and retention to occur, certain influences must be present. He introduced the nine events of instruction based on the internal and external cognitive factors that contribute to learning (Al-Eraky, 2012). The internal factors are the learner's prior knowledge, whereas the external factors are outside stimuli such as the form of instruction (in this case, e-learning). Using the nine events of instruction to develop e-learning experiences that are memorable also offers online learners the opportunity to engage in every step of the instructional process (Al-Eraky, 2012). The researcher identified with these events when developing the program:

- Create an 'attention-grabbing' introduction:
  - Al-Eraky (2012) suggested that to gain the immediate attention of the participants, the introduction must motivate and engage interest in the topic. Therefore, the researcher decided that a short personal video message was an engaging way of introducing this controversial subject.
- Inform the learner about the objectives of the e-learning course:
  - The objectives were clearly stated in verbal and written forms before accessing the first activity. The researcher's primary objective was to ensure that the participants could feel confident that they would take away a valuable experience and resource.
- Stimulate recall of prior knowledge:
  - The opening scenario examined the role of the nurse as described in Russell (2012). The researcher felt that this clarification of roles was

important, because within the answers given by the Delphi panel members, reference was continually made to the diversity and responsibilities of the nursing role when supporting a student. This scenario informed the participants of their existing skills and knowledge that would be applied to the activity ahead.

- Create goal-centred e-learning content:
  - Each piece of e-learning content—whether activity or exercise—should tie in directly to the goals and objectives. By analysing the qualitative data and identifying and grouping themes, the modules were based on specific goals to create the framework of WANTED. For example, the core objective of the first module of ‘Welcome’ was to identify the importance of creating a welcoming environment and how it might evolve. This approach to each module allowed the learner to master that topic before moving to the next topic.
  
- Provide online guidance:
  - Learning new skills and knowledge when engaging in e-learning requires support; otherwise, participants may become frustrated and disengage. In today’s world of technology, which has many varied methods of gaining knowledge, being a member of an online network that uses communication and opportunities to gather ideas should lead to learning advancement. Consequently, based on this connectivism, Kitchen (2012) maintained that rather than the transfer of knowledge from educator to learner, this model of learning encourages active engagement of learners with resources to communicate with one another. Using this premise, informative and

clear instructions were developed by the researcher. It was important to be aware and available to troubleshoot difficulties by email to support registering and navigating the program and ensure that participants were keen and able to embrace the medium of e-learning.

- Practice makes perfect:
  - Repetition is key to mastery of a task; however, it must not become boring. The learning process uses prior experience to build a new or revised interpretation as a guide to future action. Central to the adult learning process is formulating, assessing and making decisions on the resulting insights (Taylor & Cranton, 2012). Therefore, the key to motivating learning for adults is to relate assigned tasks to their own learning goals. This approach to learning can depend on a variety of influences, such as level of motivation, stimulation from the external environment and personal current goals (Kitchen, 2012). Kitchen (2012) noted that strategies or processes facilitate performance when matched to the requirements of the task. The researcher offered continual opportunities to expand knowledge, including branching scenarios (e.g., videos for reflection), simulations and resources to test actions and stimulate decision-making. The underlying message of promoting student belongingness was a continual thread throughout all exercises.
  
- Timely feedback:
  - Feedback received from the participants concerning the use of e-learning was an essential component in this research. The researcher was able to evaluate the future use of this mode of delivery of



education and gauge its effectiveness in providing the information and skills needed to improve the clinical situation for nurses and students.

- Assess early and often:
  - Assessing the surveys of the pilot study early on provided an opportunity to identify ineffectual areas in the e-learning strategy. For example, if one module is not effective in delivering expected outcomes, the opportunity exists to re-evaluate its online content and activities. For example, after receiving initial feedback from participants, the researcher changed the format of the ‘Role of the Nurse’ exercise to allow participants to identify their knowledge gap. Using adult learning principles, they were able to identify and act accordingly when deciding what they already knew versus what they still needed to acquire in order to achieve the learning objectives of the e-learning course.
  
- Enhance transfer of knowledge to real-world situations and applications:
  - Application of knowledge is important; thus, the researcher used videos with scenarios based on real-life situations and stories. These offered reflective learning for application of the information and skills being developed using the e-learning program.

After completing the pre-questionnaire using Stagg’s (1992) ‘Attitude towards Nursing Students’ survey, the storyline then continued through each of the headings—Welcome, Attitude, Nurture, Team, Encourage, Delight—offering a variety of

scenarios, support tools, display and teaching aids, as well as the opportunity for the nurses to review their own learning.

As previously discussed, an evaluation post-questionnaire was developed and incorporated at the end of the program to revisit Stagg's (1992) survey and examine the usefulness of the e-learning program in raising the awareness of the nurse–student relationship and creating an environment of belongingness. These data were collated for the quantitative analysis or second stage of the research project, as previously described in the methodology. The quantitative analysis and findings are presented in the next chapter.

### **5.5.2 'Going live': participants' access to the e-learning program**

When determining what authoring tools and LMS to use, many in the industry advise seeking reviews from other designers and examining the available features, cost and what is best for your organisation. There is no single tool that works for everybody. The researcher was required to consider the varying aspects of delivering education via this medium, such as the maximum and average numbers of persons accessing the program at one time, as well as whether the hardware used by participants could implement the technology and where the course would be accessed (facility devices or individual learner devices). Further, technological concerns centred on applications to install, back-up plans and security, server maintenance, and the type of support service needed for end users.

However, despite careful consideration of all of these aspects, some issues came to light for participants accessing the program. The LMS Moodle chosen to host the program is universally used and seemed appropriate for the design of the program because it was compatible with the authoring tool of Articulate, capable of maintaining a database of participants and capable of delivering a certificate of achievement.

However, there was an issue of its incompatibility with Google Chrome; therefore, it was recommended that participants run the program using either Microsoft's Internet Explorer browser on a PC or Safari on Apple. To ensure a smooth passage through the e-learning program, an in-depth instruction sheet was included in the information sent to participants.

The LMS remained open for just over one month, and 23 participants registered and completed the program. Despite offering email support for all participants, there was only one query concerning accessing the program, and this was responded to immediately. Once the closing date was reached, no further participants were registered; however, the program remained open in Moodle to allow participants to access the resources contained in the toolkit. The results of the survey concerning the use of the e-learning program and recommendations are presented in the next chapter.

## **5.6 Chapter Summary**

Before developing the e-learning toolkit, it became apparent that flexibility would be required in response to the feedback from nurse managers and clinical educators, who felt that paper-based tools would not be well utilised. Thus, the researcher investigated alternative methods of delivering this education using information and communication technologies. By exploring supportive ways to encourage staff to take responsibility for their learning and development through self-directed learning, the researcher increased the effectiveness of learning through reflection on people's experiences incorporating visual technologies. E-learning is a process that integrates the use of technology into teaching and learning (Ruiz et al., 2006). The researcher investigated different e-learning interventions being employed in areas of health education and compared their modalities. Using Gagné's (1977) nine events of instruction (Al-Eraky, 2012) to develop memorable e-learning experiences,

the program offered online learners the opportunity to engage in every step of the instructional process.

Consideration was given to the varying aspects of delivering education using this medium because designing for learning is a complex task that requires a holistic approach, with emphasis on the importance of carefully selecting the learning and teaching activities. Using the WANTED framework and identifying the gaps in knowledge and skills that exist in preceptoring students, clear objectives emerged for the design of the e-learning package. To ensure a smooth passage through the e-learning program, an in-depth instruction sheet was designed to support online learners. The results from the participants engaging in this program will be presented in the next chapter.

## Chapter 6: Results from the Quantitative Phase

*Learning changes who we are by changing our ability to participate, to belong, to negotiate meaning.* (Wenger, 1998)

### 6.1 Introduction

This chapter will present the analysis and discuss the findings of the second phase of the study, which used quantitative data collection methods. In this study, a sequential mixed method design was fully outlined in Chapter 3, and the presentation of the e-learning program and subsequent collection of data using technology in the form of an LMS and a contemporary paperless survey tool was illustrated in Chapter 5. Both chapters provided the context for the results presented in this chapter. The researcher used Survey Monkey to collect findings from the pre- and post-questionnaires of Stagg's (1992) attitude survey in addition to the demographic details of the participants and their assessment of using the e-learning format. This allowed for a determination on whether any of these factors influenced the usability of the WANTED tool.

The first part of this chapter will present the demographic details of the study population collected in the pre-questionnaire survey to portray their range of experience, knowledge and skills, and to present an overall picture of the participants before discussing the data from Stagg's (1992) attitude survey.

### 6.2 Study Population

In the second quantitative phase, data were randomly collected from qualified nurses working in diverse areas. Recruitment was conducted by email through professional organisations such as the University of Notre Dame Alumni, Sigma Theta Tau WA Chapter members, the Australian Rehabilitation Nurses Association and clinical coordinators of the universities of Western Australia. An introductory letter, a 'Participant Information Statement' and 'Instructions for the E-Learning Program' were

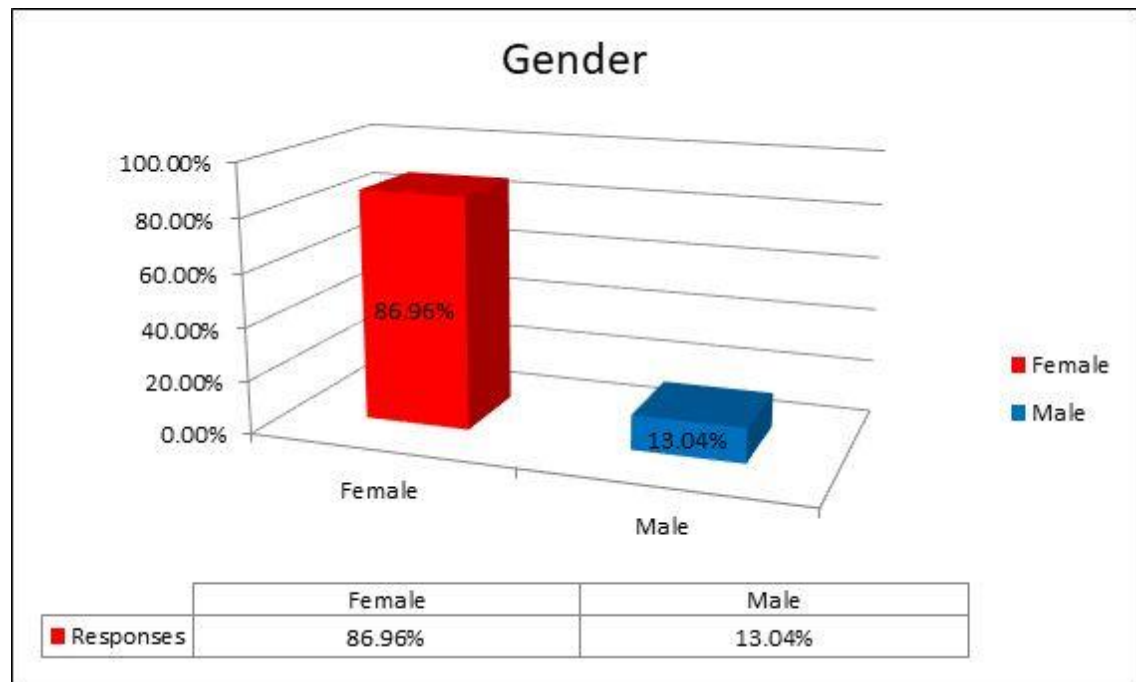
attached to the email. A total of 23 participants registered and completed both the pre- and post-questionnaire and participated in the interactive e-learning program.

### **6.2.1 Demographic characteristics**

On part two of the pre-questionnaire survey, participants were asked to respond to demographic questions (see Appendix 13). These data enabled the researcher to identify the main characteristics of this random group. The responses described the gender, designation, number of years working in nursing, area or speciality of work, previous experience of working with students and whether they held an educational or training qualification over and above their nursing qualification. This information was collected over a period of four weeks.

#### **6.2.1.1 Gender**

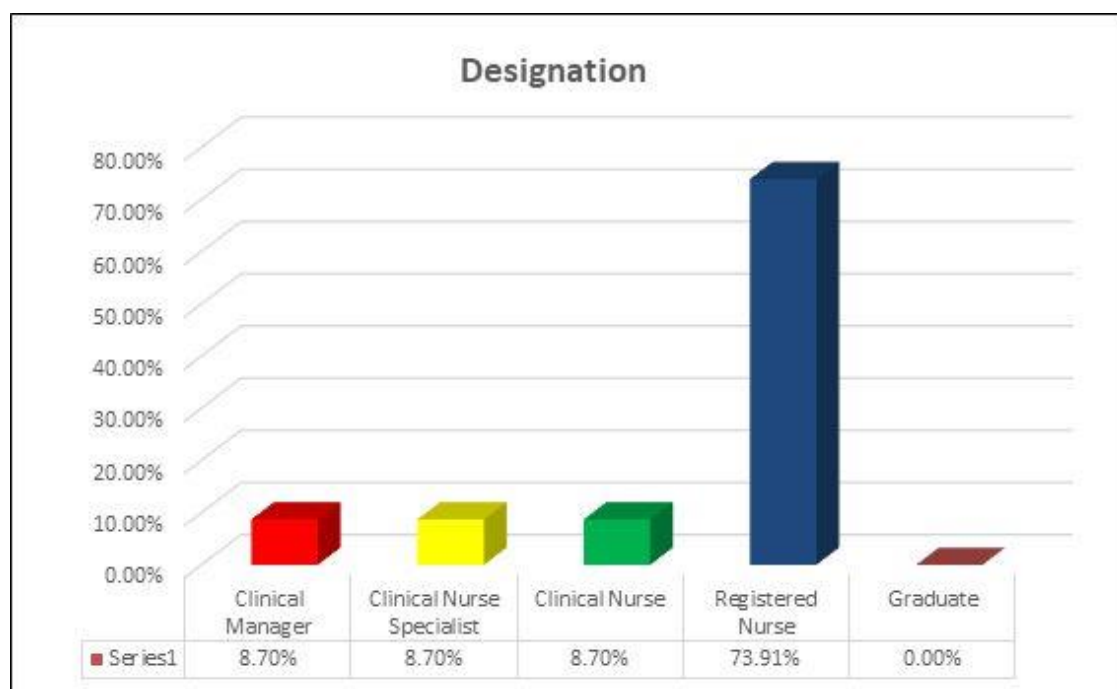
The total of 23 participants comprised both male and female nurses, with 87% women ( $n = 20$ ) and 13% males ( $n = 3$ ) (see Graph 6.1). This was comparable with data collected in previous surveys (Russell, 2012) of nurses undertaking clinical supervision training and education. However, the present survey showed a small percentage increase in the number of male nurses versus females.



*Graph 6.1.* Gender of participants.

#### **6.2.1.2 Designation**

The designation options ranged from clinical manager to graduate nurse, with the highest number recorded as RNs ( $n=17$ ). The researcher considered these findings useful given that the majority of supervising nurses are RNs; therefore, data obtained mainly from that cohort are particularly applicable for the review of the e-learning package in the future. Graph 6.2 depicts the data obtained from the completed program and surveys ( $n = 23$ ).



Graph 6.2. Designation of participants.

### 6.2.1.3 Areas of nursing

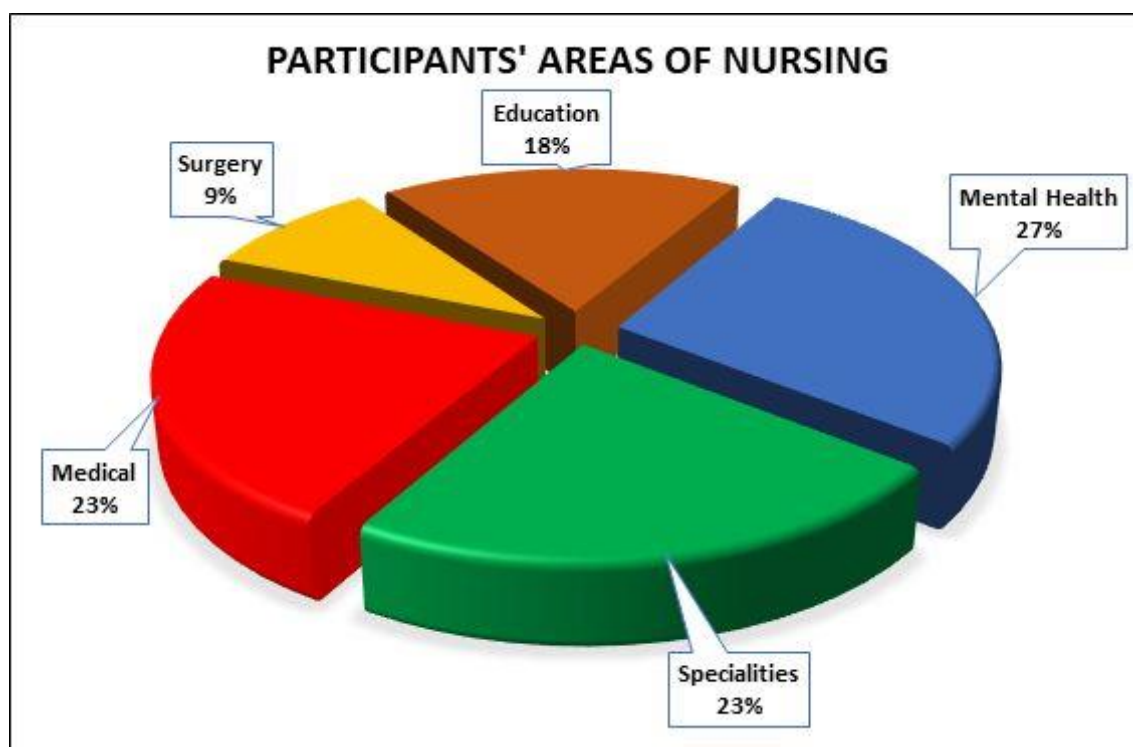
Regarding areas of nursing, most participants answered this question ( $n = 22$ ) (see Graph 6.3). The findings show that mental health nurses were the largest group and were allocated their own speciality, as recognised by AHPRA (2013). Similarly, education was allocated as a single identity, but was clustered from differing areas of education. This group included a researcher, a learning and development coordinator, a staff development nurse and a nurse working in telehealth. The researcher felt that grouping these participants was appropriate because their focus on education would be similar.

Likewise, grouping aged care within the medical group acknowledged the complex care given as a result of the many comorbidities that present with age. This grouping is similar in terms of nurses' experiences and attitudes. Specialities such as oncology, renal, intensive care unit (ICU) and midwifery were grouped together because the students' experience in these areas can often be restricted by nurses who



undertake complex procedures and therefore demonstrate less confidence in students' competency to perform these tasks.

The data were derived from a broad spread of areas in nursing; therefore, the researcher felt justified in combining certain positions because of the influence these environments can have on participants' attitudes towards students.



Graph 6.3. Participants' area of nursing.

#### **6.2.1.4 Qualification for teaching and assessing**

In addition, a question that asked whether the participant held a qualification in teaching and assessing was included. The researcher added this to the demographic section because although there is no requirement for a supervisor or mentor to have any teaching or assessing qualifications in Australia, it has been a prerequisite of assuming this role in the UK until recently (May 2018). Those undertaking supervision in the UK were required to gain an approved qualification through a mentorship course (ENB 998 or equivalent) and to meet the eight standards defined by the Nursing and Midwifery

Council (NMC) for mentors and mentorship, which sets the benchmark for the role in nursing and midwifery education (NMC, 2008). Changes in May 2018 have redefined the process and standards to align with interprofessional practice (this will be discussed further in Chapter 7). However, supervisors must still attend and record annual mentor updates and adhere to NMC guidelines that state the responsibilities of the role.

Of the 22 participants who answered this question, 26% had obtained a variety of qualifications (see Table 6.1). Although all of these qualifications would be advantageous in supporting nursing education, there was no alignment in meeting the requirements for clinical supervision of students or the appropriate standards.

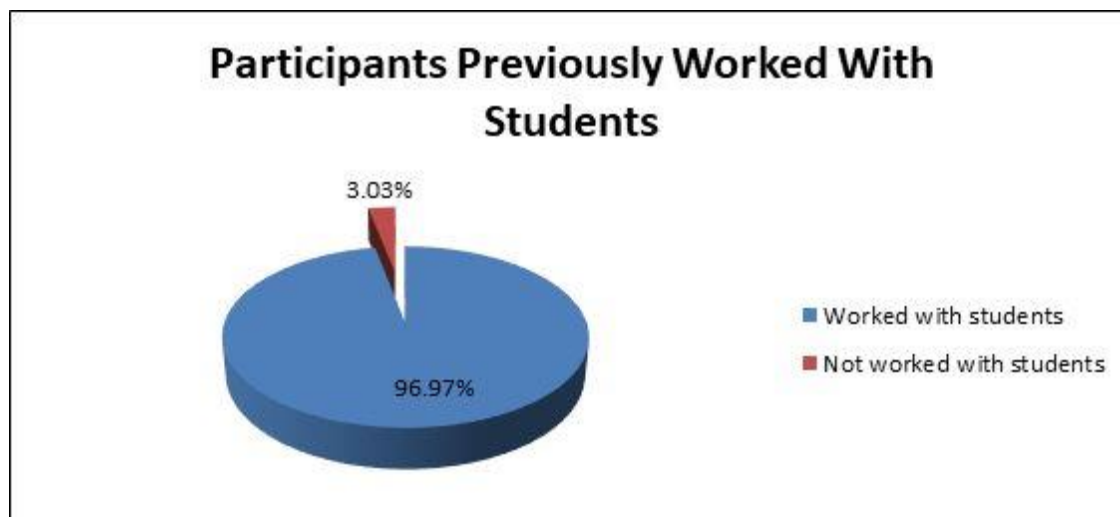
Table 6.1

*Additional Qualification for Nursing Education*

<b>Educational Qualification</b>	<b>No. of Participants</b>	<b>% of Participants</b>
PhD in nurse education	1	
Adv. Dip. & Post Grad. Cert.	1	
Grad. Dip. in Health Professional Education	1	
Assoc. degree in VET education	1	
Cert. VI in Training & Assessing	1	
Working towards Post Grad. Cert.	1	
<b>Total number of nurses with qualification in education</b>	<b>6</b>	<b>26%</b>
<b>Nurses without additional educational qualification</b>	<b>16</b>	<b>70%</b>
Did not complete survey question	1	4%

However, within this study, 97% of the participants completing the demographic survey had supervised students regardless of their educational training or qualifications

(see Graph 6.4). From the Delphi panel qualitative data, it was identified that this issue may influence nurses' understanding and comprehension of their role with students. The data revealed that only 26% nurses had any formal training. This will be discussed in greater detail in Chapter 7.



*Graph 6.4.* Previously worked with students.

#### ***6.2.1.5 Years of nursing experience***

The number of years employed in nursing ranged from one to 54 years (see Table 6.2). This indicates a broad spectrum of experience during decades of change in practice, technology, attitude, skills and knowledge expectancy. The majority of participants had 11–20 years' experience; however, the percentages indicated a reasonably even spread across the age groups. The researcher felt that as the participants were evenly spread across the age range, this would give a balanced response to the questions.

Table 6.2

*Number of Years Employed in Nursing*

<b>Demographic Survey (n = 23)</b>	<b>0–5 years</b>	<b>6–10 years</b>	<b>11–20 years</b>	<b>21–30 years</b>	<b>30+ years</b>
No. of participants	5	4	6	5	3
% of participants	21%	17%	26%	21%	13%

### **6.3 Data Collection (Pre- and Post-Questionnaires)**

For the data collection, the pre- and post-questionnaires using Stagg's (1992) attitude survey questions were situated at the beginning and end of the e-learning program. Once the participants had registered on the LMS, an instruction page guided them to a screen that contained the 18 questions to be completed before beginning the interactive stage of the program, and then 18 questions again upon completion of the e-learning activity. The researcher used these questions to determine whether the compilation of videos, reflective learning activities and supportive resources incurred a change of attitude towards students and clinical supervision after completion. Russell (2012) and Parvin et al. (2016) employed Stagg's survey questions to collect data on attitudes towards students. The researcher reported the findings using the same format and layout of results by Stagg (1992) and Russell (2012) so that comparisons could be made with the previous results obtained by these research studies; however, percentages were given in the text.

#### **6.3.1 Stagg's attitude survey analysis by themes**

Stagg (1992) themed her survey to produce seven distinct topics. Each topic comprised positive and negative statements regarding either direct or indirect supervision of students. The language used by Stagg was a little informal for academic

writing, but the researcher felt it was correct in the context and wished to keep these consistent with the original questionnaires for comparison purposes. Six of these themes that are relevant to this study have been used by the researcher to divide the 18 questions posed to the participants. They are defined as follows:

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

It is interesting to note that these themes relate strongly to the themes extracted from the data collected from the Delphi panel in the previous qualitative phase of the study.

Results from each of the six themes were tabulated according to the responses of Strongly Agree (SA), Agree (A), Undecided (U), Disagree (D) and Strongly Disagree (SD), and a comparison was made between the pre- and post-surveys. Positive reactions by participants, which indicate a positive attitude, have been shaded in line with Stagg (1992). These areas highlight positive and negative attitudes at a glance.

#### ***6.3.1.1 Professional issues***

This survey topic/component relates to the issue of students' identity and acceptance within the team environment, as well as the maintenance of professional standards (see Table 6.3). The statements were as follows:

1. I believe nursing students respect nurses as practitioners.
2. Nurses consider nursing students part of the nursing team.

3. Nurses should not have to do the teaching that clinical instructors are paid to do.
4. Nursing students should be introduced to all members of staff and patients on the ward/unit.

The response rate (pre-survey) for statement 1 was that 65% (*n.* 15) of respondents agreed and 26% (*n.* 6) strongly agreed. While strongly agreed remained the same, there was a change from undecided in the pre-survey to agree 70% (*n.* 16) in the post-survey. The disagree response remained the same in both surveys.

There was a notable change in responses to statement 2 (*Nurses consider nursing students part of the nursing team*), with a change in agreeing with this premise from 22% (*n.* 5) pre-questionnaire to 44% (*n.* 10) post-questionnaire. The variation in participants' answers had moved from undecided, disagree and strongly disagree (26% (*n.* 6), 39% (*n.* 9) and 4% (*n.* 1) respectively).

Statement 3 (*Nurses should not have to do the teaching that clinical instructors are paid to do*) elicited 74% (*n.* 16) disagreement in the post-survey. The pre-survey gave a combined strongly disagree and disagree rating of 80% (*n.* 17), with 4% (*n.* 1) undecided. This was similar to the results obtained by Russell (2012) and Parvin et al., (2016).

Statement 4 (*Nursing students should be introduced to all members of staff and patients on the ward/unit*) revealed that most participants either strongly agreed or agreed. In the pre-survey, 43% (*n.* 10) strongly agreed, but there was a significant increase post-survey to 61% (*n.* 14). This next result was affected as those who agreed moved to strongly agreed which decreased the result from 39% (*n.* 9) to 30%, (*n.* 7) while undecided reduced from a pre-survey rating of 4% (*n.* 1) to 0%, and disagree reduced from 13% (*n.* 3) to 9% (*n.* 2).

Table 6.3

*Stagg's (1992) Attitude Survey Theme of 'Professional Issues'*

	SA		A		U		D		SD	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
1.I believe nursing students respect nurses as practitioners	6	6	15	16	1	0	1	1	0	0
2.Nurses consider nursing students as part of the team	2	2	5	10	6	4	9	7	1	0
3.Nurses should not have to do the teaching that clinical instructors are paid to do	1	0	4	2	1	5	8	10	9	6
4.Nursing students should be introduced to all members of staff and patients on the ward	10	14	9	7	1	0	3	2	0	0

### 6.3.1.2 Personal issues

Questions in this section highlighted personal preferences and reflected some of the issues that arise during clinical placements that nurses sometimes find difficult to cope with (see Table 6.4). Results from the surveys indicated that nurses often feel unprepared to supervise students, and resentment may influence the manner in which they build a personal relationship. The statements were as follows:

1. Nursing students accept constructive criticism.
2. Nursing students become overwhelmed if they have to care for more than one or two patients.
3. Nursing students are too dependent on the ward nurses.
4. Nursing students do not have enough confidence in themselves.

Some nurses found the task of giving feedback and offering constructive criticism difficult. For the first statement, 57% (*n.* 13) of participants agreed that nursing students accept constructive criticism, 17% (*n.* 4) were undecided, 22% (*n.* 5)

disagreed and 4% (*n.* 1) strongly disagreed. This may reflect previous experiences of personal encounters with underperforming students and questions nurses' confidence that they are acting appropriately. However, in the post-questionnaire, 74% (*n.* 17) agreed with the statement, 13% (*n.* 3) were undecided, there was a decrease to 9% (*n.* 2) who disagreed and 4% (*n.* 1) continued to strongly disagree.

- Statement 2 divided opinion across the board in the pre-survey. Nearly 35% (*n.* 8) disagreed, with a small percentage strongly disagreeing; however, more than one-third (35% *n.* 9) were undecided, with 17% (*n.* 4) agreeing and 8% (*n.* 2) strongly agreeing. This higher percentage of indecision (35%) may reflect the nurses' lack of confidence in students' clinical abilities and their reluctance to give more autonomy or time for a student to work at an appropriate pace for them. This has been endorsed by the data collected from the qualitative phase. The post-survey answers had a high percentage of 39% (*n.* 9) undecided, which resulted in those disagreeing dropping to 26% (*n.* 6), but agreeing increasing to 30% (*n.* 7). This change of perception may have been brought about by some of the reflective videos, which depicted some of the real-life anxieties and frustrations that students have.

The third statement stimulated further thinking about initiating appropriate autonomy for students. Only 13% (*n.* 3) in the pre-survey agreed with nursing students being too dependent on ward nurses, while 52% (*n.* 12) disagreed. This was a similar result in findings by Russell (2012), leaving 35% (*n.* 8) undecided. The post-survey remained unchanged for the majority who disagreed (52% *n.* 12), but now with 13% (*n.* 3) strongly disagreeing. These combined ratings align with the increase in the post-survey findings of Russell (2012) and Parvin (2016). This reduced the percentages for being undecided and agreeing/strongly agreeing to 27% (*n.* 6) and 4% (*n.* 1) respectively.



Statement 4 in this theme pertained to student confidence. While 30% (*n.*7) agreed that nursing students do not have enough confidence and a further 9% (*n.* 2) strongly agreeing in the pre-survey, 26% (*n.* 6) disagreed and 4% (*n.*1) strongly disagreed, and one-third of the participants (30% *n.* 7) were undecided. However, after completing the e-learning program, in which student nurses relate experiences on video regarding nurses' lack of trust in their competency, 22% (*n.* 5) remained undecided; however, gratifyingly, the results showed an increase to 39% (*n.* 9)disagreeing that students do not have enough self-confidence. The post-survey results for strongly agree and agree were 4% (*n.* 1) and 35% (*n.* 8) respectively.

Table 6.4

*Stagg's (1992) Attitude Survey Theme of 'Personal Issues'*

	SA		A		U		D		SD	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
1.Nursing students accept constructive criticism	0	0	13	17	4	3	5	2	1	1
2.Nursing students become overwhelmed if they have to care for more than 1 or 2 patients	2	0	4	7	8	9	8	6	1	1
3.Nursing students are too dependent on ward nurses	0	1	3	1	8	6	12	12	0	3
4.Nursing students do not have enough confidence in themselves	2	1	7	8	7	5	6	9	1	0

### 6.3.1.3 Instructor–student relationship

The next themed section explored the instructor–student relationship (see Table 6.5). These statements refer to clinical supervision by both external and internal instructors and the understanding that builds between them. The statements were as follows:

1. Nursing students rely on their clinical instructor more than the ward nurses.
2. Nursing students ask too many questions.
3. Nurses should consider nursing students part of their team.

Considering the external instructors' limited time on the ward, the statement 1 compared the reliance of students on supervising nurses and external instructors. In the pre-survey, most participants either strongly disagreed or disagreed, with a combined score of 65% (*n.* 15). A similar result was found by Russell (2012). Nevertheless, 17% (*n.* 4) were undecided, but only 13% (*n.* 3) and 4% (*n.* 1) agreed or strongly agreed respectively. The varying and limited amount of time that clinical instructors spend on the wards would affect their ability to create a relationship both with students and staff. The post-survey revealed that there was little change in the ratings, with a slight increase to disagree (73% *n.* 17), slightly decrease to undecided or agree (13% *n.* 3 and 8% *n.* 2 respectively) and the same for strongly agree (4% *n.* 1). Again, these percentages were similar to the responses Russell (2012) obtained in both the pre- and post-surveys.

Within the context of the instructor–student relationship, the participants in both the pre- and post-surveys did not agree with the second statement (*Nursing students ask too many questions*), with 39% (*n.* 9) strongly disagreeing, 57% (*n.* 13) disagreeing and only 4% (*n.* 1) undecided. There were zero scores for both agree and strongly agree in the pre-survey. In the post-survey, strongly disagree increased to 52% (*n.* 12) and disagree decreased slightly to 39% (*n.* 9). Undecided remained the same, and agree rose to 4% (*n.* 1).

Statement 3 in this themed topic relates to the instructor–student relationship in the context of the team (*Nurses should consider nursing students part of their team*). This gained a very positive response in the pre-survey, with 44% (*n.* 10) strongly

agreeing and 48% (*n.* 11) agreeing, leaving the undecided and disagree scores at 4% (*n.* 1) each. Similar to the results obtained by Russell (2012), the post-survey showed that after undertaking the e-learning program, there was an increased score for strongly agree (61% *n.* 14), and although agree rated 39% (*n.* 9), the movement was positive because there were zero scores for undecided, disagree and strongly disagree.

Table 6.5

*Stagg's (1992) Attitude Survey Theme of 'Instructor/Student Relationship'*

	SA		A		U		D		SD	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
1.Nursing students rely more on their clinical instructor more than the ward nurses	1	1	3	2	4	3	12	17	3	0
2.Nursing students ask to many questions	0	0	0	1	1	1	13	9	9	12
3.Nurses should consider nursing students as part of their team	10	14	11	9	1	0	1	0	0	0

#### 6.3.1.4 Time

The following statements were addressed under the theme of time (see Table 6.6):

1. With nursing students who are new to the unit, nurses have time to do other things.
2. With nursing students who are familiar with the unit, nurses have time to do other things.
3. There is too much to do to have to worry about students.

The issue of time and the management of students and a workload were concerns presented by the participants in the Delphi panel in the qualitative phase.

Therefore, these findings had a significant bearing on the development of the e-learning

toolkit, which will be discussed in the next chapter. These statements also had implications when considering the allocation of students and length of stay in clinical placements. Again, this will be discussed further in the next chapter.

More than 50% (*n.* 12) disagreed with the first statement and 17% (*n.* 4) strongly disagreed, but 12% (*n.* 3) agreed. However, upon further consideration in the post-survey, 26% (*n.* 6) agreed, and disagree and strongly disagree decreased to 48% (*n.* 11) and 9% (*n.* 2) respectively.

There was a significant change in nurses' perceptions of students' contribution to the workload in the statement 2. Three-quarters (75% *n.* 17) agreed, but none strongly agreed that with students who are familiar with the ward, time was available to do other things. The post-survey saw an improvement, with 17% (*n.* 4) strongly agree, 65% (*n.* 15) agree, undecided remaining the same and only 4% (*n.* 1) disagreeing with the statement.

The findings from these two statements raise the question of whether nursing students should be able to do all clinical placements in the same hospital. Partnerships with universities and hospitals within WA exist. This will be discussed as part of the belongingness discussion in the next chapter.

The findings from the third question were again similar to Russell (2012). In the pre-survey, the nurses strongly disagreed and disagreed (26% (*n.* 6) and 52% (*n.* 12) respectively) that there was too much to do to worry about students. There was not a significant change in the post-survey, with most strongly disagreeing or disagreeing (22% *n.* 5 and 48% *n.* 11). Overall, a positive response to having students despite time constraints was demonstrated in the last two questions.

Table 6.6

*Stagg's (1992) Attitude Survey Theme of 'Time'*

	SA		A		U		D		SD	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
1. With nursing students who are new on the unit, nurses have time to do other things	0	0	3	6	4	4	12	11	4	2
2. With nursing students who are familiar with the unit, nurses have time to do other things	0	4	17	15	3	3	3	1	0	0
3. There is too much to do to have to worry about students	0	1	2	3	3	3	12	11	6	5

### 6.3.1.5 Motivation

The theme of motivation relates to the respondents' observations of students' involvement with nurses and other students in the clinical area (see Table 6.7). The following statements were used to gauge how positively or negatively these actions were perceived:

1. Students willingly help nurses to get things done.
2. Nursing students help other nursing students to get things done.

The first question reflects the relationship between the student nurse and the nurse supervisor during the ward routine and the willingness shown in participating in the teams' workload. Most participants (43% *n.* 10) replied positively (agreed) in the pre-survey. However, 26% (*n.* 6) were undecided, 9% (*n.* 2) disagreed and 4% (*n.* 1) strongly disagreed. The post-survey was even more positive: agree rose to 70% (*n.* 16), strongly agree 17% (*n.* 4) remained the same, 13% (*n.* 3) were undecided and there were zero scores for disagree and strongly disagree. This positivity may have increased after

nurses reflected on the scenarios in the e-learning program in which students demonstrated a willingness to be part of the team.

The second statement related to peer support between students and their self-motivation to do this. Previous chapters referred to the beneficial outcomes if this is encouraged in the clinical area. Most participants viewed this positively, with 61% (*n.* 14) agreeing, although 9% (*n.* 2) were undecided and one-third disagreeing (30% *n.* 7) in the pre-survey. In the post-survey, there was a small increase in their perception of students' support of each other, with 4% (*n.* 1) strongly agreeing and 65% (*n.* 15) agreeing. Similar positive percentages were recorded by Russell (2012) in her immediate post-program and eight-week surveys. With these two separate studies showing similar results six years apart, the next chapter will discuss the implication of these results for educating nurses on the importance of preparing students to support each other as part of a team.

Table 6.7

*Stagg's (1992) Attitude Survey Theme of 'Motivation'*

	SA		A		U		D		SD	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
1.Nursing students willingly help nurses to get things done	4	4	10	16	6	3	2	0	1	0
2.Nursing students help other students to get things done	0	1	14	15	2	4	7	3	0	0

### 6.3.1.6 Background comparisons

The final theme used by the researcher used statements related to participants' own student experiences and their attitude when comparing their own education and knowledge with that of current students (see Table 6.8). The statements were as follows:

1. We were all students once, so we should be nice to nursing students.
2. You cannot tell nursing students anything because they know everything.

In regard to the first question, the participants in the pre-survey overwhelmingly strongly agreed or agreed with this statement (70% *n.* 16 and 30% *n.* 7 respectively). After completing the e-learning program, which contained video clips from students recounting their positive and negative experiences, the percentage of those who strongly agreed increased to 74% (*n.*17).

Table 6.8

*Stagg's (1992) Attitude Survey Theme of 'Background Comparisons'*

	SA		A		U		D		SD	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
1. We were all students once, so we should be nice to students	16	17	7	6	0	0	0	0	0	0
2. You cannot tell nursing students anything because they know everything	1	0	1	1	2	2	12	10	7	10

The next and final question had varying degrees of agreement compared with the first question. While most either strongly disagreed or disagreed (30% (*n.* 7) and 52% (*n.* 12) respectively) with the statement, a minority were either undecided, agreed or even strongly agreed in the pre-survey. In the post-survey, the pattern remained similar, except that strongly disagree and disagree gained a higher combined percentage, with strongly disagree increasing to 42% (*n.* 10) although disagree decreased to 42% (*n.* 10). Strongly agree became zero, which was similar to the results obtained by Russell (2012).

In concluding the appraisal of six of the themes portrayed in Stagg's (1992) attitude survey, some of the findings have been found to compare favourably with

Russell's (2012) results, highlighting that participants had a more positive response towards nursing students after using educational support. While Russell (2012) developed the Art of Clinical Supervision (ACS) program in the form of a study day, it was interesting to note that some similar results were achieved in certain areas using an e-learning program with a tool and resources to assist self-learning.

Overall, the findings suggest that the participants improved in their perceptions of personal issues, professional issues, allocation of time, the instructor/student relationship and motivation of students. There was a change to a lesser degree for the other theme of background comparisons.

#### **6.4 Attitude Surveys**

For the quantitative phase of this project, the researcher chose to use Stagg's attitude survey because the study had been explored and undertaken successfully in a study by Russell (2012) in the ACS, as previously stated. Both of these studies aimed to determine the attitude of nurses towards nursing students 'in order to gain an understanding of the supervision context to inform and guide clinical facilitators and authorities' (Russell, 2012, p. 166). Determining whether a change in nurses' attitudes towards students occurs through different delivery mediums is important for future planning in nursing education. However, the focus of this research project is not to compare it to previous results from these studies in detail, but to determine whether using an e-learning package that contains a toolkit and resources positively changes attitudes towards nursing students and consequently improves the environment in which they work and ultimately want to belong.

Stagg (1992) conducted her survey just once while examining responses to individual questions and themes. Similarly, Aghamohammadi- Kalkhoran et al., (2010) like Parvin et al., (2016) from Iran whose system of health care is close to that of



developed countries also utilised the attitude survey on one occasion and the overall findings determined that nursing staff held low to moderate attitudes towards nursing staff. Whereas although Russell (2012) was able to compare the pre-findings within her research project with those of Stagg, there was no such opportunity for her immediate post and eight-week post-findings. Examining these two approaches, the researcher decided to conduct both pre- and post-surveys using the questions posed by Stagg (1992) and then organise a post-survey in a similar way to Russell (2012). The researcher did not use all of the questions from the original survey because it was felt that this would make the e-learning program too lengthy. For these types of programs to be effective, consideration must be given to its usability in the time-poor environment of health professionals. Nevertheless, the researcher felt that using questions and similar themes to Stagg and Russell gave validation to the survey of the questions posed and, as previously mentioned, similarity in percentages occurred.

### **6.5 E-Learning Survey**

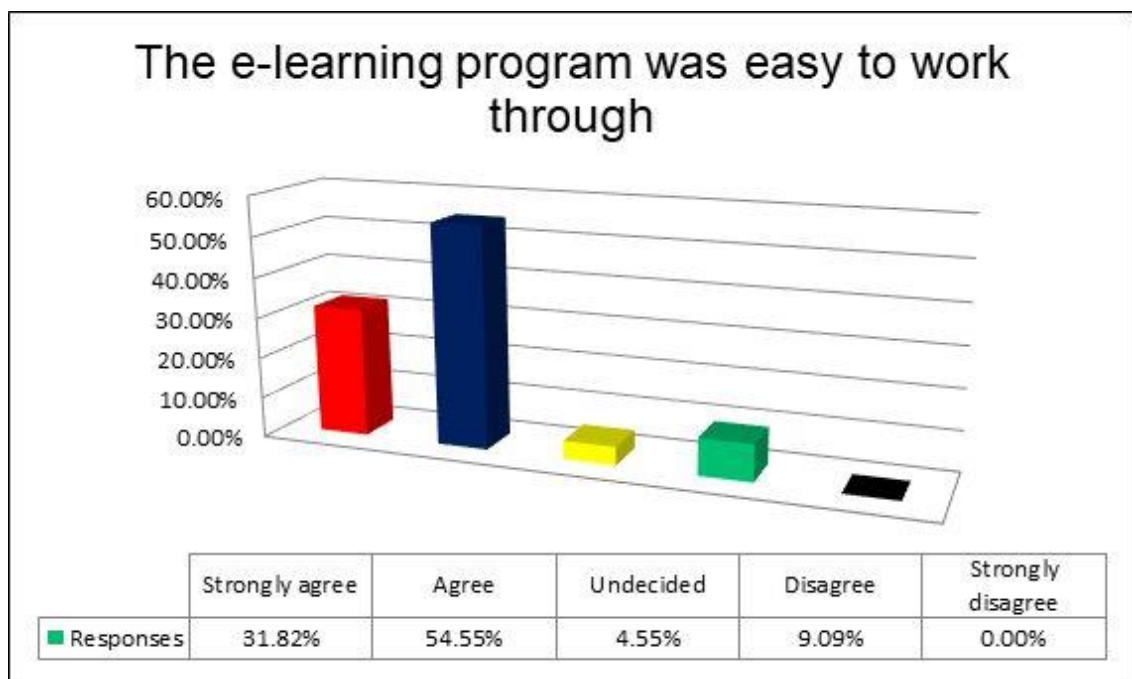
This Likert-type survey consisted of six questions added at the end of Stagg's attitude survey and asked respondents to rate the statements as Strongly Agree, Agree, Undecided, Disagree and Strongly Disagree. The sixth question asked for any additional comments. Twenty-two out of the 23 participants answered the first five questions of the survey, and 15 offered comments on the last statement. The statements were as follows:

- The e-learning program was easy to work through.
- I have found the e-learning program with the WANTED toolkit practical and useful.
- Completing the e-learning program will help me reflect and have ideas for always making nursing students part of the team.

- Using an e-learning program helps with improving my learning and education efficiently and effectively.
- I would recommend this e-learning program to a colleague.
- Do you have any comments about the WANTED e-learning program?

The tool was tested for face validity. As previously mentioned in the methodology chapter, face validity is when an assessment or test appears to do what it claims to do. No changes were required to be made following the review by the two research supervisors and clinical coordinator.

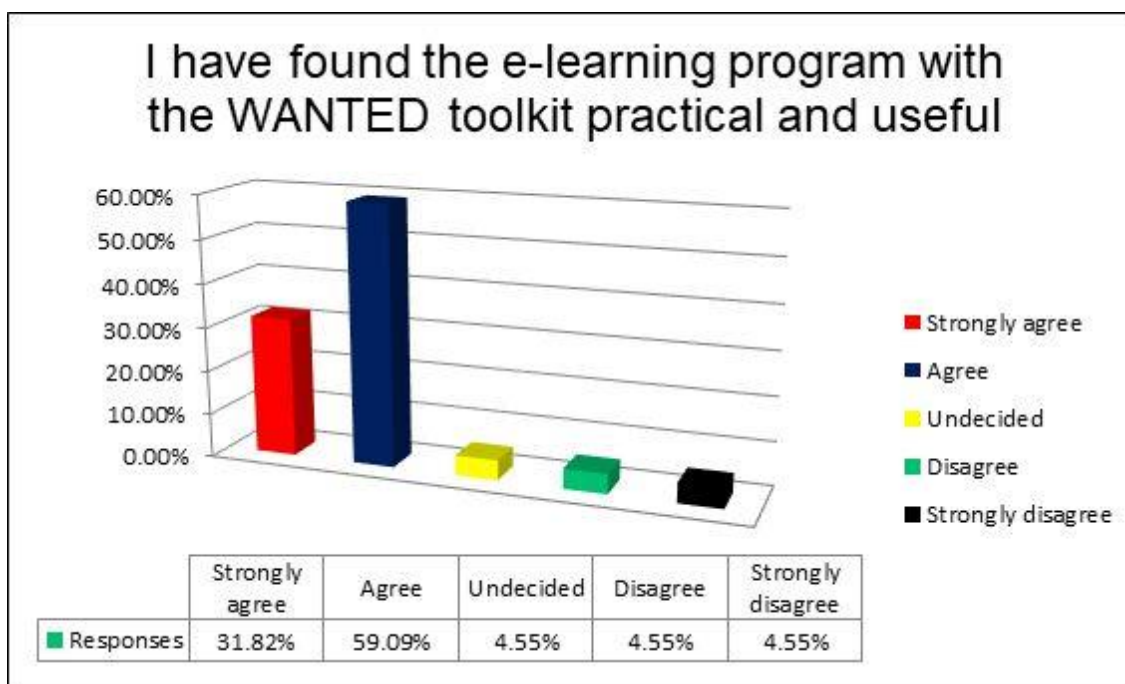
The first statement was that the e-learning program was easy to work through (see Graph 6.5). Most participants strongly agreed or agreed (32% and 55% respectively), with only 5% undecided and 9% disagreeing. Given that e-learning is a relatively new tool for education in health, these participants demonstrated a willingness to expand their options to learn.



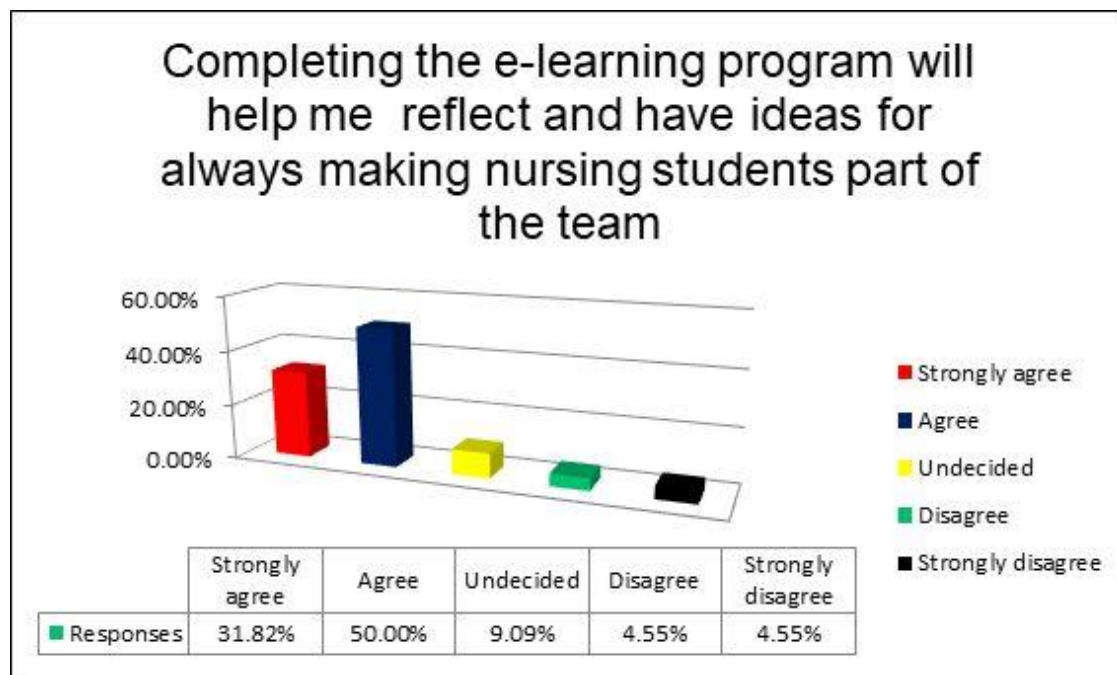
*Graph 6.5. Question 1.*

The second question (see Graph 6.6) required participants to respond to the content of the e-learning program—namely the WANTED toolkit—and decide if it was practical and useful. Fifty-nine per cent (n = 13) agreed and 32% strongly agreed (n = 7), showing that most participants had engaged positively with the e-learning package and its content.

The third statement questioned the nurses' reflective learning (see Graph 6.7). This was discussed in an earlier chapter, along with the importance of using the reflective process to generate new ideas. Again, a positive response was forthcoming, with 32% strongly agreeing and 50% agreeing; however, 9% were undecided. This positive response was supported by the comments made in the final question.



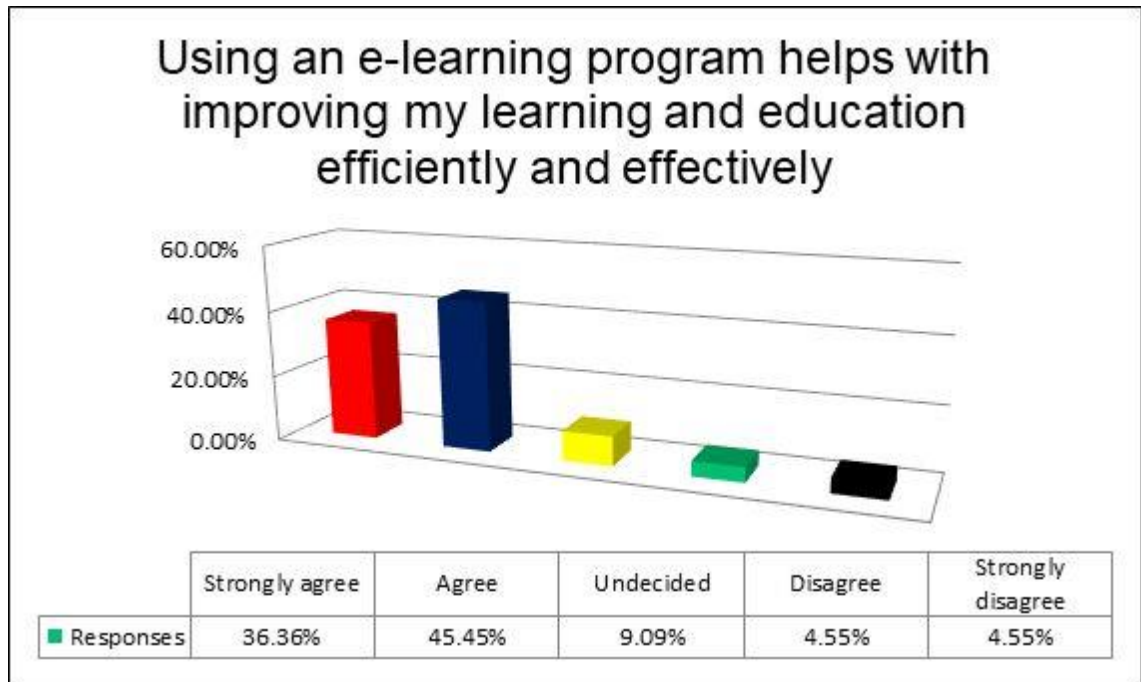
*Graph 6.6. Question 2.*



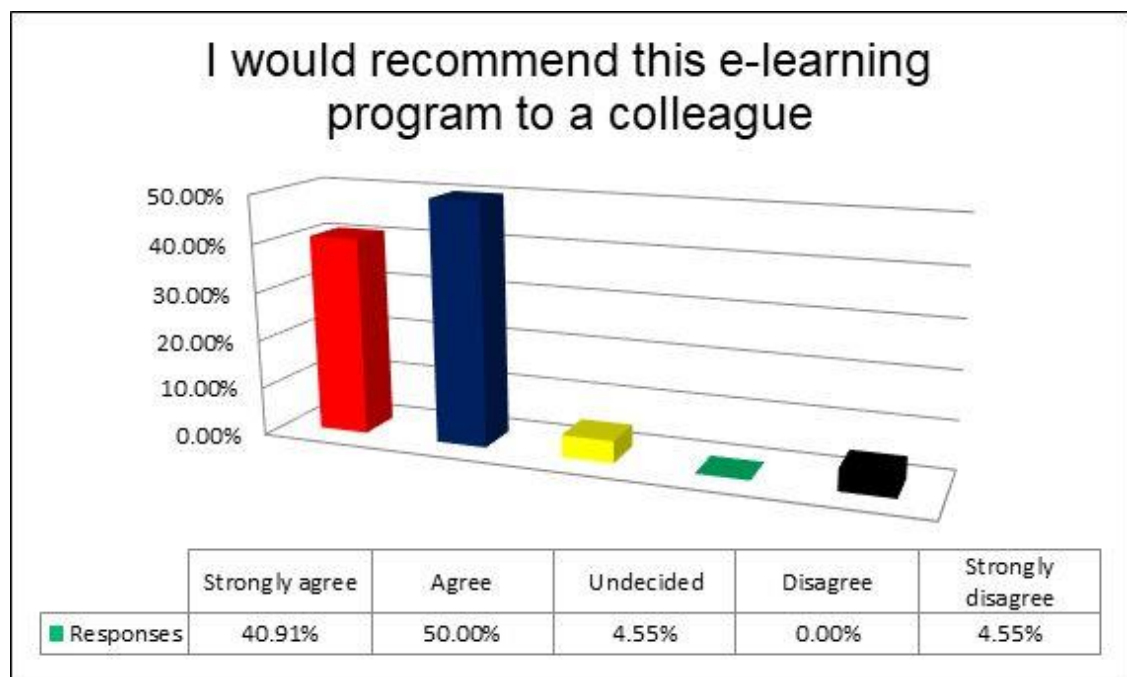
*Graph 6.7. Question 3.*

The researcher then continued with the next question to elicit the overall effectiveness of using e-learning as a teaching tool (see Graph 6.8). Participants strongly agreed (36%) and agreed (45%) with this statement, with 9% undecided and 5% both disagreeing and strongly disagreeing. This resistance to e-learning has been identified by Ramakrisnan et al. (2012) as part of participants' preference for alternative styles of learning.

The fifth question (see Graph 6.9) in this group gave the researcher the opportunity to determine whether the previous positive answers translated into a recommendation to others. This was consistently the case, with 41% strongly agreeing, 50% agreeing and 5% undecided or strongly disagreeing.



*Graph 6.8. Question 4.*



*Graph 6.9. Question 5.*

The final question was qualitative because the researcher felt that it was important for participants to express their opinions to provide a richer overall picture of the program. This will be important for future reviews and revisions. The results

showed that 65% ( $n = 15$ ) of the participants felt enthusiastic enough about the program to leave comments.

Most comments were very positive and encouraging, as several respondents were able to take away both messages and resources to be implemented in their workplace.

A summary of the comments is as follows:

- Congratulations.
- I enjoyed participating in this e-learning course. Very informative and reaffirms my enthusiasm about supporting students during clinical placements.
- This has given me new ideas to implement on my ward.
- This is beautifully made and the resources files are great.
- The use of real people works very well in the videos and pictures.
- I think this would be ideal embedded into a mandatory nursing staff training day.
- It is too long, I think it could be condensed, I can see a lot of work has gone into the design and construction of the program.
- Once I was able to understand the process it went very smoothly and was a great learning tool. It would be the best I have seen.
- Excellent information, which reflects information delivered by clinical facilitators. Would work well in community placements like medical centres where students encounter difficult cultures.
- Appropriate for graduates as perhaps an e-workshop that gives 5% towards total mark to facilitate its uptake. This aids them to view the experience as a professional and adds a feeling of control.
- Great program and easy to navigate.

- Excellent, easy to use.
- Good concept.
- The videos were informative, showing the intrapersonal thoughts of staff and students was helpful in shifting current thoughts to a new mindset. Overall what is trying to be achieved is exciting.

The suggestions will be given further thought and discussion when making recommendations in the chapter 8 in relation to usability and sustainability in the future.

## **6.6 Quantitative Findings**

The quantitative findings submitted in this chapter were extracted from data collected through Survey Monkey using Stagg's attitude survey (1992). In addition, a demographic survey and a survey about the e-learning package was included to give the researcher an overall picture of the study population to ensure it reflected the diversity of nursing and nurses and indicated their acceptance of the e-learning program as an educational tool. However, statistical testing was not applied to these two additional surveys because the purpose was to examine participants' attitudes towards students before beginning the program and then again after watching the videos, completing the exercises and reflecting on the information delivered to calculate any change that may have occurred. The surveys were embedded in the program as pre- and post-questionnaires.

Before applying any statistical tests, the data were tested for normality of distribution. The skewness and kurtosis results for the pre- and post-course data proved to be within acceptable limits (between  $-2.0$  and  $+2.0$ ), indicating that the distribution was reasonably normal (i.e., skewness  $-0.65$  and  $-0.44$ ; kurtosis  $-0.4$  and  $+1.29$  for pre- and post-surveys respectively).

The mean ratings for all 18 questions were compared between the pre- and post-course surveys using a repeated measures t-test (two-tailed). The result gave a significance value ( $p$ ) = 0.0006, demonstrating that there was a highly statistical improvement in participants' question ratings (i.e.,  $p < 0.05$ ) as a result of the course.

It is recognised that while the majority of opinion supports the use of parametric tests (e.g., t-test) with Likert-scale data (given that there are at least five scale levels and the data are reasonably normally distributed), there is some debate within the research community, and it may be regarded by some commentators that Likert scales represent ordinal rather than interval data, thereby failing the assumptions for a parametric test. A Wilcoxon (non-parametric) test was therefore applied to the mean ratings for all 18 questions to compare the pre- and post-data (Greene & D'Oliveira, 2005). The result,  $W = 0.027$  again indicated statistical significance and supported the conclusion that the course had contributed to a statistically significant change in participants' overall ratings.

## **6.7 Chapter Summary**

Upon completing the presentation and analysis of this chapter, the researcher has shown that the e-learning program containing the WANTED toolkit has supported nurses to reflect on their attitude towards nursing students and make positive changes to their thinking to promote belongingness in the clinical environment. This supports the findings of Russell (2012), who identified that within the clinical supervision relationship, a positive effect can be produced by educating nurses purposefully to undertake the supervision role.

While many participants demonstrated a favourable attitude towards students, some participants had obviously had negative relationships with students, which



challenged their own knowledge and skills competency, thereby influencing their responses.

Using the medium of e-learning to undertake supervision training also produced positive results as a way forward to address the issues of nurses being time-poor and lacking hierarchical support. Participants indicated that this type of learning could be part of a mandatory course and could be easily adapted according to the nurses' experience.

Chapter 7 will continue to explore the topics raised in this and previous chapters, followed by a discussion in Chapter 8 in which the implications of these findings for the future of nursing will be raised.

## Chapter 7: Discussion of Findings

*Discourse is the process in which we have an active dialogue with others to better understand the meaning of an experience.* (Taylor & Cranton, 2012)

Many thousands of clinical placements are allocated each year in WA, along with thousands more globally. Their success in producing competent and confident nurses for the future relies on the ability of nursing staff being able to supervise effectively. An environment that welcomes, offers an accepted role in the workplace, understands learning objectives and promotes application of theory to practice develops students with the skills, knowledge and attitudes for future professional careers. This chapter will examine the findings and their synthesis in relation to contemporary theory and practice standards, and to previous scholarly literature.

### 7.1 Introduction

Many points of discussion have emerged throughout the data collection of this study. While employing two separate methods of data collection, similar issues arose from both standpoints, thereby highlighting topics that were identified in Chapter 2 as affecting the sense of belonging for nursing students in the clinical environment (Anderson, Moxham, & Broadbent, 2016; Grobecker, 2016; Henderson et al., 2007; Levett-Jones et al., 2009.) Therefore, the main discussion points will focus on:

- requirements for the nursing supervision role (see Section 7.2)
- length of clinical placements (see Section 7.3)
- belongingness and the attitudes of individuals, teams and organisations (see Section 7.4)
- e-learning evaluation program findings (see Section 7.5).

The findings of the qualitative and quantitative research for each discussion point will be reviewed alongside the literature. The key points will be discussed that

affect clinical supervision, the workplace environment and ultimately the relationship between nurses and students. Before this review, a summary of the WANTED findings and international comparisons will be considered.

### **7.1.1 WANTED**

Participants in both the qualitative Delphi panel survey and the post-questionnaire quantitative survey proposed an approach valued by senior staff and management, which supported supervising nurses to influence changes in attitudes, attributes and behaviours. As a result of this research, the WANTED toolkit has been developed. It is important to ensure that the use of this program and toolkit is maximised to improve opportunities to prepare holistically for students' clinical placements by challenging and changing attitudes (see Figure 7.1).

Strategies contained in the toolkit have been brought together as resources best positioned to challenge and change attitudes. Using video scenarios to highlight problems had to be complimented with a means to deal with the problems – a toolkit. The main aim of the resources was to stimulate discussion among peers offering tools as to how best implement improved techniques of nursing student management and education in their workplace. It has been designed to explore and reflect on the nurses' role as a health professional and then through reflection examine personal perceptions of nursing students with an aim of changing attitudes.

With this in mind, the discussion will focus on improving the current situation. Therefore, the next section will debate the different approaches to maintaining the standards to which nurses must adhere for the delivery of nursing student education in a productive and positive clinical environment.



*Figure 7.1.* Effect of the WANTED e-learning program on a belongingness environment.

### **7.1.2 International comparison**

Levett-Jones et al. (2009) maintained that the greatest influence for students to feel a sense of belonging is the response towards them of the nurse with whom they worked. The researcher felt that of particular interest to this study is the differing approach taken by other countries to supporting nurses' education to improve their attitude to supervising. This section will therefore revisit the current status in the provision of education for the supervision of nursing students in Australia and the UK. The researcher chose to examine these two countries because she has previous experience in supervising students in both countries. Having originally trained in the UK and working at a large London hospital during the period of the changeover to the 'Project 2000' program (Burke, 2003), the researcher was able to draw on first-hand experience and therefore make a considered comparison of the two systems. In addition,

reviewing a large cross-section of the current literature, the researcher was able to determine what, if any, differences the systems made to nurse supervisors. Stagg (1992) and Russell (2012) both made comparisons with these two countries; however, recent updates to nursing practice standards have since been made in both countries, which may affect future developments in supervision and education. The comparison could have been extended to many other countries, including Canada, Ireland, New Zealand, Scandinavia and the US, because international nursing practice standards all appear to have expectations of nurses to support students' clinical experience to gain competency (Anderson, 2016). Although terminology may differ, nurses around the world follow a common set of professional values that include personal and professional responsibility and accountability (Lyneham & Levett-Jones, 2016).

## **7.2 Requirements for the Nursing Supervision Role**

This section will discuss the overall findings from both stages of the research, as well as their correlation to current literature, theory and research conclusions. However, a comparison will first be made between the training and education requirements and models for nursing supervision in Australia and the UK. Respondents to the surveys identified training and education in supervision as a high priority; therefore, the proposed requirements of nurses will be compared with the current standards for practice.

Further, this section will discuss the effect of the length of stay of nursing students, which affects the nursing supervision role. Suggestions from the literature for alternative models will be compared with the input from participating nurses, in which the current models of clinical placement have been described as detrimental to the nursing supervision role and building relationships. This will be followed by a

comparison of the qualitative and quantitative research findings and the new knowledge gained from this research in relation to the relevant literature.

### **7.2.1 Nursing education in Australia**

As previously discussed, after many years of an unchanged apprenticeship-type model of nursing training, in the 1980s and ahead of countries such as the UK, Australia made the controversial decision to move away from hospital-based education (Levett-Jones & Fitzgerald, 2005). The change established a tertiary education with a curriculum delivered through universities, with clinical placements embedded into the degree courses. Nursing was no longer a ‘vocation’, but a profession with improved education and far-reaching changes to embrace technological and rapid social change (King, Russell, & Bulsara, 2017). Experience in the clinical setting, although reduced in time, was viewed as a crucial aspect of nursing education, whereby nursing students would transfer knowledge to practice and socialise in the working environment by participating in complex situations (Bhojrab et al., 2010; Hegenbarth et al., 2015). Since then, a fundamental difference has existed within nursing education in that beliefs and values about adult learning are considered crucial for understanding learning styles, motivation, feedback and the learning environment. The researcher considers these core principles of adult learning essential in the development of the toolkit for nursing supervision. However, little has been recorded in the literature about support for nurses who supervise students and their beliefs about what is most conducive to adult learning in the clinical setting (Hegenbath et al., 2015).

#### ***7.2.1.1 Professional standards***

Although clinical supervision of nursing students is frequently referred to in health governance documents and evidence-based guidelines and standards that describe how it should best be delivered and evaluated, these responsibilities have remained

insufficiently supported with governance structures. Anderson et al. (2016) believed that this may deter many nurses from taking up their professional responsibilities to support nursing students because of issues such as confidence in teaching ability, workloads, acknowledgement by management for being involved with students and awareness of the nursing standard requirements.

Under the *Nurses and Midwives Act 1991*, Nursing and Midwifery Boards (NMBs) were established in each state and became the statutory authority for registration. The primary purpose of the NMB was to protect the health and safety of the public by:

- establishing and maintaining standards of education for nurses and midwives
- ensuring that nurses and midwives are fit to practice.

However, guidelines for ensuring education delivered to students in the clinical setting were not established, and no benchmark was given by which to judge the quality of the professional practice taught.

As stated in Chapter 1, the *HWA Act* in 2009 identified the need to provide further support for the delivery of clinical training for the purposes of the health workforce (HWA WA Act, 2009). HWA (2010) confirmed that while health and education establishments were endeavouring to achieve appropriate placements, in some cases, students were left in a less than acceptable environment. An integral initiative for improvement proposed the implementation of effective supervision through support and education for all staff.

The introduction of APHRA in 2010 amalgamated all state boards into the NMBA, which now undertakes 'functions as set by the Health Practitioner Regulation National Law as in force in each state and territory (the National Law)' (NMBA, 2016). Australian licensure standards are embedded within broader standards known as the

Registered Nurse Standards for Practice (NMBA, 2016). Within these standards, there is the expectation that RNs will support nursing students who are undertaking their clinical learning experience.

From the NMBA fact sheet of June 2016, the question was posed:

Do the standards cover what is expected of an RN in relation to accountability, delegation and supervision?

It acknowledges that accountability, delegation and supervision are crucial in relation to the standards, as seen in the given answer:

**Yes.** The standards clearly indicate the standard of practice expected of an RN in relation to accountability, delegation and supervision. It is essential that the standards, and the definitions taken from the glossary in the standards as provided below, are read in conjunction with NMBA standards, codes and guidelines. The following definitions are taken from the glossary of the Registered nurse standards for practice. These definitions relate to the use of these terms in the standards.

**Accountability** means that nurses answer to the people in their care, the nursing regulatory authority, their employers and the public. Nurses are accountable for their decisions, actions, behaviours and the responsibilities that are inherent in their nursing roles including documentation. Accountability cannot be delegated. The registered nurse who delegates activities to be undertaken by another person remains accountable for the decision to delegate, for monitoring the level of performance by the other person, and for evaluating the outcomes of what has been delegated.

**Delegation** is the relationship that exists when an RN delegates aspects of their nursing practice to another person such as an enrolled nurse, a student nurse or a



person who is not a nurse. Delegations are made to meet peoples' needs and to enable access to health care services, that is, the right person is available at the right time to provide the right service. The RN who is delegating retains accountability for the decision to delegate. They are also accountable for monitoring of the communication of the delegation to the relevant persons and for the practice outcomes. Both parties share the responsibility of making the delegation decision, which includes assessment of the risks and capabilities. In some instances, delegation may be preceded by teaching and competence assessment.

**Supervision** includes managerial supervision, professional supervision and clinically focused supervision. (NMBA, 2016)

However, again, no mention is made of practice standards or support and regulation when supervising a student, but the nurse 'who delegates activities to be undertaken by another person remains accountable for the decision to delegate, for monitoring the level of performance by the other person, and for evaluating the outcomes of what has been delegated'. Without education in any of these activities, it becomes questionable that the nurse will be able to achieve this standard. In addition, it is stated that 'delegation may be preceded by teaching and competence assessment'; however, there is no standardised level to be attained for those teaching and making the competence assessment. The demographic data from this research study identified that only 26% of the participants had any education qualifications, although these were variable in content.

The Australian Nursing and Midwifery Accreditation Council (ANMAC) is the independent accrediting authority for nursing and midwifery education. It helps to protect the health and safety of the Australian community by establishing high-quality

standards of nursing and midwifery education, training and assessment. It is responsible for accrediting education providers and programs of study for the profession. However, while these courses are of a high standard, there appears to be a gap regarding whose responsibility it is to ensure that the clinical education provided by nursing staff on the wards is at an equal level. No requirements other than their professional qualification are needed for nurses to be able to teach and supervise.

Browning and Pront (2015) maintained that there is limited support and education available for nurses who lack the confidence or ability to teach and support students, and this is a deterrent for undertaking this role. In addition, Mackay, Brown, Joyce-McCoach and Smith (2014) proposed that there is a lack of training programs available to nurses through official channels of nursing education. It is now viewed across the profession that specifically targeted standardised and accredited supervisor workshops are needed to provide guidelines for supporting and teaching nurses and enabling them to fulfil their clinical educative role with students (Anderson, Moxham, & Broadbent, 2016; Mather et al., 2015).

Australia's health system is complex, and the *National Health Reform Agreement* (NHRA, 2011) sets out the arrangements for the Commonwealth funding contribution to eligible public hospital services, and it commits to funding public hospital services on an activity basis wherever practicable. Teaching, training and research (TTR) activities are currently block funded; however, a transition to activity-based funding (ABF) by July 2019 may offer an opportunity for hospitals to revisit and review their activities when developing a classification system for teaching and training.

In 2013, the Independent Hospital Pricing Authority (IHPA) undertook a project to develop a set of nationally agreed definitions for TTR for the purposes of ABF direct activities. It defined key teaching and training activities such as 'direct activities' as

distinct and separable activities that occur outside an episode of care, but that are directed towards skills and knowledge development in the teaching and training context (e.g., lectures, tutorials, workshops). 'Indirect activities' may include the coordination of student placements and educational program development. There is scope for nursing education in clinical supervision to be itemised in the dataset of a teaching and training classification, thereby ensuring a standardised approach and availability of appropriate education for nurses.

### **7.2.2 Nursing education in the UK**

In 1986, the British Government proposed a phased transfer of nursing education into the tertiary education sector that heralded the commencement of the 'Project 2000' program. This approach was formalised by the English National Board (ENB) in 1987 and the United Kingdom Central Council (UKCC) in 1988 in the content and validation of 'Project 2000' common foundation courses and branch programmes leading to registration. Continuous assessment of theory and practice was recommended to ensure nursing standards were maintained and improved within this new Project 2000 program to deliver a well-prepared nursing workforce. (Bradshaw & Merriman, 2008).

Burke (2003) suggested that among other factors that influenced this change was the inadequacy of the current nursing education model to prepare students for a rapidly changing healthcare environment. This program was academically recognised and led to a diploma of higher education. However, criticism of its ability and fitness for purpose called for a re-evaluation. Within the literature, many maintained that deficits in the abilities of students to apply knowledge to practice resulted from the increased importance placed on academic theory without due consideration of support for translational learning (Fitzpatrick, While, & Roberts, 1996). In 1999, the Peach report

recommended that equal prominence be given to the quality of clinical education and academic components. Greater emphasis was also placed on the importance of the development of partnerships between National Health Service trusts and higher education institutions, with the outcome of earlier clinical placements and longer practice placements (Levett-Jones, 2007).

#### ***7.2.2.1 Model of clinical supervision***

Around this time, the UK regulatory and educational authorities established that student nurses would be supervised by a designated mentor. This was in response to the poor quality and nature of support for assessment and learning in clinical settings, which had resulted in poor placement experiences. The advisory standards issued by the then United Kingdom Central Council for Nursing, Midwifery and Health Visiting made clear the functions and responsibilities of the mentor. The English National Board for Nursing, Midwifery and Health Visiting educational programme in teaching and assessing (ENB 998) gave nurses the opportunity to learn and gain a qualification for mentoring students. All students were then supervised by nurses who had at least one year of postgraduate experience and the ENB 998 certificate (the Nursing and Midwifery Council approved teacher programmes have now superseded this). However, this did not address the issues of general acceptance by all nursing staff of the change in nursing training. In 1999 an independent review of the Nurses, Midwives and Health Visitors Act 1979 (as amended in 1992 and consolidated in 1997) recommended that the UKCC and the National Boards should be replaced by a more strategic and streamlined Nursing and Midwifery Council (NMC). A Nursing and Midwifery Order in Council abolished the UKCC and the National Boards and established the NMC, which came into operation on 1 April 2002 (National Archives, Kew; Bradshaw & Merriman, 2008). There was further guidance and support given to nurses wishing to mentor students,

through the development in 2008 of the NMC 2008 Supporting Learning and Assessing in Practice standards document.

Ongoing improvements have been implemented by the UK NMC (2016) in the ‘Programme for Change’ as it reviews and sets standards that will ensure a more consistent student experience. The changes that are being implemented are for learning and assessment in practice, for mentorship and preceptorship, and for practice placements and interprofessional learning. The first phase of new standards was approved by the UK NMC in March 2018 and published in May 2018. One of these is the *Standards for student supervision and assessment—how nursing and midwifery students are supported and assessed in theory and practice*. Part 8 of this standard outlines the practice assessors’ preparation and sets out the requirements, which include evidence of learning and experience by the nurse supervisor that will enable them to achieve all four outcomes for maintaining their role. The following is section 8 of a 10-part document:

‘Realising professionalism: Standards for education and training’ (NMC, 2018).

Practice assessors: preparation approved education institutions, together with practice learning partners, must ensure that practice assessors:

- 8.1 undertake preparation or evidence prior learning and experience that enables them to demonstrate achievement of the following minimum outcomes:
  - 8.1.1 interpersonal communication skills, relevant to student learning and assessment
  - 8.1.2 conducting objective, evidence-based assessments of students
  - 8.1.3 providing constructive feedback to facilitate professional development in others
  - 8.1.4 knowledge of the assessment process and their role within it

- 8.2 receive ongoing support and training to reflect and develop in their role
- 8.3 continue to proactively develop their professional practice and knowledge in order to fulfil their role
- 8.4 have an understanding of the proficiencies and programme outcomes that the student they assess is aiming to achieve. ([www.nmc.org.uk](http://www.nmc.org.uk) Part 2: Standards for student)

The standards framework ensures that those who support, supervise and assess students are suitably qualified, prepared and skilled and receive the necessary support for their role (NMC, 2018). Consistently in both the qualitative and quantitative components of this study, support for the supervising role was highlighted, and it was expressed that it should be a top-down approach from boards and senior management held to account by standards of practice.

Previously in the literature, concerns had been raised that by using only nurses with a qualification (i.e., ENB 998) for mentorship, there would be a continued lack of education and understanding of the role by those not completing this, and even for those who attended the program, there was a seeming lack of support (Barker et al., 2011; Russell, 2012). However, the UK NMC has now addressed this with comprehensive guidelines within the standards giving opportunities to all clinicians. It encourages the contemporary ideal of interprofessional education, which promotes a greater emphasis on healthcare being delivered by teams comprised a range of professions, which ultimately improves the clinical environment and patient care:

Practice supervision enables students to learn and safely achieve proficiency and autonomy in their professional role. All NMC registered nurses and midwives are capable of supervising students, serving as role models for safe and effective

practice. Students may be supervised by other registered health and social care professionals. (NMC Standards for student supervision and assessment, 2018).

The changes moving towards interprofessional collaboration give other health professionals the opportunity to educate and assess student nurses' competence from their perspective, ensuring they understand holistic care and the patient journey. Participants in the Delphi study surveys were keen to emphasise that there should be 'recognition that students are not just the responsibility of the staff development nurse, but the whole team'. Working together to provide students with an optimal clinical experience was also recognised as important by respondents to fulfil health education requirements: 'More understanding of health care as a multi-disciplinary service requiring complex teamwork and team systems'.

This study therefore endorses the necessity of a change of focus in developing standards for student supervision and assessment.

### **7.2.3 Comparison of qualitative and quantitative findings concerning clinical supervision**

Most participants who responded expressed negativity in regard to preparedness to supervise students. As discussed in previous chapters, the literature has consistently shown that there is a great deal of variability in the quality of supervision (Barker et al., 2011; Gidman et al., 2011; Hall, McFarlane, & Mulholland, 2012; Reberio et al., 2015). However, survey findings showed that around 70% of participants felt that students relied more on CNs for supervision than instructors from educational facilities.

Therefore, there is still a need for adequate preparation for clinical supervision because most nurses (80%) who participated in this study appeared to be prepared to undertake this role, but identified support and education as essential for the role. The findings of the second round of the Delphi panel survey collected for qualitative data

indicated a concern for the current provision of education for nursing staff in relation to clinical supervision. The need to ‘offer ongoing support in preceptorship and mentorship’ was a recurrent response to rectifying the situation, with some identifying that ‘workplace learning supervisors may not feel they have the requisite skill set or time to take ownership of the student’s wellbeing entirely’. When conducting her qualitative studies through online reflections and interviews for the ACS program, Russell (2012) noted the participants’ perceived lack of support; this is supported by much of the literature. Professional standards previously discussed identify the nurses’ role and responsibility to nursing students. However, the literature shows that challenges include a lack of support from management, which often manifests itself in a lack of preparation of nurses for the teaching role, as well as a lack of recognition for efforts by staff (Anderson et al., 2016).

Ten years ago, Luhanga, Yonge and Myrick (2008) proposed that it was vital that nurses be given opportunities to attend paid supervisor workshops to properly prepare them for the role of teaching students in the clinical setting. Currently, this view is supported by more than 50% of the respondents in the qualitative survey, in which they maintained that education needs to be valued by clinicians, and that the health department could improve this outlook by funding weekly education sessions. A participant in the second phase of the research study suggested that the e-learning program WANTED should be embedded in a mandatory nursing training day. A similar recommendation for this training and education to be made mandatory and yearly was proposed by Russell (2012); however, with the abolition of HWA, the intended funding is no longer available.

Globally, there are regulatory expectations of nurses to support nursing students to gain competency, but the findings from both the qualitative and quantitative data on



this topic indicate a significant concern about the current provision and regulation of education for clinical supervision, the inconsistency of support and the lack of understanding of the role. This supports the research completed by both Russell (2012) and Anderson et al. (2016), who noted that while students can feel unsupported during clinical placements, similar feelings of neglect are also indicated by nurses when requiring education and support for professional development in student supervision.

### **7.3 Length of Clinical Placement**

As with Levett-Jones's (2007) survey-based research, this study did not set out to investigate 'whether or how the structure and duration of clinical placements influenced students' sense of belonging', but as with her study, participants strongly suggested in both the qualitative and quantitative data that this issue could change perspectives in regard to nurses' attitude and students' perception of belonging. The researcher therefore decided to review the findings and investigate this issue to understand the pressures surrounding these mindsets. The complication of time (shorter length of student stay) was highlighted in both phases of the study; therefore, the success of the toolkit depended on how these difficulties were addressed and what strategies could be given to problem-solve. The process of reviewing the models of clinical placements in Australia and the UK and comparing different approaches informed the researcher when considering detailing in the e-learning program and opportunities for changes that nurse supervisors could make within the work environment.

Therefore, based on the findings from this study and those of other related research, for a nursing student to feel part of the team and gain a sense of belonging, an adequate and uninterrupted length of time in the clinical environment is seen as crucial to a positive and productive learning experience (Levett-Jones, 2007). This was entirely

supported by the participants in both phases of this study. Critical to students being able to consolidate their knowledge and skills is the feeling of being comfortable within their surroundings. While attempting to familiarise themselves with surroundings, routines and staff, they concentrate on fitting in and trying to belong. This has been documented as important and significant to them (Grobeck, 2016). However, in much of the literature, as previously discussed, students specifically commented on the length of time spent on the wards, with some claiming that staff were more committed if the placement was longer, allowing for a relationship to build.

Nevertheless, while it is not currently possible to lengthen students' placements, the toolkit delivered strategies to maximise the time available by encouraging a welcoming environment with posters and a 'Welcome Book', which would allow students to integrate more quickly rather than spending valuable time trying to familiarise. These recommendations for strategies were made by participants in the surveys:

Orientation should be given in a warm welcoming environment where students do not feel nervous or threatened but supported and cared for.

Proper communication about the student coming to do the placement. A proper package put together to enhance the learning experience of the student.

Strategies for autonomy using the 'Traffic Light' system (Russell et al., 2016) were also recommended for use to ensure that students would not continually repeat procedures without progressing forward.

Notwithstanding these measures, it is important to consider the bigger picture for making a change to the present system of placing student nurses in the clinical setting, which was consistently agreed upon by participants during this study as a recommendation.

### 7.3.1 Clinical placements in Australia

In Australia, the entire number of hours spent in the wards while on clinical placements amounts to little more than approximately 850 hours, which are divided into one to two weekly blocks in the first two years, while during the final year, a 5–6 week block will occur in the final semester. For some placements, universities and hospitals have made partnerships that allow students to complete their clinical placements in the same hospital. It is contended that this model could go some way to giving a sense of belonging by allowing the student to become familiar with the culture of that hospital (Thomas & Westwood, 2016).

The researcher's previous working experience has been involved in committees reviewing the structure of clinical placements in which the length of placements has been scrutinised and discussed. However, despite agreement from most parties involved that lengthier placements, such as those experienced by allied health students, would be beneficial, logistically, the numbers of nursing students requiring placements makes this difficult for the immediate future. Conversely, many have argued in the past that it is not the number of hours that is important but the quality of the supervision and experience gained (Mallik & Aylott, 2005).

Levett-Jones's (2007, 2008, 2009, 2016) extensive research in this area has been acknowledged globally. She conclusively advocates that the success of clinical placements depends upon collaboration between higher education and health services, which must remain responsive and flexible to meet the needs of students and to develop effective interpersonal relationships with all concerned. Qualitative responses in the first Delphi round concluded that the longer the student is allocated to the ward, and when there is time for staff to be able to teach, they become part of the team and feel like they belong. Conversely, other comments highlighted that in a time-poor workplace, time is

not set aside to create a team, and that the student turnover every two weeks may be a contributing factor to staff burnout. In addition, some maintained that having too many students at the same level on the clinical placement at the same time (for two weeks) was also a challenge, because they are all competing to achieve certain objectives for that clinical placement.

Similarly, several agreed that short periods of placement (i.e., less than four weeks) and seeing a different buddy every day across many different settings made the placement harder for both the unit and the student and a challenge to belongingness.

Restructure is now long overdue, with clinical placement redesign of innovative models such as the Dedicated Education Units (Edgecombe, Wotton, Gonda, & Mason, 1999; Nishioka et al., 2014; Glynn, McVey, Wendt, & Russell, 2017) implemented and evaluated with positive outcomes almost 20 years ago at the Flinders University of South Australia School of Nursing.

Restructuring the design of a clinical placement was identified in the surveys of this study—particularly with regard to inexperienced and very junior staff having neither the experience nor the ability in time management to cope with a busy workload and supervising a student. Comments and recommendations from respondents to the survey included:

Provide explicit and negotiated expectations of the role; perhaps start with one or 2 days only rather than the whole student placement; buddying less experienced staff with more experienced staff when the experienced staff are preceptoring students; team preceptoring.

I would argue that junior RNs should not preceptor staff until they have undertaken some form of training/ education with industry educators.

Collaboration between higher education providers and health services still remains high on the agenda for activating change in the clinical learning environment.

### **7.3.2 Clinical placements in the UK**

To provide broader context beyond Australia, nursing students in the UK undertake a minimum of 2,300 clinical placement hours over three years, with approximately 560 hours in both the first and second year, and the remainder in the third year. Fifty per cent of nurse education is undertaken in the clinical area (Murphy et al., 2012) in both acute care and the community. As previously stated, the Peach report in 1999 made recommendations that emphasised that equal prominence be given to the quality of clinical education and academic components. Therefore, to maximise the available clinical placement opportunities, students are allocated part of their placements in hospitals, and a percentage of the clinical time is spent in community nursing with health visitors, school and community health nurses. It is suggested in accordance with the UK NMC guidelines that students work the same shifts as their 'named' mentor for at least three out of five shifts per week. However, the UK NMC (2018) recognised that a flexible, diverse and varied approach to placements is needed for the future to reflect the patient journey across hospital and community settings. Health services are redesigning both in the UK and Australia to deliver care closer to the patient's home with a patient-centred focus (Department of Health, Western Australia, 2018; Sherratt et al., 2013).

Offering nursing students the opportunity to be part of the patient journey as opposed to just being on a short clinical placement, could not only broaden their learning, but enable them to feel more involved with the patient as the focal point and with all the clinicians providing the care. Roxburgh et al., (2012) using a multiple case study design to evaluate models of practice learning, proposed that the term

“placement” was restrictive and implied learning within boundaries of a specific location or team. Exploration of an alternative approach to the traditional organisation of practice learning focussed on placement philosophy of an open and flexible system that was person centred and spanned health and social care services in ways that “reflect the service users experience” (Roxburgh et al., 2012, p. 782). From this study the conclusion was that placement experiences can be expanded by a paradigm shift through broadening the physicality of the learning environment and the model of student clinical practice. The thematic summary of mentor and colleagues’ perceptions within the case studies (Roxburgh et al., 2012, p. 788) identified:

- better basis for relationships with mentors
- basis for planning ahead together
- increased student confidence
- can follow service user journeys and help families

Practice learning should promote person-centred learning rather than superficial, compartmentalised placement centred learning. This would also have the effect not only on the sense of belonging, but would open the way to students viewing a new approach to health service delivery of the future.

One approach to diversifying placements was organised by the University of Wolverhampton using a system of hub and spoke, where students were allocated to one hub placement and return on three separate occasions. Further enhancement allocates the student to spoke placements, which can be between one and four weeks. Students have highlighted belongingness as a key benefit to this model, with such comments on returning as ‘it was like coming home and reassured that I knew the area’ (Thomas & Westwood, 2016, p. 25). Similarly, in Scotland, a hub and spoke model was implemented across a health board and a university funded by NHS Education for

Scotland, involving 467 students and 577 mentors. Respondents felt that their practice experience exposed them to the reality of nursing and person-centred care:

Students felt comfortable returning to a familiar practice environment particularly one which was prepared for their arrival—The staff in my placement were great and made me part of the team. I was able to experience person centred care with regard to patients and families. (MaCallum, Lamont, & Kerr, 2016, p. 188)

Roxburgh et al.'s (2011) final report on developing, assessing and evaluating new approaches suggested that a hub placement with extended time allows nurses to invest time into mentoring a student and developing a relationship, as well as giving greater confidence and reliability for the assessment of competence. Developing a relationship with a student over the extended period provided by a hub placement affords the mentor greater incentive to invest in the student's learning. It also gives the mentor enhanced confidence when assessing the student's level of competence, providing improved consistency and reliability of assessment.

However, additional results from Roxburgh et al. (2012) identified that mentors maintained that there was an increased sense of belonging alongside a greater level of confidence in the hub placement students. It was intended that by shifting the emphasis from a university-dictated regime to a more collaborative experience would allow the student and mentor to devise the learning experiences (MaCallum et al., 2016).

A further outcome was identified by Thomas and Westwood (2016) as not only did the hub placements give consistency and build confidence, but the spoke placements broadened the overall understanding for the student as they followed the patient's journey. When reviewing the students' ability to care for a number of patients in this research quantitative survey, the positive and negative responses from the participants

were reasonably evenly spread, which may indicate that the longer the student was able to practice, the less overwhelming the situation became, allowing a greater understanding of the patients' care.

However, when spoke placements were short, it was felt that a week or two was not long enough. Overall, the model has been found to be beneficial and left students with a sense of belonging (Thomas & Westwood, 2016).

As previously stated, logistically, the numbers of students requiring placements in Australian and WA hospitals makes altering the short clinical placements practically difficult for the immediate future, but further consideration could be given to alternative models such as the hub and spoke model. Participants in the research study surveys identified issues around length of stay and lack of time for nursing students, which they felt affected the sense of belonging for both nurses and students.

In round two of the Delphi, when asked what changes need to be made to improve attitudes towards students, longer length of practicums was again highlighted so that the student is able to 'fit in' and interact with staff. One suggestion was to raise awareness of more country placements, which would require a longer practicum to be of benefit. This observation suggests that the hub and spoke model could be beneficial and encourage students to consider country placements if following the patient's journey. Education and support for supervising students would not be restricted to metropolitan hospitals if resources such as the e-learning program were established across all health facilities.

In summary, these findings have concurred with the literature in revealing the need for a greater understanding and open-mindedness for the possibility of changing the existing model of clinical supervision. Different and new models have been trialled successfully, but education and support are required to bring about change.



Nevertheless, the overall outcome could enhance the sense of belonging to the team and ultimately maximise achievement for all individuals (McCallum et al., 2016).

## **7.4 Belongingness and the Attitudes of Individuals, Teams and Organisations**

Levett-Jones's (2007, 2008, 2009, 2016) work on the concept of belongingness has influenced many researchers when examining the success or otherwise of clinical placements in achieving the outcome of competence for nursing students. Recent literature continues to identify with this work, describing a sense of belongingness as an important influence and a key benefit to student learning in practice (Grobeck, 2016; McCallum et al., 2016; Thomas & Westwood, 2016). Throughout the literature, students have identified that they assign value to being welcomed into the clinical setting and appreciate acceptance by nurses who support them to become more confident and competent (Courtney-Pratt et al., 2012). From the research survey, it was evident that the participating nurses identified this to be important: 'The culture of the workplace influences how well new team members are accepted. If the workplace culture is supportive new team members are more readily accepted'. Unfortunately, Grobeck (2016, p. 179) still identified:

that nurses who were not supportive or helpful made the students 'feel nervous and incompetent' with an obvious strain between the relationships.

Consequently, nursing students who are not confident and competent may have a more difficult time fitting in with the nurses.

Levett-Jones and Lathlean (2009) developed strategies for the development of implementing belongingness, which were crucial to the researcher's concept of the toolkit from the outset of this study. These strategies were summarised by Russell (2012) in relation to the:

- provision of student orientation (welcome)
- consideration of student placement models/length of placement
- provision of CSs
- development of students' assertiveness skills to reduce bullying
- clinical leadership to promote a learning environment that advocates for students to practice and acknowledges their contribution
- promotion of self-directed learning, lifelong learning and the development of a sense of self-concept.

When referring to this concept, Russell (2012) identified that further research and development strategies were required to promote belongingness through health services, CSs and students. This research and development of an e-learning program with a toolkit has put another perspective on the preparation for the arrival of nursing students and the importance of enhancing clinical placements.

The literature review in Chapter 2 discussed how people endeavour to improve self-esteem and the thoughtfulness that is needed when considering how strangers—in this case, nursing students—are welcomed into the daily way of being together (Block, 2008). It is often expected that attitudes, values and beliefs for professional socialisation will be gained through attainment of competencies; however, the development of professional behaviour relies profoundly on communication, interpersonal skills and observing how each person talks and responds. These models of behaviour help identify the norms of the community.

While most participants from the qualitative component of the study believed that all nurses are a contributing factor to teaching new staff and students, they also agreed that optimal learning can only be achieved when there is a positive work environment with adequate support from staff development nurses and team leaders.

Plack (2006) suggested that within health professions, the development of professional behaviours is an issue of concern; however, there is little in the literature that details how these behaviours are learned. Cockshaw, Shochet and Obst (2013) suggested that if a person perceives that the group or organisation cares about them personally, this is an element that creates a sense of belongingness to that workplace. Responsive commitment and workplace belongingness are likely to be linked because they relate to the relationship between the person and the work environment. As previously stated, Webster et al. (2016) found that nurses' actions, attitudes and enthusiasm towards teaching are crucial factors for learning and socialisation to nursing.

Responding to the survey questions, many participants felt that supportive management and senior nurses were the key to a workplace culture that values questioning, reflection, learning and learners, while maintaining an open, honest and friendly approach that is welcoming to students and makes them feel they belong. For this to succeed, it was deemed necessary to prepare nursing supervisors while maintaining adequate staffing levels.

In accordance with the literature, the participants from the Delphi panel also identified the risks of social exclusion or not belonging to the ward as students feeling isolated, leading to low self-esteem and sense of worth; either unwilling or unable to ask questions to further learning, with potential for poor delivery of care and concluding that the workplace or profession was not for them. From the responses, several identified issues contributed to these situations: 'Poor communication within teams, unmotivated staff (not wanting to supervise students in the clinical setting), time constraints and FTE strain that prevent staff from giving students the necessary attention'.

More positively, in creating an environment for belongingness, many were of the opinion that nursing students should be viewed as part of the workforce, with a clinical supervising nurse educated for the role. It was felt that this would lead to a better partnership with the learner, which would enhance communication skills and encourage greater learning opportunities and autonomy for the student while nurturing inner confidence for the teaching nurse.

Before undertaking the e-learning program, the participants answered Stagg's (1992) quantitative survey question in the negative, implying that nurses mainly did not consider nursing students part of the team, whereas the post-questionnaire improved the score to a more positive response. This in contrast to the statement that nurses 'should' consider nursing students part of their team, which returned a response of more than 80% strongly agreeing/agreeing in both the pre- and post-survey. Similarly, when the statement of 'We all were students once, so we should be nice to students' was posed, there was 100% agreement. This dichotomy of behaviour between what is happening on the wards and where people ethically stand may well support Plack (2006) in questioning how professional behaviours are learned and whether it is translated into practical action, or to question whether poor support in the workplace environment created this dilemma.

Responses to the second round of the qualitative survey conveyed that this issue was broader than staff attitudes and centred on organisational culture because 'this sets the accepted behaviours and attitudes as well as expectations'. Other participants also believed that by meeting standards of practice through organisational vision and values and having the appropriate resources to enable staff to be proactive and productive, attitudes and cultures could be changed.

## 7.5 E-Learning Evaluation Program Findings

A further discussion will follow concerning reflective practice and transformational learning to discover the effect of the e-learning format developed for this study on the respondents in comparison with other studies.

As health moves towards a collaborative model of care, MacDonald, Stodel and Chambers (2008) noted that achieving an environment in which all healthcare professionals learn to work together is challenging. Nursing is no different, with increased workloads and varying educational input. Being innovative with the logistics of clinical placements also means being contemporary with the use of technology to embrace the type of knowledge transfer delivered by numerous commercial enterprises. Currently, concerns about improving skills and maintaining staff have led many in other industries to endorse and deliver alternative training programs. One option in the commercial world that has rapidly gained momentum is e-learning, which seems relatively new but has in fact been used since the beginning of the internet (Davis & Daley, 2008; MacDonald et al., 2008).

It has become evident during this study that there are still essential changes to be made in the delivery of training and development using convenient and flexible education. E-learning offers the interactivity, flexibility, information access and communication needed for adults to learn via the internet, and it has proven to be low cost (Ruggeri, Farrington, & Brayne, 2013). It delivers learning solutions for clinicians that enhance knowledge and skills without prolonged interruptions to their busy workload.

The researcher chose to deliver the WANTED toolkit and training package using e-learning because a paper-based version had previously been produced, and feedback from clinicians felt that in a time-poor environment, this would not be used to its full

extent. The final product of the e-learning package was sent via an email link to various organisations, as described in Chapter 6, and 23 participants responded. Although 33 people registered, 10 did not complete the entire program. The excluded surveys showed no significant commonalities for not completing. Years of experience in nursing ranged from 4 to 41 years, and CNs and RNs of both genders did not complete, with no significant area of speciality identified, which may indicate that using this technology did not overly affect the program. Indeed, e-learning has been shown to be a successful medium to facilitate learning for healthcare providers (McDonald et al., 2008).

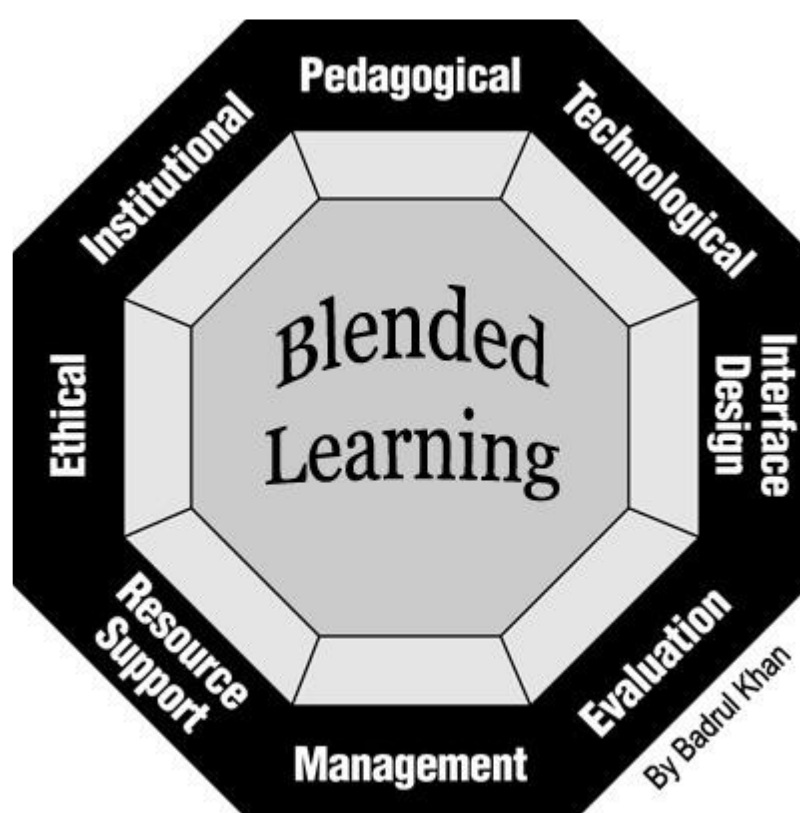
However, Ruggeri et al. (2013) observed that the effectiveness of e-learning varies from context to context and has been shown to make considerable demands on users' motivation and digital literacy. One participant initially commented that she was unclear, but once she started the process, 'it went smoothly and was a great learning tool', while others reported that it was easy to use and navigate. In support, 18 of the 23 participants agreed that e-learning helped improve their learning and education efficiently and effectively. This reflects the findings of MacDonald et al. (2008), who found that the majority of participants undertaking the 'Working Together Learning Resource' had no difficulty in navigating and did not experience difficulties in accessing the resource online.

### **7.5.1 Reflective practice and transformational learning**

The content of the e-learning package was designed from data received from the qualitative phase, in which members of the Delphi panel drilled down through three consecutive rounds to inform the framework on which the e-learning resource was based.

Khan's (2003) octagonal framework (see Figure 7.2) depicted the components to successfully plan, develop, deliver, evaluate and consider the effective delivery of

learning and management involvement as part of a continuing process. The researcher needed to provide a comprehensive accessible learning program with appropriate blended learning elements. Blended learning combines multiple delivery media that are designed to complement each other and promote learning and application-learned behaviour. Through technology, resource support and institutional and management backing, there is widening access to educational opportunities, which enhances the quality of learning and reduces the cost of higher education (Ramakrisnan et al., 2012).



*Figure 7.2.* Khan's octagonal framework (2003).

The content of the e-learning program had to encourage transformational learning as a process of using a prior interpretation of situations and actions to understand a new or revised explanation of experiences as a guide to the future. This process of transformational learning involves addressing and assessing reasons for behaviour or opinions, critical reviews of assumptions, beliefs and values, which can affect actions and choices, and then examining alternative perspectives. Taylor and

Cranton (2012) described this as an intensely emotional experience that involves subjective reframing.

The researcher considered the multiple aspects of blended learning and examined the visual and emotive educational videos that have been available through the internet and shown in the past at study days in health facilities to gain insights into why these productions were successful. These included innovative presentations such as ‘FISH—Choose your Attitude; Make their Day’ and ‘The Cleveland Clinic—Walk a Day in My Shoes’. It was deduced that these mediums had been so successful because they told real stories concerning real people.

Brand, Miller, Saunders, Dugmore and Etherington-Ber (2015) conducted a pilot project using technology to explore how photographs prompt reflective learning, and they challenged participants’ personal belief systems. The results were positive and they maintained that this type of reflection is one of the first steps in promoting a greater level of participation in professional relationships (Brand et al., 2016, p. 2). The pilot study continued challenging students’ assumptions by deliberately juxtaposing photographs of elderly people in contradicting circumstances and developing storyboards for the Depth of Field: Exploring Ageing resource (Brand et al., 2016). The aim was to achieve deeper reflections and deliberately create a mismatch between what they thought they knew and recognising their own misinformed assumptions. As described by Taylor and Cranton (2012), this intensely emotional experience and subjective reframing is vitally important for transformational learning to occur. The results were very positive in challenging and changing the attitudes and assumptions of students towards the aged. This is a great example of a digital reflective learning resource that uses ‘a story telling tool presenting ideas on a virtual canvas’ (Brand et al., 2016, p. 4) and is currently being disseminated across WA.



Throughout the literature, students have retold their stories. Levett-Jones et al.'s (2007) montage of nursing students' stories of their clinical placement experiences is one of many narratives. Russell (2012) referred to students' and nurses' stories related during a study day by participants and the effect of face-to-face discussions. Thus, by using her extensive experience of working with both nursing supervisors and students, the researcher intended that by showing real people relating their experiences, there would be the same challenge of transitional learning for those undertaking the WANTED e-learning course.

However, MacDonald et al. (2008) stated that in their study with nurses and an allied health team in a long stay care home, the data did not reveal significant changes initially in learners' attitudes towards collaborative practice. Similarly, requests to change organisational structure to enhance collaborative practice were minimal, but they thought it was reasonable to expect given the short timeframe from completion of the learning resource to evaluation. Upon reviewing some of the program, the researcher observed that it was apparent that although good examples of video activity occurred, these were based on 'made-up' situations and therefore possibly did not challenge or create an emotional experience that related to the learners.

This confirmed the researcher's belief that it was necessary to relate real stories mainly gathered during her career as a nurse and CF. Although portrayed by students and nurses acting the part, it involved real people's situations. The results from the post-survey were contrary to the findings of McDonald et al. (2008); however, they reflected and supported Brand et al.'s (2016) results. They revealed that many of the assumptions, beliefs and values of the participants that formed their attitudes distinctly changed after viewing the scenarios from both the students' and nurses' perspectives.

Watching a nurse dismiss or disrespect a student is a challenge that can be reflected upon for transformational learning (see Figure.7.3).



*Figure 7.3.* Screenshot from video of dismissive behaviour by the nurse supervisor.

However, on seeing a confident, happy student alongside a supervisor who is self-assured and welcoming reinforces positive attitudes (see Figure 7.4). One participant reflected that ‘I enjoyed participating in this e-learning course. Very informative and reaffirms my enthusiasm about supporting students during clinical placements. This has also given me some new ideas to implement on my ward’.



*Figure 7.4.* Screenshot from video of assured and welcoming nurse supervisor.

Russell (2012) also identified that after delivering the ACS, participants commented on how the program had renewed their passion and enthusiasm for the role of CS. Another participant in this study believed:

This e-learning would work well in community placements like medical centres were some students I have facilitated have encountered difficult cultures. In view of the literature on staff burn out from the number of students they are now expected to supervise, the placement and timing of the package to ensure it is used would be an important factor.

There are possibilities of being able to reach a wider audience than just main tertiary educational centres given this learning tool is digital and easily adaptable.

## **7.6 Outcomes of this Research**

Currently, there is a substantial amount of published literature on the importance of the clinical placement and the worth that is placed on the modelling of good professional values and behaviours. Bandura (1977) used social learning theory to explain why people behave as they do with many emotional responses learnt through

direct involvement; most human learning occurs through communicated conditioning. Communicated conditioning involves the process of transmitting information and common understanding from one person to another and employs readily understood spoken words with enunciation, stress and tone of voice appropriately expressed to influence a circumstance.

Staff interest in the learning and interactions with nursing students are most significant to students' perceptions of learning. Contextual factors and interpersonal dynamics within professional socialisation have a substantial bearing on students' experiences and a significant effect on their self-concept and professional role and identity (Levett-Jones et al., 2007). As previously stated an affiliation to the professional role can only be achieved through a sense of belonging to that professional body (Block, 2008). Working with many nurses and team members with a positive attitude has been identified as enabling for students to develop independence, experience a broader exposure to nursing and the value of the multidisciplinary team (Bourgeois et al., 2011; Callaghan et al., 2009).

In equal measure, publications have also described the poor attitudes of nurses towards students and the influence of this experience on their clinical practice (Curtis, Horton, & Smith, 2012; Hall, McFarlane, & Mulholland, 2012; Hegenberth et al., 2015; Henderson, Happell, & Martin, 2007; Henderson, Ossenbergh, & Tyler, 2015; Levett-Jones et al., 2009; Lyneham & Levett-Jones, 2016; Shivers, Hasson, & Slater, 2017).

Previous research also reports that good communication and collaboration between nurses and students, as well as feeling part of the team and being involved in practice (Chuan & Barnett, 2012), are paramount to successful attainment of skills, knowledge and professionalism. However, qualified supervision and support for staff to attain a recognised and valued qualification are unstandardised and not always well

supported at management level, and studies have identified a less than positive response to innovation and individualisation issues in terms of student supervision (Shivers et al., 2017). Findings from Shivers et al.'s (2017) cross-sectional survey involving a descriptive online anonymous questionnaire based on the clinical learning environment inventory tool confirmed the importance of personalisation and the sense of belonging and acceptance for nursing students as key factors in the clinical learning environment.

The need to prepare students for the reality of their future role as a qualified nurse is continually advocated (Niederhauser et al., 2012). It is suggested that this may be achieved by adopting innovative placement allocations with inventive and creative experiences; however, despite research recommending that supervisors should provide this through academic/practice agreements (Niederhauser et al., 2012), the realities of staff shortages, economic cuts and increasing clinical demands hamper new ways of working (Shivers et al., 2017). In addition, education on how to bring about change and provide improved clinical experiences is limited, and support for this kind of innovation is not well supported. Therefore, after numerous conversations with clinicians, the researcher realised that changing mindsets through transformational and reflective learning with practical applications could go some way to supporting nurses in their role as CSs.

The development of the e-learning program containing the WANTED toolkit undertook to address the issues and problems that have been highlighted and embraced technology to produce a program with strategies and problem-solving techniques that acknowledged the time-poor environment in which nurses work. In addition, it responded to their need to be able to understand their role and effect on nursing students and armed them with useful strategies and tools to meet the clinical placement experience, which is vital in the delivery of health education. The findings indicated that

this medium proved to be an effective and efficient approach for improving nurses' attitudes. In addition, when supported and informed, upon reflection, they were able to renew enthusiasm for the role and provide ideas and changes in practice to promote the success of student placements and a positive work culture in various areas.

Despite an overall positive attitude towards nursing students, this research identified that there remains a lack of support and failure to acknowledge the importance of educating all nurses to a recognised standard to improve workplace culture and value the efforts of those who strive to make changes. There was a realisation among the participants that nurses who are responsible for students find it very challenging to supervise students despite their many years of clinical expertise, but with very little, or no, teaching experience. Many feel that there is not enough acknowledgement of the role or remuneration to encourage further education and innovation.

### **7.6.1 Research questions**

As related in Chapter 1, an exploration of underlying assumptions and information concerning the concept of belongingness for student nurses in the clinical learning environment was to be taken, and then an amalgamation of the information from both the literature and a group of experts (Delphi panel) was made. The collection of data was to inform a framework for the development of a toolkit (Wilkes, Mohan, Luck, & Jackson, 2010), which was delivered through an e-learning program. The intention was to support nursing staff in developing and improving their sense of belonging to the clinical team, thereby enhancing the learning of the nursing students.

The questions and a summary of the findings are as follows:

***Qualitative: Delphi panel***

1. What attitudes and patterns of behaviour from nursing staff influence the creation and maintenance of a learning culture for students?

In Chapter 4, the researcher described the method by which the process of determining the most important issues that influence the creation and maintenance of a learning culture was implemented. Interpretive coding identified in the first round that demonstrated leadership and positive role modelling were the key to developing a positive and supportive attitude. An ability to welcome and bring a sense of belonging to the team was also identified as an important attitude, as well as a desire to supervise students. These were the foundations on which the framework evolved.

2. Who or what are the major contributors for actions and behaviours influencing an inclusive working environment and a sense of belonging?

The second round of the Delphi survey provided the information required to gain a greater understanding of what skillsets, resources and time would enable staff to take more ownership of students' education and wellbeing. The findings identified that nurses who work in a supported area and feel part of the team are more positive and open to students. This detailed information enabled the researcher to identify the topics that were important enough to nurses to be researched and included in the educational material developed.

3. What nursing practice and decision-making is required to create belongingness within a professional team in a clinical environment?

Members of the Delphi panel articulated that this needed a top-down approach, with role modelling from leaders and education and training sessions for both clinical staff and management. They specifically recommended staff education about belongingness (relative to all of us) and how to create a workplace that is proactive

about fostering a sense of belonging in all staff. This confirmed for the researcher that the development of the toolkit not only needed to encourage translational education, but also needed to deliver on several levels to appeal to and gain endorsement from management.

***Quantitative: Nursing staff***

1. What are the pre-program attitudes, behaviours, knowledge and skills of nurses towards students' requirements for an effective clinical learning experience embracing belongingness?

The methodology for this stage of the study was described in Chapter 6, in which a demographic survey (pre-questionnaire) and Stagg's (1992) attitude surveys were employed to provide data. This question was answered, demonstrating that attitudes and behaviours in some areas were negative, as with research conducted by (Russell, 2012), but it also identified a lack of qualifications or skills for teaching, which affects these attitudes, despite a range of commendable clinical qualifications. The researcher therefore needed to consider these implications.

2. Do nurses perceive that they have changed their attitudes and approach to nursing students within the clinical learning environment after completing the program using the toolkit?

The objective of this question was to calculate the effect of the WANTED toolkit on attitudes and approaches to nursing students. The mean ratings for all 18 questions were compared between the pre- and post-course surveys, and the results gave a significantly positive result for improvement in attitude and approach.

3. Has the WANTED toolkit using strategies, resources and processes for key activities been identified as an enabler to encourage belongingness within the clinical environment?



The questions concerning the toolkit about the information, mode of delivery and recommendation were answered very positively. The responses encouraged the researcher to believe that the previous qualitative research had identified and informed the key strategies and resources for the development of the toolkit, and that the overall package fulfilled a requirement for accessible, timely and comprehensive learning.

## **7.7 Limitations**

The researcher acknowledges that while the results demonstrate a definite change in attitude between the pre- and post-surveys, which indicated a positive influence of the e-learning program on behaviour, a change of practice or use of tools to enhance belongingness was not measured. The only indication that these would be implemented came through the final quantitative question, which stated: 'I would recommend this e-learning program to a colleague'. This provided responses of 44% strongly agreeing and 48% agreeing. As previously identified by MacDonald et al. (2008), change practice may not occur immediately, which is reasonable to expect given the short timeframe from completion of the learning resource to evaluation.

The researcher also acknowledges that the number of participants that completed the e-learning package was small, and therefore provides no statistical power in its transferability to other nurses. It was the aim of this study to focus on the development of the toolkit, with its implementation providing an opportunity to pilot the program. This evaluation of the program has provided significant findings to support its integration into the health services, and further research into its implementation is recommended.

The researcher also acknowledges that while the Delphi panel members were selected for their expertise, as is permissible in the literature, the participants for the quantitative phase were a random group, but they too may have had a strong interest in

students' clinical education; in which case, bias in the data may have resulted. However, given the broad spread of sources for recruiting, it is possible that some undertook the program with more of an interest in the use of technology and its future possibilities, as statistical significance indicated that at the onset, there was considerably less positivity towards nursing students.

## **7.8 Chapter Summary**

This chapter compared the qualitative and quantitative data with the current theories, standards of practice and literature to investigate whether a sequential mixed methodology to answer the research questions can help develop a support mechanism to bring about a positive change in the way nursing students are taken care of, both clinically and professionally, to advance in the workplace and achieve a sense of belonging.

In summary, these findings support current knowledge in the fact that transformational education can be a strong agent for cultural change. The WANTED toolkit that was developed, implemented and evaluated has demonstrated that there is a role and place for this kind of technological education. The usability of the e-learning survey (post-questionnaire) strongly demonstrated that the use of a technological medium has advantages in improving learning and education efficiently and effectively. The use of videos to encourage participants to reflect on behaviours was a powerful resource for changing attitudes in a positive way, and the opportunity to download resources instantly appealed to others making change, using the provided tools. The participants identified that this program could be usefully employed in many areas in the healthcare sector, and all that would be needed is a link to the internet to make this accessible to many people.

Further use of this economical format should not be disregarded when increasing the reach of education for nurses who should all undertake clinical supervision for the future of the profession. The implications and recommendations for the future will be discussed in Chapter 8.

## Chapter 8: Implications and Recommendations of the Findings

*Interdisciplinary communication is where truly great ideas emerge.* (Carl Seger, 2018)

### 8.1 Introduction

This final chapter will discuss the intention of the study following on from recommendations made by Levett- Jones (2007) and Russell (2012). It will examine the implications of the findings for improving nurse education in clinical supervision and the new opportunities now available to achieve this. The effect on the clinical environment of cultural change made by improving education and resources will be appraised and discussed to inform recommendations for the future. Finally, recommendations will be directed towards the revision of current standards and practice, as described below, to strengthen workplace culture and organisational structure.

Levett-Jones (2007, 2008, 2009) has been referred to many times in this thesis, and she has been referenced in many other studies that discuss the issues surrounding clinical supervision of nursing students from various perspectives. Her work is highly respected globally. Therefore, the researcher saw merit in working with her recommendations to take another alternative contemporary approach to meeting the challenges of student belongingness. In her thesis, Levett-Jones stated that the intention of her study was to ‘re-present the participants’ stories in a way that resonates with readers and invite them to “brood upon” or “dwell with” the story while at the same time consider the broader implications’ (Levett-Jones, 2007, p. 264).

The intention of this study in developing the WANTED toolkit could be described in much the same way, but with a focus instead on progressing the messages

from the stories to inform practical strategies. Using a sequential mixed method approach to collect data and then mind mapping the information to develop a framework for the toolkit, the researcher subsequently employed digital technology to promote reflective learning and transformational education. Implementing guidelines for clinical supervision to improve nursing education will lead to more meaningful learning experiences, which will maximise opportunities and extend the reach for improving a culture of belongingness (see Figure 8.1). This concurs with Johnson, Onwuegbuzie and Turner (2007), who described the fundamentals of mixed method research as real-life contextual understandings, multilevel perspectives and cultural influences.



*Figure 8.1.* Recommendations to meet challenges of student belongingness (Levett-Jones et al., 2009a).

### **8.1.1 Guidelines for clinical supervision**

To improve the support given to CSs, guidelines need to be clearly identified and developed for implementing clinical supervision. To date, this has not happened in

Australia; rather, there is a reliance on the code of conduct and scope of practice documents to be interpreted by each individual. Reviewing the recently revised guidelines in the UK could identify the criteria to produce a comparable document for Australia.

However, a flexible framework for use in a range of practice settings has been developed by the QCPE research team previously mentioned, over a five year period through a partnership in Tasmania between health care and tertiary sectors. It entails a sustainable three step program to address quality, evaluation and understanding of clinical placement to meet the needs of all stakeholders (Courtney-Pratt et al., 2015). This Port Macquarie Clinical Placement Partnership Model (PMCPPM) (2015, p.2) identifies that the focus must be placed on the preparation of mentors and existing placement models supporting investigation and innovation to improve the clinical placement model.

### **8.1.2 Improve nurse education**

This study has shown that there is a desire by many nurses for improved access both in time and convenience to further their education in clinical supervision.

Clinical supervisors in a survey conducted by the QCPE research team identified that they valued the educational opportunity and to network with others as well as the opportunity for reflection and to challenge assumptions around clinical supervision. They also appreciated that issues in clinical supervision were often shared across practice settings (Courtney-Pratt et al., 2015). Therefore, the role of the CS needs to be a high priority in educational planning.

### **8.1.3 Meaningful learning experience**

Developing compassionate attitudes towards nursing students will ultimately make their learning experience more meaningful. Nurses need to be encouraged and

supported to understand how and why this affects the sense of belonging for a student and the ultimate outcome for patient care.

#### **8.1.4 Extend the reach and maximise opportunities**

By using modern technology that is readily available, education can now reach further to send a consistent unambiguous message and supply greater opportunities using simulation and e-learning for practice in a safe environment. Future investment in new technology is essential for students and nurses to be able to improve their education, which will assist in them being able to work together in a partnership.

#### **8.1.5 Improve culture to create belongingness**

The steps described above will lead to the ultimate goal of improving culture and creating an environment of belongingness. As with Levett-Jones et al.'s (2009) ascent to competence, each component is required to be addressed to reach the ultimate goal of promoting student belongingness. This process has implications for nursing education in the future.

### **8.2 Nursing Education Implications**

As internet use increases, options to deliver a program that is meaningful and readily available have exponentially risen. Self-directed learning has become more prevalent, accessible and varied (Kop & Fournier, 2011). Nowadays, many organisations that need to deliver training and education to staff are exploring strategies for effective learning and performance. However, they have to consider a variety of issues to ensure effective delivery of learning and a high return on investment.

This study has developed, implemented and evaluated an e-learning program containing the WANTED toolkit to work within the logistical issues of time and cost and to meet the ongoing educational needs of nurses who undertake clinical supervision.

The main focus throughout was to promote belongingness for students within the clinical environment.

Levett-Jones (2007, p. 269) made a list of comprehensive recommendations for creating a belongingness environment. Two of these statements related directly to this study:

- The recommendations are generic and can be implemented in a range of contexts.
- The recommendations are designed to be an evolving set of beginning guidelines and are open to review, revalidation, amendment and improvement as part of an iterative process.

The implications were therefore to evolve and move forward from previous studies by adding a meaningful learning experience that fitted with updated standards and management systems. Courtney-Pratt et al., (2015, p. 515) concludes that practice development approaches enable opportunities for health care and education providers to interact, share experiences and collaboratively develop plans for ongoing support to both undergraduates and those who work with them.

Conceivably, the finest form of blended learning is to supplement learning with practice performance support tools using process simulation models that facilitate the appropriate situational approach (Singh, 2003).

### **8.2.1 Extending the reach**

The literature researched for this study came from many countries; therefore, from the literature it is identified that the issues surrounding student clinical placements are universal (WHO,2010). The opportunities for delivery of education that are now offered with the internet are endless and easily available. With the growing need for skilled CSs to meet demand for increasing standards, a single delivery mode, such as a



physical classroom training program, limits the reach of education, whereas a virtual classroom is inclusive of remote and time-poor audiences. An interprofessional collaborative approach has also been highlighted as an essential strategy using technology to enable healthcare outcomes in rural, remote and isolated settings (Drolet, Christianson & Clark, 2011).

The e-learning program developed in this research was easily distributed to varying groups via a link, which allowed each individual to dictate when, where and how long they wished to engage with the learning. It gave them the opportunity to reflect within a safe environment and the chance to assimilate this learning to their own work environment.



*Figure 8.2.* Simulation of a ward environment.

The concept of blended learning using multiple methods of interacting with learning is still relatively new, and research about the construction of effective program design is mixed and not abundant. The use of simulated environments (see Figure 8.2) is a viable option to overcome inadequate clinical education resources. This study's findings suggest that the effect of using this individual component was positive, and the effect of the resources implemented was successful. This is in line with the survey

conducted by the QCPE research team whose responses from participants offered the opportunity of action planning, indicated a desire and intention for change to improve experiences (Courtney-Pratt et al., 2015). Consequently, its strength could lie in being part of a multifaceted course. Therefore, the implications are that there should not be a limitation to the number of nurses who could have access to this type of training. With the support of senior staff and management, given the adaptability of time and place using this mode of delivery, this could more easily be adopted to support training and development initiatives.

However, in the researcher's experience, it has been recognised that when delivering training using e-learning, expecting clinicians to undertake an individual course can incur difficulties of compliance and uptake, unless accompanying a set study day or mandatory obligation. Therefore, it is suggested that unless healthcare facilities and health services seriously consider the need to support and develop strategies to improve clinical supervision, opportunities will be missed for improvement, which much of the commercial world recognises as beneficial and cost-effective. In support of the program, several of the nurses who participated in the course gave feedback and concluded that e-learning would work well in various settings and would benefit from being embedded into a mandatory nursing staff training day.

### **8.3 Improving Culture—Clinical Implications**

The main purpose behind the development of the toolkit was to identify what strategies, resources and processes would promote student belongingness and influence the quality of the clinical placement experience. The degree of belongingness is strongly linked with the quality of interactions and relationships with others, and the validation of students' role as learners is governed by the receptiveness, acceptance, support and interest demonstrated by the clinical team. Levett-Jones (2007, p. 267) maintained that

unless the most basic needs are met, higher-level needs will become less important as previously demonstrated in Figure 2.7. They use this concept framework to influence any decision-making for future clinical placement models to be more meaningful and of practical significance. The goal of the toolkit was to support nurses who supervise students to guide their attitude and decision-making through collaboration, interaction and teamwork. However, improving culture needs to be a ‘top-down’ approach; thus, the researcher delivered scenarios that involved reflecting on the attitudes of students, nurses and managers.

The framework came together to improve attitudes and culture in the form of ‘WANTED’: Welcome, Attitude, Nurture, Team, Encourage, Delight (see Figure 8.3).



Figure 8.3. WANTED toolkit.

## 8.4 Recommendations

Figure 8.4 highlights the essential features that have been identified by the participants in the study to create a belongingness environment in the workplace. These components highlight that the solution to the problems identified in the research may be

to embed these ideals into the workplace culture. The WANTED toolkit has undertaken to address this and develop strategies around the components to create a belongingness environment. Each component is interchangeable within the WANTED framework, which demonstrates the flexibility of the toolkit (see Figure 8.5). The researcher strongly recommends that healthcare facilities and education providers consider the findings that have underpinned the development of the strategies described below to strengthen workplace culture and organisational structure.



*Figure 8.4.* Strengthening workplace culture: a belongingness environment.



*Figure 8.5.* Components of a belongingness environment within the WANTED framework.

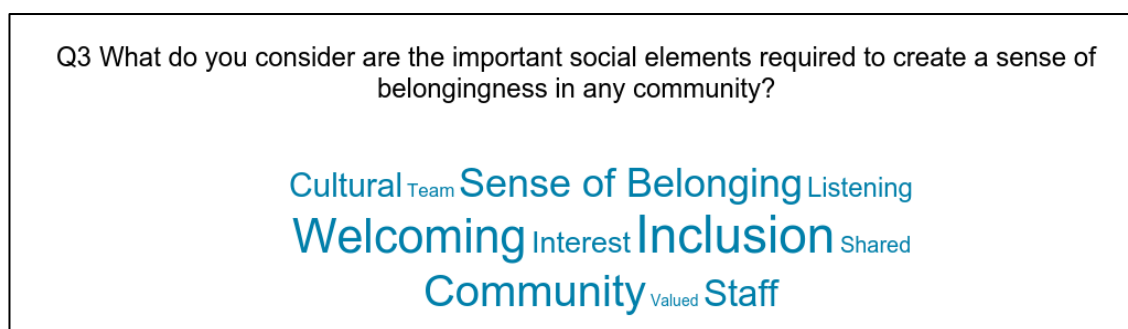
#### 8.4.1 Welcome

Being valued as a learner is mostly dependent upon the supervising nurses who support and assess nursing students in clinical practice. The power of a welcoming gesture cannot be underestimated, and recognising students' anxieties and alleviating a stressful encounter is paramount if learning needs and experiences are to be fulfilled and successful. Sometimes this is manifested in simple gestures such as being introduced to others by name. To create such an environment, the toolkit suggests the following ideas:

- display a bulletin that alerts all staff to students' schedules and when they will be present
- be aware of what students are able to perform within the ward prior to placement
- discuss with colleagues and managers identified issues before the commencement of placement

- students' names should be displayed on the Welcome Poster (resource included)
- copies of the Welcome Notepad (resource available) should be made available for all students
- create a non-clinical student liaison 'buddy' system.

Figure 8.6 demonstrates the main points that the participants agreed were important in the creation of belongingness in the clinical environment. Welcoming and inclusion are seen as the most important elements to be implemented into the clinical area for belongingness.



*Figure 8.6.* Word cloud from question three.

#### **8.4.2 Attitude**

Effective and safe nursing practice is more than knowledge and skills attainment; it requires the ability to function and work within complex teams while maintaining evolving and changing relations offering mutual trust and respect (O'Lunaigh, 2015). For nurses to have a positive effect as educators and health promotion advocates, they must be aware of the necessity of self-care to maintain an encouraging attitude towards students and others. Mills and Chapman (2016) defined self-compassion not as self-important, but rather as the foundation for compassionate care. Healthcare services need to acknowledge that compassion is an integral part of delivering good outcomes in healthcare (Curtis et al., 2017), and that for nursing students to thrive, healthcare services must demonstrate meaningful responses with

recognition and appreciation of the challenges of working in busy and demanding environments.

### **8.4.3 Nurture**

A belongingness environment nurtures both similarities and differences in the way people work. The toolkit encourages nursing supervisors to reflect on how they learn and how the student may learn, and to consider the difficulties that these differences may have on their relationship. The findings showed that these adult education principles were often not appreciated or comprehended. Therefore, for nurses and students to maximise each experience, serious consideration should be given to moving towards an education program that encompasses adult learning principles to enable nurses to be clinically competent and to be able to teach professionally.

The toolkit recommends actions by which the supervising nurse can structure their input:

- Individualisation—Extent to which students are allowed to make decisions and are treated differently according to ability or interest.
  - Action—Give time and permission to allow students to work at their own pace to encourage critical thinking and clinical reasoning.
- Involvement and Personalisation—Students participate actively, with an emphasis on opportunities to interact with staff and patients, while concern is shown for students' personal welfare.
  - Action—Consider students' anxieties and fears while giving opportunities to engage, express opinions and develop ideas.
- Innovation and Task Orientation—Plan new, interesting and productive ward experiences, teaching techniques, learning activities and patient allocations that are clear and well organised.

- Action—New ideas are recognised among staff, ward tasks are clear and patient involvement is encouraged so students know what to do with confidence.
- Satisfaction—Encourage the enjoyment of a positive clinical placement.
  - Action—Make their day and yours fun, and give the student a sense of satisfaction at the end of the shift (Acknowledgement to the Clinical Learning Environment Inventory; Chan, 2002).

#### **8.4.4 Team**

Ward managers play a significant role in students' experiences of clinical placements because they have the ability to affect group cohesion and create a positive learning environment based on mutual trust and respect (Mamchur & Myrick, 2003). It is difficult for staff to promote a caring attitude when the staff themselves feel neglected, taken for granted and unappreciated, and this was strongly highlighted in the findings. Being able to make a valuable contribution to nursing care in a team environment is important. As discussed in the previous chapter, the UK NMC now urges all clinicians to be involved in the supervision of nursing students, encouraging other professions to see merit in this by accepting their capabilities to assess nursing students. Healthcare can no longer afford to silo each profession. Current research indicates that patient care and satisfaction is improved with an interdisciplinary team approach (Didier et al., 2017); in addition, budgetary restraints continue to reduce staffing numbers in all areas.

Therefore, team building must become an essential part of clinical education, which includes both students and patients. To achieve this, there should be greater collaboration between education providers and healthcare facilities in providing



education to understand each other's roles, including supervision using the interdisciplinary team.

A recommendation to further progress this type of e-learning program for team building could be to extend its reach to the medicine, allied health and health science professions.

#### **8.4.5 Encourage**

Clinical environments that are supportive, inclusive and receptive reinforce students' feelings of self-worth and encourage a self-directed approach to learning (Levett-Jones, 2007). Being challenged and given opportunities to extend themselves in a secure environment, supported by the nursing staff they are working with, reinforces a sense of being valued. Nurses who supervise students have the most significant influence on students' ability to be autonomous and self-directed. This is crucial in developing their critical thinking and clinical reasoning skills, without which competence will not be achieved. Therefore, encouragement to negotiate learning opportunities should be forthcoming, preparation in understanding students' stage of training (year, previous placements, experience) is essential, and feedback from other clinicians should be sought to help inform the supervising nurse. However, in most ward situations, little time or opportunity is afforded to nurses to be able to prepare, resulting in little support for optimal exposure to patient care. The toolkit recommends the use of a tool called the 'Traffic Light System', which was created by Russell (2017) to encourage the supervising nurse and student to meet to work out a meaningful clinical experience for both.

#### **8.4.6 Delight**

To influence organisational change, nurses must be encouraged and strongly supported so that they believe they are making a significant contribution to developing

future nurses with competences and values they respect. This requires commitment from both education providers and healthcare facilities to develop strategies for raising the profile of the supervisory role and acknowledging achievements and contributions made by many clinicians.

To reflect on their achievements, the toolkit raises these points:

- What difference do you think you make to the student?
- Share with your colleagues how your actions make a difference.
- What values are involved?
- How might you develop what you have learned for the future?

The findings of this study and the literature strongly advocate for recognition of the importance of the role, with many respondents suggesting monetary remuneration. However, given the economic constraints of present times, others thought that celebrating excellence could be achieved at the ward or facility level by management acknowledging achievements openly and committing to providing greater understanding of the role and improving workplace culture.

## **8.5 Conclusion**

In conclusion, the researcher considered how to promote belongingness for nursing students by developing, implementing and evaluating a toolkit for nurses. Having been in nursing education for quite some time, it has not gone unnoticed that although there have been many changes with commendable progress, the recurring theme of students not being prepared adequately both in personal and professional competency continues to be brought to our attention in the literature. There is great emphasis placed on the need for strategies that enhance student belongingness and wellbeing, without which learning cannot take place.

Further, given the enormous changes in technology and the opportunities to use these to reach many people, the option to combine the two seemed a progressive step to ongoing support for nurse supervisors. This was supported by the participants who undertook the program and who felt that this could be part of a blended learning strategy to be distributed state-wide. However, for this to be successful, the researcher recommends that certain revisions to present standards and practice need to be implemented:

- Incorporate specific guidelines and benchmarks for clinical supervision into nursing standards for practice.
- Formalise the role of nursing supervision with appropriate education and support for preparation for clinical placements.
- Incorporate time and support into nursing shifts to deliver beneficial clinical experiences with the support of senior nurse managers.
- Orientation sessions for both new nurses and students, which include the use of the e-learning program to outline the role.
- Support from educational providers to promote this type of learning through CFs.
- Further research into changing the model of clinical placements to increase the development of relationships between nurses and students.
- Further research into interprofessional education to maximise the opportunities of clinical placements and promote belonging to the team.

This study has contributed to the continuing endeavour to encourage a clearer understanding of how we can change clinical placements for the better. However, without the combined will of the profession and healthcare management, despite the

best efforts of many people, the ability of clinical placement to provide belongingness will not progress as hoped.

## Epilogue

Completing this study over the past four years has been a journey of discovery. I had always wanted to be a nurse, and after meeting so many people who are just as passionate and committed to what they do as I am, I can only say that it is a privilege to be part of our profession.

My experiences with so many students who wanted to join this profession led me to believe that we must pass on this pride and commitment if the patients we care for are to receive the best attention for their needs. This inspired me to take up the challenge of nursing education. However, the needs of all nurses must be supported, and through education, I believe we can ensure that not only can they be experts in clinical practice, but also compassionate carers.

Many things have changed since I was that enthusiastic novice, not least of which is the technology that is now part of our daily lives. It is not appropriate to compare how my generation was trained through a hospital system with the opportunities that are now available through higher education. However, there still needs to be respect and support for all that can be learned at the bedside and in the clinical environment. Embracing new ideas and challenging our practices will keep our profession at the forefront of healthcare.

For me, it has been an exciting time completing this study and thesis. I have learned many new skills that I have been able to bring to my work as an educator. I believe there are many nurses who are keen to supervise and educate the next generation, but they just need the time and support to do so. I hope this program will contribute to guiding them to inspire confidence, compassion and professionalism in all students.

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## Appendix 1: Sample of Theses using the Delphi Method

Table A1

### *Sample of Theses using the Delphi Method*

<b>Thesis Author</b>	<b>Delphi Focus</b>	<b>Rounds</b>	<b>Sample Size</b>
Rosenbaum (1985)	Identify what knowledge, skills and experiences will be needed by college graduates for careers in non-broadcast telecommunications industries during the 1980s, and construct a descriptive curriculum designed to prepare students adequately for those future careers.	4	144
Whittinghall (2000)	Identify the initial curriculum components necessary for the preparation of graduate-level substance abuse counsellors.	3	28
Kincaid (2003)	Identify student and faculty perceptions of factors that facilitate or hinder learning in web-based courses.	5	27
Holmes (2005)	Identify and investigate the nature of emerging practice within the profession of occupational therapy, its rewards and challenges, and professional competencies for practice.	3	24

## **Appendix 2: Inclusion and Exclusion Criteria for Delphi**

### **Panel**

#### **Inclusion Criteria**

##### *Participants:*

###### Essential

1. Tertiary qualification, preferably in nursing or a health-related profession.
2. Recent experience in student supervision, facilitation, mentorship or preceptorship.
3. Interest in learning environments and student education development.
4. Able to commit to participate in several rounds of surveys required for the Delphi method.

###### Preferable

1. Experience in management of clinical area or department.
2. Experience in clinical and/or tertiary-level teaching and education.
3. Knowledge of adult learning principles.

##### *Computer literacy:*

- Access to computer and knowledge of Microsoft Office suite.
- Good written communication skills, including critiquing and editing information.
- Ability to undertake survey using Survey Monkey.

#### **Exclusion Criteria**

##### *Participants:*

- Less than three years' postgraduate experience.
- More than three years since exposure to the clinical/student education environment.

- Low-level computer skills.
- Restricted time commitment.
- Limited knowledge and understanding of the subject matter.

## Appendix 3: Invitation to Participate in Research

Promoting Student Belongingness: The development, implementation and evaluation of a toolkit for nurses

### An Invitation to Participate in Research Information Leaflet



Dear Colleague,

You are invited to take part in a Delphi Panel which will inform part of a research project. For the purpose of this project, you will be requested to give an expert opinion on the reality of the environment for student nurses undertaking a clinical placement. Your input will be utilised to inform the second part of the project, namely the development and utilisation of a toolkit.

#### **Purpose of Study**

The intention of this project is to develop and validate a toolkit for the purpose of supporting and guiding nursing staff in creating the experience of belongingness for students undertaking a clinical placement. Literature suggests that the need to belong to any given community influences health and wellbeing, which in turn affects behavioural, emotional and cognitive responses. This process will incorporate these components to encourage a team approach to student involvement within the clinical environment.

The toolkit will be developed from data extracted from a series of rounds conducted using the Delphi method. The panel of experts is to participate until

consensus is reached on the concept of belongingness to inform the design of the tools. The toolkit will be distributed to selected clinical areas for use during periods of clinical practicum for students, and evaluation of its applicability, usefulness and sustainability will be conducted.

### **The Delphi Method**

The Delphi method is a group communication process which aims to consensus build opinion on a specific real-world issue (Hsu & Sandford, 2007). A researcher or coordinator constructs structured questionnaires and feedback reports on how the group views the issues. It is an iterative process possibly of several rounds exploring significant disparity and results in an output. It can be continuously iterated until consensus is determined to have been achieved, although it appears from the literature that three iterations are often sufficient to collect the needed information (Biondo et al., 2008; Hasson et al., 2000).

#### **Input from Panel Participants**

- Commitment to process of at least three rounds of questions. Each set of questions will take approximately one hour to complete.
- Required to complete open-ended questionnaires anonymously through Survey Monkey using your own words and comments to capture data not explicitly asked.
- To complete questionnaires in a timely manner so that analyses can be conducted and the feedback report and next questionnaire can be constructed and distributed for successive rounds.

#### **Input from Researcher**

- Create process using Survey Monkey to gather opinions without the need to bring the panellists together physically.

- Use successive questionnaires to consider opinions in a non-adversarial manner.
- Ensure responses are summarised between rounds and communicated back to participants through a process of controlled feedback.
- Ensure current status of the group's collective opinion is repeatedly fed back to inform the group and identify items that participants may have missed or thought unimportant.
- Maintain the privacy and confidentiality of all panel members and participants.

I hope that you will be able to participate in this important project aiming to improve the learning and development of students.

For further information, please contact Chris King via email.

With thanks,

Chris King

University of Notre Dame Australia

PO Box 1225 Fremantle WA 6959

Email: [chris.king@my.nd.edu.au](mailto:chris.king@my.nd.edu.au)

## Appendix 4: Participant Information Sheet

(PLAIN LANGUAGE STATEMENT)



### Participant Information Sheet

**Project Title:** Promoting Student Belongingness  
**Chief Investigator:** Dr Kylie Russell; Associate Professor Caroline Bulsara  
**Student Researcher:** Chris King, PhD Candidate  
**Student's Degree:** Doctor of Philosophy

Dear Delphi Panel Participant,

You are invited to participate in the research project described below.

#### **What is the project about?**

The intention of this project is to develop and validate a toolkit for the purpose of supporting and guiding nursing staff in creating the experience of belonging for students undertaking clinical placement. Literature suggests that the need to belong to any given community influences health and wellbeing, which in turn affects behavioural, emotional and cognitive responses. This process will incorporate these components to encourage a team approach to student involvement within the clinical environment.

The toolkit will be developed from data extracted from a series of rounds conducted using the Delphi method. A panel of experts is to participate until consensus is reached on the concept of belongingness to inform the design of the tools. The toolkit will be distributed to selected clinical areas for use during periods of clinical practicum



for students, and evaluation of its applicability, usefulness and sustainability will be conducted.

For the purpose of this study, the research strategy will be a sequential mixed method which consists of two distinct phases: qualitative and quantitative research. The sequential mixed method model will aim to connect the results of the initial phase to the design, implementation and evaluation of the subsequent phase.

### **Who is undertaking the project?**

This project is being conducted by Chris King and will form the basis for the degree of PhD at the University of Notre Dame Australia under the supervision of Dr Kylie Russell and Associate Professor Caroline Bulsara.

### **What will I be asked to do?**

- Give commitment to the process of at least three rounds of questions. Each set of questions will take approximately one hour to complete.
- Be required to complete open-ended questionnaires anonymously through Survey Monkey using your own words and comments to capture data not explicitly asked.
- To complete questionnaires in a timely manner so that analyses can be conducted and the feedback report and next questionnaire can be constructed and distributed for successive rounds.

### **Are there any risks associated with participating in this project?**

There are no foreseeable risks; however, every project contains some risk, and by ensuring all opinions are considered in a non-adversarial manner, risk will be minimised.

### **What are the benefits of the research project?**

The benefit of this research project will be the creation of a toolkit which will assist nursing staff to optimise a clinical placement experience for students using strategies that enhance belongingness, acceptance and social wellbeing.

**Can I withdraw from the study?**

Participation in this study is completely voluntary. You are not under any obligation to participate. If you agree to participate, you can withdraw from the study at any time without adverse consequences; however, you cannot withdraw a survey after you submit your survey.

**Will anyone else know the results of the project?**

Information gathered about you will be held in strict confidence. This confidence will only be broken in instances of legal requirements such as court subpoenas, freedom of information requests or mandated reporting by some professionals.

Confidentiality in phase one will be maintained through anonymity of each participant from another, and all individuals will be de-identified in any information given through subsequent rounds. Individuals will be identified by the allocation of a numeric code. Information obtained by all the differing means (i.e., computer-generated input) will be suitably secured using confidential passwords. Similarly, in phase two, individuals will not be identified by name, all responses will be coded to ensure any inferences made concerning other colleagues or workplaces will not be public knowledge or cause social harm. All paperwork generated through questionnaires etc. will be kept locked in a secure place.

Once the study is completed, the data collected from you will be de-identified and stored securely in the School of Nursing at the University of Notre Dame Australia

for at least a period of five years. The data may be used in future research, but you will not be able to be identified.

**Will I be able to find out the results of the project?**

The results of this project will be written up for the PhD thesis and be available through the University of Notre Dame Australia library.

**Who do I contact if I have questions about the project?**

Chris King is contactable by e-mail: [christine.king2@my.nd.edu.au](mailto:christine.king2@my.nd.edu.au)

**What if I have a complaint or any concerns?**

The study has been approved by the Human Research Ethics Committee at the University of Notre Dame Australia (approval number #####). If you wish to make a complaint regarding the manner in which this research project is conducted, it should be directed to the Executive Officer of the Human Research Ethics Committee, Research Office, the University of Notre Dame Australia, PO Box 1225 Fremantle WA 6959, phone (08) 9433 0943, [research@nd.edu.au](mailto:research@nd.edu.au).

Any complaints or concerns will be treated in confidence and fully investigated. You will be informed of the outcome.

**I want to participate! How do I sign up?**

Contact to sign up can be made through my email address.

Yours sincerely,

Chris King

Researcher

University of Notre Dame Australia

PO Box 1225 Fremantle WA 6959

Email: [christine.king2@my.nd.edu.au](mailto:christine.king2@my.nd.edu.au)

## Appendix 5: Informed Consent Form



### Informed Consent Form

I, (*participant's name*) \_\_\_\_\_ hereby agree to

being a participant in the above research project.

- I have read and understood the Information Sheet about this project and any questions have been answered to my satisfaction.
- I understand that I may withdraw from participating in the project at any time without prejudice.
- I understand that all information gathered by the researcher will be treated as strictly confidential, except in instances of legal requirements such as court subpoenas, freedom of information requests or mandated reporting by some professionals.
- Whilst the research involves small sample sizes, I understand that a code will be ascribed to all participants to ensure that the risk of identification is minimised.
- I understand that the protocol adopted by the University of Notre Dame Australia Human Research Ethics Committee for the protection of privacy will be adhered to, and relevant sections of the *Privacy Act* are available at <http://www.nhmrc.gov.au/>.
- I agree that any research data gathered for the study may be published provided my name or other identifying information is not disclosed.

- I understand that research data gathered may be used for future research, but my name and other identifying information will be removed.
- I understand that I will be using Survey Monkey, an independent survey builder.

<b>Participant's signature:</b>		<b>Date:</b>	
---------------------------------	--	--------------	--

<b>Researcher's full name:</b>	Christine Louise King		
<b>Researcher's signature:</b>		<b>Date:</b>	

*If participants have any complaint regarding the manner in which a research project is conducted, it should be directed to the Executive Officer of the Human Research Ethics Committee, Research Office, the University of Notre Dame Australia, PO Box 1225 Fremantle WA 6959, phone (08) 9433 0943, email [research@nd.edu.au](mailto:research@nd.edu.au)*

## Appendix 6: Round One Questionnaire

### Promoting Student Belongingness: The development of the toolkit

1. In your experience, are nurses adequately prepared for supervising students? (Give reasons for answer.)

2. In your opinion, who or what are the major contributing factors for creating and maintaining optimal learning in the clinical environment?

3. What do you consider are the important social elements required to create a sense of belongingness in any community?

4. What do you see are the risks attached to social exclusion, particularly in the clinical setting?

5. What are the basic elements in your opinion necessary in a clinical environment to create an atmosphere of belongingness for a team?

6. What constraints, if any, have you experienced as a practitioner to create a sense of belongingness within your team or workplace?

7. What physical features of the clinical environment do you perceive are conducive to the enhancement of students' sense of belonging? (e.g., is it computer availability, study or social space?)

8. What psychological attributes of staff do you perceive are conducive to the enhancement of students' sense of belonging? (e.g., is it open friendliness?)

9. What are the challenges for managers and ward staff when trying to optimise clinical placement experiences?

10. To what extent do you think that the present system of supernumerary placements for students makes a difference to their sense of belongingness to the team?

11. Are you able to describe the impact of the ward manager in influencing attitudes of staff? (Give examples and/or reasons for answer.)

12. To what extent do you think the senior nursing team influence attitudes of staff?

13. How do you envisage a toolkit promoting belongingness in the clinical environment?

## Appendix 7: Delphi Panel Survey Two

1. Attitudes: In your opinion, what changes need to be made to improve attitudes towards students?

2. Attitudes: What incentives would be useful for motivating staff to take ownership of students' education and wellbeing?

3. Belongingness: How do we improve an understanding of belongingness?

4. Belongingness: How could we improve access to social groups associated with the staff during the students' clinical placements?

5. Culture: What practical actions within staff learning and development would need to be employed to improve a team culture that includes students?

6. Culture: How can we encourage staff to move further towards a culture that has a respect for education that challenges and enhances clinical practice?



7. Leadership: What provision and support could be given to develop leaders and champions to engage and take up the role of ensuring that student inclusion and development occur in the clinical environment?

8. Learning Environment: What action is required to create a team vision of an improved learning environment for staff and students together during clinical placements?

9. Learning Environment: What activities could be employed both clinically and socially to improve the working environment?

10. Learning Environment: Do you have ideas or perhaps innovations that have been implemented for resourcing and improving student/staff space and time, given the current changes, financial and ward area limitations?

11. Student Supervision: What incentives could be used to encourage staff to take formal training, and how could this be incorporated into their clinical practice commitments?

12. Patient Care: What different strategies could we employ to encourage patient participation in student clinical learning?

13. Patient Care: What ideas do you have for optimising patient care but at the same time increasing student learning experiences?

14. Welcome: How could working and social spaces be made welcoming for students?

15. Welcome: What approach and support could be used that included all staff in the workplace in welcoming and orientating students?

16. Time: What supportive measures could be given to junior staff with inexperience and inability in time management to cope with both a busy workload and preceptoring a student successfully?

## Appendix 8: Panel Member Letter for Round Two



Dear Panel Member,

If you have already completed the first questionnaire, thank you so much. Some very valuable data has already been received. If you have completed this, but have not sent a copy of the signed consent form (attached), I would be pleased to receive that by email.

If you have not yet had an opportunity to complete the Survey Monkey questions, they are still available and completion of this would be a very much appreciated contribution to my research.

If you have any questions, please do not hesitate to contact me.

Kind regards,

Chris King

University of Notre Dame Australia

PO Box 1225 Fremantle WA 6959

Email: [chris.king@my.nd.edu.au](mailto:chris.king@my.nd.edu.au)

## Appendix 9: Delphi Panel Round Three

Please rank the following statements in each set; #1 being the most important statement in your opinion.

### Set 1

1. Attitudes towards students are likely to be formed by good or bad prior experiences.
2. Staff who work in a supported area and feel part of the team are more positive and open to students.
3. Staff need to understand how important the clinical placement is to a student.
4. A nurturing environment may encourage students to be polite, enthusiastic and helpful.
5. Understanding belongingness could form part of a workplace learning supervisor/preceptor training session or module.

### Set 2

1. Organisational vision and values are seen as important with support from the team leader.
2. Staff need to feel that their educational approaches are valued by universities, students and health services.
3. Increase formal education of clinical supervision, acknowledging excellence in supervision.
4. Students need to take ownership of their own education in partnership with supervisors.
5. Reward and acknowledgement should be given through preceptor and mentor awards (e.g., study time, conference leave).

**Set 3**

1. Let staff be reminded of their own student experience by compiling a video of how it may feel to be new in the ward environment as seen through the eyes of a student/new staff members.
2. Have ‘social champions’ in a ward/unit area whose role is to welcome new staff and meet either prior to or at the commencement of a placement.
3. Students need to be seen to be welcomed into the team, acknowledge them as contributing members of the team. This will raise the profile of the students.
4. Form a ‘Welcoming Committee’ to include all levels of staff in the students’ orientation; encourage involvement by all.
5. Discussion should occur on how staff as professionals ensure that students are included in all ward/unit activities.

**Set 4**

1. Encourage and ensure the ward teams are up to date by asking students how they would like to be represented and included in the clinical environment.
2. Encourage students to research and present to staff on an issue or area of practice to be improved.
3. Students should provide some staff professional development—something new from the university or a case study presentation.
4. Students and staff should share their learning experiences and reflections at team meetings and should be able to voice their ideas.
5. Allow the students more autonomy by creating an expectation of staff to ‘stand back’ to allow students to think of their ‘next step’.

**Set 5**

1. Managers/leaders need to provide a positive environment; negativity should be quickly dealt with.
2. Students should ‘shadow’ managers, DONs or Nursing Directors to understand nursing administration.
3. Debriefing or workshopping should occur, facilitated by senior staff on the ward to understand how best to manage students effectively and positively in the ward/unit.
4. ‘Star of the Week’—small notes or tokens from managers and staff to others to let them know their positive behaviours have been appreciated.
5. Managers/leaders should raise expectations beyond a reward system to ‘why wouldn’t you want a student’.

**Set 6**

1. Avoid any negative stereotypes when talking to patients about students; avoid such terms as ‘practise’ and use more positive terminology of ‘administer under supervision’.
2. Let patients know about students by developing generic handouts discussing the value of student learning and information put up everywhere in the clinical area with posters developed by students.
3. Give opportunity for patient feedback as to how they felt during care administered by the student.
4. If the patient, student and staff member work in collaboration, this will optimise patient care and increase student learning experiences.

5. The creation of a regular journal club in work hours would enable staff, students and university staff to share experiences and information to understand each other's perspectives.

#### **Set 7**

1. There is a need for a nominated 'go to' person in the work environment to advocate for students and support inclusion into the team.
2. Have information relating to the team available, such as team photos, team vision and values displayed on the unit.
3. Invite staff to create a 'Welcome' board, conduct a morning/afternoon tea especially to welcome students, encourage a 'non-clinical' buddy system.
4. Students should have a place to put belongings, plus a space on a noticeboard for notes and suggestions from staff.
5. Display an education bulletin that alerts all staff to student schedules and when they will be present in the workplace so care is taken to make students feel welcome.

## Appendix 10: Letter of Request for Stage 2 Nurse

### Participants



Dear Colleague,

My name is Chris King and I am a current PhD research student at the University of Notre Dame, Australia within the School of Nursing and Midwifery. My research project involves the development of an e-learning program containing a toolkit to promote student belongingness during a clinical placement. The aim is to improve the workplace learning experience for both students and nurses.

As part of this research, I need to pilot the e-learning program to ascertain if it is successful in delivering the education and resources to participants and if this is a practicable means by which to provide learning to nurses.

In order to do this, I have attached a **Participant Information Sheet** giving details of the research and **Instructions for Accessing the E-learning program—WANTED Promoting Student Belongingness**. Follow the instructions carefully to ensure smooth progress through registration, enrolment and obtaining your certificate at the end.

There will be registration into the Learning Management System—Moodle, a short pre-questionnaire followed by an interactive program, and on completion, you will be required to complete the short post-questionnaire. A certificate will be issued automatically by the program at the time of completion, but at no time will you be individually referred to in this research.



Kind regards,

Chris King

University of Notre Dame Australia

PO Box 1225 Fremantle WA 6959

Email: [christine.king2@my.nd.edu.au](mailto:christine.king2@my.nd.edu.au)

## Appendix 11: Participant Information Sheet



### Participant Information Sheet

<b>Project title:</b>	<b>Promoting Student Belongingness</b>
<b>Chief investigator:</b>	Associate Professor Kylie Russell; Associate Professor Caroline Bulsara
<b>Student Researcher:</b>	Chris King PhD Candidate
<b>Student's Degree:</b>	Doctor of Philosophy

Dear Nurse Participant,

You are invited to participate in the research project described below.

#### **What is the project about?**

The intention of this project is to develop and validate a toolkit for the purpose of supporting and guiding nursing staff in creating the experience of belonging for students undertaking clinical placement. Literature suggests that the need to belong to any given community influences health and wellbeing, which in turn affects behavioural, emotional and cognitive responses. This process will incorporate these components to encourage a team approach to student involvement within the clinical environment.

The toolkit has been developed into an e-learning program using data extracted from a series of rounds which obtained expert panel opinion (the Delphi method). The panel of experts participated until consensus was reached on the concept of belongingness in the clinical environment to inform the design of the tools. The toolkit

is then to be distributed to nurses, and evaluation of its applicability, usefulness and sustainability will be conducted.

**Who is undertaking the project?**

This project is being conducted by Chris King and will form the basis for the degree of PhD at the University of Notre Dame Australia under the supervision of Associate Professor Kylie Russell and Associate Professor Caroline Bulsara.

**What will I be asked to do?**

- Complete the questionnaire prior to beginning the e-learning program.
- Complete the e-learning program provided.
- Complete the questionnaire post-completion of the e-learning program.

**Are there any risks associated with participating in this project?**

There are no foreseeable risks; however, every project contains some risk, and by ensuring all opinions are considered in a non-adversarial manner, risk will be minimised.

**What are the benefits of the research project?**

The benefit of this research project will be the creation of a toolkit which will assist nursing staff to optimise a clinical placement experience for students using strategies that enhance belongingness, acceptance and social wellbeing.

**Can I withdraw from the study?**

Participation in this study is completely voluntary. You are not under any obligation to participate. If you agree to participate, you can withdraw from the study at any time without adverse consequences; however, you cannot withdraw a survey after you submit your survey.

**Will anyone else know the results of the project?**

Information gathered about you will be held in strict confidence. This confidence will only be broken in instances of legal requirements such as court subpoenas, freedom of information requests, or mandated reporting by some professionals.

Individuals will not be identified by name; all responses to questions in Survey Monkey will be anonymous to ensure any inferences made concerning other colleagues or workplaces will not be public knowledge or cause social harm. All paperwork generated through questionnaires etc. will be kept locked in a secure place.

Once the study is completed, the data collected from you will be de-identified and stored securely in the School of Nursing at the University of Notre Dame Australia for at least a period of five years. The data may be used in future research, but you will not be able to be identified.

**Will I be able to find out the results of the project?**

The results of this project will be written up for the PhD thesis and be available through the University of Notre Dame Australia library.

**Who do I contact if I have questions about the project?**

Chris King is contactable by e-mail.

**What if I have a complaint or any concerns?**

The study has been approved by the Human Research Ethics Committee at the University of Notre Dame Australia (Approval number 016015F). If you wish to make a complaint regarding the manner in which this research project is conducted, it should be directed to the Executive Officer of the Human Research Ethics Committee, Research Office, the University of Notre Dame Australia, PO Box 1225 Fremantle WA 6959, phone (08) 9433 0943, [research@nd.edu.au](mailto:research@nd.edu.au)

Any complaints or concerns will be treated in confidence and fully investigated.

You will be informed of the outcome.

**I want to participate! How do I sign up?**

Read carefully the INSTRUCTIONS FOR ACCESSING THE WANTED E-LEARNING COURSE.

Yours sincerely,

Chris King

Researcher

University of Notre Dame Australia

PO Box 1225 Fremantle WA 6959

Email: [christine.king2@my.nd.edu.au](mailto:christine.king2@my.nd.edu.au)

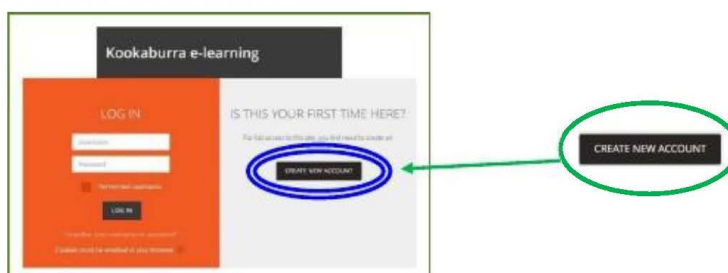
## Appendix 12: Instructions for Accessing the WANTED e-Learning Course Promoting Student Belongingness

Please read through these instructions before starting the course and have a printed copy available when you begin.

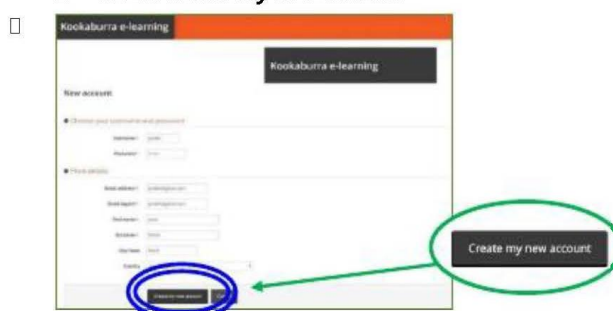
The **WANTED** e-learning package – Promoting Student Belongingness operates under the Moodle Learning Management System and it is recommended that this is run using either Microsoft's Internet Explorer browser on a PC or Safari on Apple. There are known problems between Google Chrome and Moodle, therefore running the package in Chrome is not recommended.

### 1. Registration and Enrolment

- a. Access the Kookaburra e-learning page on the Moodle website using the link <https://wanted.moodle.school/login/index.php> and select **CREATE NEW ACCOUNT**



- b. Complete the required registration information:
  - Create (and note down) a **Username** and **Password** (enter your chosen password with care as there is no password confirmation, therefore if you mis-type it you will not be able to access the course)
  - Complete e-mail, name, and location details
  - Select **Create my new account**



- c) View the message notifying that an e-mail has been sent to you.  
**DO NOT** click **Continue** on this screen, but close the window down now.



- d) Click on the link in the e-mail you receive confirming your account and you will be presented with an acknowledgement screen - click **Continue**.  
NB/ if your computer has been set up with Chrome as the default browser, clicking **Continue** may cause the next screen to open up in Chrome. If this happens close the window down and then close down Chrome. Open Internet Explorer (or Safari on Apple) and open the Moodle website using the link (<https://wanted.moodle.school/login/index.php>). Then log-in using your username and password as in 6.a) below and return here to follow the instructions in 1.e).



- e) On the screen that opens, click the **WANTED** course picture.



- g) Enrol for the course by clicking **Enrol me**



## 2. Starting the Course

a) This screen shows:

- The **WANTED** course icon
- The **Certificate of Completion** icon (only clickable when the WANTED course has been completed – shown by a tick in the box to the right)

Click the **WANTED** course icon



b) Click **Enter**



c) Click **Launch**



d) Click the poster to start the **WANTED** course





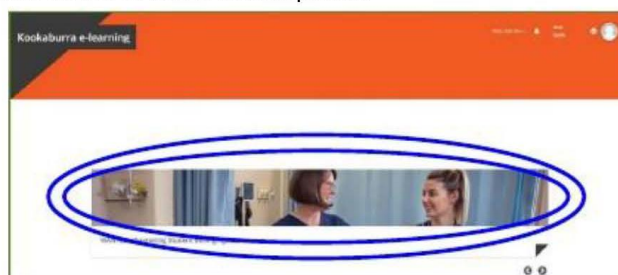
- e) When you access the *Pre-Course Questionnaire* and *Post-Course Questionnaire* and *Resources* from within the course they will open in new windows so that your course is not interrupted. This is useful, particularly for the *Resources* as you can leave the new window open while you proceed.

### 3. Exiting the course and Producing the Certificate

- a) When you complete the course, you will automatically exit. However, you can voluntarily exit before this (see section 6. on *Continuing* below) but you should always do this by following the instructions within the course.  
**DO NOT** exit by simply closing your browser.
- b) When you exit you will be returned to the launch screen. Click the black *Kookaburra e-learning* box. **DO NOT** click *Launch*.



- c) The main *WANTED* screen will then open. Click on the *WANTED* course picture.



### 4. Certificate of Completion

- a) When you have successfully completed the course (indicated by a tick in the box to the right of the *WANTED* course icon) you will be able to click on the second option, *Certificate of Completion*.
- b)



- c) This screen allows you to download your **Certificate of Completion** to a selected location and then view or print it. Click **Download certificate**.



## 5. Logging Out

If you have finished with the course **Log out** of the Kookaburra e-learning environment by clicking on your identity icon (top right of the window)



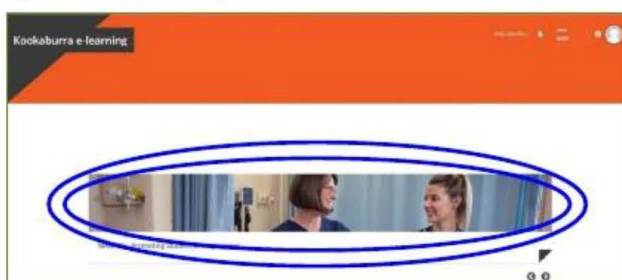
## 6. Continuing the Course

- a) Login again from the link

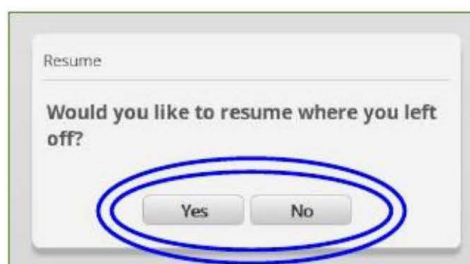
<https://wanted.moodle.school/login/index.php>  
and enter your **Username** and **Password**



- b) Once you are logged-in again, click the **WANTED** course picture to start.



- c) If you are returning to the course and have not previously completed it, you will be presented with the options below:



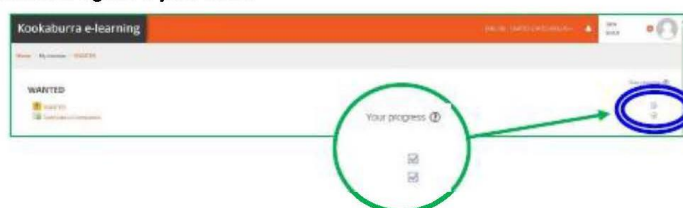
- d) If you **resume** you will return to the course **Exit Page** from where you can return to the **Home Screen** and navigate to your last previously completed module (which you can 'fast-forward' through) to continue the course. You will not have to redo any previously completed modules. On the Home Screen you can select previously completed modules by clicking on the appropriate box file on the nursing station desk.



- e) If you **do not resume** you will start the course from the beginning again and **the record of previously completed modules will be erased**. In addition, you will require your pre-course questionnaire code to proceed.

## 7. Reviewing (re-starting) the Course

- a) Once you have completed the course the record of your previously completed modules will be erased. If you return later to review the course or view/print the **Resources** you will have to start the course from the beginning and will therefore require your pre-course questionnaire code to proceed. As soon as you pass the introductory video you will arrive at the Home Screen from where you can access **Resources** without proceeding further should you not wish to do so.
- b) Your **Certificate of Completion** will be ticked as completed but you will be able to download it again if you wish.



## **Appendix 13: Promoting Student Belongingness Pre-program**

### **Survey**

Welcome to the Promoting Student Belongingness Survey.

Thank you for agreeing to participate in this survey. This is the first part of the two-part pre- and post-surveys and will assist in evaluating the impact of the e-learning program.

1. I have read the Participant Information Sheet and understand all information therein.
2. I hereby agree to be a participant in the Promoting Student Belongingness research project.

#### **Part 1 Stagg's Attitude Survey**

Please use the scale to indicate the level to which you agree or disagree with each statement by ticking the box (strongly agree, agree, undecided, disagree, strongly disagree). There is no right or wrong answer. The response we require is one that reflects your personal opinion. This will be anonymous.

1. I believe nursing students respect nurses as practitioners.
2. Nurses consider nursing students part of the nursing team.
3. With nursing students who are new on the unit, nurses have time to do other things.
4. Nursing students accept constructive criticism.
5. With nursing students who are familiar with the unit, nurses have time.
6. We were all students once, so we should be nice to nursing students.
7. You cannot tell nursing students anything because they know everything.
8. Nursing students willingly help nurses to get things done.

9. Nurses should not have to do the teaching that clinical instructors are paid to do.
10. Nursing students become overwhelmed if they have to care for more than one or two patients.
11. There is too much to do to have to worry about students.
12. Nursing students ask too many questions.
13. Nursing students rely on their clinical instructor more than the ward nurses.
14. Nursing students are too dependent on the ward nurses.
15. Nursing students help other students to get things done.
16. Nursing students do not have enough confidence in themselves.
17. Nurses should consider nursing students part of the team.
18. Nursing students should be introduced to all members of staff and patients on the ward

## **Appendix 14a: E-mail of Request to Dr S. Stagg**

King, Chris

Actions

To: sstagg@shorehealth.org

Tuesday, 19 December 2017 2:30 PM

Email to Dr S Stagg

Dear Dr Stagg

I am writing to you regarding your Master's thesis on Staff Nurses' attitudes towards nursing students in 1992. I am currently enrolled in my PhD at the University of Notre Dame, Australia and would like to use your survey tool used in this study. My proposal approved by the School of Nursing and Midwifery Ethics Committee is entitled 'Promoting Student Belongingness—The development, implementation and evaluation of a toolkit for nurses'.

I will be implementing an e-learning program I have developed for registered nurses. The content contains modules which involve working through the program of WANTED (Welcome, Attitude, Nurture, Team, Encourage, Delight). Each incorporates video clips of acted out scenarios using previous real-life incidents for reflective learning. In addition, teaching content contains principles of adult learning, critical thinking and clinical teaching, as well as compassionate care. The aim is to focus on nurses' attitudes towards students' learning and to encourage the use of tools and strategies to improve this. Work in Australia by Tracy Levett-Jones, and more recently Kylie Russell, links a sense of student belongingness to improving student clinical learning environments. My aim is to achieve further improvement.

I would like to use your survey both immediately pre and post the program with the possibility of a survey nine weeks post-program. I hope that you will be able to support me in this project by consenting to the use of your tool. It will be referenced and acknowledged.

I look forward to your reply and thank you for your time in advance.

Kind regards,

Chris King

PhD Candidate 20143858

University of Notre Dame Australia

## **Appendix 14b: E-mail of Reply from Dr S. Stagg**

Stagg, Sharon [sstagg@umm.edu]

Tuesday, 19 December 2017 8:54 PM

Chris,

You are certainly welcome to use the survey.

Please let me know the results of your study. It sounds very interesting.

Best wishes.

Sharon

Sharon Stagg, DNP, MPH, CRNP, CHCQM

Palliative Care Nurse Practitioner

Shore Regional Palliative Care Program

219 S. Washington Street

Easton, MD 21601

410-822-1000 extension 5043



## **Appendix 15: Promoting Student Belongingness Post- Program Survey**

### **Part 2 Stagg's Attitude Survey**

Please use the scale to indicate the level to which you agree or disagree with each statement by ticking the box (strongly agree, agree, undecided, disagree, strongly disagree). There is no right or wrong answer. The response we require is one that reflects your personal opinion. This will be anonymous.

1. I believe nursing students respect nurses as practitioners.
2. Nurses consider nursing students part of the nursing team.
3. With nursing students who are new on the unit, nurses have time to do other things.
4. Nursing students accept constructive criticism.
5. With nursing students who are familiar with the unit, nurses have time.
6. We were all students once, so we should be nice to nursing students.
7. You cannot tell nursing students anything because they know everything.
8. Nursing students willingly help nurses to get things done.
9. Nurses should not have to do the teaching that clinical instructors are paid to do.
10. Nursing students become overwhelmed if they have to care for more than one or two patients.
11. There is too much to do to have to worry about students.
12. Nursing students ask too many questions.
13. Nursing students rely on their clinical instructor more than the ward nurses.
14. Nursing students are too dependent on the ward nurses.
15. Nursing students help other students to get things done.

16. Nursing students do not have enough confidence in themselves.
17. Nurses should consider nursing students part of the team.
18. Nursing students should be introduced to all members of staff.

### **Using e-learning**

1. The e-learning program was easy to work through.
2. I have found the e-learning program with the WANTED toolkit practical and useful.
3. Completing the e-learning program will help me reflect and have ideas for making nursing students part of the team.
4. Using an e-learning program helps with improving my learning and education efficiently and effectively.
5. I would recommend this e-learning program to colleagues.
6. Do you have any comments?

## Appendix 16: Unconditional Ethics Approval



19 Mouat Street (PO Box 1225) Fremantle WA 6959  
+61 8 9433 0555 | enquiries@nd.edu.au

25 February 2016

Dr Kylie Russell & Ms Christine King  
School of Nursing & Midwifery  
The University of Notre Dame Australia  
Fremantle Campus

Dear Kylie and Chris,

**Reference Number: 016015F**

**Project Title: "Establishing belongingness in the Clinical Practice Setting: A toolkit to support and guide a professional team of nursing staff to create the experience of belonging for students in a practice environment."**

Your response to the conditions imposed by a sub-committee of the university's Human Research Ethics Committee, has been reviewed and assessed as meeting all the requirements as outlined in the *National Statement on Ethical Conduct in Human Research* (2014). I am pleased to advise that ethical clearance has been granted for this proposed study.

***All research projects are approved subject to standard conditions of approval. Please read the attached document for details of these conditions.***

On behalf of the Human Research Ethics Committee, I wish you well with your study.

Yours sincerely,

Dr Natalie Giles  
Research Ethics Officer  
Research Office

cc: Prof Elaine Pavlos, Dean, School of Nursing & Midwifery;  
A/Prof Caroline Bulsara, SRC Chair, School of Nursing & Midwifery.

Broome Campus 88 Guy Street (PO Box 2287) Broome WA 6725  
Sydney Campus 140 Broadway (PO Box 944) NSW 2007

Fremantle Broome Sydney

ABN 69 330 643 210 | CRICOS Provider Code: 01032F

nd.edu.au

## Appendix 17: The WELCOME Notepad



## **Come and Join with Us**

**We want you to  
enjoy your time  
spent with us and  
this Notepad is to  
help you become  
part of our team**



## Getting Settled In



### Where to put your belongings

*We have a designated place for your belongings, although it is not a big space we would appreciate you keeping them to a minimum. Your designated space is.....*



*Ensure that your mobile is switched to silent while working with patients/ clients, use breaks to check them.*



## Who is The Team?

### Senior Nurses:

The Nurse Manager .....

Clinical Nurse Specialist (CNS).....

Staff Development Nurse.....

Student Liaison .....

### Nursing Team:

.....

.....

.....

.....

### Medical Staff

Consultant.....

RMO.....

### Allied Health Staff

Physiotherapist.....

OT.....

Speech Pathologist.....

Dietitian.....



### Useful phone numbers

.....

.....

.....

## Lunch & Breaks

Where to go: .....

Where to store your lunch .....

When to take your breaks .....

Where to buy food.....

What's happening this week at lunchtime .....



## Ward Schedules/Team Meetings



Times of Shifts are as follows:

AM Shift.....

PM Shift .....

Night Shift .....





*Please arrive 5 - 10 minutes prior to the start of shift ready for handover*

*Check the roster regularly*

*The next Team Meeting is.....*

*Is there something of interest you can bring to the meeting; if so arrange a time slot with the Nurse Manager*



## **In-house Education Sessions**



1)  
Subject.....

Where.....

Date & Time.....

2)  
Subject.....

Where.....

Date & Time.....

3)  
Subject.....

Where.....

Date & Time.....

4)  
Subject.....

Where.....

Date & Time.....

5)  
Subject.....

Where.....

Date & Time.....

## Notes to Self

### Reflections

- *What did I learn about the roles of the team in this unit?*
  
- *What are the similarities and differences between the roles?*
  
- *What else do I want to learn about the team and its members?*
  
- *How will this experience influence my role as a professional?*



## **Activities**

- *Who do I need to engage and talk with to know about*
  - *Key issues and topics specific to this clinical setting*
  - *Experiential activities I would like to be involved in*
  - *Case studies I would like to know about*

## **Goals of Achievement**

- *What personal goals of achievement do I want to accomplish?*
- *How will I do this?*
- *Who do I need to help me achieve them?*

## **My Contribution to the Ward**

- *Design a poster or handout leaflet to:*
- 1. Tell patients of the value of student learning  
or*
  - 2. Alert staff to student schedules and arrivals  
or*
  - 3. Identify for staff what you need to achieve and at  
what stage  
(Select one and work together with other  
students)*



- *Identify and research on an issue or area of practice to be improved on the ward, offering solutions to be presented to staff either at team meetings or handovers.*



## Daily Diary

*What went well*

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

*What I need to revise*

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

*Expected workload tomorrow*

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

*How well I thought I managed today*

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

*Expected Preceptor*

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



## Appendix 18: The WELCOME Poster



## Appendix 19: The Staff Poster

### HOW CAN I SUPPORT MY STUDENTS TO FEEL “WANTED”

#### 3Cs: Co-ordination, Cooperation, Collaboration

##### Looking after You

###### Self-care is not selfish.

For the wellbeing of nurses and patients—as educators and health promotion advocates—it is essential. Self-compassion is not self-centered, rather, it is a foundation for compassionate care. (Wills et al. 2015)

##### Aim

To support all staff in the role of creating a positive and friendly learning environment for students



##### Methods

- An ALL team approach and agreement
- Nominate a GO TO buddy for the ward
- Use the “WANTED” toolkit
- Discuss concerns arising WITH THE TEAM
- Seek resolution TOGETHER
- ENCOURAGE student feedback

##### Knowledge to Action

###### Autonomy and Supervision

The Traffic Light System



(Russell et al. 2012)

###### ALWAYS – Patient Participation



(Adapted from RPHS OSU 2015)

###### IIITOPS – Action Plan



(Adapted from Chan, 2012)

##### “WANTED”

**Welcome:** student as part of the team

**Attitude:** compassion - self & students

**Nurture:** encourage exchange

**Team:** involve everybody in ward activity

**Encourage:** appropriate autonomy

**Delight:** in shared or individual success

##### Celebrate the Relationship

###### Making a positive difference

- What was good about it?
- What difference did you make to the Student?
- Share why you acted that way.
- What values were involved?
- How might you develop what you have learned for the future?

##### Acknowledgements

To all staff for a job WELL DONE

To students for their CONTRIBUTION

## Appendix 20: The Nurse Support Notebook

How can I support my  
Student to feel  
**WANTED.**



A Range of Resources & Enablers  
Part of the Promoting Student  
Belongingness Toolkit

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# WANTED – The Toolkit

## **The Toolkit**

The toolkit has been created with the intention of assisting and supporting health professionals to generate a welcoming and supportive learning environment for students on clinical placement thus enabling them to belong to their chosen profession .

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Author: Chris King PhD Candidate

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The University of Notre Dame

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Nursing and Midwifery Office WA

## Introduction

The development of this toolkit has been a long held vision to support busy nursing and clinical staff so that the clinical environment becomes a place of welcome and compassionate learning. This toolkit has been designed to assist all clinical staff working with undergraduates on clinical placement. It contains this Support Notepad, plus a Welcome Notepad for Students, two posters for display on the ward and a short video depicting the thoughts from both nurses and students about their sense of belonging to the clinical learning environment.

This Support Notepad is a tool that can be used as a resource and reference with activities to guide clinical staff together as a team to improve the environment on a daily basis without increasing paperwork or workload.



I would be very pleased to receive feedback concerning the toolkit, so should you wish to make contact for further information, please e-mail me Chris King.

e-mail: [cking2@iinet.net.au](mailto:cking2@iinet.net.au)

# WANTED – The Toolkit

## “WANTED”



**Welcome** – Legitimisation of the student role

**Attitude** – Compassion for self and students

**Nurture** – Encourage sociable exchange

**Team** – Involve everybody in ward activity and discussion

**Encourage** – Appropriate autonomy for completion of tasks

**Delight** - In a supportive relationship and success

What is it?	Who is it for?	What is in it?
Tools all Team Members will need to successfully engage with students. It is a collection of resources, ideas and templates to support nurses create a learning environment for students.	All staff who will be working with students during their clinical placement.	<ul style="list-style-type: none"> <li>• Self-compassion and self-caring</li> <li>• Team Support</li> <li>• Educational Support</li> <li>• Cultivating Compassion for Students</li> <li>• Enablers and Blockers</li> <li>• Knowledge to Action</li> <li>• Create a Positive Learning Environment</li> <li>• Support Autonomy with Safe Practice</li> <li>• Patient Participation</li> <li>• Encourage Student Involvement</li> </ul>



## **Your Participation in Creating a Belonging and Learning Environment**



# Welcome



## Information Sharing

### 1. Notification of Upcoming Students

- Display a bulletin that alerts all staff to student schedules and when they will be present
- Be aware of what students are able to perform within the ward prior to placement
- Discuss with colleagues identified issues prior to commencement of placement
- Students' names to be displayed on "Welcome" poster
- Copies of "Welcome Notepad" to be made available for all students
- Create a non-clinical student liaison "buddy" system

### 2. Role Modelling and Mentorship

- Create and encourage opportunities for the student to get to know you and visa versa through informal conversation. (Break times could be ideal opportunities)
- Positively influence student's perceptions by engaging a supportive manner and developing an initial understanding of their requirements. (Encourage the use of the "Welcome Notepad")
- Seek advice and support from Clinical Placement Supervisors, Staff Development and experienced mentors on placement objectives
- Use IIITOPS\* and the Traffic Light System\* and ALWAYS\* (below) to support the student's involvement in structured activities to facilitate learning and practice



## Create a Positive Learning Environment



### ACTION:

- Apply IIITOPS actions to each individual student you undertake to supervise

### IIITOPS

(Acknowledgement to the Clinical Learning Environment Inventory; Chan, 2002)

Support	Description	Action
<b>Individualisation</b>	Extent to which students are allowed to make decisions and are treated differently according to ability or interest	Give time and permission to work at their own pace to encourage critical thinking and clinical reasoning
<b>Innovation</b>	Extent to which the nurse plans new, interesting and productive ward experiences, teaching techniques, learning activities and patient allocations	New ideas are recognized and patient involvement is encouraged
<b>Involvement</b>	Extent to which students participate actively and attentively in ward activities	There are opportunities for students to express opinions and ideas on the ward
<b>Task Orientation</b>	Extent to which ward activities are clear and well organised	Ward assignments are clear so students know what to do with confidence
<b>Personalisation</b>	Emphasis on opportunities for the individual student to interact with the nurse and emphasis on concern for student's personal welfare	The nurse considers the students feelings and anxieties
<b>Satisfaction</b>	Extent of enjoyment of clinical placement	Make their day, make it fun, give the student a sense of satisfaction at the end of the shift

# Attitude



## Tools to Support Me

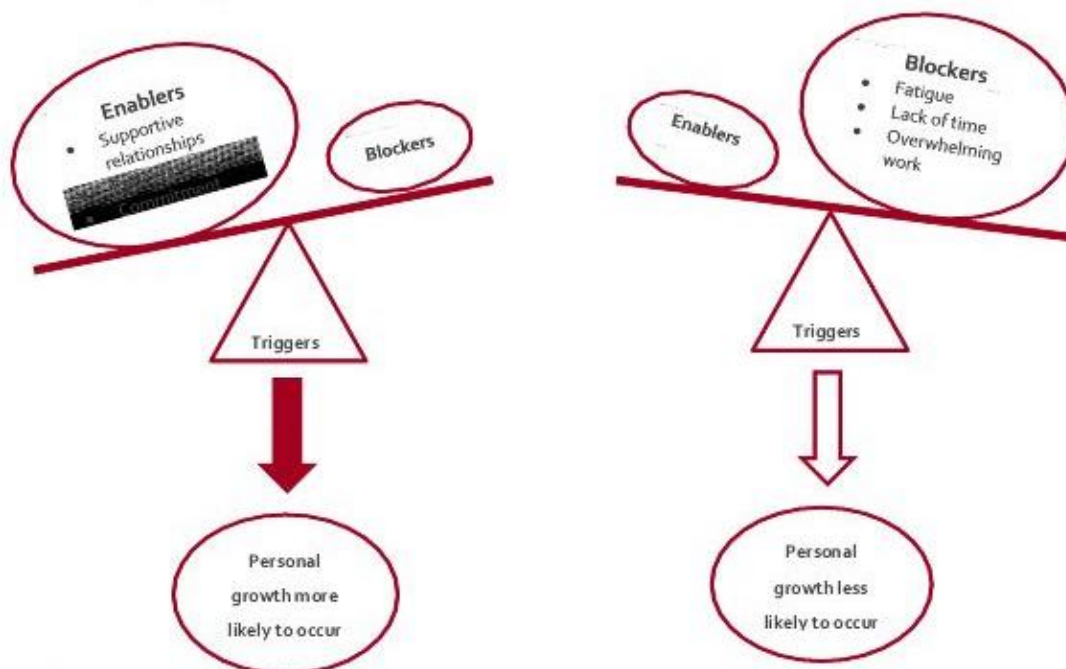


What strengths and resources can I use to support me?



## ENABLERS AND BLOCKERS

Effective and safe nursing practice is more than knowledge and skills attainment, it requires the ability to function and work within complex teams while maintaining evolving and changing relationships (P. O'Lunaigh, 2015).



(Adapted from R.B. Levine et al., 2008)

Enablers	Blockers
Attitude and commitment towards students	Poor levels of support and supervision
Professionalism and Leadership	Skill mix and staff shortages
Communicating appropriately	Inadequate supply of qualified mentors
Being an example of how to be a nurse	Time constraints and workloads
Listening and encouraging reflection	Poor quality role modelling
Supporting and passing on clinical skills	Poor level of Senior Clinician support
Attending to the little things	Negative external factors
Formal recognition of the mentoring role	Little interest in the student as a person
Self-compassion and compassionate acts	Difficult to approach

## EDUCATIONAL SUPPORT

Using a strengths based strategy can be useful as a reflection tool or learning framework

### Strengths – What can you build on

- What are you most pleased about having achieved with previous students?
- What strengths contributed most to these achievements or successes?
- What makes you unique?
- What are you most proud of in your contribution to the team support of students?

### Opportunities – How can you get even stronger

- How could you make an exciting opportunity for the student?
- What have you done in the past that has worked?
- What could you do if there were no obstacles getting in your way?
- What are some different ways in which you could approach this?

### Aspirations – What do you care about

- What would give you the most satisfaction?
- What opportunities appeals most or feels best to you?
- Where could you focus your efforts?

### Results – How will you know you are succeeding

- What plans can you make to ensure that progress is made?
- What support do you need and from whom?
- What training and resources do you need?

(Adapted from the Think Book of SOAR J.M. Stavros and Gina H Inrichs 2016)



### ACTION:

- Take some of these reflections to the team meeting or discuss with colleagues and managers.

## RESOURCES



### ACTION:

- Use the resources below to inform and support your learning and participation in creating a Belonging and Learning Environment

On Track e learning package

[http://www.health.wa.gov.au/wactn/home/wachs\\_resources.cfm](http://www.health.wa.gov.au/wactn/home/wachs_resources.cfm)

SCIPE Program from TRACS WA

<http://www.subacutecare.org.au/ji/index.php/scipe-2>

The Art of Clinical Supervision - Dr K. Russell University of Notre Dame (2011)

Kylie Russell <kylie.russell@nd.edu.au>



"Practicing Self-Care for Nurses: A Nursing Program Initiative" Blum, C., (September 30, 2014) OJIN: The Online Journal of Issues in Nursing Vol. 19, No. 3, Manuscript 3. DOI: 10.3912/OJIN.Vol19No03Man03

Essence of health

Health and Wellbeing, Mindfulness

<http://www.monash.edu/health/mindfulness/programs>



In today's beleaguered healthcare system, burdened with epidemic levels of stress, depression and burnout, *TIME to CARE* offers health professionals the opportunity of renewal. Here are the secrets to building a happy and fulfilling practice, wellbeing and resilience. Youngson relates his own transition, from a detached clinician to a champion for humane whole-patient care; at times poignant, sometimes funny but always brutally honest. Drawing on advances in neuroscience and positive psychology, and tapping the power of appreciative inquiry, Youngson conveys in clear and simple language how health workers can strengthen their hearts, learn the skills of compassionate caring, and rise above institutional limitations to transform patient care.... and rediscover their vocation. *TIME to CARE* is recommended reading for today's health

professionals, students, health leaders, patients, and all those passionate about re-humanizing healthcare.

Harvard Mindfulness research leading the way

<https://hbr.org/2015/01/mindfulness-can-literally-change-your-brain>

Brene Brown on Empathy

<https://www.youtube.com/watch?v=1Fvwgu36gJw>

Cultivating Compassion

<https://cultivatingcompassionatecare.wordpress.com/>

# Nurture



## CULTIVATING COMPASSION FOR STUDENTS



Here is a **COMPASSION** mnemonic to help you reflect on episodes of compassion (Montgomery et al., 2016)

**C**ompassion, **c**are, **c**ourage, **c**ompetence, **c**ommunication and **c**ommitment. Which were relevant and how were they demonstrated?

**O**bjectivity – how did you show that you were fair and impartial and non-discriminatory?

**M**inimise harm – what risks were involved and how did you minimise them?

**P**romote benefit- what good did you do in the situation and how did you know?

**A**utonomy- how did you show that you respected the person as an individual?

**S**uffering – were they suffering? If so how?

**S**ympathy – was this needed in this situation? How did you demonstrate this?

**I**ntegrity –how did you demonstrate this and how would an observer recognise it?

**O**ptimism- was it appropriate to be hopeful in this situation? How did you do this?

**N**on complacency- how might you develop what you have learned for the future?



### ACTION:

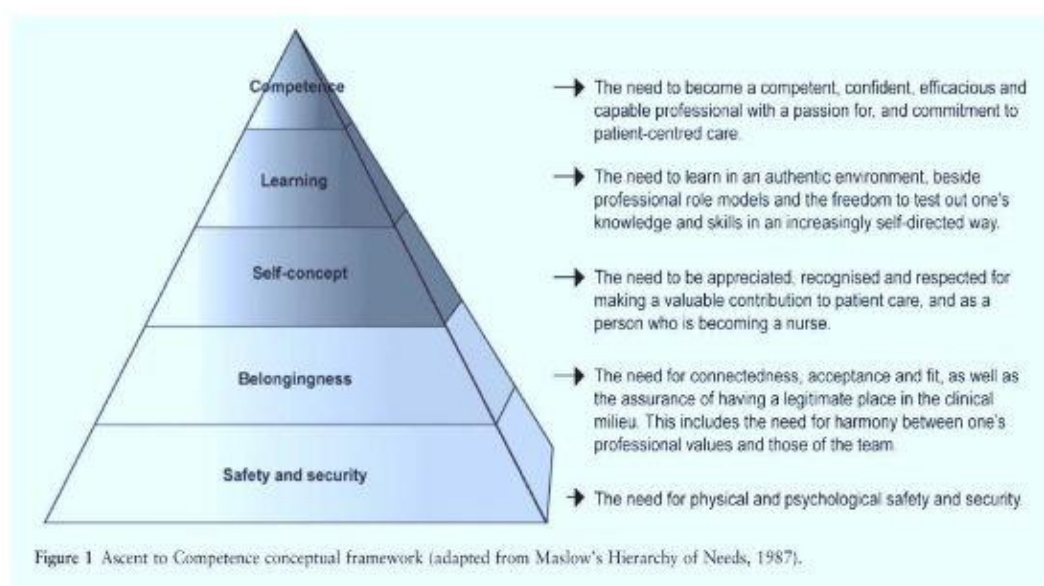
- Offer students the opportunity to participate in a social activity that involves the team. (i.e. Welcome morning or afternoon tea; after work activity)
- Nominate a "Social Champion" in the ward, possibly a graduate whose role it is to welcome students at start of placement



## Ascent to Competence

(Levett-Jones & Lathlean, 2009)

- Competence can only be obtained if all of these steps are in place
- A competent and confident student will reduce your workload



### ACTION:

- Identify if these needs are being met in your ward or unit area
- Discuss at team meetings to ensure each step can be met in your ward or unit area

## Patient Participation in the Student Learning Experience



### ACTION:

- Encourage patient involvement in educating the student, let them relate their patient journey to the student in their words involving their families.
- Ask patients to comment on the Person Centred Care given by the students, using the model of **ALWAYS\*** to guide their responses on the attached form. Use this feedback when completing assessment of student performance.



\* Adapted from FHHS CAC & Always Events, The Pickering Institute, 2009.

## **Patient Centred Care given by the Student**

It would be really appreciated if you could take a few minutes to complete these questions. This helps us to support the learning of our students.

1. Did .....introduce his/herself to you?	
2. How did ..... describe their role?	
3. What do you think ..... learnt from you?	
4. Did ..... display listening ability and act accordingly? How was this demonstrated?	
5. How did ..... show respect and compassion during your care?	
6. Were you addressed appropriately at all times?	
7. Was ..... able to support you when communicating with other nurses or doctors? If so how?	
8. How well did ..... communicate with your family members or carers?	

Thank you for taking the time to support our students.

# Team



- **Coordination:** Team members talk and provide each other with necessary information
- **Cooperation:** Team members negotiate and plan to minimize duplication/ensure resource efficiency
- **Collaboration:** Team members interact, negotiate and jointly work with each other.

(Adapted from World Health Organisation (2010) Framework for Action on Interprofessional Education & Collaborative Practice, Health Professions Network Nursing & Midwifery Chair, Geneva 19/5/15)



Who do you collaborate most closely with on the team?	
How do you work to establish and maintain relationships?	
How do you see your relationship with recent students?	



## ACTION:

- Support and encourage the use of the "Attitude and Readiness for Students" tool at the team meetings.



## PREPARATION FOR STUDENT INCLUSION INTO AN APPRECIATIVE LEARNING CULTURE



**ACTION:** Complete the following form by just ticking the appropriate boxes

- What aligns with your work area?
- Note an **ACTION** that can make a positive change and **DISCUSS** at Team Meetings

**Attitude and Readiness for Students to work within the Team**

<b>Goal</b>	<b>Absent</b>	<b>Questionable</b>	<b>Adequate</b>	<b>Effective</b>	<b>Action</b>
Management provides a positive environment and gives support to staff to understand how best to manage students effectively and positively in the ward/unit					
<b>Goal</b>	<b>Absent</b>	<b>Questionable</b>	<b>Adequate</b>	<b>Effective</b>	<b>Action</b>
Continual learning and development for precepting is part of the team culture					
<b>Goal</b>	<b>Absent</b>	<b>Questionable</b>	<b>Adequate</b>	<b>Effective</b>	<b>Action</b>
Senior staff clearly demonstrate an expectation of staff to allow students more autonomy					
<b>Goal</b>	<b>Absent</b>	<b>Questionable</b>	<b>Adequate</b>	<b>Effective</b>	<b>Action</b>
Time and people are committed to an appreciative learning culture					
<b>Goal</b>	<b>Absent</b>	<b>Questionable</b>	<b>Adequate</b>	<b>Effective</b>	<b>Action</b>
Contribution by both staff and students to share their learning experiences and reflections and to voice their ideas is welcomed and trusted					

**Structures and Supports for Students to work within the Team**

<b>Goal</b>	<b>Absent</b>	<b>Questionable</b>	<b>Adequate</b>	<b>Effective</b>	<b>Action</b>
A place to put student belongings, plus a space on a notice board for notes and suggestions from staff has been sourced					
<b>Goal</b>	<b>Absent</b>	<b>Questionable</b>	<b>Adequate</b>	<b>Effective</b>	<b>Action</b>
Tools and resources (i.e. Welcome notepad, poster, computer access time) are available					
<b>Goal</b>	<b>Absent</b>	<b>Questionable</b>	<b>Adequate</b>	<b>Effective</b>	<b>Action</b>
A "GO TO" person has been nominated in the work environment to advocate for students and support inclusion into the team					
<b>Goal</b>	<b>Absent</b>	<b>Questionable</b>	<b>Adequate</b>	<b>Effective</b>	<b>Action</b>
Staff are educated and prepared to be engaged and comfortable with students who present with difficulties or inadequacies					
<b>Goal</b>	<b>Absent</b>	<b>Questionable</b>	<b>Adequate</b>	<b>Effective</b>	<b>Action</b>
Contributions to student education and support are recognized and celebrated by all the team					

# Encourage



## KNOWLEDGE TO ACTION (SUPPORT TOOLS)

### Opportunities during Student Placement



#### ACTION:

Enable a student to be able to demonstrate appropriate autonomy with a person-centred approach

1. Allocate an appropriate caseload using the Traffic Light System (Russell et al, 2012) on page 22 to broaden experience and increase autonomy with patient input.
2. Identify and share information with colleagues about patients with suitably complex needs for student learning at handovers or team meetings.
3. Share these actions with other members of staff on different shifts to ensure continual support for the students.
4. Encourage students to set goals of achievement for themselves with your advice and support.



## Support Autonomy with Safe Practice

(Acknowledgement to K. Russell et al. 2012)

The following table is a guide to the clinical knowledge, skills and behaviours that students may be able to perform in your clinical area. However, prior to delegating responsibility the student and the supervisor should consider the students:

- Stage of training (year, previous placements, previous experience related to the delegation)
- Appropriate level and amount of clinical duties
- Feedback from other colleagues regarding student competence
- Level of competence
- Level of knowledge skills and communication skills

<p><b>Indirect Supervision</b></p> <p>"Is when the supervisor works in the same facility or organisation as the supervised person, but does not constantly observe their activities"</p>	<p><u>What can students be delegated to do under indirect supervision?</u></p>
<p><b>Direct Supervision</b></p> <p>"Is when the supervisor is actually present and personally observes, works with, guides and directs the person being supervised"</p>	<p><u>What can students be delegated to do under direct supervision?</u></p>
<p><b>Observation Only</b></p> <p>Students may not be able to take part in most activities because of regulatory standards or organisational policy. We will also consider their own abilities</p>	<p><u>What are students only able to observe?</u></p>



### ACTION:

- Discuss with student the use of this tool and how it can be applied to them.
- Encourage the student to keep this as a record to enable them to progress during the clinical placement.

## Encourage Student Involvement



### ACTION:

- Encourage students to design posters or handout leaflets for your ward or unit area to:
  1. Tell patients of the value of student learning
  2. Alert staff to student schedules and arrivals
  3. Identifying what they need to achieve and at what stage
- Encourage students to openly identify and research on an issue or area of practice to be improved on the ward, offering solutions to be presented to staff either at team meetings or handovers.



- Share learning experiences by creating a regular Journal Club - invite students, staff and university staff to discuss and share experiences and information to understand each other's perspectives.

# Delight



## Making a positive difference



- What was good about it?
- What difference did you make to the Student?
- Share why you acted that way with colleagues and other wards or units
- What values were involved?
- How might you develop what you have learned for the future?

(Cultivating Compassion, J. Montgomery et al. 2016)



### ACTION:

- Acknowledge each other for a job well done in improving your clinical area as a learning environment
- Acknowledge the students for their contribution

## References

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## Appendix 21: The Toolkit Assessment Form



Promoting Student Belongingness: The development, implementation and evaluation of a toolkit for nurses.

The toolkit has been created with the intention of assisting and supporting health professionals to generate a welcoming and supportive learning environment for students on clinical placement thus enabling them to belong to their chosen profession. The goal of the WANTED toolkit is to provide resources for nursing staff to better support their needs and wellbeing during the clinical placements to create a positive situation.

### Toolkit Assessment

Please answer the following **7 questions** and complete **the grid** to enable improvements to be made.

1. What features of the toolkit do you think work well and why? Please distinguish between content and structure.

*The student note book is fantastic and an excellent resource!  
Posters will also be great for quick reference on busy wards.*

2. What features of the toolkit do you think need changing? Why? What suggestions for improvement do you have? Please distinguish between content and structure.

*I like the toolkit "booklet" but do worry it will end up on a shelf as staff too busy. The posters, videos and student booklets will be important prompts to find the book/toolkit.*

3. Could the toolkit be utilised by your facility?

*Yes. We could incorporate into pre clinical placement reading materials.*

4. Would you recommend the toolkit to others?

Yes!

5. Please list any additional resources that you would suggest adding to the toolkit:

I think along with the videos,  
This toolkit is excellent.

6. Please note any further ideas to promote the toolkit to the clinical staff:

Incorporating as a mandatory inservice  
in areas scheduled to receive students.

7. Do you have any further suggestions or comments?

No

Rate the toolkit on elements listed in the table below by placing a tick or a cross in the appropriate box. Please provide any additional information in the respective 'Suggestions' sections to inform areas for improvement. You can fill out as many or as few of the sections in this form as you wish.

Toolkit Elements	YES	Variable	NO
The overall structure of the WANTED toolkit makes logical sense Suggestions:	✓		
It is clear what information is available in each section of toolkit Suggestions:	✓		
The content contains sufficient detail and is relevant to nursing staff supporting students Suggestions:	✓		

The additional recommended resources are useful Suggestions:	✓		
The language used is clear, simple, jargon-free and appropriate for nursing staff, patients and students Suggestions:	✓		
The pictures/graphics used compliment the written material Suggestions:	✓		
The toolkit appears to be easy to refer to when facilitating a student placement Suggestions:	✓		
I would use the toolkit for future student placements outside of the research period Suggestions:	✓		

Thank you for participating in reviewing the WANTED toolkit

Chris King  
PhD Candidate  
University of Notre Dame  
January 2017

## Appendix 22: Storyboard for Video—Promoting Student Belongingness

### Overview

#### *Clinical Placement*

#### Introduction:

This video is part of the WANTED toolkit developed to support nurses and managers in creating a learning environment that enables the student nurses to feel and be part of the team.

The clinical placement can be a very stressful experience for the Student, the Nurse and the Ward Manager. In this video, we want to show how, on various occasions, the experience affects these people from their perspective. This is not about criticism of the individuals, but is an honest look at how many feel. The scenarios have all been taken from real-life experiences of students, nurses and managers.

The tools in the WANTED toolkit have been designed to address the issues you will identify in this video to enable you as a preceptor or mentor to improve the experience of being with a student for both of you.

### Student Nurse Perspective—3 Settings

#### 1st Scenario: 30 seconds



#### *Background:*

First-year student about to embark on a clinical placement in a major hospital.



She has feelings of apprehension and concern about the environment she will be going to.

*Scenario:*

Student sitting in lecture theatre with other students looking apprehensive and contemplating the next few weeks—not really listening to the lecture.

*Venue:*

Lecture theatre with Lecturer—Carolyn Bulsara

*Action:*

Pan in on identified student singled out from the group.

Face into the camera.

*Voiceover (or animation) script:*

Student: Why do I want to be a nurse?

1. What will I be expected to do on a real ward?
2. Will I be able to cope with a real patient?

**2nd Scenario: 30–45 seconds**



*Background:*

Student now has to put into practice the theory she has learned at university. Safely walking a patient is different with a real person who is unwell than theory or role play at university.

*Scenario:*

Student walks with elderly patient with a Zimmer frame on the way to the toilet.

*Venue:*

Large Nightingale ward using main centre aisle. Equipment required will be a Zimmer frame.

*Action:*

Face to patient and then face to camera.

*Script:*

- Student: I know what to do, but sometimes the nurses don't want to know how I can help.
- Will the patients trust me to care for them?
- Patient: Such a caring young person, wish she had more time to talk to me, I'm sure I could help her.

**3rd Scenario: 45 seconds**



*Background:*

This is the chance to put theory to practice. It seems very straightforward in the classroom, but in real life it is scary.

*Scenario:*

A group of students gathered at the bedside with Clinical Supervisor being given the opportunity to check on the patient (i.e., observations, assessing cannula etc).

*Venue:*

New smaller ward using the middle bed to allow room for students and CF. Bed to be set up with patient, drip stand, BP machine and stethoscope.

*Action:*

A group of students stand around the bed, with one student checking patient as instructed. In the background, there is one student who distances her/himself slightly from the group, almost looking disinterested and not wanting to be there or noticed.

*Script:*

- A real patient at last, just don't want to mess up or look stupid. Perhaps if I stand back I won't be noticed or asked to participate, I just need more time.

**Registered Nurse Perspective—3 Settings****1st Scenario: 45 seconds***Background:*

The first nurse has been allocated a student; however, because of staff sickness, her patient load has been increased, and she is now concerned that with this extra load, how is she going to find time to make sure that she covers all the safe practices the student requires.

*Scenario:*

The nurse and student together preparing a drip. The nurse is demonstrating, but has a look of not really being happy with the situation as she has many other things occupying her mind (i.e., extra patient load, slowness of the student, irritation with the student's constant question-asking, getting out on time).

*Venue:*

Nurse (Katie) and student working at the end of the table in the large Nightingale ward. Equipment required will be a drip stand, infusions and lines, trolley, gloves.

*Action:*

Student and nurse working together to prepare an infusion. Nurse looking questioningly at the student as she may appear to not be getting on with the job. Student looks at lines and infusion with hesitation. The nurse shows frustration in her face and takes over the equipment in the student's hands.

*Script:*

- Nurse: Why is it always me that has the student?
- Can I be sure that this student knows what she is doing?
- I don't really have time to listen to the latest research. I could do this quicker without her.
- Student: I have done this several times before and feel confident to do this.
- It could help her workload if she didn't make me feel so nervous.

**2nd Scenario: 30 seconds***Background:*

The first nurse has little compassion or self-care for herself and is therefore struggling to show compassion for others.

*Scenario:*

The nurse (Katie) is showing signs of burnout as she is trying to be all things to everybody. She is not taking time out or even confiding in a friend or colleague. She is afraid of appearing incompetent and fearful of losing her job.

*Venue:*

An outside bench in the courtyard.

*Action:*

The nurse is sitting on an outside bench in a courtyard, possibly with head in hands, appearing unhappy and overwhelmed.

*Script:*

- How am I going to be able to continue to concentrate on the student (can't even remember her name). I need to go back home to Queensland to help Mum as she is getting so much weaker.
- Why do the family expect it to be me?
- I just want to get on with my job.
- I wish this student wouldn't keep insisting on doing things I'm not sure she is capable of.

**3rd Scenario: 30 seconds***Background:*

The second nurse does enjoy having students and is a good role model. She practices self-care and is positive in her attitude to students and finds that both she and the patients gain personally from the students' contribution to the team.

*Scenario:*

Nurse and student at the bedside engaging together in conversation with the patient. All three look relaxed in each other's company.

*Venue:*

New ward with patient sitting in the bed.

*Action:*

The nurse and student will be working together repositioning the patient while engaging the patient in conversation.

*Script:*

- Nurse: I see Clare (the student) is becoming more confident, and we are really enjoying working together.
- Today I made a difference to two people's lives: my patient and Clare my student.
- Her feedback to me has made me feel good about what and why I do it.
- Student: I want to come back here to work as a nurse. Nobody forgets to smile and say what a good job has been done.

**Nurse Manager's Perspective—1 Setting: 45 seconds***Background:*

While the manager agrees in principle to having students on the ward, she does not openly encourage her staff to make the students part of her team. She considers their placement a low priority in dealing with the day-to-day problems that arise on her ward.

*Scenario:*

The Nurse Manager (Kylie) is in her office and has not engaged with the students. Appears to be focused on the paperwork and is not able to disengage herself from it. Clinical supervisor tries to speak with her concerning the shortage of preceptors.

*Venue:*

Kylie's office with desk, books etc.

*Action:*

NM at desk with CS entering office. No real eye contact is made.

*Script:*

- NM: Yet another member of staff is off sick, I'm unlikely to get a replacement now.
- What can I do about the students if I have fewer staff available?
- Perhaps they can just read the notes and familiarise themselves.
- Maybe they should come and understand my job to realise the difficulties that arise on a busy ward.
- CS: Why don't managers realise that student nurses could become part of the team if they lead the way and encourage their staff to support autonomy with safe practice?

**Final Voiceover**

These scenarios have been used to highlight some of the difficulties we come across in the clinical setting on a daily basis. The WANTED toolkit is there to support and guide you when next you take action to present your student with a great clinical experience that will enable her/him to be part of the team.

Date of filming: 7 February at Notre Dame Clinical Laboratories

*Venues:*

- Large Nightingale Ward
- Smaller modern Ward
- Lecture classroom
- Courtyard
- Kylie Russell's office

*Players:*

- Six Notre Dame students
- First nurse: Katie Sutton
- Second nurse: Chris Adams
- Clinical Supervisor: Darren (ND)
- Nurse Manager: Kylie Russell
- Two patients: Chris Adams' parents

*Equipment*

- Blood pressure monitors
- Drip stand
- Bags of fluid
- Trolley
- Zimmer frame
- Uniforms or scrubs



## Appendix 23: Submission for ANZAHPE Conference



## SPEAKER PRESENTATION ABSTRACTS (CONT)

**ID: 12658**

**Title:** The Quality of Clinical Supervision. Should Clinical Supervisors be Employed by the Hospitals and Care Providers Rather than Educational Institutions

***Mrs Christine King***

### **Introduction/Background**

Are we short changing our students? When considering the following; evaluation and feedback received, anecdotal evidence from students of poor clinical supervisor attendance and input, a lack of understanding by ward staff of assessment requirements, plus poor performance issues of graduates after completing their training and education, questions must be asked about the quality of clinical supervisors in regards to their performance and capability. However, there is no register or recording of competencies as to the expertise, time management, hands-on performance, teaching ability and commitment of those entrusted with this role in our hospitals, to ensure compliance with the competency framework. University lecturers educating on campus are required to have qualifications, expert skills in educating as well as clinical skill sets, however when a student is in the actual clinical setting in hospital, where certain essential skills can only really be taught and assessed, there is a distinct variance as to the educating abilities of the clinical supervisors deployed by the universities.

### **Purpose/Objectives**

The Purpose is to discuss a workable model that will enable the hospital to have greater control and confidence in the quality of clinical supervision of students, provided in their facility.

### **Issues**

Comparing the theoretical role of the clinical supervisor (Project Plan National Clinical Supervision Competency Framework 2011) and the reality of the provision of clinical supervision in the setting of a public hospital, should we be concerned enough to support the idea that a clinical supervisor role be on the hospital payroll, managing student learning, championing clinical skills and encouraging student recruitment and retention.

### **Ideas for discussion**

Qualifications/career pathways for clinical supervisors. Accountability and performance management of clinical supervisors. Financial support from universities to hospitals to support their role as an educational facility.

## Appendix 24: Certificate of Nursing & Midwifery Leadership Conference



THIS IS TO CERTIFY THAT

**Mrs Chris King**

Presented at the Nursing and Midwifery Leadership Conference 2015

**Presentation Title**

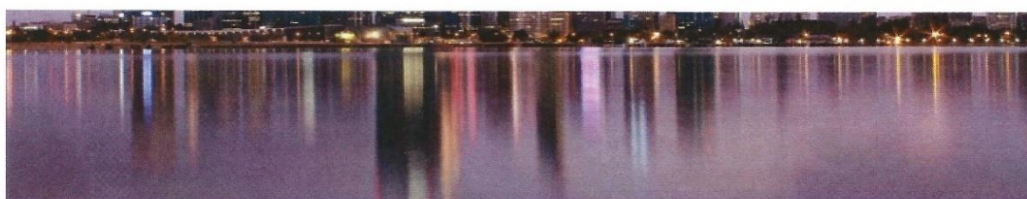
*Promoting Student Belongingness: The development, implementation and evaluation of a toolkit for nurses*

A handwritten signature in black ink that reads "K. Bradley".

**Karen Bradley**  
*Chief Nurse and Midwifery Officer*  
WA Nursing and Midwifery Office



Government of Western Australia  
Department of Health  
Nursing and Midwifery Office



# Appendix 25: Getting to the Heart of Nursing & Midwifery Research

Getting to the Heart  
of  
Nursing &  
Midwifery  
Research  
at  
The University of  
Notre Dame



**Program of Events**

Friday 3 June | 12pm



Fremantle

Broome

Sydney

## *Chris King*

**Title:** Promoting Student Belongingness: The development, implementation and evaluation of a toolkit for nurses (PhD Study)

**Author:** Chris King

**Organisational affiliation:** School of Nursing & Midwifery, The University of Notre Dame, Australia

### *Background and Aim*

Literature suggests that the need to belong to a community influences health and well-being, which in turn affects behavioral, emotional and cognitive responses. However student nurses are often in a vulnerable position of being excluded intentionally or otherwise from ward/unit activities leading to feelings of isolation and poor achievement.

The aim of this study is to design and develop a toolkit for nurses using data extracted from a series of rounds conducted with a Delphi panel. It will then be distributed to selected clinical areas for use during periods of clinical practicum for students and evaluation of its applicability, usefulness and sustainability will be conducted.

### *Method*

A sequential mixed method is used which employs the results of the initial qualitative phase to inform the subsequent quantitative phase.

### *Results so far*

Two rounds of questionnaires using the Delphi method have been completed with themes emerging to inform the framework for the toolkit.

### *Discussion/Conclusion*

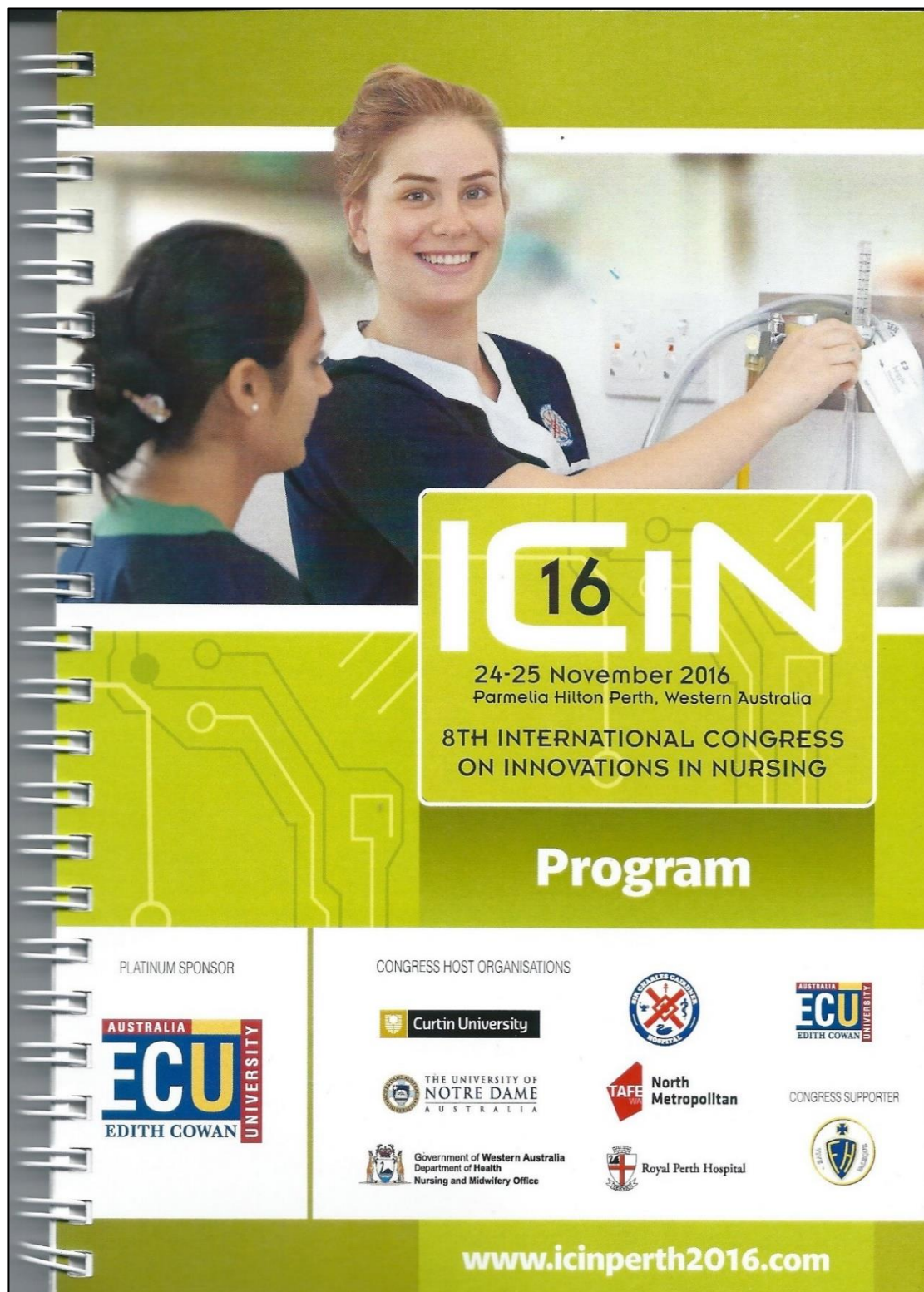
Addressing the issues of student integration into the nursing team and creating a belongingness environment with the use of practical tools, will give an opportunity to optimise student learning in the clinical setting.

### *Key nursing/midwifery messages*

The developed toolkit will encourage and enable a fundamental shift in attitude towards students by taking into account individual personal values and characteristics, the impact of the direct environment, along with the need to belong in order to create a learning environment.

## Appendix 26: International Conference of Innovative Nursing

### Submission



**ICIN 16**

24-25 November 2016  
 Parmelia Hilton Perth, Western Australia


**8TH INTERNATIONAL CONGRESS  
 ON INNOVATIONS IN NURSING**


**Program**


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CONGRESS SUPPORTER



[www.icinperth2016.com](http://www.icinperth2016.com)

## Abstracts

Thursday 24 November

1535 - 1655

Session Details:

Research

Fremantle Room

**Presentation Title:** Promoting Student Belongingness: The development, implementation and evaluation of a toolkit for Nurses

**Presenter:** Christine King *The University of Notre Dame*

**Presentation Time:** 1555 - 1615

**Background/Introduction:** For this PhD study the literature review suggests that the need to belong to any given community influences health and well-being, which in turn affects behavioural, emotional and cognitive responses. However student nurses are often in a vulnerable position of being excluded intentionally or otherwise from ward/unit activities leading to feelings of isolation and poor achievement. A toolkit is being designed and developed from data extracted from a series of rounds conducted using the Delphi method. It will then be distributed to selected clinical areas for use during periods of clinical practicum for students and evaluation of its applicability, usefulness and sustainability will be conducted.

**Purpose of presentation:** The purpose of this presentation is to demonstrate the research undertaken so far as well as the significance of this project. It will also illustrate the proposed design of a framework for a relevant and practical 'belongingness' toolkit for nurses working in the clinical practice setting.

**Methods/Intervention/Activity:** The research strategy is a sequential mixed method which consists of two distinct phases, qualitative and quantitative research. The aim is to employ the results of the initial qualitative phase to inform the design of the toolkit and subsequent quantitative research phase.

**Results/Outcome:** The results from the Delphi panel questionnaires have produced thematic data which have informed the construction of a framework to design individual tools to be collectively implemented in the clinical area.

**Discussion/Conclusion:** By addressing the issues of student integration into the nursing team and creating a belongingness environment with the use of practical tools, there will be an opportunity to optimise student learning in the clinical setting. The developed toolkit will encourage and enable a fundamental shift in attitude towards students by taking into account individual personal values and characteristics, the impact of the direct environment, along with the need to belong in order to create a learning environment.

## Appendix 27: Submission for 6<sup>th</sup> World Nursing & Healthcare Conference

conferenceseries.com

Chris King, J Nurs Care 2016, 5:4(Suppl)  
http://dx.doi.org/10.4172/2167-1168.C1.019

# 6<sup>th</sup> World Nursing and Healthcare Conference

August 15-17, 2016 London, UK

### Promoting student belongingness: "Wanted" - The development, implementation and evaluation of a toolkit for nurses

**Chris King**  
University of Notre Dame Australia, Australia

This presentation will illustrate the research method and toolkit development process of a PhD project undertaken for the purpose of supporting and guiding nursing staff to create a sense of belonging to the team, for students undertaking clinical placement. Literature suggests that the need to belong to any given community influences health and well-being, which in turn affects behavioural, emotional and cognitive responses. However student nurses are often in a vulnerable position of being excluded intentionally or otherwise from ward/unit activities leading to feelings of isolation and poor achievement. The toolkit is to be developed from data extracted from a series of rounds conducted using the Delphi method. The toolkit will be distributed to selected clinical areas for use during periods of clinical practicum for students and evaluation of its applicability, usefulness and sustainability will be conducted. For the purpose of this study, the research strategy is a sequential mixed method which consists of 2 distinct phases, qualitative and quantitative research. The aim is to connect the results of the initial qualitative phase to the design, implementation and evaluation of the subsequent quantitative phase. The significance of this research lies in designing a relevant and practical 'belongingness' toolkit for nurses working in the clinical practice setting. It will encourage and enable a fundamental shift in attitude towards students by taking into account individual personal values and characteristics, the impact of the direct environment along with the need to belong in order to create a learning environment.

#### Biography

Chris King is a Registered Nurse for both adult and paediatrics and has worked in many roles during her nursing career including in intensive care. She has worked as Primary Health Manager, Regional Manager in Aged Care, Clinical Facilitator for Edith Cowan University Western Australia and now as Unit Coordinator for the Training Centre for Subacute Care WA. With an interest in undergraduate nursing education she is undertaking her PhD and has presented at conferences at Melbourne and Perth Australia. She is awaiting confirmation of a publication of her work on the development of a toolkit for nurses.

cking2@inet.net.au

#### Notes:



**conferenceseries.com**



DATAFLOW

*World Nursing 2016*  
*Young Researchers Forum*

Prof/Dr/Mr/Ms. **Chris King**

University of Notre Dame, Australia

for presenting the oral entitled

***Promoting student belongingness: "Wanted" - The development, implementation and evaluation of a toolkit for nurses***

at the "6<sup>th</sup> World Nursing and Healthcare Conference"  
held during August 15-17, 2016 in London, UK

The award has been attributed in recognition of research paper quality, novelty and significance.

*Heather MacDonald*

Heather Macdonald  
University of New Brunswick, Canada

## Appendix 28: 12<sup>th</sup> National Nurses Education Conference

Reply Reply All Forward

### FW: NNEC 2018 - Abstract Submission Outcome

C King [cking2@iinet.net.au]

To: King, Chris

Monday, 8 January 2018 12:35 PM

You replied on 9/01/2018 10:29 AM.

From: EventsAIR [mailto:no-reply@eventsairmail.com] On Behalf Of NNEC 2018 Conference Secretariat  
Sent: Friday, 22 December, 2017 6:13 AM  
To: Chris King <cking2@iinet.net.au>  
Subject: NNEC 2018 - Abstract Submission Outcome

<<https://az659834.vo.msecnd.net/eventsairaeuprod/production-dcconferences-public/66244e78a80e400b915767c480510fff>>

Mrs Chris King  
University Of Notre Dame Australia

Friday, December 22, 2017

Dear Chris,

Thank you for your abstract submission for the 2018 National Nurse Education Conference (NNEC 2018), being held at the Crown Promenade Melbourne, from the 1-4 May 2018.

Abstract Submission Details

The NNEC 2018 Scientific Program Committee are delighted to advise you that the following abstract submission has been selected for inclusion in the 2018 program.

Title

Promotina Student Belonainness: The development, implementation and evaluation of a toolkit

## Appendix 29: Scholarly Paper Published in AJAN

**From:** C King <cking2@inet.net.au>  
**Sent:** Tuesday, 7 March, 2017 7:38 PM  
**To:** King, Chris  
**Subject:** FW: AJAN Volume 34:3

**Follow Up Flag:** Follow up

**Flag Status:** Flagged

**From:** Ajan [mailto:ajan@anmf.org.au]  
**Sent:** Tuesday, March 7, 2017 8:58 AM  
**To:** Ajan  
**Subject:** AJAN Volume 34:3

Dear Authors,

I am writing to advise that your manuscript has been published in the current edition of AJAN, Volume 34 Issue 3. This edition is now available on the AJAN website ([http://www.ajan.com.au/ajan\\_34.3.html](http://www.ajan.com.au/ajan_34.3.html)). Would you please advise your co-authors where appropriate.

I would like to thank you for your patience and assistance with finalising this edition.

Regards,

Anne Willsher | AJAN Administrator | Canberra

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## Promoting student belongingness: 'WANTED' - the development, implementation and evaluation of a toolkit for nurses

### AUTHORS

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### KEY WORDS

Belongingness, clinical environment, toolkit, nurses, student nurses, Delphi method.

### ABSTRACT

**Objective**

Literature suggests that the need to belong influences health and well-being, behavioural, emotional and cognitive responses. This paper describes the impending development and validation of a toolkit for nurses to create the experience of belongingness with a team approach, for student nurses undertaking a clinical placement.

**Setting and Subjects**

The design of the toolkit will be developed from a selected Delphi panel process involving nursing experts' experience and opinions. The toolkit will then be distributed to nurses in selected clinical areas for use during periods of clinical placements.

**Primary Argument**

Clinical placements are essential for professional socialisation in which nurses provide compelling role models for how to think, feel and act. However, students have often identified a sense of alienation through poor clinical experiences. The need to belong and be part of a team exerts a powerful influence on cognitive processes and behavioural responses. The absence of meaningful interpersonal relationships can result in failure to develop optimal clinical reasoning and critical thinking skills to manage patient care safely.

**Conclusion**

More needs to be achieved than to simply justify the core attributes of a good clinical learning environment. Understanding of the key role that clinical leaders and supervisors exert to create a belongingness environment can influence positively the attitude of other staff towards students. For a valued positive clinical learning experience to become the benchmark of best practice, it requires a structured process, a toolkit to enable nurses to comprehend the concept of belongingness and to support them in embedding this model into their role of supervision.

## INTRODUCTION

A positive clinical learning environment is essential to effectively provide the opportunity for students to integrate theoretical knowledge into nursing care. In preparing them for a practice-based profession, many complex issues influence their learning experiences, not least the attitude and empathy that clinical nurses have towards supporting the nurse/student relationship. While numerous evidence exists on the experiences of nursing students which range from supportive to challenging and concerning, the focus of this research is to develop practical strategies in the form of a toolkit which will assist registered nurses to actively engage in managing the clinical learning environment in a positive manner. The purpose built toolkit can be described as a suite of interactive strategies, resources and processes designed for and around key activities such as orientation, legitimisation of the student role and informal social inclusion strategies that will guide nurses in providing an effective, sustainable and inclusive environment both now and into the future.

## BACKGROUND

The challenges confronting the Australian healthcare system are widely acknowledged in many global publications and included among other things, an ageing population and workforce with a constricting labour market. More advanced technical and medical possibilities and limited financial resources are emerging global trends. The identified problem of attrition in nursing student programs has raised international anxiety for the future and the workforce development targets (Hamshire et al 2012; HealthWorkforceAustralia 2012).

Health Workforce Australia (HWA) Act in 2009, identified as one of its functions, a need to provide other support for the delivery of clinical training for the purposes of the health workforce (HWA WA Act 2009). The Clinical Supervisor Support Program Discussion Paper for Health Professionals (Health Workforce Australia 2010) confirmed that whilst health and education establishments were endeavouring to achieve appropriate placements, there was still remaining confusion regarding the role of the supervisor leading to, in some cases, a less than acceptable environment. An integral initiative for improvement proposed was the implementation of effective supervision through support and education for all staff.

Hospitals are sociologically rich places with a complexity of cultures which are often hard to understand for the outsider and even harder to change. Price (2009) maintains that early socialisation experiences, such as exposure to romanticised views of nursing, may cause angst for many students as assumptions and expectations of their chosen profession are not realised in actual practice. Specifically, there is often a mismatch between perceived and preferred expectations resulting in lost opportunities to engender safe practice, to build sound clinical judgement and to thereby develop professional identity.

Brown et al (2011) maintain there has been limited research evaluating the clinical learning environment (CLE) from the holistic approach of relating the perspective view of students. Instead the literature concentrates repeatedly on the significance of the immediate environment in how and what students do (Henderson et al 2012). However, O'Mara et al (2014) found that whilst interviewing students, two main sources of concern were identified in the CLE. One area of concern was the relationship with others and the challenge for students this presents in building a bond with the clinical staff. The second challenge identified was the context in which their learning experiences occurred; the timing, the amount and type of clinical experience which impacts on their learning and on them as individuals. Conversely, elements identified that were highly valued by the students as being positive for a successful clinical placement were a receptive welcome, appreciation, autonomy and recognition, support, and quality of supervision (Brown et al 2011).

## DISCUSSION

Supportive learning relationships are key for nursing students to feel they have a place in the team. This not only includes the supervisor/supervisee relationship but also a sense of group belonging within the clinical environment (Henderson et al 2012). Findings from focus group interviews throughout the literature suggest students who are supported with a positive attitude are able to support each other in clinical placements and can thereby reduce feelings of social isolation, reduce feelings of incompetence and actively create a heightened sense of readiness (Christiansen and Bell 2010). The absence of meaningful interpersonal relationships has been identified as a barrier to developing higher order clinical skills amongst students. Levett-Jones et al (2007) maintain this can lead to an increase in associated behaviours such as unquestioning agreement with another's decision and resulting in failure to develop clinical reasoning and critical thinking skills to manage patient care safely.

Success for improved clinical placement experiences is dependent upon a number of factors, one of which is the development of effective interpersonal relationships between all stakeholders (Levett-Jones 2007). Further research is required to explore methods to support and recognise the need of registered nurses in their supervision role and that belongingness needs to be actively fostered before valuable and prospective members of the healthcare community are lost to other professions (Levett-Jones et al 2008).

A recent report by the Department of Health Victoria (Victoria, DOH 2014) indicated that clinical staff required both clear instruction and tools to assist them in their supervisory role. While there is an awareness of accountability and responsibility for students by nurses generally, the role appears to be understood in varying degrees. Hence there is potential significance in designing a relevant and practical 'belongingness' toolkit. Despite substantial past research into student clinical learning environments, specific studies from the psychological educational perspective are very limited. Many researchers agree that more needs to be done than simply justify the key attributes of a good clinical learning environment (Chan 2001).

Recommendations for practice have been proposed by Levett-Jones and Lathlean (2009) for ascent to competence. They maintain the key role for clinical leaders and supervisors is to create an environment of belongingness and to influence positively the attitude of other staff towards students. This approach will thereby promote dialogue and debate on professional issues. However, from the health professional's perspective, belongingness is not clearly defined, nor understood. A common example is demonstrated in the practice of orientation before the start of a clinical placement. Often much time and effort is placed on the orientation process in many organisations, however this process is often based around the physical environment and not the psychosocial one, which could promote a sense of belongingness to the organisation. Therefore providing a purpose driven toolkit based on current research could encompass activities that will support busy staff, lead to a student-friendly culture and enhanced satisfaction and morale (Cleary and Walter 2010).

## THE FRAMEWORK OF A 'WANTED' TOOLKIT

**Welcome** – legitimisation of the student role

**Attitude** – compassion for self and students

**Nurture** – encourage sociable exchange

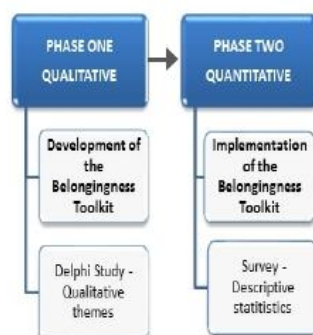
**Talk** – involve in ward and work discussion

**Encourage** – appropriate autonomy for completion of tasks

**Delight** - in a supportive relationship and success

This framework is the foundation on which it will be possible to build a research based, creative and realistic method of how best to support nurses creating a belongingness environment. In the course of the design of this toolkit, both qualitative and quantitative methods will have been used as a mixed method model, which will provide a more holistic approach. This methodology will deliver wider exploration of the social, philosophical and ethical issues related to belongingness in clinical placements and will encourage the use of one type of investigation to inform the development of another. In comparison to previous work based on the learning environment in which the value of the studies lay in the resulting implications for nursing education (Levett-Jones and Lathlean 2009; Chan 2001), this methodology will go one stage further to produce a practical instrument whose value could be in supporting the provision of better educational experiences and environment.

**Figure 1: Sequential Mixed Methods Design (Creswell et al 2011)**



For the initial stage of this study the Delphi technique was employed for the collection of expert opinion to refine assumptions, options and supporting evidence within given areas (Wilkes et al 2010). The aim was to achieve convergence of opinion for tool development and then attempt to address what could/should be in creating an environment of belongingness. The Delphi technique has been used previously for the development of assessment tools in health (Biondo et al 2008).

The panel for the Delphi method consisted of a number of subject-matter experts. The criteria for deciding who was the most appropriate did not only rest on knowledge of the subject, but also personal experiences, which is essential to understanding the socialisation of the nursing culture. An inclusion criteria checklist was created to identify potential experts for the Delphi panel both nationally and internationally (with an understanding of Australian education and health care practices). A comprehensive report of the collective data and a template for the toolkit will be prepared and submitted to the panel for feedback.

The design of the toolkit is based on the findings from the Delphi study which involved a panel of eighteen experts. From three rounds of questionnaires that were conducted over a six month period using a survey tool and qualitative software, nine major themes have emerged. These have proved to be similar to the views expressed by students in the literature identifying a positive learning environment. These themes have been used to develop the framework. However, the useability and sustainability can only really be assessed over a period of time by those trialling the WANTED toolkit prototype. This will require surveys using pre and post implementation questionnaires. Using descriptive statistics to summarise the pattern of responses of participants will indicate the overall performance of the toolkit in the selected clinical areas. It would be ideal for the pre questionnaire to include demographic details such as age, sex, designation (EN/RN/CN), years of nursing and nursing education (university/hospital based). This could provide further analysis of findings



against these demographic parameters which, may provide interesting findings and ramifications for the future and support the successful expansion of the toolkit into other clinical areas.

Given that nurses are often time poor and may be supporting students on a continual basis throughout the year, serious consideration must be given to ensuring this initiative does not add to further paperwork or load. Instead by putting strategies into place that will enable the student to become more autonomous it could reverse the role so the student is supporting the nurse, facilitating the development of trust.

### CONCLUSION

There is considerable evidence that many students have experienced poor clinical placements, where they did not establish a rapport with the clinical team and were treated disrespectfully (Hamshire et al 2012). Much has been written in psychosocial research identifying the consequences of exclusion from groups. Society usually associates hospitality with culture, a social practice, a more personal quality to be admired. However in our western culture individualism and the need to feel safe and secure from a perceived hostile environment seems to be a priority that translates into our work through exclusion, or fear of involvement. Conversely important behaviour activities of cooperation and maintaining harmonious relationships within the group do allow a greater success rate in all areas of life.

A popular definition of belongingness (Levett-Jones et al 2007) is described as the need to be and the perception of being involved with others at differing interpersonal levels, a need for self-esteem which contributes to one's sense of connectedness. However from students' perspectives described in the literature it is apparent they are often overwhelmed by the magnitude of their surroundings in the health care setting, but are compelled to integrate and belong. This unfortunately often proves difficult and impacts on their ability to become competent (Levett-Jones et al 2008). It is therefore evident from previous research that in order to function effectively a sense of belongingness is a prerequisite of successful professional and clinical development. Nonetheless and perhaps regrettably, from a nurse/student perspective, belongingness is not clearly understood by many clinicians.

The art of creating belongingness in the clinical environment is to discover the means and new possibilities for staff to encourage students to be part of their community or team. A positive learning experience can only be gained through not complex, but simple principles that should be part of daily life. The strong need to 'belong' has been recognised by early societies who lived in environments where survival and the continuation of the next generation were reliant on cooperative group members. This concept is no less important for the nursing profession. Therefore, when looking for a practical solution, straight forward strategies are often the most effective. The problems are known, solutions are needed.

Ultimately, the focus of this paper is not to establish if belongingness is necessary for enabling learning to take place, as this has been identified and documented extensively. The focus is rather to explore and pilot an initiative to address the problem. The challenge is the wider investigation of the social, philosophical and ethical issues related to belongingness in clinical placements and establishing a toolkit that will have useability and sustainability to embed the key attributes of a good clinical learning environment into all clinical placements.

A qualitative study approach can be beneficial and improve understanding through the investigation of the underlying complex phenomenon of belongingness. Although this approach does not offer the rigour of clinical hypothesis testing, nonetheless it is a technique developed to facilitate deliberation on a problem, providing scientific methodology to aggregate informed opinion. Therefore every effort will be made to ensure that the toolkit will become the benchmark of best practice and that it will provide the key prerequisites for clinical leaders and supervisors to create a belongingness environment and to influence positively the attitude of other staff towards students.

## RECOMMENDATIONS

Although quality supervision is the key, nonetheless, it is still challenging for many nurses regardless of the fact they may have numerous years of clinical expertise. Indeed many supervising nurses, have very little or no teaching experience to be able to appropriately support the student (Carrigan 2012). Continuing to maintain learning on a day to day basis will be reinforcing and requires questioning, feedback, guidance, shared discussion and problem-solving. This has already proven to be worthwhile as increased time and energy spent in the initial development of the students produces positive long term benefits, not only to the clinical areas but also to the profession.

It is recommended that further research be undertaken after the results from the pilot studies have been collated identifying the usability and sustainability. This further research could be a longitudinal study to identify if there has been a significant change in the attitudes and behaviours of nurses to create an environment of belongingness and its influence on student learning.

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## Appendix 30: TRACS WA E-Bulletin



Government of Western Australia  
Department of Health



### MESSAGE FROM THE TRACS WA COORDINATOR

Dear Colleagues,

**We have a very full edition of this month's e-bulletin with interesting reports coming from Busselton, Kalgoorlie and Metro subacute care (SAC) teams demonstrating yet again the excellent work that is taking place state wide in SAC.**

After gaining a grant from the Workplace Learning Fund (WLF), Busselton Health Campus developed a 'Welcome to Rehabilitation' video with planning support from TRACS WA staff. The video is accessible for patients via the Patient Entertainment System to promote understanding of the rehabilitation program for both patients and new staff. It is also available on the [TRACS WA website home page](#).

With funding also from the TRACS WA WLF, a [three day visit to Kalgoorlie Health Campus](#) took place in April. Stroke champion and experienced clinician Jacqui Ancliffe presented training related to early mobilisation of people post stroke to allied health, nursing and medical staff (including Esperance via VC) together with talks on National Stroke Foundation guidelines and outcomes from AVERT.

The [Goal Setting project](#) originally proposed by the Speech Pathology department at Fremantle Hospital and funded by the WLF has been completed and a pilot study on V5 at Fremantle Hospital concluded under the leadership of Senior Physiotherapist Tanya Regan. Valuable resources have been developed and trialed and will soon be available under the resources section of the TRACS WA website.

The [Community of Practice \(CoP\)](#) held in May in partnership with Disability Health Networks concerning the interaction between Health and the NDIS was very successful; [PowerPoint and video presentations](#) are again available on the website.

As a centre for subacute care and rehabilitation training, TRACS WA is pleased to share

resources provided by local clinicians on our website. From Osborne Park Hospital we have received the [Occupational Therapy Rehabilitation Upper Limb Clinical Reasoning Guide](#). Thanks to Senior Occupational Therapist, Toni Heinemann and colleagues for allowing us to share this excellent tool with you.

The Australian Rehabilitation Nurses Association (ARNA) in partnership with TRACS WA will be [holding a study day](#) that will be open to all clinicians.

We would like to congratulate our Development Facilitator Helen McLean who was commended at the [Nursing and Midwifery Excellence Awards](#). A great night was had by all the TRACS WA team.

Following the departure of Dr Stephen Ford, we are delighted to [welcome Professor Osvaldo Almeida](#) (MD, PhD, FRANZCP, FFPOA) as one of our Medical Leads (Psychogeriatrics).

Finally, we are very sad to announce Sandy Dumas will be leaving TRACS WA after being with us for three and a half years. Sandy's knowledge, experience and commitment to building and delivering the SAC modules have been invaluable. We thank you Sandy and wish you all the very best. You will be missed!



Sandy in Albany ready to deliver TRACS WA Subacute Care training modules

Kind regards,



**Chris King**  
Unit Coordinator  
TRACS WA

## SUBACUTE CARE NEWS

### Featured – Busselton Health Campus 'Welcome to Rehabilitation'

Busselton Hospital patients, volunteers and staff recently had the opportunity to star in their own video production. It was all 'lights, camera, action' when the hospital was turned into a movie set for the day. Rehabilitation staff at the hospital received planning support and a grant from the TRACS WA Workplace Learning Fund, to produce an educational video for patients and their families coming to the hospital for rehabilitation after an accident, illness or surgery. A first in the state, the video aims to promote understanding of rehabilitation goals and the team involved in supporting patient recovery. It adds value to the written educational information currently available, and is easily accessible to all patients, their families/ carers and staff in a format that can be understood by those with differing literacy levels.

The video is accessible for patients of Busselton Hospital on the Patient Entertainment System at the bedside. It is also available on the [TRACS WA front page](#) under *TRACS Features*, or **directly** via [Youtube](#).

### News items

- [Welcome to Professor Osvakdo Almeida](#)
- [Improving goal setting – TRACS WA Workplace Learning Fund](#)
- [NDIS – Health Community of Practice - 7 May 2018](#)
- [Kalgoorlie Health Campus – TRACS WA Workplace Learning Fund](#)
- [Congratulations Helen!](#)
- [Caring for Aboriginal people in a person centred way – short videos](#)
- [Aboriginal Person Centred Care Module](#)
- [Aphasiology Symposium of Australasia 2018](#)
- [Introduction to Neurorehabilitation course](#)



## GET IN CONTACT WITH TRACS WA

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*"Interdisciplinary communication is where truly great ideas emerge"*

- Carl Seger

### TRACS WA

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