

**SUPPORTING THE STRUGGLING NURSING STUDENT
IN CLINICAL PRACTICE:**

A Qualitative Descriptive Study

A thesis submitted in partial fulfilment of requirements for the
Masters of Health Sciences

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KEY TO TRANSCRIPTS

The following information is the key to the abbreviations used within the research findings.

[]	Information added to clarify context or meaning
(---)	Words, phrases or sentences edited out
---	Pause present within the narrative
<i>Italics</i>	Participants' quoted narrative

GLOSSARY OF TERMS

Dedicated Education Unit (DEU) Model:- In this model of clinical teaching and learning, an Academic Liaison Nurse (ALN) from the education facility and a Clinical Liaison Nurse (CLN) from the clinical practice area support the learning of six to eight nursing students for the duration of that clinical placement. The CLN and ALN work collaboratively to facilitate and evaluate student learning, and complete the clinical assessment process.

Preceptorship Model:- In this model of clinical teaching and learning nursing students work with an allocated preceptor who is an experienced nurse in the clinical setting. The preceptor guides, supports and assesses the student in their clinical learning. The preceptor is supported in the role by the Clinical Lecturer from the education facility.

DEDICATION

This thesis is dedicated to two generations of my family

To my Mum and Dad thank you for the years of love and support and for being great role models of ‘they that work hard, reap the rewards’.

To our five grandchildren, Tessa, Ruby, Luke, Archie and Gus (and future grandchildren) Thank you for giving me lots of love and fun times through the challenge of this study. You are all great learners already and may you continue to enjoy learning throughout your whole life’s journey.

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ABSTRACT

Clinical practice experience can be challenging for the undergraduate student nurse. The clinical environment is unfamiliar and consistently changing. They may feel isolated or experience a fear of the unknown, and together with expectations of achieving learning outcomes, the student can feel overwhelmed. There is a paucity of literature in how to support the struggling student nurse in the clinical setting. This research utilised a descriptive design methodology to explore the experiences of 14 clinical lecturers who work alongside student nurses while on their clinical practice component of their nursing education programme. The aim of the research was to identify strategies that can be put in place, to support the struggling student nurse in clinical practice. However, for this aim to be plausible, it was also necessary to explore the issues that face the student in this environment. Findings showed; ineffective communication can be a result of low self-confidence, honest and timely feedback is necessary for personal and professional growth, and a lack of continuity in key clinical relationships can be concerning when a student nurse is having difficulty. Being able to identify early that a student nurse is struggling and offering the right support, can prevent a failed placement. Hearing the voice of the Clinical Lecturer has gained insight into potential clinical practice issues and when equipped with helpful strategies, the student nurse's learning will be positively supported towards a successful clinical practice experience.

CHAPTER ONE: INTRODUCTION

In New Zealand (NZ), the practice experience in the clinical setting is a fundamental component, in the journey of the undergraduate nursing student. For the Bachelor of Nursing (BN) student, this setting is where the world of nursing comes alive. Learning experiences within clinical practice present opportunities for the application and integration of theoretical knowledge and skills, together with the privileged opportunity of developing therapeutic relationships that are patient-centred (Levett-Jones & Lathlean, 2008; Mannix, Wilkes, & Luck, 2009). The clinical placement experience is an exciting and well anticipated opportunity to become acclimatised to the professional practice of nursing. The student should expect to be supported by an experienced Registered Nurse who provides supervision and instruction. In a small number of NZ Nursing Education Facilities, a Clinical Lecturer (CL), is allocated to work alongside the student in clinical placement, providing support and facilitation of the learning (James & Chapman, 2010; Vallant & Neville, 2006).

The current clinical environment is dynamic. Health care is changing and becoming more challenging. Drivers of these challenges include: evolving technology, complex patient needs requiring higher acuity of care, pressure on beds resulting in decreased patient length of stay, and current trends in staffing. Particular staffing trends facing the NZ clinical landscape consist of an ageing nursing population, delays in staff recruitment, a failure to replace staff on leave, and overall, clinical areas being run with low core staffing levels (Kai Tiaki Nursing New Zealand, 2014; North, Leung, & Lee, 2014). These pressures, although not directly related to the student, affect the clinical environment the student has entered. This can alter student perception, resulting in the clinical placement being an area that is foreign and unfamiliar. A student entering this setting may experience a form of culture shock. Symptoms include personal disorientation, isolation, and possibly fear of the unknown (Duchscher & Cowin, 2004). The student is meeting and working with unknown staff who are an established team, carrying out personal cares for patients while improving their interpersonal skills, and getting formative/summative feedback on whether he or she is reaching the level of competency expected. This new experience during clinical placement may feel completely overwhelming to the student, who may then begin to struggle (James & Chapman, 2010; Mannix, Faga, Beale, & Jackson, 2006; Mannix et al., 2009; Peters, Halcomb, & McInnes, 2013).

My interest in this research stemmed from my experiences over a three year period of working as a CL alongside students. During this time I was involved in the decision to fail two year three nursing students who were in their final clinical placement. This left me with feelings of despondency for the students. I also experienced self-doubt which raised such questions as ‘Have I done enough to help this student?’ ‘What else had contributed to this final outcome, along the learning journey for these students?’ ‘What other earlier supports could I have put in place, to have prevented a failed placement?’

The Research Aim

This research has focussed on Clinical Lecturers (CLs) who work alongside the nursing students while on clinical placement. The CL monitors and assesses the nursing student’s attainment of course outcomes, and progress towards meeting the required level of competence of the Nursing Council of New Zealand (NCNZ) competencies. The CL will facilitate the learning/teaching process, in collaboration with the Registered Nurses (RNs), Charge Nurse Manager (CNM) and Nurse Educators, of the clinical area (Jamieson, Hale, Sims, & Casey, 2008; Nursing Council of New Zealand, 2012).

The aim of the research is to undertake a qualitative descriptive study to

Identify the strategies Clinical Lecturers can put in place, to support the struggling nursing student in clinical practice.

The Research Questions

1. What are the issues Clinical Lecturers identify, that face the BN student in clinical practice?
2. What strategies can Clinical Lecturers put in place, to support the struggling BN student while in clinical practice?

Background

Within the BN programme the NCNZ requires each nursing student to complete a minimum of 1100 clinical practice hours over three years (Nursing Council of New Zealand, 2014). The nursing student is assigned to a number of varied clinical practice settings. The students are expected to provide nursing care within the clinical context. This allows opportunity for the student to utilise the relevant skills and knowledge learnt in the academic setting to provide effective patient care within the assigned clinical setting.

The requirements of the clinical practice experience for the student include the progression towards, and the attainment of NCNZ Nurse Competencies for Registered Nurses. These competencies include four domains of practice: Professional Responsibility, Management of Nursing Care, Interpersonal Relationships, and Inter-professional Health Care and Quality Improvement (Nursing Council of New Zealand, 2012).

Domain One – Professional responsibility:- Competencies that link to ‘professional, legal and ethical responsibilities and cultural safety’. These comprise competent knowledge, and being responsible for one’s own actions and judgements, while endorsing an environment that sustains ‘health consumer safety, independence, quality of life and health’ (Nursing Council of New Zealand, 2012, p. 4).

Domain two – Management of Nursing Care:- This domain involves competencies, that are associated with the assessment and management of the health consumers care. As the consumer’s health needs change, the requirements for care and nursing interventions also change. This competency is underpinned by ‘nursing knowledge and evidence based research’ (Nursing Council of New Zealand, 2012, p. 4).

Domain three – Interpersonal relationships:- Domain three has competencies that relate with ‘interpersonal and therapeutic communication with health consumers, other nursing staff, and interprofessional communication and documentation’ (Nursing Council of New Zealand, 2012, p. 5).

Domain four – Interprofessional health care and quality improvement:- These competencies demonstrate that as a representative of the healthcare team, ‘the nurse evaluates the effectiveness of care and promotes a nursing perspective within the interprofessional activities of the team’ (Nursing Council of New Zealand, 2012, p. 5).

Throughout the undergraduate programme the student’s growth and development are assessed against NCNZ competencies discussed above. In the clinical practice setting, an RN will supervise the student’s progression towards attaining the competencies at different levels. The RNs and the CL together, will assess the student throughout each practice experience, utilising a clinical assessment form with indicators that align to the four domains. Alongside this, the student is to complete a self-assessment form. Both the clinical assessment form and the student’s self-assessment form are used at a formative assessment, which occurs at the mid-way point of the clinical placement. This is a valuable opportunity for both the RN, and the CL to provide feedback for the student on their

progress. A summative assessment will be completed at the end of the clinical placement. The student must pass this in order to progress and will be assessed for entry to the RN scope of practice, at the completion of their BN programme (Nursing Council of New Zealand, 2012, 2014).

Two other attributes that will contribute to meeting these competences are critical thinking and clinical decision making. Critical thinking involves ‘thinking professionally’ and embraces a process where, theories are challenged, evidence is assessed, and other solutions are recommended, thus reaching a place of informed decisions (Kaddoura, 2011). For student nurses to develop critical thinking skills, requires them to engage in discussions around case-based learning, or real life patient-centred problems. These opportunities occur in the clinical environment. It is here the student can identify the patient problems, and learn to access the appropriate resources collaboratively, in order to create possible solutions to these problems (Kaddoura, 2011; Pitt, Powis, Levett-Jones, & Hunter, 2012).

Clinical decision making is another important skill for the student nurse to develop, and again, clinical practice creates an ideal opportunity for growth. Clinical decision making, is about applying scientific and professional knowledge and skills to clinical practice. The student is supervised in clinical practice by RN/mentors. Through the RN/mentor role modelling, the student develops and acquires the skill of clinical decision making, and at the same time, learns the worth of reflection around the decision-making process (Bakalis & Watson, 2005; McNamara, 2015; Nursing Council of New Zealand, 2012).

During this research, two models of clinical teaching were identified, the Preceptorship model and the Dedicated Education Unit (DEU) model. The CLs interviewed may work in one or both of these models. A brief explanation will be given of both:

Preceptorship Model:- The student nurse works in the clinical setting with an allocated preceptor who is a RN. The preceptor acts as a role model for the student, while guiding, supporting, and assessing his or her learning. The preceptor is supported in this role, by the CL, whose responsibility is that of a facilitator, and the CL assists the student to make the links between theory and practice, and complete the clinical assessment process.

Dedicated Education Unit (DEU) model:- In this model, a Clinical Liaison Nurse, who is an experienced RN in the clinical practice area, supports the clinical learning of six to eight nursing students for the duration of a clinical placement. The Academic Liaison Nurse

employed by the Education facility, works collaboratively with the Clinical Liaison Nurse to facilitate and complete the clinical assessment process.

For the purpose of this project and to avoid confusion the term CL will be used throughout the discussion and represents both the CL from the preceptorship model and the Academic Liaison Nurse from the DEU model. The CL is employed by the Nursing Education facility, and works alongside the student while out in clinical practice.

If the nursing student is struggling to show clinical competency, there appears to be little research to guide the clinical educator in how to support them (Brown, Douglas, Garrity, & Shepherd, 2012; Diekelmann & McGregor, 2003; Elliott, 2016; Hunt, McGee, Gutteridge, & Hughes, 2016). It is acknowledged, however, that earlier identification and management of a struggling student is needed. The CL supports and guides student learning, whilst facilitating a clinical practice experience, where the student ideally, should feel secure to learn (Adelman-Mullally et al., 2013; Booth, Emerson, Hackney, & Souter, 2016; Brown & Sorrell, 2017; Carlson, Pilhammar, & Wann-Hansson, 2010).

This research will aim to investigate possible strategies to support struggling nursing students in clinical practice.

Structure of the thesis

This thesis consists of six chapters. Chapter one gives an overall picture of the importance of the clinical practice experience for the undergraduate student nurse, and provides a setting for this research. An overview of current literature where comparison and critique is discussed on both NZ and international literature is presented in chapter two.

Chapter three will discuss methodology and the choice of qualitative descriptive design that underpins this research. The methods used to answer the research questions will be identified in chapter four.

The main findings, in the form of themes will be presented in chapter five utilising participant excerpts from the interviews. Chapter six will discuss the findings and limitations of this research. The recommendations for education and nursing practice are also included in this chapter.

CHAPTER TWO: LITERATURE REVIEW

Introduction

A review of the literature was conducted to determine current knowledge about the struggles the nursing student faces when completing the clinical placement component of his or her undergraduate nursing programme. This literature review will include challenges that present to the RN and the CL, who provide the essential support that underpins the student nurse in this unfamiliar setting.

This chapter begins with a description of how the literature search was conducted and explains the selection of evidence. It gives a background to the search inquiry, discussing literature from three viewpoints, examining the different challenges that present for each, then recommending possible strategies to overcome those challenges. Gaps in the literature will be identified, that highlight the need for this research.

Literature Search Strategy

The aim of the search strategy was to compare both national and international literature gaining insight into the position of the New Zealand (NZ) setting, on which this research is based. The search was conducted electronically using databases Cinahl, Science Direct, Proquest and Academic Onefile. The search utilised Boolean mode and included articles in English language, peer reviewed and written within the last 15 years. The search terms included; 'clinical competence' or 'nursing student skill', 'struggling' or 'learning difficulty', and 'nursing student'. Other search terms used 'competence' or 'skill', 'attitude' or 'attrition' and 'nurse student'. This resulted in 83 articles, of which 27 were selected as being suitable. The articles deemed most useful due to their transferability to the NZ nursing context came from the United Kingdom, Canada and Australia. Literature from NZ was also included, however literature from the United States of America (USA) was excluded as not as transferable. Attention in the search was drawn to the challenges/issues facing the BN student in clinical practice experience, and the workable strategies to help with these challenges, as these relate to the overall aim of this research.

Evidence-based literature appraised, highlighted three clear viewpoints. The nursing student, the RN (clinical support role /mentor within the clinical practice area), and the CL (Clinical lecturer/educator from the nursing education facility).

Student Nurse Viewpoint: Outline

As the focus of this research is on the struggling student from a CL perspective, I did not interview nursing students. However, to set the scene, it is helpful to review literature from the student perspective.

Eick, Williamson, and Heath (2012), led a systematic review and confirmed the management of the theory-practice connection is championed worldwide as an education model for training future nurses. However, due to the fact that attrition from nursing is also a worldwide problem, Eick et al. (2012) examined specifically, the clinical-placement-related challenges behind this concerning trend. This review included 18 studies which were focussed on nursing education provided by Higher Education Institutions. The key purpose was to identify the reasons behind nursing students leaving their education programme. The review examined both qualitative and quantitative data and the design was checked against the Cochrane Handbook for Systemic Reviews. Ten of the 18 papers included student viewpoints into the disappointing placement experiences, and what they identified were the main reasons were for leaving the programme.

Placement-related issues included unpleasant experiences such as, 'negative staff attitudes' and the placement environment deemed to be, 'non-friendly to students' (Eick et al., 2012, p. 1306). What student nurses get confronted with according to Eick et al. (2012) are the everyday truths of nursing, reflected by demanding, busy clinical areas that have problematic staffing/resource issues to contend with and increasing amounts of documentation to complete.

A narrative study of 16 nursing students, carried out by Hamshire, Willgoss, and Wibberley (2012) confirmed similar outcomes to that of Eick et al. (2012). Nursing students who had discontinued their programme shared incidents of unsatisfactory clinical experiences, one example given by an exiting student, related to a nurse/mentor being unqualified to facilitate the student's learning. A few of the interviewees expressed frustration related to feeling as though their role was to support/help the RN rather than, the RN/nursing staff facilitating their (the student's) learning and skills. Feelings of being unsupported by their mentors, and discouraged by a perceived lack of respect from other multi-disciplinary team members, contributed to the clinical placement being the 'tipping point' which caused them to leave the programme.

There were few comparable research articles from the New Zealand setting. A small descriptive/interpretive study by Vallant and Neville (2006) focused on the relationship between the student nurse and nurse clinician (RN) while in the practice setting. From 64 nursing students (all in 3rd year of programme) who had been exposed to working in a variety of clinical situations over the three years of their nursing education, 11 students volunteered to contribute to focus group interviews. Vallant and Neville (2006) acknowledge that half of the BN programme is spent in the clinical practice setting. In this setting the RNs are the main overseers of the students, and their learning, therefore exploring this relationship was significant to this research. To secure insight into the interactions between RNs and student nurses, two main questions were posed to the student nurses: What kind of relationships do student nurses have with nurse clinicians and what impact does this have on the students' learning in the practice setting? Three key themes identified from the literature will be discussed as they link well with the focus of my research.

Inhibited learning

Students described themselves as not being recognised as individuals, and therefore not being identified as having unique learning needs. They used the phrase, 'invisibility in the relationship', their feelings around this were portrayed as, 'frustrating' and 'soul destroying'. They felt forgotten and ignored due to negative attitudes coming from the nurse clinician/RN (Vallant & Neville, 2006, p. 26).

One interviewee commented, 'I've found if you don't step on anyone's toes then everyone is supportive'. Eleven students participated in focus group interviews and the 'need to tread carefully' was a recurring comment (Vallant & Neville, 2006, p. 27). The students didn't want to attract attention to themselves or advocate for their own learning needs, as they thought that to avoid doing so would ensure a more positive clinical environment for them to remain working in (Vallant & Neville, 2006).

Another issue adding to the challenge of inhibited learning, as suggested by Vallant and Neville (2006) is that of 'busyness' or lack of time for learning, lack of time for the nurse clinician/RN to allow students to participate in patient care, a theme labelled as lost opportunities for placement learning. The students referred to the nurses as always moving fast, 'sometimes all I used to see was the back of my preceptor as she's running down....' (Vallant & Neville, 2006, p. 28). These authors expressed, a concern around the lack of time the nurse clinicians had to answer questions and/or, provide the student with rationale around nursing practice, therefore the opportunity for learning in the key moments, was gone. Eick

et al. (2012) alluded to these realities of nursing, busy clinical areas with busy under-resourced staff, none of which make an environment conducive to learning.

Unrealistic expectations

A cohort study presented by Wilson, Chur-Hansen, Marshall, and Air (2011) revealed increased attrition from a BN programme in Australia, attributing this to the students having idealistic and naïve expectations of nursing as a profession. The clinical practice component played a prominent role in this study. From a nursing university, 15 participants agreed to be interviewed. These students had either left voluntarily or were withdrawn from the course due to theoretical failure. Wilson et al. (2011) discussed the fact that students were bringing, ‘unrealistic expectations’ into the clinical placement component of their course (p. 458). This was substantiated by interviewees reporting emotional and psychological impacts of stressful situations, for example, as they struggled to cope with blood, sickness, patients in pain and an appropriate level of attachment to the patients (Wilson et al., 2011).

When coping with the practical aspects of clinical placement the combination of shift work, study, family needs and personal health problems overwhelmed not only the more mature student but the younger students as well. Financial problems were a prominent issue amongst the participants of the Wilson et al. (2011) study and a reason that contributed to students withdrawing. The structure of the programme made it difficult to manage a part-time job and be independent. Two study participants commented that the time commitments of clinical practice meant they were unable to work part-time and therefore could not afford to pay the rent, hence needed to look for other accommodation alternatives, such as living with parents. Manchester (2015) reports similar concerns in NZ for students who are parents themselves, struggling to support their family’s basic needs, childcare, part-time jobs while studying and fulfilling required clinical placement hours.

Ethical issues

Eick et al. (2012) suggest clinical placements can often be a ‘reality shock’ for students. Unpleasant situations have been witnessed such as ethical issues of ‘bad practice’ and poor role modelling from senior nurses, resulting in inadequate patient care particularly within the aged care sector. A New Zealand article by Sinclair, Papps, and Marshall (2016) highlighted related ethical issues, such as breaches of autonomy, informed consent, beneficence, confidentiality and dignity. These breaches result in ‘moral distress’ and ‘feelings of powerlessness’ for the undergraduate student. This distress is evident in this quote from a year three nursing student, “I found this (breach of dignity) highly distressing, but now that I

have seen it several times I am probably moderately distressed about this situation, as I feel powerless to change the situation” (Sinclair et al., 2016, p. 6). The witnessing of poor practice and lack of support for the student within placement settings were considered to be the main contributing factors for students to leave (Eick et al., 2012).

Practising caring and fitting in

A key contributor to student nurse attrition as discussed, is unrealistic perceptions around nursing. Both Eick et al. (2012) and Wilson et al. (2011) suggest, as a prerequisite to being accepted into nursing education, the potential student should strongly consider gaining work experience within the ‘caring profession’. Volunteer work experience available within the community such as working with the elderly, disabled or homeless is thought to prepare potential students with more realistic expectations before committing to a three year nursing programme. Eick et al. (2012) report, students who participate in work experience within caring areas, suffer reduced ‘placement-related reality shock’. Furthermore they discuss the fact that mature students found placements unproblematic because of their maturity and prior experience in the clinical environment.

The fundamental goal of clinical placement is for the student nurse to learn ‘how to be a nurse’. Evidence discussed in Vallant and Neville (2006) and Eick et al. (2012) agreed that learning can be inhibited in the placement environment. However, Levett-Jones and Lathlean (2008) present a clear link between the ‘sense of belonging’ and the quality of learning in this environment and give a definition of ‘belongingness’, as ‘where an individual feels secure, accepted, included, valued and respected by a defined group’ (p. 104). When a student has the ‘sense of belongingness’ they are motivated to absorb the learning opportunities but also confident in negotiating their learning needs and feel free to ask questions (Levett-Jones & Lathlean, 2008). When students are secure, feel part of a team and work alongside other health team members who are approachable and encouraging of their learning, the students energy shifts, from trying to ‘fit in’ to absorbing the new learning and knowledge. Therefore it is expedient for CLs and Nurse managers to promote a positive and welcoming environment for the student (Grobeck, 2016; James & Chapman, 2010; Levett-Jones & Lathlean, 2008; Mannix et al., 2006). Eick et al. (2012) agree, but further reiterates, even with existing supports in both the clinical placement area and the education institute, the student still needs to be informed and aware of how to access that support and who to approach if issues arise.

Discussing answers in response to ethical issues faced by students, Sinclair et al. (2016) suggest that the RNs need to be aware that students on clinical placement do recognise ethically compromising practices being role modelled and are subsequently distressed by them. Sinclair et al. (2016) refer to Nursing Council of New Zealand (NCNZ) competency based standards for the RN, these clearly require that ethical and professional behaviour is not only fundamental but is expected to be role modelled by the RN. The authors recommend that, 'training and education must be a priority to ensure that competency based ethics is incorporated into continuing professional development for registered nurses' (Sinclair et al., 2016, p. 6).

Student Nurse Viewpoint: Summary

A number of challenges are present for the student completing the clinical component of their nursing degree, including 'feeling ill equipped' with 'little support' and being confronted by the 'realities of nursing'. The challenges are compounded with students working in busy, stressed clinical areas, with under resourced and under prepared nursing staff. Some potential answers to these issues may be linked to developing a 'sense of belonging' for the student and feeling they are an important part of the clinical team. Some introduction to the 'realities of nursing' is encouraged in the form of gaining work experience within the health sector. Other strategies to address student challenges will be further explored in the next two sections.

Registered Nurse Viewpoint: Outline

As emphasised in chapter one the learning that takes place in the clinical environment is a critical component of the undergraduate nursing education. The success of this learning is strengthened by the support the student nurse receives from the RN. For a long time the RN has been a steady overseer of student nurse learning and they are expected to have current knowledge and experience as well as interpersonal characteristics such as patience, empathy, understanding and a willingness to teach (Astin, Mckenna, Newton, & Moore-Coulson, 2005; Coyne & Needham, 2012; Duffy & Hardicre, 2007; Mannix et al., 2009). The RN must care for the patient and teach the student nurse in the current clinical environment, which can be time consuming and stressful. Appreciation of the challenges that arise within the RN role will further enhance general understanding in helping to support the struggling nursing student.

Time consuming and personally demanding

The clinical setting provides opportunity not only for the incorporation and application of theoretical knowledge and skills, but also for the development of applied and social skills required to be an effective member of the health care team. Both Henderson et al. (2010) and Mannix et al. (2009) have investigated and discussed the Australia clinical setting, recognising the role of the RN as being crucial to building and enhancing the clinical learning experience for the BN student. According to Mannix et al. (2009) every working RN has a role to ensure learning in the clinical setting is not only effective but of worth, as 'the very future of the discipline lies in being able to produce a sustainable workforce' (p. 62). They further suggest with this expectation come challenges for the RN, such as, the difficulty of accommodating the student into their daily practice. The RN themselves may feel deficient in the essential skills needed for facilitating student learning and secondly, when managing the increasing changeableness of the clinical environment, both of these can result in friction arising between the student and RN (Mannix et al., 2009).

A quasi-experimental study suggests similar challenges for the RN. This study compared observation feedback from RNs and nursing students, who worked together in two surgical wards over six months. Henderson et al. (2010) reported that many RNs concentrate on the clinical needs of the patients without identifying the significance of including students in the nursing care and management of those patients. The authors comment that may be due to the factor of little or no instruction being given to the RN, especially around how to create appropriate clinical learning. Henderson et al. (2010) acknowledges the student's learning is supported when a partnership is established between the student nurse and the RN. This partnership enables the student to approach the RN and together discuss and reflect on their observations of different practice situations. A barrier to this relationship is the unpredictable and somewhat pressurised clinical environment. It cannot be assumed that the RNs have the time, or an understanding of how to form a partnership. They therefore need to be provided with education and support in order to enhance the overall student learning experience.

Other Australian studies provide additional insight into RN issues. Coyne and Needham (2012) discuss RNs accounts of assisting student learning within the clinical environment, commenting on this mentoring role as 'both time consuming and personally demanding', recognising the nursing student 'slowed them (RN) down' (p. 102). One RN felt the pressure to have the 3rd year BN student ready to graduate, as collegial feedback from

clinical areas reported a lack of 'practice readiness', when referring to newly graduated nurses. Grealish and Smale (2011) relate a lack of information disseminated by the educational institute/university around what level of progression the students are at, in terms of theory and knowledge within their curriculum. Another RN, found it increasingly challenging to find time to explain the essential theory behind a certain nursing practice if the student was unsure. Additional comments included inadequate support from the university or learning institute in terms of communication and dissemination of student learning objectives and goals (Coyne & Needham, 2012; Grealish & Smale, 2011).

One NZ study supported similar findings to those from Australia, and discussed the relationship of the RN and the nursing student as one of a preceptorship model, whereby the preceptor (RN) assists, nurtures and supports the student. Vallant and Neville (2006) recall findings from their study that impact negatively on this relationship; the 'highly complex patient load' lessens the quality and amount of time available for RNs to work with the student, insufficient formal training/preparation in preceptorship and teaching may contribute to the RN having little or no professional aspiration to teach.

A second qualitative study, Haitana and Bland (2011) conducted five semi-structured interviews with RNs from a provincial NZ hospital. They understood the aim of the RN/preceptor from the initial onset was to establish a unified working relationship in order to have a positive and successful placement for both student and RN. However, conclusions from the interviews, uncovered a parallel yet dissimilar barrier to this intention. Preceptors/RNs reported, due to lack of continuity in rostering and little time with the students, the RNs were constantly feeling unsatisfied. Due to this limited time, the ability to build a rapport and develop 'a sense of trust' was not present. An example from an RN explains, 'Part of preceptoring is developing trust and developing a relationship. You can't do that if you have only got that person for a day, you would actually spend half of that shift getting to know that person, assessing them, what can they do what can't they do' (Haitana & Bland, 2011, p. 7). Time is important in developing trust. Once developed, this in turn gives the RN confidence by allowing the student nurse some level of autonomy. This NZ study reported this 'weighed heavily' on the RN, who felt an enormous sense of responsibility to decide when it is safe to let the student care for the patient. When time spent together is shortened or disrupted, this can result in the RN having concerns around patient safety, and general dissatisfaction for the role of the preceptor (Haitana & Bland, 2011). Finally, Peters et al. (2013) reported, RNs expressed a 'lack of support' and 'feelings

of isolation', as a result of insufficient contact with the CL from the Higher Education Institute, while students were on clinical placement within the RN's specialty practice area.

Student issues become RN issues

Two researchers from the UK, Duffy and Hardicre (2007) are well known within Schools of Nursing for their work on the 'Failing Nursing Student in Practice'. These two authors suggest common 'indicators' or 'red flags' that may signal to an RN when a nursing student is struggling on clinical placement. These indicators include: the nursing student having lack of theoretical knowledge, inconsistency in meeting the required level of competence, inconsistent clinical performance, lack of insight into weaknesses, inability to change following constructive feedback, lack of interest or motivation, limited interpersonal and communication skills, absence of professional boundaries and/or poor professional behaviour, experiencing continual poor health, feelings of depression, lack of commitment, feeling withdrawn, sad, tired or listless and lastly, unsafe practice.

Brown, Neudorf, Poitras, and Rodger (2007) a team of nursing researchers from Canada agree with some of these indicators, however, they regard them as predictions of unsafe practice, evident when a student displays a failure of accountability and professional behaviour such as 'failure to accept responsibility for one's own actions' and 'dishonesty'. Other unsafe practice includes lack of respect and judgement, such as the student exhibiting 'impaired judgement due to drugs, alcohol or lack of sleep', obvious patterns of behaviour, where a student nurse may fail to alter conduct in response to feedback. Other indicators may be that there are certain competencies missing, such as preparation around patient care, unreliable patient assessments, and poor clinical decision making. Lastly, ineffective communication with both clinical staff and or patients, is deemed as unsafe practice. An extensive list of indicators and/or predictions has been noted from the literature, all of which if they appear individually, or together for a nursing student, can reflect unsafe practice.

Duffy and Hardicre (2007) acknowledge that for the RN, when dealing with students, who exhibit some or more of the above indicators or predictions, it can be a difficult and 'emotionally fraught' experience, which leave the RN with 'feelings of sadness, anger and exhaustion', and the resultant belief of a 'sense of personal failure' (p. 29).

Include and value

A number of authors highlight the importance of a welcoming clinical environment with the provision of student orientation. Both the RNs and Clinical Nurse Manager of the clinical

area would be crucial to this and would find this beneficial in assisting the student nurse to feel more relaxed and valued from the onset. The sense for the student of feeling included and valued is something that the RN can establish early on in the clinical placement. The inclusion of the student into any of the clinical area's activities, whether that is a patient/team learning situation or a clinical area social event, gives the student a sense of being part of a team (Brown et al., 2007; Coyne & Needham, 2012; Grealish & Smale, 2011; Vallant & Neville, 2006).

The relationship of mentoring/preceptorship that exists between the RN and the student is an expected outcome in placement, nevertheless, this does not always mean it comes easily for the RN. Vallant and Neville (2006) agree with Henderson et al. (2010) that preparation and training for the RN must be provided by nursing leadership and the education facility to enhance 'capacity building'. This idea focusses on helping the RN to connect with the student, identify their learning needs, and then to align the learning opportunities with the learning objectives. The Clinical Nurse Manager plays a central role in providing support for the RN mentor/preceptor. They can do this by reducing the RN's patient work load to appropriate and realistic levels, thereby acknowledging the extra time involved in teaching and building of the relationship required with the student. The Clinical Nurse Manager can value the student/RN relationship further by ensuring the RN and student are being rostered regularly together. Not only does this allow consistency of learning but gives opportunity for a mutual understanding of each other's roles. Valuing relationship continuity will have a follow-on effect of RN job satisfaction and unhindered learning and development for the student (Haitana & Bland, 2011).

Timely and ongoing feedback from the RN to the student is essential throughout the entire clinical placement. Guidelines for the RN need to be clear around verbal and non-verbal/documented feedback in relation to poor student behaviour and/or attitudes. If a mentor/RN can identify a struggling student and give early, constructive feedback, this will greatly enhance the potential for improvement (Elliott, 2016; Heaslip & Scammell, 2012).

Brown et al. (2007) expands this point by stating the importance and availability of online guidelines around the process of unsafe practice for the student. Regular allotted times throughout placement should be organised in an unhurried and uninterrupted space for both RN and student to sit down and reflect. Honesty is needed from the RN when discussing both 'strengths and weaknesses' of the student's clinical work. Lastly, in relation to feedback it is imperative that communication between the education facility and clinical area occurs,

for the correct processes to be implemented effectively (Brown et al., 2007; Duffy & Hardicre, 2007; Grealish & Smale, 2011).

Registered Nurse Viewpoint: Summary

‘A jack of all trades’ would be a legitimate way to describe what the RN has to manage in their daily working lives. The challenges that come with this are varied, and many. Time is limited for the RN when aiming to develop a trusting relationship, whilst assisting the student nurse to adapt to the unfamiliar clinical environment. When one adds expectation of the RN to teach, encourage the student to practice self-reflection, and then combine with this, assessment and evaluation on the student’s progress in terms of whether they are completing learning outcomes, one can see that it is a very fraught role. Understandably, RN feedback includes comments that having students is ‘time consuming’ and ‘personally demanding’, and unfortunately this can lead to a ‘sense of personal failure’, not only for the RN but at times the student also. Answers depend on the support of the Clinical Nurse Manager in acknowledging the need for a lighter patient load when working with a student. Education should be offered to the RN to develop skills and abilities to teach, and role-model professional behaviour to the student nurse. Finally, a major element of support for the RN is a close and respectful working relationship between the RN and the CL.

Clinical Lecturer Viewpoint: Outline

The important role and responsibility of the CL is to work in partnership with the RN, and student nurse, while the student nurse completes the clinical practice experience of their under graduate degree. What is expected from the CL role is the ability to facilitate the learning opportunities in order for the goals of the student’s learning to be met. The CL accomplishes this by visiting the students on placement, assisting the learning process in consultation with the RNs while evaluating and monitoring the progress of specific learning objectives and relevant NZNC competencies (Nursing Council of New Zealand, 2012). There are a number of barriers and challenges that present themselves for the CL. These will be identified, discussed and combined with some practical strategies from the literature.

Big expectations in the liaison role

In contrast to the familiar and ordered surroundings of the academic setting, and as discussed earlier, the unfamiliar, busy clinical practice area, with its many procedures and technical equipment are confronting and foreign for the nursing student. The literature examined

emphasises that RNs play a big role in supporting students in this foreign environment, as does the CL role. Together both roles have the ability to work as either ‘enablers or detractors to a positive clinical experience’ (Astin et al., 2005, p. 280).

The literature was examined to understand more fully the challenges that present for a CL. Peters et al. (2013) describe a negative clinical environment experience as one with poor communication and inadequate organisation. These authors suggest an important component or goal for a positive and sustainable placement, is a mutually appreciative relationship between the Higher Education Institute and the Health Care Provider. As a key liaison person between the two, the CL has a number of expectations and challenges to meet in order to reach this goal (Peters et al., 2013).

A Heideggerian phenomenological study undertaken in New South Wales, Australia, interviewed ten CLs who had been working with undergraduate nursing students for more than two semesters. Dickson, Walker, and Bourgeois (2006) highlighted the ever fluctuating changes of health care, the pressured clinical environment and changing staffing trends as relevant challenges. These issues, according to the authors, present an ongoing challenge for the CL who is expected to relocate to different clinical locations and communicate with a number of different nursing staff, while supervising and assessing the students.

Therefore a key CL role is one of connection, and is highlighted throughout literature as essential. The barriers that present for the CL in regard to making significant connections are that the practice area is unfamiliar, or the specialty area has not been a practice area where the CL has worked before. If this is the case, time will be required for familiarising themselves with the geographical location and clinical equipment, and establishing certain key connections with management and nursing staff, before the students arrive (Astin et al., 2005; Dickson et al., 2006; Peters et al., 2013). Often this role of connecting is seen as ‘forming alliances,’ an essential aspect in allowing the CL to have access to clinical areas and resources. This, however, takes time and effort. One CL put it like this, ‘I do see it as public relations role being nice to the staff, smoothing the way for the students’ (Dickson et al., 2006, p. 419). Mannix et al. (2006) acknowledge orientating to different environments, practices and people, is a constant process for the CL. One important goal, explained earlier, was creating a positive clinical experience for students, helping them feel as though they belong, so a certain expectation is on the CL to form positive connections, thereby safeguarding the best chance for both student and CL to fit in and be part of the team. To

build a rapport with each clinical area, a CL commented may require flexibility, understanding and negotiation, all adding to a demanding workload (Dickson et al., 2006).

According to Astin et al. (2005) CLs have the responsibility of communicating to the nursing staff what clinical practice learning involves for the student. This includes the proposed student's learning aims and objectives, and the associated clinical skills that are expected to be practised and achieved. This can be a pressurised task with the need to reinforce this information often in varied locations with varied staff. Both Astin et al. (2005) and Peters et al. (2013) identified the fact that due to a lack of communication between the Higher Education Institute and Health Care Provider, different clinical areas had reported the CLs were absent at times, and also students were mentioned as being unprepared and lacking in theory knowledge. In general, Peters et al. (2013) suggest the, 'inconsistencies in the organisation of clinical placements created confusion and less than optimal clinical practice outcomes' (p. 188).

Dickson et al. (2006) commented that the clinical atmosphere can be strained with negative attitudes existing between staff and students. They suggest that the job of the facilitator CL is to try to circumvent these negative mentor relationships which may have a negative impact on student learning outcomes. The CL is also required to communicate with the Clinical Nurse Manager and RNs to ensure the rostering of appropriate RN support for the students. The requirement for clear communication not only involves the RN, the student and the Clinical Nurse Manager but should also involve the patient at the bedside. Consequently, for the CL, the responsibility of guaranteeing the necessary information is being communicated at all these different levels, can be daunting to say the least (Dickson et al., 2006).

An Australian article highlighted the fact that the number of students within certain nursing schools extends to thousands. This presents an enormous challenge in the role of the placement organisation, and the facilitation of learning for these large cohorts. Mannix et al. (2009) suggest, consideration must be given to whether the CLs have the right attributes for the role. Astin et al. (2005) reported some CLs as being out-dated with their clinical practice, and specified that without regular clinical experience it is difficult for them to maintain clinical currency. According to Mannix et al. (2006) recent clinical experience and sustaining its currency is the ideal picture, but does not exist. The more realistic picture is one of CL inexperience lack of familiarity with the clinical situation causing the CL in their role of facilitation to feel isolated. This feeling of isolation is reflected by the CLs not feeling part of a team. Other challenges for the CL are not being given many opportunities

for professional development within the facilitator role, and missed opportunities to share experiences and opinions with their other CL team-mates.

Facilitation and collaboration

Facilitation is one of the key roles of the CL, assisting the student nurse to make the most of the learning opportunities that clinical practice has to offer. Critical reflection is an important relevant skill, as it gives meaning to the experience. It is therefore helpful for the CL to have some degree of self-confidence to critically reflect on their own knowledge, and practice limitations (Dickson et al., 2006). In acknowledging these limitations the CL is more likely to resource the right skilled personnel and other learning resources, thus promoting a broader collaborative learning platform. 'Facilitation is a goal-orientated dynamic process, in which the participants work together in an atmosphere of mutual respect, in order to learn through critical reflection' (Burrows as cited by Dickson et al., 2006, p. 417). Mannix et al. (2006) identify the importance of 'personal and clinical credibility', and discuss the fact that within the clinical facility the credible CL is seen as one who re-establishes and maintains respect by availing themselves of regular clinical exposure. This practice keeps them well-informed about new developments and assists them to retain their clinical currency (Astin et al., 2005; Henderson et al., 2010; Mannix et al., 2006).

A theme of discussion throughout the literature is the Higher Education Institute's ability to facilitate and support the student in clinical practice. Mannix et al. (2009) comment, 'it is crucial that tertiary education providers work creatively with health industry partners to foster positive learning relationships to ensure that students do get the best out of clinical learning experiences' (p. 64). As well as a facilitator, the CL is seen as a central support person for the students, a connector and key organiser of the learning opportunities whilst being the vital link between the two organisations, Higher Education Institute and Health Care Provider. In preparing a clinical area to receive students the CL needs to spend considerable time on 'forming alliances' with the clinical staff, in resourcing not only the experiential learning but also actual clinical space and equipment, thus helping to create easy integration for students. Dickson et al. (2006) recommend that the CL should be assigned to the same Health Care Provider every placement to strengthen these alliances (Astin et al., 2005; Dickson et al., 2006; Peters et al., 2013).

Mannix et al. (2009) suggest the right attributes for a CL fall into three fundamental areas: familiarity with the curriculum, familiarity with the clinical facility and having relevant up-

to-date teaching skills. Astin et al. (2005) add that, not only should the CL know the learning objectives and clinical skills the students are expected to attain, but in addition, their job is to communicate clearly with regular reinforcement to the nursing staff who work on a day-to-day basis with the students. For the CL to have adequate teaching skills it is first suggested by Brown et al. (2007) that a mentorship and orientation programme is made available for the new CL. This way they will have access to resources and be aware of the relevant guidelines in order to assist a student having difficulty. Mannix et al. (2006) consider there is a need for CLs to feel welcome in, and have regular chances to feel included in the academic community of the Higher Education Institute. A valuable contribution will be made to nursing education if these supports are endorsed for the CLs. The result would be the retention of suitably equipped CLs (Mannix et al., 2006).

Clinical Lecturer Viewpoint: Summary

Clinical facilitation and support is seen as a complex and dynamic relationship between CL, student and staff of the clinical area. It becomes clearly evident why barriers may develop, with the juggling of the different roles the CL is expected to fulfil. As their role encompasses not only working with the student nurse, but also in collaborating with varied clinical staff, while being the key liaison person between the Higher Education Institute and Health Care Provider. The CL must have flexibility, leadership skills and negotiating abilities, whilst demonstrating self-awareness in knowing when to resource others, if knowledge limitations exist. They must remain 'clinically credible' themselves, which is a big responsibility and a lot to expect, but unfortunately there is an absence of literature and information to guide and resource the CL.

Gap in the Literature

To understand the strategies needed to support struggling students one first must understand their struggles. The literature resoundingly agrees that further information should be gathered to understand the challenges that students are presented with in the clinical environment. Further exploration of strategies to support students in these challenges will only enhance future student nurse clinical practice learning (Astin et al., 2005; Brown et al., 2007; Eick et al., 2012; Mannix et al., 2006; Pitt et al., 2012; Wilson et al., 2011).

A further strong theme throughout the literature is that of poor or non-existing communication between the Higher Education Institute and the Health Care Provider. The

gap that exists here reflects the all important role and acknowledgement of the CL and their liaison role. Closer collaboration between these two organisations may aid positive relationships in order for the student nurses to have positive learning environments (Astin et al., 2005; Carlson et al., 2010; Coyne & Needham, 2012; Grealish & Smale, 2011; Mannix et al., 2006; Mannix et al., 2009; McNamara, 2015; Peters et al., 2013).

The literature appears to be deficient in preparation and ongoing guidance for the CL role, Mannix et al. (2006) stress the urgent need for combined efforts to formulate ideas and strategies to enhance the student nurse clinical education, in which the CL plays a key role. Brown et al. (2007) suggest the need for orientation and mentorship of new clinical educators. Guidelines must be available to the CL, not only for situations when a student is struggling, but in general, to facilitate the important link between theory and practice that takes place in the clinical situation (Astin et al., 2005; Brown et al., 2007; Eick et al., 2012; Mannix et al., 2009; Peters et al., 2013).

Literature Review Summary

It is evident from the literature that difficulties and challenges arise for the student nurse when on clinical placement. Some of these issues were discussed from the student viewpoint to set the scene for this research. The RN plays an important role in supporting and working alongside the student in a mentorship capacity. This can be time-consuming and demanding for the RN personally. However with the right backing, the RN can gain satisfaction in seeing the student progress. It is evident from the literature, that the facilitator role of the CL, is instrumental in offering strategies to manage student issues in collaboration with other members of the clinical team. Sometimes the CL is new to the role and may lack knowledge or current clinical experience, the education facility can help to underpin this role in the form of mentorship and professional development. The literature stresses the importance of positive relationships between the education and health service sectors. One of the central roles in these relationships appears to be the liaison role of the CL.

Overall there are insufficient studies available to provide guidelines for the CL when needing to support the struggling student in clinical placement. Although this study is aimed at supporting the struggling student, one of the questions posed in the interviews for this research, concerned gathering ideas from the CLs on how they in their role can be better supported and equipped.

CHAPTER THREE: METHODOLOGY

Introduction

This chapter will consider the methodology selected for this research. The research question called for an inquiry into the experiences of the CLs. A qualitative descriptive design was chosen as suitable to deliver interpretations of the human experience. This approach allows the description of combined experiences to be represented well, as CLs work closely in partnership with the BN students, hence their accounts will be important in gaining answers to the research questions (Sandelowski, 2000). The chapter will continue to expand on the mode of inquiry and data collection methods to be utilised, whilst reviewing the type of analysis chosen and the importance of evaluation in terms of the data being reliable and valid.

A Qualitative Paradigm

All research should have a theoretical perspective, a world view that lies behind the methodology, thus offering a context and a clear approach to go forward (Denzin & Lincoln, 2005). Bogdan and Biklen (2007) call this theoretical perspective a paradigm and describe it as a collection of assumptions, concepts, values and practices that represent a way of viewing reality.

A qualitative paradigm will be the model that characterises this research, Denzin and Lincoln (2005) discuss a worldview where the research information is represented by inquiry and words. Ritchie and Lewis (2003) encapsulate the aims of qualitative inquiry by describing it as ‘providing an in-depth and interpreted understanding of the social world, by learning about people’s social and material circumstances, their experiences, perspectives and histories’ (p. 11). Qualitative research uses the words of participants in describing their world or the ‘nature of their reality’ (Denzin & Lincoln, 2005; Dwyer, Moxham, Reid-Searl, & Broadbent, 2014). Sandelowski (1997) concurs that ‘words’ and ‘descriptions’ go hand-in-hand with qualitative research data, proposing that it is a ‘value-laden, holistic inquiry’ which in turn gives ‘description as opposed to explanation or prediction’ (p. 125).

In order to capture perspectives and gain descriptive data, videos, personal documents or interview transcripts may be used (Bogdan & Biklen, 2007). Quotations within the transcripts can illuminate the meanings behind the words and thus broaden contextual understanding for the researcher (Bogdan & Biklen, 2007).

The goal of this research is to obtain insight into the challenges that present for the CL whilst they support the nursing student in the crucible of clinical placement, by listening to the CLs' descriptions and questioning further their experiences.

A Qualitative Descriptive Methodology

The research methodology chosen for this project is a Qualitative Descriptive Design with thematic analysis. This methodology will allow the researcher to gain unembellished answers to questions that are of special relevance to the research questions and aims. The use of this design will result in valuable descriptions from participants in the form of words and then these will be sorted into patterns and themes. Quotes collected along the way will give substance to these themes, presenting a realistic view of the perceived student struggles and the strategies implemented by the CLs to support them (Bogdan & Biklen, 2007; Sandelowski, 2010).

Sandelowski (2010), underpins this methodology of choice calling it an uncompromising form of inquiry, seeking to interpret human behaviour whilst not requiring the researcher to intellectualise or translate the data. In itself, qualitative descriptive data produces a 'complete and valued end product' and the themes that emerge from the analysis of data can assist the present situation but also be the 'entry point' for future research (Sandelowski, 2010, pp. 335 & 339).

Sandelowski (2010) comments in relation to the Qualitative Descriptive Design that 'all description entails interpretation'. Translating descriptions must be accurately expressed, events must be in proper sequence, and meanings of the event from the participants' report must be accurate, in order to achieve descriptive and interpretative validity. In appreciating the researcher's role Sandelowski (2010) firmly expresses the view that the researcher must ensure the research project is explicit and of interest to themselves and those involved. She encourages the researcher to make something of the data collected, it must shift 'things forward' to the point of change if the data signal the need for this. In this design Sandelowski (2010) suggests gathering the data by talking with relevant individuals to answer the question. 'Language is the vehicle of communication' and thematic analysis is the technique to be utilised in interpreting the data (p. 80).

Sandelowski's (2010) approach resonates with me and my interest in gathering the personal experiences of the present in order to gain insight for potential future strategems. As already

noted colleagues were keen to share their stories from clinical practice and be involved in improving student outcomes and experiences in clinical practice for the future.

Form of Inquiry

Qualitative research involves the collection and the use of first-hand material to describe normal or problematic moments and their specific significance in the individual's life. Examples of this type of material include personal experience, case studies, life stories and interviews (Denzin & Lincoln, 2005).

'Stories are a powerful means of making sense of our social reality and our own lives. The interview is a key site for eliciting narratives that inform us of the human world of meanings' (Kvale & Brinkmann, 2009, p. 65). The 'art of storytelling' sits comfortably with nurses and their culture. Nurses use stories amongst their peers and with other health professionals, when encouraging their patients to tell their own story. Likewise nurse educators use storytelling to relay important concepts of patient care. The stories told add to descriptive evidence and show other approaches that have worked in the past. At the same time stories offer worthwhile stratagems for the future (Myers, 2015). A nurse herself, Jennifer Mote (1998) collected stories from retired nurses, reflecting their personal and working lives during the 1930s & 1940s on the West Coast of the South Island, New Zealand. From the varied conversations, Mote (1998) describes parts of their story as being 'fragments' and 'glimpses in time' of their lives. She then compared the commonalities, patterns and themes of these to that of a patchwork quilt. 'Conversations are presented as whole patterns which are quilted together to form a story within a story' (Mote, 1998, p. 181).

Mote (1998), gave an 'opportunity for these women from the West Coast to have their voices heard' and the links of being 'coasters', women and nurses were interwoven throughout. Mote (1998) comments 'the shared memories were treasured much like a quilt' (p. 187). The experience of sharing their reflections gave the retired nurses not only a sense of gratification in telling their stories, but also a sense of reward as Mote (1998) suggests they will be of interest and give insight to future generations of nurses.

The researcher likewise seeks a similar aim for this project, where an opportunity is given in the form of an interview, which allows the CL to have a voice. This gives a chance for them to share their story and for myself as the researcher to gather their insights. In turn, this can result in education and learning tools for CLs to effectively support students in future clinical practice experiences.

Interviewing is a qualitative data-gathering method which involves collecting stories. Kvale and Brinkmann (2009) liken the interviewer to a traveller who is on a journey to a far distant country. Along the way the traveller (interviewer) has many conversations and asks numerous questions of the inhabitants. The traveller becomes absorbed in the dialogue and the stories that transpire and at the end of the journey the traveller will return home and have many tales to tell. In applying this metaphor Kvale and Brinkmann (2009) describe the interviewer as not only just someone who is interested in analysing facts, but rather a participant and at times a creator of the conversation.

This research will use semi-structured interviewing, where a conversation is initiated by the researcher inviting the participant to talk. Encouragement is given by the interviewer to the interviewee to 'talk freely' and tell their story in their own words. However, to keep the participant on the topic, some structured questions that correspond to the research have been decided upon. This type of interviewing allows flexibility for the researcher to broaden a specific topic of interest by probing further, and asking follow-up questions (Bernard & Ryan, 2010; Kvale & Brinkmann, 2009; Polit & Beck, 2012; Richardson-Tench, Taylor, Kermode, & Roberts, 2011).

The empirical approach of this qualitative descriptive study allows the researcher to explore the CL experience through their stories, when giving clinical support to the nursing student. Thematic analysis will be utilised to analyse the interview data, to summarise the ideas, and to identify themes.

Thematic Analysis

Thematic analysis will be undertaken and ideas and themes highlighted. Richardson-Tench et al. (2011) discuss the fact that thematic analysis generally falls into two main themes: explicit themes, that are very clear and provide direct answers to the research question, and implicit themes or inferences that are not so easy to identify and may be more hidden within a story.

Braun and Clarke (2006) describe the attraction of thematic analysis being the flexibility around the 'framework of inquiry.' Inquiry should be guided by the research question, aims and objectives of the research; this alongside semi-structured interviewing allows the researcher to stay close to the research questions, but also gives flexibility when asking the participant to expand on an area where a theme or pattern starts to materialise. This

amendable inquiry will accommodate similarities from a literature review completed around the research topic, and also integrate anecdotal evidence from the researcher's experience.

Braun and Clarke (2006) describe six steps required in thematic analysis. In the beginning of the analysis and throughout the interview process, the researcher will begin to be aware of patterns and similarities. Braun and Clarke's (2006) six steps will be discussed.

Step 1. Familiarising yourself with the data

It is best to start by reading the data. However, it is repetition of the reading that will further highlight the meanings and patterns. If interviewing was the vehicle to collect the data, transcription of the data, a 'verbatim' account of all verbal information, needs to happen. This is where the notes taken at the time of the interview can be useful as non-verbal communication but can sit alongside the verbal. It is suggested the researcher read the entire data set at least once before coding ideas and themes, although notes taken during the transcribing and the reading will frame ideas around potential themes.

Step 2. Generating initial codes

Step two involves making a list of interesting ideas from the data, as these ideas form the initial codes. The codes then represent the data and should identify features that are of interest to the researcher. Coding may come in the form of writing notes on the transcription or using post-it notes and/or colour to highlight them. It is important to code for as many themes and patterns as possible, as coding helps locate the quotes and extracts that fit together with the themes. Coding consists of arranging the data into significant groups and these groups form patterns which go on to form themes across the data set.

Step 3. Searching for themes

Searching for themes begins with the recognised codes from the data set. These codes are sorted into a wider group of potential themes. Visual aids such as tables, mind maps and/or a thematic map may be helpful for this stage. General over-arching themes or subthemes can be visualised at this stage, though these may be quite crude and still require refining, so the researcher should not discount any outlying information.

Step 4. Reviewing themes

With a set of unpolished themes in hand, the refining process begins. This entails re-reading all collected extracts for each theme. The researcher asks whether they form a coherent pattern and correspond with the themes. If they do not at this stage, the themes may need re-

working, but if the extracts sit well with the themes, the final step is to place the themes into a thematic map. The second question to contemplate is how well the thematic map reflects the accuracy of the data set as a whole. If it does not, again some further refining needs to occur in terms of devising new themes and a new thematic map. A truly reflective thematic map reflects the entire global story from the data.

Step 5. Defining and naming themes

Step five begins with a reasonable thematic map of data. With this in hand the defining and refining of the themes takes place, which means identifying the core or substance that each theme represents. For each theme recognised, one should consider what the ‘story’ of that theme is and what the overall ‘story’ of all the themes is revealing. As a written analysis is conducted and the refinement process continues, the researcher should ascertain whether sub-themes exist. A sub-theme is a theme within a theme and can improve the structure of a bigger more complex theme. By the end of this step the themes should be clearly defined.

Step 6. Producing the report

This last step consists of writing up the thematic analysis in a report format, thus informing the reader whilst persuading them that the analysis has some worthwhile and reliable rationale. This will succeed if sufficient themes are backed-up from the data and should be illuminated by the extracts and quotes, but then fortified by the researcher’s story around the data, finishing with the link that ties it to the original research question.

In summary thematic analysis has been chosen for its inclusiveness of data from which patterns and similarities can be identified in order for them to be evaluated. Using this method, according to Braun and Clarke (2006) identifies themes that are strongly linked to the data itself, thus supporting Sandelowski’s (2010) framework.

Evaluation of Qualitative Data

Qualitative research findings are evaluated according to the authenticity of the reported events. Denzin and Lincoln (2005), discuss the fact that research findings should aim to be as accurate as possible to ensure ‘credibility’. Credibility is an important component in establishing trustworthiness. ‘Credibility’ is the situation where the researcher has earned ‘good standing’ in accurately reflecting the study participants’ views and values. Credibility is underpinned by using a suitable methodology and research design. Morse (2015) discusses using the word rigor when evaluating research, by asking the researcher to consider how well the question represents the true experience. This research will discuss

other 'trustworthiness' terms that Morse (2015) expands on, more specifically 'reliability and validity'.

For the data to be reliable in research it entails the presentation of themes that link well to the data and are backed-up by supporting quotations. The researcher should read and re-read the transcriptions and ask further questions of participants if necessary for clarification or expansion on unclear points. The researcher who desires their work to have 'credibility' will embrace feedback from peers and/or academic supervisors in order for biased assumptions to be challenged. This will be further discussed in the methods chapter (Denzin & Lincoln, 2005; Graneheim & Lundman, 2004).

Morse (2015) discusses the fact that the authentic representation of the 'actual phenomenon' is important, if research is to be found valid. 'Validity' requires experiences or descriptions shared to be recognisable by those who have had the same experiences. They too can appreciate the experience because the description given has been so thorough. Quotations from interviewees will be utilised to support this.

When considering research transferability, I contemplated a question regarding my research: Can the findings of this data set, be applied to another data set? When considering transferability it is important that sufficient information on the context of the study, the qualities of participants, and the collection with analysis of that data, is provided. Dependability can be explained similarly to transferability, in that when the research process has been recorded thoroughly, it allows a future researcher to repeat the same work (Lincoln & Guba as cited in Denzin & Lincoln, 2005; Graneheim & Lundman, 2004). Morse (2015), terms this 'reliability' and takes it one step further by explaining that if the research was repeated the same results would ensue.

Lastly, confirmability, includes the objectivity of the researcher to the findings and experiences of the participants besides acknowledging their own bias if one exists (Lincoln & Guba as cited in Denzin & Lincoln, 2005). Reflexivity helps this by requiring the researcher to scrutinise their own assumptions or any preconceived ideas they may bring, challenging the researcher to be willing to analyse themselves honestly throughout the whole research process, from examining relationship dynamics in the interviews to any preconceived ideas around the findings. Denzin and Lincoln (2005), stress the importance of this 'openness' emphasising that reflexivity is a 'process of conscious self-reflection' (p. 1027). (How this will be achieved is explained further in the methods chapter).

To conclude, whatever criterion is used be it ‘credibility’, ‘validity’, ‘transferability’ or ‘reliability’, the challenge remains for the researcher to depict the true picture of the inquiry. Along with attention given to ethical aspects the aim is to install a sense of trustworthiness in the overall research process.

Summary

This chapter has identified the fact that the researcher will employ a Qualitative Descriptive Design, methodology, underpinned by Sandelowski (2010), using semi-structured interviews as the form of inquiry. Step by step thematic analysis, informed by Braun and Clarke (2006), has been discussed, concluding with discussion on the importance of evaluation in ensuring validity and trustworthiness. The next chapter will discuss the methods used in this research.

CHAPTER FOUR: METHODS

Introduction

This chapter describes the methods used to answer the research question. It discusses the conversation held with the stakeholders including the ethical and cultural considerations that took place before and during the project. Description will be expanded upon around the participants and rationale related to recruitment method and data collection. Lastly discussing the type of analysis selected and why it aligned best with the data.

Research Questions

1. What are the issues CLs identify, that face the BN student in clinical practice?
2. What strategies can CLs put in place, to support the struggling BN student while in clinical practice?

Stakeholder Support

Consultation was undertaken with the relevant stakeholders from Nursing Education Institutions within New Zealand. There was supportive interest in the research, particularly the aspect of being able to detect and intervene early in a situation where a nursing student was not meeting the required competency, as this would be beneficial not only for the student but also the organisation. Two stakeholders agreed ‘a gap’ in the literature exists in terms of available strategies for CLs. However, they stressed the importance of acknowledging the wealth of anecdotal knowledge available from the more experienced CLs. There was an expression of interest from the stakeholders to identify in the data collection what model of clinical support the CL was representing, for example the Preceptorship model or the Dedicated Education Unit (DEU). The difference is explained in the background chapter. Consensus from the stakeholders was that this is a ‘useful’ and ‘worthy’ research project. Consequently, funding was approved and made available to support the research.

Ethical & Cultural Considerations

Before and throughout the research process I continued to contemplate my role and position within the project. As a CL/ALN myself, I recognised I would bring my own experiences, emotions, prejudices, agendas, assumptions and opinions around supporting the struggling nursing student, to the research. Hertz as cited in Finlay and Gough (2008), ‘urges

researchers to be aware of their own positions and interests and to explicitly situate themselves within the research' (p. 5). The interviewee data set included responses from colleagues who had agreed to participate, and it was from a position of high regard for them, that I approached the project, acknowledging there to be a potential issue of power imbalance due to the fact we share similar roles, yet in this situation, I as the researcher was in the position of directing the project.

Ethics approval was gained from the Human Ethics committee at Canterbury University, Christchurch, as well as the Education Institution ethics committee (appendix 1). All participants were invited to take part by group email, with clear details on the proposal and their participation. Their involvement was on a voluntary basis. Written consent (appendix 2) was gained from those who volunteered to participate and they were free to withdraw from the research up until the time of data analysis. However, there were no participant withdrawals throughout the project.

In the planning of this project I considered a potential interview scenario where a possible sensitive issue might be shared, such as an interviewee disclosing a situation of intimidation or harassment. The process I would have employed in this circumstance was to offer them a professional counselling contact at no cost to them, encouraging them to seek relevant advice and help. Alongside this, prior to the interviews commencing, the interviewees were informed they did not have to answer any question/s they were uncomfortable with. They were also given the contact details of my supervisors if they needed to validate any project information.

Throughout the interviewing process a good sense of rapport and trust developed. This appeared to happen for two reasons; I had the ability to identify with the interviewee, having a receptiveness to hear others' experiences, coupled with a keenness from the CLs to share their stories. Throughout the 14 interviews my respect increased enormously for the participants and their ability to support the nursing students within the stressful clinical environment.

Another principle facilitating trust was confidentiality and anonymity but the reality was I as the researcher knew the participants, therefore to maintain confidentiality for both the CLs and the student situations a pseudonym was used. A list of alternative names was presented, and the interviewee was invited to choose an alternative name. This became something of an 'icebreaker'. The name change was offered at the beginning of the interview process and

due to the often humorous significance of it for the participant, this assisted in relaxing both the interviewer and the interviewee. The chosen pseudonym was then used by the researcher throughout the interview and in the transcription. Transcribers who signed a transcriber confidentiality agreement were used to transcribe the recorded taped interviews (appendix 3).

Communication to the participants reassured them that all data would be dealt with in a way that safeguarded the confidentiality and anonymity of the CLs. Interviewees were told that dictaphone recordings and transcribed interviews will be kept secure and held for seven years by the University of Canterbury as required by both Ethics committees. Before the commencement of the recorded interview any questions or queries were addressed and, as discussed, a consent form was read by the participants and signed.

Due to the possibility that the CL would discuss situations that involved Māori or Pasifican nursing students the ethics process of the Education Institute guided the researcher to seek consultation with Māori. This was achieved early in the ethics process. The author had two separate informal discussions with a Māori Student Advocate staff member (MSA) and one of the Nurse Lecturers (NL) who was of Samoan descent. To gain a clearer perspective of supporting Māori and Pasifican students the main emphasis of the discussion was around the research question, so that the author could gain some understanding of cultural considerations for these students within the clinical placement areas. However, in reality, only one CL shared a brief example concerning a Pasifican student, and the focus of the conversation was outside the aim and questions of this research. As a result it was not included.

Recruitment

As discussed a group email invitation was sent out to both full-time and part-time CL staff of the Education Institutions giving the background of the researcher, the goals of the research, the research question along with the research method and information on the data set to be interviewed (appendix 4).

The guiding interview questions (appendix 5) were made available, allowing the potential interviewees to determine if their experience aligned with the research question and identifying early to the researcher whether the CL had some experience of working with a 'struggling nursing student', thereby assisting with purposeful sampling. According to Richardson-Tench et al. (2011), purposive/purposeful sampling consists of a homogenous

group of individuals who share similar experiences thus offering understanding into the research topic. Sandelowski (2000) states the ultimate goal of purposeful sampling is to obtain cases deemed information-rich for the purposes of the study. Therefore CLs were considered to be a valuable and appropriate group of participants to interview in order to explore the research question.

The interview questions were semi-structured. For the interviewer this provided guidance, but also allowed scope to investigate further the different participant insights and thoughts by using 'probing questions'. Examples of probing questions used were, 'can you tell me more about that situation?' Or 'can you recall how you felt when the student was having some difficulty?' Secondly, semi-structured interviews are flexible in their nature and therefore appropriate for a range of clinical practices, year groups and models of education that were represented within the interviewee data set (Barriball & While, 1994; Bernard & Ryan, 2010).

Data Collection

Interviews were scheduled in a quiet, relaxed setting during work hours of both the researcher and participant utilising a smaller classroom space not visible to students or other colleagues. The Education Institution offered support to the researcher and CLs in allowing interviews to occur within work time. When welcoming the interviewee and to assist with developing a rapport the offer of refreshments was made and the choosing of a pseudonym.

Summation of Interview Questions

The first questions asked were broader in their make-up, for example, what is the clinical area you work in? What is your history of affiliation to the area? How long have you worked there? and at what level of the programme do you work with students? These broader questions got the conversation flowing and appeared to put the participant at ease and at the same time gave useful foundational information to the researcher. The questions then narrowed down to the more specific student issue questions such as what makes clinical placements challenging for the nursing student? And what specific struggles do they come up against in this environment? The memory of a specific 'struggling student' example could be shared here with the accompanying support that was put in place by the CL for that particular student. The interviewee/CL was then asked to offer some reflection on that situation and encouraged to share other support strategies they had seen employed by their colleagues.

The interviews conducted were on an average 45 minutes to one hour in length and recorded using a dictaphone as well as interviewer note-taking. The offer was made to the participants, of reading the transcription of their own interview, as per initial ‘participant information’ agreement, but also in keeping with Morse’s (2015), research values of ‘reliability’ and ‘validity’. Only one participant took up this opportunity, and was pleased with the resulting transcript, giving permission for use within the research. Reflecting why the other participants did not ask for their transcription, I believe there was a certain amount of trust granted towards me as both the researcher and a colleague.

Research Participants

Table 1. Participants

CL	Clinical area	Years of experience	BN year group	Model
Tess	Mental Health & NZ University	6 years	2 nd year	DEU
Harriet	Acute General Medical Ward	28 years	2 nd & 3 rd year	DEU
Ruby	Medical/Surgical & ICU	3 years	2 nd & 3 rd year	Preceptorship
Tina	Medical/Surgical & Aged Care	2 years	1 st 2 nd & 3 rd year	Preceptorship
Burt	Mental Health, Disability & Primary Health	29 years	2 nd & 3 rd year	Preceptorship
Amelia	Mental Health	8 years	2 nd year	Preceptorship & DEU
Lucy	Orthopaedics/ Rehab Medical /Surgical/ED & ENT	11 years	2 nd & 3 rd year	Preceptorship & DEU
Ella	Aged Care/ED & Surgical	2 ½ years	1 st 2 nd & 3 rd year	DEU
Margie	Australia University/Paed/ Neonates Medical/ Surgical/ICU/ED & Primary Health	30 years	1 st 2 nd & 3 rd year	Preceptorship
Naomi	Orthopaedic/Brain Rehab	4 years	1 st 2 nd & 3 rd year	Preceptorship & DEU
Moana	Mental Health	5 years	2 nd & 3 rd year	Preceptorship
Aubrey	Cardio-thoracic/Vascular & Surgical	11 ½ years	1 st 2 nd & 3 rd year	Preceptorship & DEU
Frankie	Child Health/ Neonatal ICU - United Kingdom & NZ	12 years	1 st , 2 nd & 3 rd year	Preceptorship & DEU
Sara	Orthopaedic/OT/ PACU & Aged Care	5 years	1 st 2 nd & 3 rd year	Preceptorship & DEU

Analysing the Data

From collecting the data to analysing the data, Sandelowski (2010) explains how both these processes can often synchronise and influence each other. The semi-structured questions allow for an extensive range of information on the ‘who, what and where of events or

experiences'. In this way, patterns (themes) that emerge in the analysis should result in a descriptive summary that best matches the data (Sandelowski, 2010, p. 338). Subsequently, a thematic analysis was undertaken to examine the interview data, utilising the Braun and Clarke (2006) step process.

I familiarised myself with the data by reading and re-reading the transcripts. To re-acquaint myself with the non-verbal communication, and the different ideas that 'sparked' in my mind, at the time of each interview, I referred to my note-taking. I formatted a list of ideas from the data and started coding these by using different coloured squares of paper.

Alongside the ideas on the coloured paper, the verbatim quote that supported the idea, would get aligned. It was at this point I had five different groups or codes of information. These codes were quite wide in their nature, but it was here I started to notice small beginnings, such as 'students inability to initiate small talk', 'lack of initiative' and student working with 'different nurses everyday'. To find the themes I utilised a large notice board and moved the coloured squares of paper around this area. This mind mapping was useful as it offered some early, glimpses of themes beginning to emerge, and this inspired me to go back and re-read a number of the transcriptions to ensure accuracy. Morse (2015) comments that following these steps ensures clarification and expansion of the research themes, safeguarding 'credibility'. During this time clearer patterns started to develop and I chose to write these down on three different lots of coloured paper. This formed a thematic map on the notice board. With three themes becoming clearer and while aligning the corresponding quotes, I returned to listen again to some of the recorded interviews. My aim was to hear again the different emphases and nuances, and think about the story behind the themes that had transpired. This gave considerable confirmation that I had reached three well-defined themes, which will be reported on in the findings. This process overall was time consuming and lengthy, however, the constant revisiting of the source/transcriptions, kept me on track. It became a thorough process. This process ensured that I as the researcher, 'stayed close to the data and to the surface of words and events', providing 'descriptive validity' (Sandelowski, 2000). Sandelowski (2010) supports this type of analysis and summarises thematic analysis as an investigation into the 'rich information' given by the data set, to find recurrent themes of significance.

Data saturation was reached after interviewing 14 CLs. Useful information, corresponding to the research aims and questions was provided up until the twelfth interview. However following this, there was little to no change in the ideas being shared. Guest, Bunce, and

Johnson (2006) found in purposive sampling where the participant group is homogeneous, data saturation is expected to be reached by 12 interviews. I continued to complete 14 interviews as the last two CLs expressed a keen interest in the research and were keen to share their 'stories'. As has been said, the participants came from two different NZ Nursing Education facilities, and represented a number of varied clinical practice areas, with their work experience spanning two to 30 years (table 1). A large percent of the CL group came prepared for the interview. Having considered the research questions, they came ready with student examples and communicated these clearly. All the participants came with an enthusiastic attitude and a keenness to share their experience and journey as a CL, expressing gratitude at the end of the interview for the chance to do so.

The aim throughout this process was to ensure trustworthiness. To help safeguard this the researcher has two supervisors with vast experience and qualifications in both research and nursing. Their experience, help and understanding was invaluable and aided in preventing bias during the research process. To sit alongside this the researcher endeavoured to practice reflexivity by maintaining a research journal with reflections and evaluation throughout the research journey. I am aware that even though a method is indicated, not all things go according to plan, and changes and adaptations along the way will need to happen. Gerrish and Lacey (2010) suggest, an 'openness' on the researcher's part is vital for these changes to occur.

Summary

This chapter has outlined the beginning conversations that directed this project and issues related to ethical consent and other relevant considerations. This chapter has described 'purposeful sampling' and the recruitment process of the data set. Data collection with a summation of the interview questions was explained along with an outline of data analysis used.

CHAPTER FIVE: THE FINDINGS

Introduction

This chapter will discuss the findings of this research. Thematic analysis was applied to investigate the gathered data, resulting in three key themes emerging. The themes will be explained and participant excerpts from interviews will be shared. These will be analysed in the context of current literature. This chapter gives paramount value and appreciation to the CLs for sharing their stories. In order to produce a ‘complete and valued end-product in itself’ (Sandelowski, 2000), it is an aim of the researcher to ensure the gold within the participants stories be made evident.

The Key Themes

The three main themes to emerge from the findings were; ‘communication and confidence’, ‘feedback and reflection’ and ‘lack of continuity and valuing’. One further finding emerged as well, around challenges confronting CLs.

Each theme will be discussed separately in this chapter under two headings that align with the research questions:

1. What are the **issues**, CLs identify, that face the BN student in clinical practice?
2. What **strategies** can CLs put in place, to support the struggling BN student while in clinical practice?

Communication and Confidence: Theme one

It became evident from the first to the last interview that communication is an important skill for the nursing student and that there are ‘issues’ with communication skills. Clinical placement offers a great opportunity to learn and practice this skill.

Effective communication from a healthcare perspective is patient-centred communication, this type of communication, ‘invites and encourages the patient to participate and negotiate in the decision-making regarding their care’, thereby giving them a sense of empowerment (McCabe, 2004, p. 42). This kind of communication does not develop immediately, it takes time for the student nurse to develop this skill. Loureiro, Severo, Bettencourt, and Ferreira (2011) suggest growth in the skill of effective communication will only happen through repeated exposure to different communication opportunities. McCarthy, O’Donovan, and

Twomey (2008) concur, emphasising communication skills need to be taught and reinforced throughout the entire undergraduate nursing programme, giving opportunity for consolidation and growth.

As discussed earlier, in order for the student nurse to reach Registered Nurse status, they must demonstrate a steady progression throughout the BN programme in reaching competency in all four domains (Nursing Council of New Zealand, 2012). Although the four domains require the need for clear effective communication, two domains require this in particular, domain three and domain four.

Domain three contains competencies related to interpersonal and therapeutic communication with the patient. The BN student achieves this by initiating, maintaining and conducting therapeutic interpersonal interactions, demonstrating counselling skills while showing respect, empathy and rapport with the patient and their family. Domain four covers inter-professional health care and expects the student to effectively communicate with the multi-disciplinary team (MDT) by using appropriate language and engaging a range of alternative communication methods as required. For example, in today's healthcare the collaboration and the communication required when planning a patient's discharge involve increased use of information and communication technology (ICT). Due to more accessibility to cell phones, pagers, faxes and emails the demand for a 'slicker' handover with faster processing of legal documentation is paramount. Nonetheless, no matter what communication avenues are employed, information needs to be objective, concise and accurate, thereby ensuring the correct referrals are made to the appropriate MDT, thus ensuring safe discharge planning (Levett-Jones & Bourgeois, 2015; Nursing Council of New Zealand, 2012).

The issues

A number of communication issues shared by the CLs related to ineffective communication. Interestingly, often linked to ineffective communication was decreased self-confidence.

The following six quotations from participants illustrate the issue of ineffective communication:

Ruby had worked with students out in clinical practice for three years. One student had some difficulties in their communication and, *'sticks in her mind, (---) I was working with a student in transition to practice, so their final placement in their third year (---) they [Student] elected to go to a community placement [in a rural setting] (---) the student academically on paper was fine, had passed all academic exams, with really high grades, but from year one*

[of the programme] *had struggled with communication and confidence. It had kind of been addressed throughout the years, but probably hadn't been addressed adequately during that whole time. [In this rural placement] she [student] was on her own (---) [The] student had [had] previous placements where she was with other students and they probably helped carry her along (---) her [student] evaluations [from community placement] came back as reading that she lacked confidence and needed to build on her communication but, she had never been given any clear directions on how to do that (---). So I guessed she slipped through the net in a way (---). She progressed to third year and onto this final placement [community placement] where she worked with two RNs (---) and they could see these weaknesses in her. They identified [the fact that] the student lacked initiative and confidence in the social setting. She lacked the ability to talk with patients [and had an] inability to initiate small talk. She was awkward in her approach, appeared nervous and anxious (---). Unfortunately she failed the placement.'* (Ruby)

Sarah shares her experience of a student who was keen to get involved in the tasks of clinical placement, however disregarded the patient by not acknowledging or communicating with them, '*(---) a student in a smaller OT [operating theatre] environment had communication issues (---) The student [was] very keen, hands on, wanted to be scrubbed in [and] wanted to be in the OT but ignored the patient. [The] student had no concept of patient advocacy (---) [the student was] not being there for the patient. [The] student asked inappropriate questions in front of the patient while the patient was being anaesthetised'* (Sarah)

Aubrey identified a few concerning signs of poor communication with associated low self-confidence that started to appear for a student who had '*no previous issues'*. This student was not reading the medication prescription correctly, not initiating circulation observations on a vascular patient and did not communicate to the appropriate staff that the patient had a '*blackened toe'*. These were indications for Aubrey to check the situation further, '*I noticed the student was coming across as being a little bit quiet (---) I sat down with him (---) he was going through a tough time [personally] had broken up with his girlfriend and had been on a break for three weeks (---) it appeared he had lost his confidence completely (---) absolutely spiralled downward'* (Aubrey)

Tina identified a third year student who was shy and introverted, and having a number of issues in clinical practice. As a result this student was pulled out of placement, Tina explains, '*(---) this can be very upsetting for everyone but as the clinical educator [CL] we have to be confident that they [student] are meeting the competencies of Nursing Council (---) it was about communication (---) the student was very shy, reserved and introverted ---*

they [the student failed placement] had to repeat 3B [the last part of third year of the BN programme]’ (Tina)

Sarah identified the fact that for a few students, poor communication and lack of insight are an issue for CLs to manage in clinical practice. *‘The biggest issues clinical lecturers face is students not communicating effectively with preceptor, not communicating their own learning needs’ (Sarah)*

Margie believes there are so many ‘tensions’ that the student nurse has to ‘grapple with’ and communication is one of them, *‘I believe they are coming to terms with the whole thing around the development of their professional nursing voice. Nursing is verbal (---) we talk a lot, we share stories, but it is the development of that professional nursing voice and I believe that can be quite challenging’ (Margie)*

The participants therefore described ineffective communication to consist of inability to engage in small talk and inability to communicate own learning needs. One student was unable to determine the appropriate communication for the situation. Two examples made it apparent, that where there was a lack of self-confidence there was an absence of communication.

When highlighting the significance of effective communication skills, Jackson, Daly, Mannix, Potgieter, and Cleary (2013) recognise this as an important non-clinical skill needed to prepare the nursing student for clinical practice. Brown et al. (2007) view ineffective communication as one indicator of unsafe practice whether this is when the student is communicating with patients, mentors (RNs), CLs or other healthcare team members. Ineffective communication may be the result of a number of things and two of these can include the student being anxious and having a decreased level of self-confidence. Pitt et al. (2012) refer to anxiety making an impact on the nursing student’s ability to learn. If increasing levels of anxiety are experienced, for example in a busy clinical environment, errors may occur in their clinical performance, consequently decreasing confidence even further.

Empathy is a crucial ingredient in successful communication as it enables patient-centred communication. Teaching nursing students that empathy rather than sympathy brings about a sense of equality and assists the student to experience the feelings of their patient. Empathy is considered an important emotional quality. It is related to building a good rapport with the patient (Bolstad, 2015). McCarthy et al. (2008) suggest some nurses lack ability in communication skills, especially therapeutic person-centred communication. In a nursing degree programme in Ireland communication skills are taught in the first two years,

however McCarthy et al. (2008) question whether the students can apply these skills at this stage, due to the fact they have not had enough clinical experience with patients or other healthcare team members.

Feedback and Reflection: Theme two

A robust theme emerged from the data around the role of 'feedback' and 'reflection', and the importance of both occurring in the clinical practice component of the BN programme.

Feedback is a form of response given following logical and reliable assessment about the student's performance. The intention of feedback is to identify both student strengths and areas for development. Feedback offers the student details around specific actions required and also presents a gauge on how they are improving (Levett-Jones & Bourgeois, 2015).

If feedback is about the facts, reflection can offer insight into the facts. Therefore reflection as a learning tool should follow feedback. Maclean cited by Chong (2009), explains reflection as requiring some thinking around situations, and then being able to seriously scrutinise the experience and actions at the time of those circumstances, with the end goal of improving professional practice. Levett-Jones and Bourgeois (2015) think that when nursing students reflect, they are considering their clinical experience and their understanding of not only, 'what they are doing, but why they are doing it' (p. 85). Reflection is a fundamental skill for both the CL and the student to practice, as clinical encounters and the learning from these, not only affect themselves but the patients, clinical staff and other students they get to work alongside in the future (Levett-Jones & Bourgeois, 2015).

The issues

The participants provided examples of poor or inadequate feedback, expressing the opinion that feedback is not always challenging or offered when it's most beneficial.

Frankie suggests that CLs should be able to challenge and give honest feedback in order to help students, '*I actually think most students have the ability to pass and be really, really good [nurse] but we don't do them any favours when we don't challenge them and give them the opportunity to grow and we're not being honest [in terms of feedback]*' (Frankie)

Ella has seen a variety of feedback used. She considers that the feedback is not always helpful or on time, '*Feedback [is] not always constructive and not always timely and it's not always honest which makes it really hard for [the] student*' (Ella)

Tess agrees, commenting that in her experience student feedback has often been *'inconsistent (---) [student] not getting any [feedback and the feedback given] is not constructive or timely'* (Tess)

These findings of inadequate or inconsistent feedback correspond with a project that was piloted in 17 universities in the United Kingdom. Fitzgerald, Gibson, and Gunn (2010) researched issues relating to assessment of pre-registered nursing students in practice. Their conclusion was 'student nurses are not receiving the feedback they desperately need and ought to have, in order for them to grow and develop into the kind of professional nurse required' (p. 162). Similar findings are evident in the comments of the participants in this study.

As outlined in the introduction to this research, students are facing 'increasingly complex, uncertain and multifaceted realities in practice, which do not always neatly fit into existing research'. The tool of reflection can be beneficial in making some sense of these realities (Barksby, Butcher, & Whysall, 2014).

Sarah questions the CLs' understanding of reflective learning. She asks if the CLs understand the concept of reflective learning, *'we want them [students] to be critically reflective practitioners, but as CLs do we understand reflection as a learning tool [as] opposed to just a personal reflection (---)? [For the student there] needs to be guided reflection and CLs need to be ok with commenting on students' reflections'* (Sarah)

Frankie clearly stated that she would like to see further reflection at the conclusion of clinical practice, *'I'd like to see more reflection, like we don't seem to bring them back in after clinical to reflect on the learning. I'd like to see that'* (Frankie)

To sum up, reflection is valued by the CL participants who consider more structured reflection would be helpful.

Lack of Continuity and Valuing: Theme three

The third theme to surface from the analysis was related to the issue that the 'same' RNs were not working with the students on a daily basis. Literature points to the importance of the preceptor/RN relationship with the student. This relationship has implications for both individuals. For the student, it is about how well the student can learn and develop, and for the preceptor, it gives a sense of achievement, and satisfaction, in helping that student learn and develop. Gillespie (as cited by Haitana & Bland, 2011) describes the connection felt in

the RN/student relationship, mentioning that it allows the student, 'to feel at ease, feeling valued and respected, and experiencing positive self-regard' (p.10).

The issues

The following eight participants provided examples of the issues that arise for students, when there is a lack of continuity in working with the same or familiar nursing staff in the clinical setting

Margie indicates that lack of continuity with the same nursing staff is a real issue. *'Nursing students have different tensions to deal with and one of these is lack of continuity with an RN that gets to know them. So if you are looking at a nursing student from a holistic perspective, the continuity and the development of the relationship, and the rapport [with the] student (---) [for the] RN working with her, is very important. It is kind of like a multi-layered thing, if the student does not have continuity then there will be only a very superficial layer that is addressed in their knowing [knowledge]'* (Margie)

If a student is struggling they need to work alongside the same RN who takes responsibility and helps support them, Lucy explains this doesn't always happen. *'Sometimes it was awkward for a student (---) there is no nurse assigned and people would say, "Who wants to work with the student?" It was difficult getting them [RN] to have consistency with a student [particularly] if there were any problems and if the student had difficulty. [The] nurse would think, "oh typical", [but] wouldn't actually do anything to help that student, (---) instead they kind of avoided the student and avoided the lecturers when they came to the hospital'* (Lucy)

Due to some students working with different staff on a daily basis, Tess comments that these students may feel as though they are a 'burden'. *'A consistent concern is lack of staff continuity, students do struggle engaging with casual pool nurses, very much so, and I have had several incidents when I've had casual nurses say, "I don't work with students". They [casual nurses] don't consider what they're saying and the impact on the student, (---) then the student starts (---) to feel like a burden (---). When new [nursing] staff teams come in they don't understand the level of progression that the students have made (---) so they [students are] forced to go back to basics or sort of re-justify their skills'* (Tess)

Harriet agrees that some students may feel like a 'burden'. She explains further that changing staff can bring inconsistent expectations, *'one of students' greatest fears is that of not feeling welcome or, feelings of being a burden in the clinical placement (---) they're working with a different nurse --- perhaps every day and every nurse has different expectations of them'* (Harriet)

Under the preceptorship model, Tina reflected, *'I do know a problem exists in the year two and three placements, they don't get a consistent preceptor. (---) Sometimes right in front of the student, nursing staff don't put their hands up to have a student work with them (---) having a student can be bit of extra [inconvenience] on [top of] their workload'* (Tina)

Lack of continuity in nursing staff working with some students was noted by Ella, who felt that due to this issue, the RN expectations of these students was unreasonable, *'Due to high turn-over of staff and lots of junior staff [Ella comments] the clinical environment is confronting, (---) perceptions and expectations of RNs and staff towards students, these [RNs' and staff] expectations are totally off'* (Ella)

Aubrey works in both preceptorship and DEU models of education and comments that inconsistency of staff has sometimes occurred in both of these models. In the DEU model the Clinical Liaison Nurse (CLN) is appointed specifically to support students in that clinical area, so the CLN should be rostered on with the students. *'The DEU model does work really well from my point of view (---) although in one particular ward the CLN is not always rostered on [with the students]. It seems to be happening more so lately, where they've [CLN] been rostered on nights, so not available during the day. Sometimes they are rostered on annual leave as well, so not there, not available for the student. We really do need those CLNs to be on the ward area, certainly if we've got a student that's struggling and needing support (---). In the preceptorship model you are wanting consistent preceptors. (---) One main issue would be an inconsistent preceptor. Nobody knows what's happening with the student'* (Aubrey)

Lack of continuity 'knocks' a student's confidence, according to Ruby, [if the student is] *'working with a different RN each day they [students] get their confidence knocked and the things they thought [they] were okay at, they start to doubt themselves and you know become clumsy'* (Ruby)

It is evident from these participants' experiences that some students can feel like a burden. They do not feel welcome, and lose confidence, especially if there is not continuity in working with the same, well-known nursing staff. To appreciate the importance of consistent nursing staff working with the nursing student, it is necessary to revisit the overall role of the preceptor/mentor/RN.

Preceptorship is outlined in the literature as an individual teaching/learning method, in which each student is allocated to a particular preceptor/RN, so that they (the student) can experience the reality of daily clinical practice. The preceptor/RN role is effectively a 'role model and a resource person' (Earle-Foley, Myrick, Luhanga, & Yonge, 2012, p. 28). Throughout the preceptor/student journey the preceptor/RN should display effective

interpersonal skills, for example, ‘clear communication, compassion and supportive attitudes’ (Zilembo & Monterosso, 2008, p. 203). Walker (2005) discusses this interaction, as the student is ‘learning how to care’, the RN/preceptor is ‘teaching how to care’. This partnership, is bolstered through ‘critical conversation’ along the way (p. 40). Ultimately, it is the preceptor/RN who is directly involved in assessing and evaluating the student or, as Yonge cited in Earle-Foley et al. (2012) states, the preceptor, ‘acts as the last quality control measure to ensure those nurses who are about to enter the professional work environment are competent to do so’ (p. 28). Dobbs (2015) agrees. ‘Public safety remains the responsibility of registered nurses. The crux of nurse education is to ensure public safety---’(p. 168).

Therefore it’s imperative, the role of preceptor/RN be highly-valued so the student does not have to repeatedly build new relationships with clinical nursing staff. Unfortunately however, due to mounting pressures within clinical environments, and high turn-over of nursing staff the preceptors/RN’s supernumerary status is not always valued or respected by management and/or organisational structures (Haitana & Bland, 2011; Hamshire et al., 2012).

A number of concerning student issues identified under the three themes have been presented. The CLs continued to share a wealth of strategies from their own experiences when working alongside students. The findings in the next part of this chapter will endeavour to answer the second research question, ‘what strategies can be put in place to support the struggling BN student while in clinical practice?’

The Strategies: Communication and Confidence

CL participants presented different strategies they had put in place to assist students with their communication and confidence.

Sarah discussed what she would say, to guide the student, ‘*you need to communicate your learning needs [when in clinical placement] to the assigned RN/preceptor*’. However, even before clinical practice begins, Sarah challenges the student to think about what their learning needs entail, ‘*identify what your [the student] learning needs are [even] before you get to placement*’ (Sarah)

To improve communication for a shy, reserved student who had been facing some clinical challenges and eventually ‘*got pulled out of placement*’, Tina suggested to the student that she work as a health care assistant, with the aim of improving communication skills. ‘*Just in [the] six months that she*

[student] *had been working in an aged care facility (---) it's amazing how she [the student] has transformed and blossomed'* (Tina)

Ruby suggested a similar strategy, in addition to advising a student who had poor communication and confidence, to attend a self-awareness course, '[I] *advised her [student] to seek work within the healthcare industry (---). [The student is now working as a care giver in a residential facility. (---) We [also] advised, and gave her information about, a communication course, run through the counselling programme (---). The course includes teaching on self-awareness and self-image'* (Ruby)

Another student Ruby was working alongside was placed in a rural/community practice. This student had challenges when interacting with her patients. Ruby put a plan in place to improve the student's interpersonal skills. '*The plan for the student was to focus on small talk and watch other people and see how they might bring up the weather [as a conversation topic]'*. Ruby encouraged the student to ask, and read about happenings within the community. [The student was advised to] '*make conversation about different community events, everyday news, with the different patients. We gave her [student] hints on how to conduct small talk'* (Ruby)

For the student working in the operating theatre (OT) who did not engage in communication with the patient, Sarah organised a different clinical area, '*We brought the student out of the OT area and placed her into the PACU [Post Anaesthetic Care Unit] area, as well as pre-admission area. [Both these areas meant] the student had to interact with the awake patient'* (Sarah)

The strategies provided by the CLs required the student to be a listener and learn from others. An additional strategy suggested, was to encourage some students to participate in extra work experience within caring settings, thus having opportunity to practice the interpersonal skill of communication, a similar strategy to that described in the literature.

For the past 20 years in New South Wales (NSW) Australia, changes have taken place within undergraduate nursing programmes. These changes have led to a reduction in clinical practice hours for students. Mannix et al. (2006) describe how, because of these changes, the students are seeking out extra opportunities to gain further clinical experience 'over and above' what their nursing education programme provides. The NSW nursing students are choosing to work as nurse assistants either in hospitals or nursing homes. Mannix et al. (2006) explains that, although these students in this type of employment will not have the same supervision and assessments as they would in the programme placements, they will however, develop skills in problem solving and time management, and they will increase confidence in interpersonal skills. Eick et al. (2012) suggest that former work experience in

healthcare may reduce the unrealistic expectations and culture shock of clinical practice for the undergraduate nursing student. For the education facility and health care provider, prior work experience provides evidence that, not only does the student have an idea of what nursing entails, they also have learnt some basic nursing care skills. They have increased their confidence, thereby enhancing the clinical practice experience (Bambini, Washburn, & Perkins, 2009). Wilson et al. (2011) presented a report on the different reasons for attrition from nursing programmes, and suggest a few methods to reduce attrition in the future. They say ‘work experience of some type in a caring profession should be a pre-requisite for acceptance into the nursing programme’ (p. 459).

In the next section the participants discuss the value of earlier, proactive preparation, and comment on the significance of this kind of experience for building students’ confidence.

In 11 years as a clinical lecturer, Lucy has utilised a number of earlier strategies to support the student before clinical practice begins. Lucy emphasised that what helps build confidence in some students is to, *‘set things up well (---) in the beginning. It’s worth it, to spend a lot of time (---) going over expectations, going over familiarising with the area, procedures and terminology, it’s so helpful. (---) [There are] so many terms, complex terminology (---), common complex drugs [students] might not have heard of (---). [Familiarising in this way] gives them a better head start (Lucy)*

Frankie agrees, early pre-clinical practice preparation, may aid certain students in understanding expectations, and therefore, according to Frankie, increases placement confidence. *‘Speaking to the students [at each education facility] before they went on placement about expectations [was useful] (---). We scheduled two hours for this and called it practice preparation (---), went through patient expectations, professionalism, behaviours, action planning, smart objectives. (---) The bar was set very clear, everything [was] open and transparent’ (Frankie)*

Harriet has an open forum discussion on orientation day, this being the first day of clinical practice. Harriet believes it is a useful proactive measure to ask the students, *‘a tough question, I ask about their [students’] fears about clinical, (---) I find asking that question on orientation day [is] very, very valuable. Because there is an open forum, we discuss it. (---) Often some of the students have experienced these situations before and they come up with their own coping strategies that they have utilised in the past. The others get to hear this [sharing of coping strategies] too’ (Harriet)*

The literature agrees with the participants and suggests that assisting the student to enjoy the overall clinical experience results in increased confidence. Astin et al. (2005) and Urwin et

al. (2010) indicate that socialising them into the hospital environment is part of the answer. Effective socialisation requires relaying basic information to the student: how to recognise individual clinical roles, understand the layout of ward areas, equipment, 'ward etiquette' and teaching early 'hidden skills' such as admitting and discharging patients (Astin et al., 2005; Urwin et al., 2010). Mannix et al. (2009) agree, discussing professional socialisation is an integral component of undergraduate education, and stress that the student enters as a stranger but the goal is for them to fit into a health care team, and have a 'clear sense of belonging'. Mannix et al. (2009) explain the necessity, for an orientation period to help both with confidence and socialisation. This may include helping the student to negotiate travel to and from clinical location, and familiarisation with the staff and routines of the new area, all aiding the student to feel welcome (Earle-Foley et al., 2012; Grealish & Smale, 2011; James & Chapman, 2010; Mannix et al., 2009).

At one of the represented education facilities, simulation was employed as a learning tool before placement. The aim was to help prepare students, by increasing confidence, in learning to manage a potentially similar, real clinical situation, Frankie comments, *'we now do a simulation of a home visit, and we also do a waiting room simulation (---), it's confidence building, (---) better to be vulnerable and wrong in simulation. They [the student involved in simulation] scan the room, assess who's their priority, who's really unwell (---). A part-time clinical lecturer involved in the simulations said, "I'm seeing them better prepared (---) they're understanding things differently, so simulation is huge"'* (Frankie)

The last sets of quotes from Lucy, Frankie and Harriet express the view that some earlier preparation in terms of a robust orientation, clarifying expectations and dispelling 'fears', is advantageous. When addressing the 'unknown', of the clinical practice experience, a participant highlighted the benefits of working through scenarios in a simulated environment, and how this can improve student confidence before facing the real situation.

Simulation can assist a student to place themselves into 'realistic life encounters'. This helps to prepare them for the reality of the clinical environment. During and after a simulation session a student can consolidate theoretical knowledge, and thus gain confidence when faced with a similar situation out in practice. Promoting professional teamwork was also part of simulation. McNamara (2015) described a situation which involved patient care and a referral made to the multidisciplinary health team. This assisted in practicing effective verbal communication with correct clinical documentation (Grealish & Smale, 2011; McNamara, 2015, p. 199).

The next few participant quotes relate to more specific strategies in supporting the struggling nursing student:

Different approaches Ruby employed, while working with a struggling student in clinical practice, *'I would help the student to set specific goals or targets [each] week (---) if needed increase my [CL] visits with student, and if required I would work in [the] clinical area with the student (---). [Ruby would also] increase visits to talk with the preceptor, RN. Another useful support is getting students to work in pairs'* [this point was checked with Ruby post transcription and she confirmed that a student doing well can be a positive role model for a student not doing so well, [peer encouragement] (Ruby)

For a student whose confidence had *'spiralled'* [downwards] due to a break from clinical practice and upsetting personal issues, Aubrey developed an action plan with accountability. *'After reviewing specific assessments, hospital fluid and medication policies, and identifying actual and potential patient problems (---), I [CL] worked out an action plan, which was discussed at commencement of the shift with the student, and the RN [who was working with the student at the time]. The student was to discuss this plan with his supervising RN during and at [the] end of [the] shift. (---) Also his workload was reduced to two patients instead of four (---) so he can [have time to] develop and consolidate his skills really well, to be confident again'* (Aubrey)

It is acknowledged by the participants that the struggling student requires more concentrated focus and time to be put in by the CL. This focus involves action plans in collaboration with clinical staff, regular CL follow-up visits and if need be, decreasing the patient load so the student can focus on achieving specific learning goals, with the end result of increasing self-confidence. These shared excerpts demonstrate the worth of the CL facilitation role .

Both Heaslip and Scammell (2012), and Carlisle, Calman, and Ibbotson (2009) emphasis the valuable role of the CL, (stated as PEFs, practice education facilitator). They identify this role to be one of encouragement and 'on the job' support to the mentors/RNs, especially when dealing with evaluations and/or a 'struggling student' situation. To aim for successful collaboration and communication, between the RN and the CL, Fitzgerald et al. (2010) along with Astin et al. (2005) give details to guide the RN and CL. The aim is to meet on a regular basis, discuss specific student focussed learning goals, and then together evaluate the outcomes. Dobbs (2015) study corresponds and confirms, that clinical educators rely on preceptors (RNs) for feedback on student progression, commenting further, that the actual relationship between the preceptor, clinical educator, and student is a 'three-way partnership' (p. 166).

In addition the student, who's being prepared for clinical practice, should have a certain degree of 'work readiness.' Jackson et al. (2013), Grealish and Smale (2011) and Astin et al. (2005) suggest that 'work readiness' is evidenced by the student having sufficient curriculum work/theory consolidation. Pitt et al. (2012) state, in order for the 'theory to practice' link to be made in clinical practice, the student must have self-efficacy, a motivation to apply individual effort, especially in relation to attending class and completing homework.

The Strategies: Feedback and Reflection

For nursing students to grow professionally and mature personally, they need to receive, reflect, and act on feedback given. The more immediate and regular the feedback, the better the capability for learning to take place (Heaslip & Scammell, 2012; Levett-Jones & Lathlean, 2008).

The next seven participant excerpts endorse the literature discussed by reiterating the importance of early, regular feedback. They share strategies on what worked, and the different types of questioning utilised stressing the importance of partnering with the student.

Burt suggests, it's about partnership in the learning, with a commitment to giving early feedback. *'Earlier feedback [is] needed on a regular basis. (---) [The CL and RN should] negotiate a plan [with the student] re' dates or times for this to occur (---). Sometimes we [CLs] need to have [a] more direct and earlier confrontation on performance issues with students, but as we are partnering with them in their learning, start by saying [to the student], I heard this ---, I'd like to help you by ---, or this is not like you, what's going on for you right now' (Burt)*

Ella encourages gathering the information before giving the feedback, *'If the student is having issues gather all the evidence that you can and talk to everyone that's involved (---) talk to the nurse, talk to the charge nurse, [and] don't make a rash decision. Questions to ask [RNs/preceptors/Charge Nurse Manager] "Are you happy with [the] student's medication knowledge? Are you happy with how the student acted in that situation?" I found these questions really helpful' (Ella)*

Lucy concurs, specifically around the importance of talking with the RNs when gathering 'specific examples' in order to give clear feedback to the student. Lucy remembers a student, *'(---) not picking up on things. (---) She [student] doesn't seem to notice when [the] catheter bag needs emptying or what it means when [the patient's] blood pressure is dropping (---). [The student was] not prioritising stat order [medication to be given immediately to patient] for pain relief'. When asked how Lucy approached this situation she answered, 'first [I, CL would] gain specific examples, concrete examples*

from RNs working with students. Ask the student, how do they think they are going? [With] Socrates questioning [I, CL have] been able to gain insight to where [the student is] really at (---). We, [CL and student] sat down and made some goals (---) they [student] would practice pain assessment with me, of what they would actually say to [the] patient. Afterwards, I (CL) met with them, much more regularly to see how they were doing' (Lucy)

Socratic questioning, as discussed by Lucy above, poses questions that activate critical thinking skills. Included with critical thinking skills, is learner collaboration and reflection. These three characteristics together, according to Socrates, result in a deeper understanding of the issues and concerns, or the situation at hand (Kost & Chen, 2015). Socratic questioning has three components:

1. An interpretative question is presented to a group of learners working collaboratively together
2. The interpretative questions may lack a specific answer however their aim is to activate prior knowledge, identify and explore misconceptions and facilitate discussion amongst the group that will assist insight into the problem
3. Group reflection, or debriefing on the discussion analyses both the content and process, refining the thinking of individual members and promoting the growth of a safe and supportive future learning community (Kost & Chen, 2015).

The challenge for educators when posing a question, is to ensure the learner feels 'safe, respected, and supported' (Kost & Chen, 2015, p. 22). Three recommendations for improving questioning include: the educator presenting learner-centred questions, the application of Socratic teaching methods to engage critical thinking, and finally, a preparedness by the clinical educator to be more open-minded in exploring adult teaching theories to improve the use of questioning in their practice (Grealish & Smale, 2011; Kost & Chen, 2015).

A student had developed 'fear' in the clinical practice situation. They had become 'shutdown and quite surly'. Margie said she was called into clinical placement to see the student and dealt with the situation like this, 'I call it the art of gentle questioning (---) it's around trying to unpick what is happening and checking it out earlier rather than later. [In the art of gentle questioning] I get the student to tell me about that [the situation that happened]. [The types of questions I, CL would ask], how was that for you? How did that feel? What did you learn?' (Margie)

Frankie discusses the importance of reflective learning, following clinical practice and suggests asking the student, '*What did you get out of this placement? Where does it fit? How does this fit in your learning?*' (Frankie)

When gaining information from a student or testing their knowledge, an open ended question is asked, to get the information required. Schein (2013) looks into this form of inquiry more deeply by exploring the meaning of 'humble inquiry'.

'Humble inquiry is the art of drawing someone out, of asking questions to which you do not already know the answer, of building a relationship based on curiosity and interest in the other person' (Schein, 2013, p. 21).

Schein (2013) promotes 'humble inquiry' as opposed to 'leading, embarrassing or rhetorical' questions, as these are often intentionally challenging types of questions, regularly used by journalists, and can have a demeaning effect. Whereas 'humble inquiry', is the form of asking questions out of mutual respect, builds an environment where a person feels safe to bring up any issues and does not feel judged for doing so.

Schein (2013) makes a point about the culture of today being a 'do & tell culture', an individualistic culture, where it's all about the individual getting the job done to benefit themselves alone. The opposite is a culture of listening and asking questions whilst building a relationship to work as a cohesive team. When educating health professionals to manage and provide safe patient care, 'humble inquiry' creates a climate that gives permission for help to be given, and leads to trust and improved communication, whilst working in a partnership model (p. 3).

Feedback is a useful tool. Ella agrees it's a, '*good way to grow yourself*'. Ella, when working with a third year student, suggests guidelines she has found useful, '*Be direct in conversations [with the student] and embrace difficult topics*'. However, sometimes when discussing difficult issues with the student, Ella explains they (the student), can go on a, '*downward spiral and lose confidence (---) that's why I like the feedback sandwich, so you give a good bit of feedback and then some not [so] good feedback and [lastly] some more good feedback, so it's like softening the blow. I think as a Clinical lecturer you have to be really careful about how you give feedback and how it's going to be interpreted by the student*' (Ella)

Sarah explained a similar style of feedback that she employs when signing off competencies. Sarah emphasises, if a student is '*marginal*' [indicating the student is not fully independent in attaining certain NZNC competencies] it is important for the CL to mark it down as '*marginal*'. However, Sarah

stressed, *'Don't leave it there'*. Get them [the student] to think about *'learning goals'* for going forward. Sarah explains the feedback tool she uses, *'[As the CL, I give] guidelines of instructive feedback. Look, [speaking to the student] you're doing really well in this, this bit is ok, however, there is room for improvement [here]. But actually here [in this area] I have concerns about this (---). A year three BN student should come up with their own goals around feedback, but of course, a struggling student won't!'* (Sarah)

The CLs make it obvious that regular feedback is important, and highlight that, when gathering information around the issue, it is crucial to get specific, concrete examples from the student themselves and other clinical staff. Different models of questioning are suggested along with the direct approach, always, remembering constructive feedback includes positive reinforcement of things that are going well. It was agreed the student should not feel judged, but instead, after the feedback, have a clearer direction to go forward in their learning

It's clear that most nursing students want honest feedback, to pinpoint areas for improvement. Dryden (2013) suggests the feedback needs to be immediate, following the event, rather than days later. She asks the students to comment on their own performance, which is useful in showing the bases of their understanding, as the student may have been misled or misguided by others, or subjected to poor role modelling. Dryden (2013) then applies the 'feedback sandwich' technique, when giving feedback. This consists of positive feedback in the beginning, and at the end of the conversation, with 'negative aspects in the middle' (p. 61). Schartel (2012) argues this technique has some drawbacks. He qualifies this by saying, the feedback sandwich is thought to be a technique that makes it easier for both the receiver of the information and the giver of the feedback, however he claims the learner (receiver) of the feedback, often disregards the positive information waiting with much anxiety for the negative feedback, and where a critical breach of practice has taken place the 'feedback sandwich' tool, could confuse the issue. Schartel (2012) suggests, whatever feedback model is utilised by the educator/feedback provider, they should first consider the PEARLS approach (Table 2) in creating a supportive setting, and ensure the feedback is directed specifically towards knowledge or actions that can be changed.

Table 2. PEARLS approach (Milan et al. as cited by Schartel, 2012)

Partnership for joint problem-solving
Empathetic understanding
Apology for barriers to the learner's progress
Respect for the learner's values and choices
Legitimation of feelings and intentions
Support of efforts at correction

Effective feedback combined with reflection are important components of student learning and both have the ability to facilitate the development of personal and professional growth (Levett-Jones & Lathlean, 2008). Critical reflection comes through an openness to new experiences. It can be described as a, 'systematic, experience-based and theoretical analysis' (Dickson et al., 2006; Klaeson, Berglund, & Gustavsson, 2016). Before assisting the student to critically reflect, the education facilitator, or CL, should know themselves and know their limitations. When these are recognised, the facilitator is usually more collaborative in the use of other resources in the clinical learning environment. The literature states, an educational facilitator can increase professional self-confidence and self-awareness in a student, while role modelling the habit of critical reflection in their own practice (Cassidy, 2009; Dickson et al., 2006; Dobbs, 2015; Grealish & Smale, 2011).

Klaeson et al. (2016) suggest three things to observe in a nursing student who practices critical reflection; firstly, an openness to change, which could be evident in a willingness to change their self-perception or having self-motivation towards extending their professional development. A second characteristic is the student's ability to step back from the situation and be in a better position to process and understand it. This may occur by using a reflective journal or diary, thus reminding the student of what was learnt, or to discuss the events by initiating a conversation with their mentor/RN, or learning facilitator/CL around the event. And thirdly, can the student deepen their understanding by showing confidence and willingness to ask brave questions?

Reflection is seen as a positive learning tool, and one encouraged by the participants in this research as a worthwhile strategy.

A valuable questioning/reflection tool, that was role modelled for Sarah was to *'listen to other really experienced Clinical Lecturers (---) leave a question [posed to the student] hanging. Don't answer it and just leave it [the question] hanging, see what they [the student does] with it. We [the CL] want*

to help, we want to direct, and we want to say what the problem is, but this doesn't help them [students]. Guide reflection, get [the] student to see or have insight into themselves' (Sarah)

Ella comments about reflection from her CL experience. *'Clinical experience reflection is really useful, and again, it's a good way to grow yourself (---) get [the] student to do self-assessment [asking the student] what are your strengths? What are your weaknesses? and What do you need to work on?' (Ella)*

From Ruby's perspective, reflection during clinical practice is a positive thing. *'Where there is more than one student, bring them together and get them to reflect on their experiences within that clinical area (---). When I first started the role [CL role] we had weekly [reflection] sessions, they were not too structured (---). In my [group of students] reflective sessions, I utilised a reflective model, Gibbs reflection model. (---) We got quite a lot of value from that (---). The RNs perception on the ward was, "oh reflection is a waste of time", but from the students' perspective, they got a lot from that and that was comradery' (Ruby)*

A reflection model called, 'The Gibbs reflection model' is discussed by Chong (2009). She claims it to be a well-known reflection model, used by many practitioners. This model implies that to be successful, the process of reflection must follow a logical format of six basic stages: describe the event, identify your feelings, evaluate the experience, analyse the experience, draw conclusions and draw up an action plan. Chong (2009) carried out a descriptive survey of 108 final year nursing students, who used 'The Gibbs model' of reflection and concluded, 'the majority of the students did not do well in their reflective practice. Only a minority of students felt comfortable with reflection, as the course progressed' (p. 112). Barksby et al. (2014) question 'The Gibbs model', stating it to be 'vague', repetitive, and overall a model where the steps are not easy to recall. According to Barksby et al. (2014) a new reflection framework was needed and therefore further developed, by Butcher and Whysall as cited by Barksby et al. (2014). This model is called the REFLECT Model, (see Table 3) and has seven stages, guaranteeing the student/students a more in-depth but uncomplicated reflective learning cycle with mnemonics making it easy to use and remember (Barksby et al., 2014).

Table 3. The REFLECT Model (Butcher & Whysall as cited by Barksby et al., 2014, p. 22)

R – RECALL the events (stage 1)

Give a brief overview of the situation upon which you are reflecting. This should consist of the facts – a description of what happened

E – Examine your responses (stage 2)

Discuss your thoughts and actions at the time of the incident upon which you are reflecting

F – Acknowledge FEELINGS (stage 3)

Highlight any feelings you experienced at the time of the situation upon which you are reflecting

L – LEARN from the experience (stage 4)

Highlight what you have learned from the situation

E – EXPLORE options (stage 5)

Discuss options for the future if you were to encounter a similar situation again

C – CREATE a plan of action (stage 6)

Create a plan for the future – this can be for future theoretical learning or action

T – Set TIMESCALE (stage 7)

Set a time by which the plan outlined in stage 6 will be complete

Lucy appreciated the value of group reflection not only for the students, but also found it useful in her own CL role. Group reflection guided Lucy to adjust the education, to meet the learning needs of some students. *'We always had reflection once a week and it's wonderful because we have groups of students together, sometimes two [clinical] ward areas. It is [group reflection] so valuable for one area to hear about the other area, and hear common themes and common concerns. Each week we'd go over some key competencies (---) so they [students] knew what those competencies actually meant, and it was really good learning (---) sometimes you hear them reflecting on things [and] it made me [CL] realise gosh, they don't understand some things and I could put a quick little teaching in (---) this helped to clarify some misconceptions'* (Lucy)

Margie also agrees that a weekly group reflection is a *'professional way'* to learn from each other, as it gives an opportunity for certain students having difficulty to be encouraged by one another *'When articulating their practice (---) they [the students] are blown away by each other, they look at each other and they go wow, haven't we come a long way!'* (Margie)

Aubrey made group reflection a part of the weekly plan, *'sitting down weekly in a group to reflect on their [the students] week (---) I think they sort of feel, they can talk to other students, if there's an issue'* (Aubrey)

In summary, the participants agree guided, regular reflection is an effective way to develop professional practice. Three participants commented on the value of group reflection, firstly, for themselves, by identifying existing student knowledge gaps, and secondly, for the students and the value of learning from peers.

To help students integrate the learning and make ‘informal and incidental knowledge more visible’, Roberts (2009) advises bringing the students together on a regular basis to reflect on and share their experiences from clinical practice (p. 371). Klaeson et al. (2016) agree, and consider the reflective group meetings are useful to help particular students to articulate and merge the theoretical and experienced-based learning.

The Strategies: Lack of Continuity and Valuing

The participants provide two strategies that could support the students as well as the nursing staff in the clinical setting.

Tina considers there’s a need for organisational changes, from a higher District Health Board (DHB) level, to promote a better continuity of nursing staff working with a student, *‘they [the student] might just be with that Registered Nurse on that day, for [just] one day and [in general] the nurses are so busy, they don’t seem to get a reduced workload when they have a student, which is something we could maybe do better in the future. (---) this is the whole idea around the Dedicated Education Units which we are actually trying to implement --- we are hoping in the future that will be a better solution (---) as this is a challenge for us and the students as well, to get that continuity’* (Tina)

Sarah points out the benefits for a struggling student of staying in the same, smaller post anaesthetic clinical area, *‘[This clinical area works] with the preceptorship [model]. That area was reasonably good [with] the student being with one or two people, not somebody different every day. (---) She [the student] stays here, she doesn’t go there [different clinical area], she stays here and she stays with the staff that know there are concerns around her knowledge and practice’* (Sarah)

The literature augments the research findings, by confirming that the quality of students’ learning in clinical placement, is dependent on interactions with, and consistent support of the nursing staff/RNs. It is beneficial and confirming therefore, to have both the appointed RN, and the student rostered together. This can provide some enlightenment into each other’s roles and, assist the links between theory and practice. It also gives the opportunity

and quality time to negotiate how each person may fulfil their responsibilities, while in clinical practice (Haitana & Bland, 2011).

The literature also reminds us the RN's primary focus is the clinical needs of their patients. These are complex and demanding on their own, nevertheless the RN is expected to involve the student in the provision of care of patients, thus creating opportune moments to facilitate student learning (Earle-Foley et al., 2012). Henderson et al. (2010) discuss support for the RN as a solution and expand on an experimental study carried out with 62 undergraduate students (year two and year three), situated in two acute/surgical wards. The aim of the experiment was to 'build capacity of RN's to enhance the clinical learning environment' for the BN students (p.177). To support the RN, whilst working with the student, a supernumerary clinical facilitator (CF) from the education facility was assigned to a particular clinical area. The CF was assigned to eight students, and was knowledgeable about their learning objectives and competencies to be achieved while on placement. Throughout the experiment, the CF obtained feedback about the students from the RNs, the CF also whilst working alongside the RN, was responsible for supervising and assessing the students. The second resource role in this experiment was that of an experienced educator/researcher, who was not only involved in managing the intervention, but every second day came to the identified areas and offered education to the RNs on how best to support and engage the undergraduate student. The results of this 'capacity building' experiment, showed it to be an effective model in assisting and supporting RNs to engage with students. However it was suggested, for positive changes to be maintained, this type of intervention or something similar, must be valued enough to be put-in-place for the long term (Henderson et al., 2010).

The CF in the discussed experiment is equivalent to the CL role in this research. One of the CLs interviewed, works in the Dedicated Education Model (DEU), a similar type of education model used in NZ, to that of the Henderson et al. (2010) experiment. The DEU model has been discussed in the introduction section. However, to clarify the comparison, the principle of the DEU model is to, provide clinical placement areas with a designated education facilitator, known as an Academic Liaison Nurse . Combined with this Academic Liaison Nurse role, an RN from the clinical placement area, is identified as a Clinical Liaison Nurse. Both the roles of the Academic Liaison Nurse and the Clinical Liaison Nurse work collaboratively, to support the learning of six to eight students (Jamieson et al., 2008).

Self-Care and Support on the Job

The findings of this research revealed a few challenges that confront the CLs themselves, and although these concerns do not directly relate to the research questions, I have chosen to include them, as they do indirectly relate, to the CL and their ability to support the ‘struggling’ student.

Throughout the interviews three CLs discussed the importance of avoiding isolation, when working as a CL, stressing the need to work in a team setting:

‘Clinical lecturers should try to avoid working in isolation. More support is needed, more forums and discussions are needed around the struggling student’ (Harriet)

‘Get together as clinical lecturers regularly, liaison and offer support’ (Ruby)

‘Work in team, [make] no decision alone’ (Tess)

These findings are consistent with another study, where 21 Clinical facilitators (CFs, a similar role to that of the CL) were interviewed. The study showed that Nurse Clinicians are often employed into adjunct CF positions, ‘based solely on their clinical expertise and not on their knowledge of adult education’. Themes identified in this study for CFs were, ‘feelings of unpreparedness’, ‘ill equipped’ and ‘a sense of isolation’ (Roberts, Chrisman, & Flowers, 2013, p. 300).

Useful suggestions and solutions to avoid isolation, and feel supported, as suggested by the CLs.

Tess gives her reasons, for valuing the team approach. *‘(---) I think that [working as a team] would really help Clinical Lecturers [understand] how [the] formative assessment is used (---). [This would help] to provide consistency for clinical lecturers when assessing students (---) it would really improve student confidence in their performance, if we could use this tool [formative assessment] properly’* (Tess)

Amelia appreciated the fact that some positive changes have occurred in supporting CLs. She had other suggestions for the future, *‘it’s good how they have formalised Clinical Lecturer meetings (---) I think that’s actually a good forum to come and share examples. (---) We’re looking for consistency but also to see what sort of feedback other clinical lecturers [have given] as this may help some of us’* (Amelia)

Harriet expressed the opinion that CLs should get together to discuss ideas in a forum setting. *'I think there need to be more forum discussions for clinical lecturers to be able to share their ideas, to share their practice experiences as well. I think we encourage our students to learn from each other and we should be doing the same with ourselves. At Clinical Lecturer orientation day [we should] have an open forum about worst fears, anxieties [we should] look at solutions, come up with strategies, as a group look [we should] at what was utilised in the past, this helps alleviate [CL] fears and anxieties'* (Harriet)

When asked how, CLs could be more supported in their role, Burt recommended, more dialogue and the sharing of cases, *'the opportunity for dialogue (---) is not [always] there in a formal way. So case conferences for example, these sorts of forums, more focus, case conference (---) be prepared to challenge each other, I suppose (---) that takes confidence and maturity in the group (---) and [in] any meetings we have it [should] always [be] about knowledge exchange or research'* (Burt)

The participants in this research agree that working more together *'as a team'* rather than in a *'isolated'* way would help to champion the CL role. According to the CLs, the result of team support would be; better consistency in feedback and formative assessments, case conferencing struggling students in order to recognise early signs of issues, and lastly, the sharing of ideas and strategies in supporting the struggling students. The literature underlines the need for further supports for the new CL.

Based on study results from Roberts et al. (2013), certain strategies could be put in place for CFs (CLs), who are new to the role. This includes, orientation to both the education facility and the curriculum/course requirements. Brown et al. (2007) agree, adding new CLs require clear communication and guidelines around how to respond to, or manage a student, who is facing issues, when on clinical placement. Neese as cited by Roberts et al. (2013) suggests, socialisation into the role, for the new clinical educator is essential, and can take place by being included, in meetings and student handover sessions. Furthermore, having a more experienced member of the education facility mentoring the new comer, offers support and endorsement of this key role. Dickson et al. (2006) agree and indicate, mentorship is helpful and can help guide the new CL to the importance of setting up significant meetings and forming alliances with key clinical staff. Throughout the clinical placement, the new CF/CL should have access to online resources, text books and policies, guidance in learning how to moderate students' written work, and an invitation at the completion of the clinical placement to be involved in the evaluation processes. With ongoing support and mentoring,

the new CF/CL will learn to critically reflect on their practice thus facilitating a positive shift into their new role as educator (Dickson et al., 2006; Roberts et al., 2013).

Summary of the Findings

The key findings presented in this chapter, have shown the importance of communication and confidence, feedback and reflection, and lack of continuity and valuing, when it comes to supporting nursing students. Firstly, effective communication is a necessary skill for nursing students, in order for a rapport to be built with their patients. Useful strategies were identified, varying from the student working in caring settings to prepare themselves, and increasing simulation scenario work, prior to clinical placement. The second theme demonstrated that personal and professional growth comes from honest and timely feedback, shown to be valuable when offered in a supportive setting. From this analysis, the useful tool of reflection was identified as a follow-up to feedback, this being effective either individually or in group. Reflection has been shown to be a 'good way to grow yourself'. Thirdly, convincing evidence outlines the importance of the connection between the student and the RN in the unfamiliar clinical practice environment. It is concerning to see the lack of continuity, in the same or familiar RNs working with the students, this having the potential to undermine their (student's) 'sense of belonging' and ability 'to fit in'. More support for the RN, in sustaining continuity in working with students, is paramount as the literature confirms. Successful student learning comes from this consistent relationship.

Lastly, a finding which may indirectly affect student learning and that is the challenge of feeling alone in the role of being a CL. Solutions suggested to endorse and strengthen this role could include: mentorship, orientation, inclusion and the overall importance of 'working as a team'.

The findings have produced 'information-rich' data, assisted by purposeful sampling of the data set. The participant excerpts presented the 'facts in everyday language', representing valuable 'end product' research (Sandelowski, 2000, p. 335 & 336). Further discussion, with recommendations for the future, will continue in the next chapter.

CHAPTER SIX: DISCUSSION

Introduction

‘Today’s students are the nurses of tomorrow ----- these nurses of tomorrow deserve the best preparation we can provide them’ (Mannix et al., 2006, p. 10).

Utilising a qualitative descriptive design this research explored the insights and experiences of CLs working alongside the BN student nurse. There are undeniable challenges for some NZ student nurses when encountering the clinical practice experience. The present clinical environment is dynamic and becoming increasingly more confronting. For some BN students entering this unfamiliar setting can be somewhat of a culture shock leaving them with a sense of uncertainty and confusion. In response to this and combined with the challenges of meeting course outcomes and expectations, the BN student may start to struggle.

The research aim was to identify strategies that CLs can put in place, to support the struggling nursing student in clinical practice. Using purposeful sampling 14 participants volunteered to be interviewed all of whom are registered nurses as well as CLs. At the time of the interviews 13 of the participants were employed at two different NZ nursing education facilities and one participant had been recently employed. Each CL had supported nursing students at varying levels of the BN programme together totalling 157 years of CL experience.

Semi-structured interviewing was used on a one-to-one basis and encouragement was given to the CL to talk freely. Informed consent was gained and the interview was recorded and later transcribed. Broader questions were asked initially to place the participant at ease, then the questions became more focussed and were guided by two research questions: What are the issues CLs identify that face the BN student in clinical practice? What strategies can CLs put in place to support the struggling BN student in clinical practice? The CLs’ stories flowed easily as they became absorbed in the opportunity to reflect on their practice experiences.

Three main themes emerged: communication and confidence, feedback and reflection, and lack of continuity and valuing. Student nurse communication was described as ineffective at times and this, according to the CLs, was often linked to low self-confidence. Both the tools of feedback and reflection are required to learn and develop as a nurse. However, both were

often portrayed by the CLs as not being well understood or utilised. The lack of continuity and valuing was the third theme, revealing the student nurse was not always able to work with the same familiar RNs on a regular basis. This was expressed as a significant issue particularly if the student was struggling in clinical practice. The resultant outcome sometimes meant both the student and the RN felt undervalued due to the continuity of relationship not being respected. I will address the three themes further in this chapter and discuss additional, noteworthy comments made by the participants.

Developing a Professional Voice

The student nurse when learning how to communicate is developing his or her own professional voice. The research participants identified the fact that some of the nursing students they had worked alongside had poor communication skills. This issue was shown in two ways:

Firstly, poor and inappropriate communication with, and in front of the patient:

‘She lacked the ability to talk with patients as well as inability to initiate the small talk’ (Ruby)

‘Student asked inappropriate questions in front of the patient while the patient was being anaesthetised’ (Sarah)

Secondly, ineffective communication with others in the clinical area:

‘Biggest issue, is students not communicating effectively with preceptor, not communicating their learning needs’ (Tina)

Unsafe clinical practice is recognised as behaviour that places the patient or clinical staff at risk of either physical or emotional harm. Brown et al. (2007) had examined what constituted unsafe clinical practice researching collaboratively with three other nursing education facilities. It was established there were five key indicators of unsafe practice and one of these is ineffective communication both with patients and clinical staff (Brown et al., 2007; McCarthy et al., 2008).

Due to the development of therapeutic and relational communication skills being a core component of the BN programme, the student nurse is required to develop and become competent in this kind of communication with the patient, nursing staff and other inter professional team members (Nursing Council of New Zealand, 2014).

One CL suggests the student nurse will develop a '*nursing voice*', though, it is a challenge for the student to '*grapple*' with, '*I believe they are coming to terms with the whole thing around the development of their professional nursing voice. Nursing is verbal we talk a lot but it is the development of that professional nursing voice and I believe that can be quite challenging*'.

Previous literature studies suggest ineffective communication may be the result of a student being anxious or having low self-confidence. In a busy and unfamiliar clinical environment a student may experience anxiety which in turn can affect his or her ability to learn.

Subsequently errors can occur, resulting in a further decrease of confidence (Loureiro et al., 2011; Pitt et al., 2012). The research findings reflect the literature as participants also identified students presenting with decreased self-confidence and explained this as a possible reason for ineffective communication. A CL recalled a student who had '*lost his confidence completely*' and '*absolutely spiralled down*' and another student who '*lacked initiative and confidence in the social setting*'. In terms of other possible reasons for ineffectual communication, two participants identified the fact that a few students lack the ability to engage in small talk, and secondly, some students are reported as lacking theoretical knowledge which is needed in order to make the theory to practice link in the clinical setting.

To improve communication and increase confidence, the CLs shared strategies that were consistent with those outlined in other academic studies. One of these strategies comprised the student being encouraged to consider part-time work, for example a healthcare assistant in residential aged care. Another strategy suggested was the organisation of a student orientation to the clinical area. This included '*going over expectations, going over familiarising with the area, procedures and terminology*'. Asking the students on orientation day, in an open forum what were their '*fears*' about clinical practice proved to be a worthwhile strategy. The students '*fears*' were discussed openly and sometimes other students had the same concerns or '*fears*', then together the group could come up with the right solutions to manage these.

The literature agrees an orientation is necessary to assist with building student confidence and this also helps to socialise the student into the clinical environment. Socialising involves helping the student to become familiarised with clinical staff and routines which gives the student a sense that they belong to a team (Astin et al., 2005; Bambini et al., 2009; Eick et al., 2012; Grealish & Smale, 2011; Mannix et al., 2006; Mannix et al., 2009; Urwin et al., 2010; Wilson et al., 2011).

Both the literature and research findings pinpoint simulation to be a key strategy to increase confidence, as it prepares the student for what to expect and teaches the student how to conduct themselves in the clinical setting (McNamara, 2015). One CL considered simulation to be a useful learning tool that should take place in the Education Institution before clinical placement begins as it will help in '*confidence building*'. Other results of simulation were identified by another CL. '*We are seeing them [the students] better prepared*' and '*they're understanding things differently*'.

Although the literature is sparse on specific methods for teaching effective communication to the student nurse, there is plentiful literature that supports the role of simulation. Simulation integrates the skills, knowledge and assessment of nursing whilst learning how to communicate with the patient and other multidisciplinary team members (Grant & Jenkins, 2014; Grealish & Smale, 2011; Hood, Cant, Leech, Baulch, & Gilbee, 2014; McNamara, 2015). Simulation can be described as 'something that isn't real but is authentic'. This is useful as it exposes nursing students to active learning in preparation for the clinical environment (Bland, Topping, & Wood, 2011, p. 665). It is reported that students favour simulation over other teaching methods and Bland et al. (2011) suggest this is due to simulation being conducted in a safe non-threatening environment with active participation and engaged student learning.

Conclusively the literature and research findings are both in agreement that the roles and collaboration of both the RN and the CL offer crucial support and encouragement to the nursing student. The student has a privileged opportunity to observe, listen and learn through role modelling of both the RN and CL and in so doing learn how to communicate effectively (Carlisle et al., 2009; Coyne & Needham, 2012; Dobbs, 2015; Fitzgerald et al., 2010; Grealish & Smale, 2011; Mannix et al., 2009; McCarthy et al., 2008; McNamara, 2015).

A Good Way to Grow Yourself

The second theme to emerge from the findings was feedback and reflection. These findings were described by the participant as '*a good way to grow yourself*'. Previous studies inform us that students expect honest and immediate feedback (Fitzgerald et al., 2010). The research findings reveal that student nurses are not getting effective feedback. Mistakes are going uncorrected and at times causing the student's professional and personal growth to be slow or absent. One CL comments, [as clinical support staff, whether it be the RNs or the

CLs] *'we don't challenge'* the students and are *'not being honest'* with them. Two other CLs explain that the feedback can be *'inconsistent'* or *'not always constructive'* and not *'always timely'*.

The literature cited further reasons for ineffective feedback processes. Wells and McLoughlin (2014) explain that both managing a struggling student and dealing with the conflicting demands of the clinical setting are time consuming. Kost and Chen (2015) express the opinion that there is not enough knowledge about the correct feedback tools available to clinical educators.

Student nurses in clinical practice are required to complete formative and summative assessments. The formative assessment is approximately mid-way during clinical placement and it measures performance against learning objectives and competencies. The summative assessment must be completed at the end of each clinical placement and the student must pass this. Formative feedback identifies earlier, student strengths and areas for development around the different competencies. It is therefore extremely important for feedback to be delivered logically, honestly and clearly at the formative stage.

Research findings confirm that feedback should be given to the student *'earlier'* and on a *'regular basis'*. The more immediate and regular the feedback the better the capability for the learning to take place, thereby allowing the student to have optimum opportunity to pass the summative assessment. Two CLs comment that it is valuable to ask questions of other clinical support staff in order to gain *'specific examples'* and clear facts before giving feedback. In terms of feedback tools that get utilised, two CLs commented that they use *'Socratic questioning'* and the *'gentle art of questioning'* in their practice. Another CL uses *'instructive feedback'* a tool that expects the student nurse to come up with their own learning goals following the feedback. However, it was acknowledged that a struggling student would probably not manage to compile these goals.

When promoting effective feedback for future nursing students it's suggested by Heaslip and Scammell (2012) that more immediate feedback is required. This type of feedback will help to improve learning opportunities and assist students develop to their full potential, whereas feedback given only at the end of clinical practice denies them this opportunity. Feedback is most beneficial when it is given to address specific incorrect interpretations rather than just addressing a lack of understanding overall. However, where there is a lack of knowledge the learner would most likely benefit from further education (Schartel, 2012). Solheim, Plathe,

and Eide (2017) propose the use of a tested and workable feedback framework if formative assessment is to be successful. They devised a scenario assessment tool where nursing students were being assessed on practical, holistic competence and patient-centred skills. The feedback on the student's performance was given by both peers and educators and was intended to help in two ways, firstly, to help prepare the student for the formative assessment and secondly, the chance to practice the skill of reflection. Solheim et al. (2017) on completion of the study suggest a recommendation, that constructive feedback should be guided by clear criteria that align to the learning outcomes. They also noted that critical thinking for the student nurse was initiated when observing others working through the scenarios. Together with the use of reflection the learning in this study became more evident for both the student and educator (Solheim et al., 2017).

One CL commented that clinical reflection is a useful tool and she encourages her students to use it as *'it's a good way to grow yourself'*. Also the sharing of experiences and learning from each other through regular group reflection is something that a few CLs described as a positive strategy. One participant suggested group reflection is a *'professional way'* to learn from each other and witnessed students sharing in a group being *'blown away by each other'* when they heard how far they had all come. Another CL supported a weekly reflection opportunity as *'they can talk to other students if there's an issue'*.

The literature discussed a similar stance by encouraging clinical educators to organise students to work together with peers while in clinical practice as this will facilitate both a sense of community support and allow integrated peer learning (Klaeson et al., 2016; Roberts, 2009). Reflection requires the student to think and critically analyse their clinical experience and actions with the end goal of reinforcing the learning whilst improving their practice. Within the current clinical environment students are facing *'increasingly complex, uncertain and multifaceted realities in practice, which do not always neatly fit into existing research'* therefore the tool of reflection can be beneficial to make sense of these realities (Barksby et al., 2014, p. 21).

Lastly both the findings and the literature concur about the positive benefits associated with critical thinking and self-reflection. Furthermore the literature emphasises that both of these skills are essential for the work ready graduate (Heaslip & Scammell, 2012; Jackson et al., 2013; Levett-Jones & Lathlean, 2008).

Valuing the Continuity of the Relationship

A challenge presents itself for some students if there is a lack of continuity in working with the same nursing staff on a regular basis. This research highlights this finding as significant particularly if the student is facing some struggles within the clinical component of their course.

Ten CLs identified lack of continuity to be an issue:

Two participant explained that sometimes the RNs who have been allocated to work on a regular basis with the students are not rostered on the same shifts and this can make things very difficult, especially if the student is struggling and needing support:

'In the preceptorship model you are wanting consistent preceptors. One main issue would be inconsistent preceptors and nobody knows what's happening with the student'.

'It was difficult getting them [the RNs] to have consistency with a student [particularly] if there were any problems and if the student had difficulty'.

The research findings on this theme, lack of continuity and valuing, agree with the literature. The literature identifies the fact that there are several factors causing this situation such as mounting pressures within clinical environments, high turn-over of nursing staff and an increased number of junior staff in certain clinical areas. Sometimes, the literature explains, the plans that have been put in place for example, having specific experienced RNs working alongside the students are not always valued by management or the wider Healthcare organisational structures (Haitana & Bland, 2011; Hamshire et al., 2012; Zilembo & Monterosso, 2008).

Two participants described student outcomes that relate to lack of continuity:

Firstly, for the student it's as though they are being a burden, *'one of the student's greatest fears is that of not feeling welcome or feelings of being a burden'*. The CL shared an incident where a casual nurse [a RN who works in a different clinical area every shift] was allocated to work with a student and made the statement, *"I don't work with students"* the CL commented [in this situation] *'the student starts to feel like a burden'*.

Secondly, the lack of continuity can have an impact on the student's learning, as working with a different RN everyday can mean *'different expectations'* and sometimes a student is *'forced to go back to basics or having to re-justify the skills'*. A CL comments that due to

lack of staff continuity *'there will only be a very superficial layer that is addressed in the knowing'*.

The literature confirms the RN plays a crucial role in clinical learning. The student nurse experiences the reality of daily clinical practice when working alongside the RN. Not only is the RN a role model and resource person in teaching the student how to care, but the RN also acts as the last quality control measure ensuring the nurse graduate is a competent professional (Dobbs, 2015; Earle-Foley et al., 2012; Mannix et al., 2009). The literature states this clearly 'Public safety remains the responsibility of registered nurses. The crux of nurse education is to ensure public safety' (Dobbs, 2015). Consequently it's very important to value the role of the RN. Likewise in valuing the student it would greatly aid their success in the clinical learning journey if they did not have to repeatedly build new relationships with nursing staff (Earle-Foley et al., 2012; Elliott, 2016; Vallant & Neville, 2006).

Findings in this research explain that the strategies for this issue are not so straightforward due to the wider challenges at management or Health Care Provider organisational level. A CL suggests that the managers of the clinical areas can both value and support the student by understanding the importance of continuity in the relationship and can assist by regular rostering of students with the same familiar RNs. If the student is struggling, the continuity of relationship is particularly important. A CL described how a smaller clinical area supported a struggling student by identifying two specific RNs to work constantly alongside that student in the last part of their placement, making the comment the student *'stays with the staff that know there are concerns around her knowledge and practice'*.

Extra support from managers would come in the form of reducing the RNs patient workload this can bring value to the time that it takes for RNs to offer quality student teaching (Carlson et al., 2010; Fetherstonhaugh, Nay, & Heather, 2008). Zilembo and Monterosso (2008) suggest collaborative efforts between the Nursing Education Facility and Healthcare Provider could ensure that RNs get the preparation and continuing support they need for the mentoring role. One experimental study from the literature discusses 'capacity building' as a possible strategy. This is where a clinical educator similar to CL role is placed in the clinical area to work alongside the RN. In this situation both roles are responsible for supervision and assessment of the students so therefore provide support for each other. This experiment also identified 'capacity building' to be an effective model in assisting and supporting RNs to engage with the students (Henderson et al., 2010). In the findings two CLs shared about

the DEU education model, a similar model to the ‘capacity building’ idea. The DEU model is where the clinical educator or CL works collaboratively with the clinical area including the management, and offers support by working in partnership with both the student and RN (Jamieson et al., 2008).

Put Your Own Oxygen Mask on First

When flying on a plane we are instructed to ‘put on your own oxygen mask before helping those around you’. This important emergency message is something I feel relates to the CL role as, in order to care for and support others, you must first sustain and equip yourself.

Additional comments by the CLs identified a possible indirect reason why some students may struggle. A few CLs explain that they themselves have experienced a genuine feeling of ‘*a sense of isolation*’ in the CL role. The literature echoes this finding and adds other examples where clinical educators have had ‘feelings of unpreparedness’ and feelings of being ‘ill equipped’ (Roberts et al., 2013).

Looking into the future, the literature proposes that new clinical educators would benefit from receiving an orientation, and working with a designated mentor for a period of time, thereby assisting the new CL to meet key clinical staff and have an awareness of resources available to them for the role (Brown & Sorrell, 2017; Brown et al., 2007; Dickson et al., 2006; Roberts et al., 2013). Adelman-Mullally et al. (2013) suggest the role goes further and challenges the clinical educator to develop leadership skills. ‘Inspiring others and leading change are attributes of effective leaders that are crucial in preparing nursing students for professional practice’ (p. 30). They therefore advocate a ‘clinical scholar model’, or other programs that develop leadership skills (Adelman-Mullally et al., 2013).

The literature agrees with the findings by stressing that clinical nurse educators contribute greatly in guiding and facilitating the student nurse’s learning. It is crucial therefore that provision is made for education and teaching resources to be available for the clinical educator in order to be equipped for this demanding role (Adelman-Mullally et al., 2013; Brown & Sorrell, 2017).

Recommendations for Education and Nursing Practice

In order to support the undergraduate nursing students in their clinical practice learning experience I propose the following eight recommendations that emerged from the research:

1. To ensure the students feel welcome in the clinical environment, a well-designed orientation package is needed. The CL and identified clinical staff could work collaboratively on this package which could include: safe travel options to and from the clinical area, introduction to and photograph recognition of different clinical staff roles, clinical area layout tour, demonstration and location of clinical equipment, explanation of staff facilities, access to emergency resources and equipment and teaching about managing the phones and pager systems. Familiarisation of the rosters and everyday clinical area routine should be included. A robust orientation package incorporating these and other features specific to the clinical area will assist the student to feel part of the clinical team.
2. When students arrive at their allocated clinical placement area they should be equipped with clear learning objectives and explanation of expectations of what is required from the clinical practice learning experience. Some earlier pre-clinical preparation from the Nursing Education facility would be beneficial to facilitate this. Formalised pre-clinical preparation will support understanding as to what level of NCNZ competencies the student is required to progress towards. Addressing professional behaviours with the nursing students such as: respect for self and others, appropriate interpersonal communication skills, maintaining professional boundaries and working within professional frameworks will offer clear guidance and therefore increase confidence around clinical expectations.
3. When preparing the undergraduate nursing student for the real life situations of clinical practice and to help improve communication and confidence, I recommend the use of simulation learning before they go to clinical placement. A choice of scenarios could be presented to the students and they could choose to engage in the scenario that best reflected the reality of the clinical setting they were going to be working in. From the interactive learning of simulation the student can identify important issues that arise and assess for themselves the impact of certain interventions. They will engage in a variety of interpersonal communication experiences and also learn to work as a team. The learning from the simulation would be greatly enhanced if time was allowed at the completion of the simulation scenario for critical reflection. Ideally the reflection process could be with both peers and educator/s as well as being guided by a designated reflection framework such as the REFLECT model (referred to in The Findings chapter).

4. Early honest feedback supports the student's professional growth. Formative feedback can provide clarity in identifying student learning gaps. Feedback in the form of discussion between the clinical educator and student is recommended as the student has the opportunity to be part of the dialogue. Then the student, the RN and the clinical educator working together can come up with specific actions to achieve the agreed individual learning goals. It is therefore valuable to create a clear and consistent feedback framework to be utilised at the formative assessment. Further exploration of a suitable framework of this type is needed. It should align with the learning competencies that the student is progressing towards, ensuring the comments and guidance are directly related to specific learning needs, thereby enabling outcomes to be measured and evaluated. This framework will offer the educator an assurance of consistency in the formative feedback process. It is recommended for the struggling student nurse, that weekly follow-up meetings occur with the clinical educator following formative assessment. This will help to ensure that the learning goals put in place at the time of formative assessment are being achieved, or it will be possible to assess whether these goals are even achievable for the student.
5. To assist in giving effective feedback this research recommends the CLs and the RNs who work with students should be given education and support, specifically in the assessment, discussion and reflection involved in student feedback. Feedback is more readily accepted by the receiver if the giver of the feedback has some credibility (Schartel, 2012). Therefore it is expedient for the CL and RN to be equipped to give accurate and honest feedback. Then the student may be more open to receiving the feedback. Valuing these key support and facilitation roles by providing education is important. However, there is a need for further research around the specific feedback tools available.
6. The CL or clinical educator should be encouraged to facilitate regular group reflection both during and on completion of clinical practice. This gives opportunity for the student nurse to share with and learn from their peers. The struggling student through group reflection can learn the right and the wrongs of clinical practice. Verbalising the clinical experiences can assist a student to use the correct nursing or medical terminology, and when sharing in the group setting, patient scenarios get discussed and the link between theory and practice is consolidated. Group reflection

can be a training ground for students also, as this is where they learn to question their peers or clinical educator. This is an important aspect of growing professionally since the student nurse is a patient advocate they must be able to question or challenge other clinical staff if those staff members' actions or behaviours are not in the best interests of the patient. For the clinical educator, group reflection can be advantageous in directing them to any disparities in the student's knowledge and therefore direct them to facilitate future learning to accommodate this.

7. It is recommended the partnership and collaboration of the Nursing Education Institute and the Healthcare Providers (Clinical areas) be strengthened to further enhance the student experience, as the benefits are many and reciprocal. For the education facility this partnership signals a commitment to supporting students' learning. One way this commitment can be endorsed is when a Charge Nurse Manager rosters allocated RNs who have received training in mentoring or clinical supervision to work with students on a committed basis. Benefits for the clinical area/Healthcare Provider include the RNs being supported by a clinical educator/CL from the Education Institute. The CL can facilitate orientation and ongoing student learning in the clinical area and together with the RN assess and evaluate student learning outcomes and progression towards competencies. Within this partnership model the student themselves get to have the support of two roles, the CL and the RN. The relationship established between the student and the Healthcare Provider can also have the mutual and future benefit of recruitment once the student is qualified as a registered nurse. Furthermore as a newly registered nurse opportunity for professional development at the Education facility is more accessible and appealing due to an existing established relationship. An example of two models where this partnership between the Nursing Education Facility and the Healthcare Providers is demonstrated is the DEU model and 'capacity building' model, both discussed in this research. It appears to have merit that once this type of partnership model is established and strengthened it can produce a cooperative and interactive representation that offers a smooth transition from student nurse to registered nurse.
8. The last recommendation includes having an orientation package and mentorship for the new clinical educator or CL. When aiming to support and sustain the role of the CL the promotion of working as a team and regular provision of CL team meetings is beneficial. It provides: opportunity for discussion around the struggling student, case

conferencing, the sharing of strategies and action plans, and a chance to discuss formative feedback which is valuable in maintaining some feedback consistency. Moving into the future it is important to give opportunity for CLs to engage in ongoing professional development such as a 'clinical scholar model' or other postgraduate education to develop leadership skills.

Limitations

There are some limitations to this research. The inquiry for this research was carried out at only two, NZ Nursing Education Institutions, although a reasonable data set of participants the findings may not necessarily apply to other NZ or international Nursing Education facilities. Student nurses and registered nurses were not interviewed for this research. Their perspectives would add further insight. The data set interviewed were predominately female gender with only one male participant. Therefore there was a limited representation from a male viewpoint.

Recommendations for Further Research

It would be advantageous to extend this research by including a wider number of Nursing Education facilities both in NZ and internationally. Additional research could be carried out by increasing the number of clinical educators or CLs interviewed. Likewise gathering stories and experiences from BN students and RNs would add further understanding to the research questions. Further research is required into the challenges that face both the Māori and Pacifica nursing students and to understand what appropriate strategies could be put in place to support them in the BN programme.

Conclusion

I began this research journey with a few questions from my own experience as a CL: 'What challenges face the student nurse in clinical practice?' 'What earlier strategies can be put in place to support them?' I finished this journey with gratitude and a sense of humbleness in the privilege it has been to listen to the participants' stories, and to have learnt so much along the way.

The research used a qualitative descriptive design to explore CL experiences, when supporting the struggling nursing student in clinical practice.

Three themes were established from this research; communication and confidence, feedback and reflection, and lack of continuity and valuing. Under these themes different issues for the student nurse were revealed.

The student nurse is required to cultivate a 'professional nursing voice' and this entails developing the skill of effective interpersonal communication. Exposure to the real world of nursing experienced in clinical practice assists with the development of effective interpersonal communication. The findings of this research identified low self-confidence and anxiety as factors that can negatively affect the developing of this skill.

Professional growth for the student nurse is also enhanced by the receiving and processing of effective feedback. This research demonstrated student nurses are not receiving timely or constructive feedback during their clinical practice. This is placing some students, in particular the struggling student, at a disadvantage when they are expected to pass summative assessments at the end of their clinical learning experience.

This research revealed a significant issue around the lack of continuity in the relationship between the student and familiar nursing staff. If a student nurse is already having some difficulty and also working with a different RN every day, the findings suggest there will be a paucity of recognising and managing two key areas, one, the student's practice knowledge, and two, the areas of concern that need addressing for that particular student.

The findings have shown direct challenges that face the student in the crucible of clinical practice. To address these issues the research suggests, firstly, that there's additional work done from the classroom to the clinical area. The strategies proposed are extra pre-clinical preparation around expectations and understanding of learning outcomes to be achieved. In addition the role of simulation has been shown to be beneficial in building confidence before clinical practice begins. Secondly, during clinical practice and particularly at formative assessment clear and concise feedback must be offered to the student nurse. The CL and RN ought to be educated and equipped with effective feedback processes and tools to achieve this. Regular group reflection has been promoted as a useful way to facilitate critical thinking and self-reflection. A commitment by both students and CLs to engage in group reflection will also develop a sense of community support while on placement. Thirdly, in order to value both the student nurse and the RN, the continuity of their relationship needs to be respected. To ensure continuity of this relationship the strategies indicated by this

research suggest extra support from Clinical Nurse Managers and the wider collaborative relationship between the Education Institute and the Health Care Provider may be useful.

This research has in addition recognised some concerns that confront the CL and these may indirectly affect the student nurse's clinical learning. A few CLs expressed feeling a 'sense of isolation' and a lack of preparedness in their role when supporting the student nurse. CLs contribute greatly to students' learning and are key liaison staff between the Education Institute and Health Care Providers. In order to champion this role it is important to provide regular team support and ongoing professional development for them.

It is evident from this research that the relationship between the student, the RN, and the CL, is crucial to a constructive student learning experience. Nonetheless further research is needed in supporting both the CL and RN roles. It is clear, though that if the Education Institute and Health Care Providers have a positive and continuing collaborative relationship this will underpin the RN and CL roles and in turn be an indirect but constructive support for the student nurse.

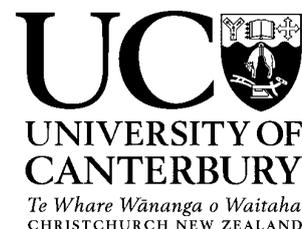
This research highlights the voice of the CL, depicting certain issues that confront the student nurse in their clinical component of the BN programme. Furthermore it delivers feasible strategies to support, whether directly or indirectly, the student nurse on their journey towards a successful completion of their clinical practice experience.

APPENDICES

Appendix 1: Human Ethics Application

HUMAN ETHICS COMMITTEE

Secretary, Lynda Griffioen
Email: human-ethics@canterbury.ac.nz



Ref: HEC 2014/75/LR

17 November 2014

Karen Cadigan
School of Health Sciences
UNIVERSITY OF
CANTERBURY

Dear Karen

Thank you for forwarding your Human Ethics Committee Low Risk application for your research proposal “Strategies for supporting struggling nursing students in clinical placement”.

I am pleased to advise that this application has been reviewed and I confirm support of the Department’s approval for this project.

Please note that this approval is subject to the following:

- In the information sheet, please include the following statement – “This application has been reviewed and approved by the University of Canterbury Human Ethics low risk process. Any complaints should be addressed to the Chair of the University of Canterbury Human Ethics Committee, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz).”

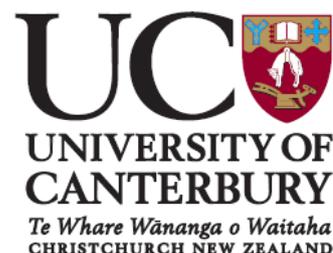
With best wishes for your project.

Yours sincerely

Lindsey MacDonald
Chair, Human Ethics Committee

A handwritten signature in black ink, appearing to read 'L. MacDonald'.

Appendix 2: Consent Form for Clinical Lecturers



Department
Telephone: +64 3 940 8416
Email: Karen.Cadigan@cpit.ac.nz

Supporting the 'struggling' nursing student in clinical placement: What strategies can Clinical Lecturers put in place?

Consent Form for Clinical Lecturers

I have been given a full explanation of this project so I understand what is required of me but also realise I have the opportunity to ask questions along the way.

I understand that participation is voluntary and I may withdraw at any time without penalty. Withdrawal of participation will also include the withdrawal of any information I have provided should this remain practically achievable.

I understand that any information or opinions I provide will be kept confidential to the researcher and transcriber (who has signed a confidentiality agreement document) and that any published or reported results will not identify the participants or institution of employment. I understand that a thesis is a public document and will be available through the UC and CPIT library.

I understand that all data collected for the study will be kept in locked and secure facilities and/or in password protected electronic form and will be destroyed after ten years.

I understand that I am able to receive a summary of the findings from the researcher on completion of the project.

I understand that I can contact the researcher **Karen Cadigan**, (ph: (03) 940 8416) or supervisors, **Kate Reid**, (ph: (03) 366 7001 ext. 3680) or **Kaye Milligan**, (ph: (03) 940 8288) for further information. If I have any complaints, I can contact the Chair of the University of Canterbury Human Ethics Committee, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz).

By signing below, I agree to participate in this research project.

Your name :(printed in full) _____

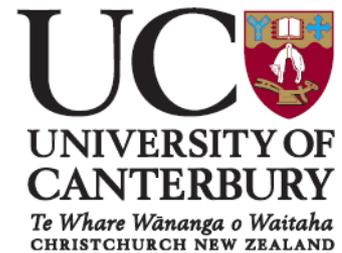
Signature: _____

Date : _____

PLEASE BRING ANY QUESTIONS AND THE SIGNED CONSENT FORM WITH YOU TO THE INTERVIEW

Karen Cadigan

Appendix 3: Transcriber Confidentiality Agreement



To ensure confidentiality for the persons being interviewed

I, ----- as transcriber of this research for Karen Cadigan, understand that I will be hearing recordings of confidential interviews. The information on these recordings has been revealed by interviewees who agreed to participate in this research on the condition that their interviews would remain strictly confidential. I understand that I have a responsibility to honour this confidentially agreement.

I will not divulge any information contained in the transcripts I produce, with anyone except the Researcher of this project and/or her Supervisors.

I agree to:

1. Keep all the research information shared with me confidential by not discussing or sharing the content of the interviews in any form or format (e.g. tapes, transcripts) with anyone other than the Researcher or her Supervisors.
2. Keep all research information in any form or format (e.g. tapes, transcripts) secure while it is in my possession.
3. Return all research information in any form or format (e.g. tapes, transcripts) to the Researcher when I have completed the transcription tasks.
4. After consulting with the Researcher, erase or destroy all research information in any form or format regarding this research project that is not returnable to the Researcher (e.g. information stored on my computer hard drive).

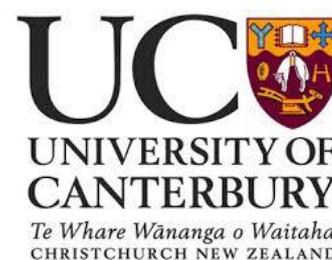
Thank you for signing this agreement

Signature

Date

Karen Cadigan - Researcher

Appendix 4: Information Sheet for Clinical Lecturers



Supporting the struggling nursing student in clinical placement: What strategies can Clinical Lecturers put in place?

An invitation to participate

PROJECT OVERVIEW

The aim of this project is to investigate what different strategies can be established to support the 'struggling' nursing student, when on clinical placement whilst completing the Bachelor of Nursing programme within a tertiary institution in New Zealand.

INTRODUCTION

For a number of different reasons nursing students may have difficulties with completing the clinical component of their degree. Clinical lecturer's provide targeted support to students to maximise their learning opportunities, however little research is available to guide the clinical lecturer in assisting a nursing student who begins to have difficulties or struggles within these busy and often very stressful clinical environments.

RESEARCHER

My name is Karen Cadigan, I am a graduate student enrolled in the Masters of Health Sciences at Canterbury University. I am also a registered nurse and have worked primarily in surgical nursing areas where I was a Clinical Nurse Specialist for five years before coming to teach at CPIT where I have been for the last three years. Unsure here!! *This project was out of desire to discover different approaches when facilitating learning for the under graduate nursing student who may face difficulties/hurdles during clinical placement in order to be proactive/prevent loss of confidence &/or failing clinical course.* My supervisors for this project are Kate Reid and Kaye Milligan and their contact details are included below

INVITATION TO PARTICIPATE

You are invited to participate in an individual interview with the researcher. The questions (attached) will generate discussion of your insights & experiences from when you have worked alongside nursing students in the different clinical environments.

Your participation is entirely voluntary and you are under no obligation to accept this invitation. However, if you decide to accept/participate you have the right to:

- confidentiality and privacy throughout the research process (name change of your choice for anonymity purpose)
- be aware your interview will be recorded and transcribed by a transcriber who has signed a confidentiality agreement. Recordings of interviews will then be securely locked in a filing cabinet for storage and destroyed after five years
- read the transcription of your interview once completed
- ask any questions about the project at any time
- be given a summary of findings when project is concluded
- decline to participate and to withdraw from study without giving a reason at any time

YOUR PART:

If you agree to take part in this project contact the researcher and a consent form will be arranged for you to sign as well as a suitable time where a meeting can be arranged for a semi-structured interview which should only take approximately 45 minutes.

Thank you for being interested in this research if you decide to participate it is hoped information gleaned will be helpful to equip the Clinical lecturer and in turn be beneficial for the nursing student.

Kind Regards

Karen Cadigan

Nurse Lecturer | Department of Nursing and Human Services

CPIT | Madras Street, Christchurch | PO Box 540, Christchurch 8140, New Zealand

DDI (03) 940 8416 | 027 375 3010 : Email Karen.Cadigan@cpit.ac.nz

SUPERVISORS CONTACT DETAILS:

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College of Education

University of Canterbury

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T: (03) 366 7001 ext. 3680

Kaye Milligan

Nursing Department

CPIT

E: Kaye.Milligan@cpit.ac.nz

T: (03) 940 8288

This project has been approved by UC ethics committee and your manager has also agreed to this project

Appendix 5: Interview Schedule



Research Project: Supporting the ‘struggling’ nursing student in clinical placement: *What strategies can Clinical Lecturers put in place?*

Primary researcher: Karen Cadigan

Semi-structured interview questions for Clinical Lecturers

1. How long have you been a Clinical Lecturer (CL) for the Bachelor of Nursing students and in what clinical area do you work with them?
2. What stage of their programme do you support them (year 1, 2 or 3)?
3. What resources did you use when commencing this role?
4. In your opinion what are some of the issues that make clinical placements challenging for the student nurse?
5. When you worked with the student nurse who was struggling or facing some difficulties while on clinical placement can you describe in as much detail as possible about this situation and how you worked through the issue/issues with that student?
6. On reflection of that situation would you have done anything different and if so what?
7. Have you learnt any other strategies from other CL colleagues in regard to supporting the ‘struggling’ student and what ones stand out as feasible strategies?
8. Any opinions or ideas how CLs can be supported or equipped better for their role?

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