REDESIGNING CLINICAL EDUCATION FOR NURSING STUDENTS AND NEWLY
QUALIFIED NURSES: A QUALITY IMPROVEMENT STUDY

Authors

Laurie Grealish^{1,2,3}

Thea van de Mortel¹

Candy Brown³

Valda Frommolt¹

Eileen Grafton¹

Michelle Havell³

Judith Needham¹

Julie Shaw⁴

Amanda Henderson^{1,5}

Lyn Armit³

Affiliations

1. School of Nursing and Midwifery, Griffith University
2. Menzies Health Institute Queensland, Griffith University
3. Gold Coast Hospital and Health Service
4. Central Queensland University
5. Princess Alexandra Hospital

Corresponding author

Laurie Grealish

Phone: +61 (0) 7 5635 6277

Mob: +61 (0) 41 2091968

Email: l.grealish@griffith.edu.au

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ABSTRACT

Rising numbers of students are required to address the forecast nursing shortage. Health services are challenged to release experienced nursing staff to become supervisors in clinical supervision models and preceptorship models require significant investment in registered nurse education for effectiveness. One health service in southeast Queensland, Australia, developed an innovative clinical education model that draws upon the strengths of supervision and preceptor models, and is consistent with the Dedicated Education Unit model, without the dedicated university and prescribed attendance requirements. Using an iterative qualitative approach and learning circle methods, the aim was to determine feasibility of the model, using information gathered from clinical facilitators, who were the key implementers. Model feasibility was found to be dependent upon three key activities undertaken by the facilitators: align stakeholder expectations with the new model, clarify roles and responsibilities within clusters, and develop strategies for collecting information about student performance. The experience of implementing the model has raised further questions about how students, newly qualified nurses and registered nurses learn in localised work units and what practice pedagogies can be developed to support learning from, as well as improve practice.

Highlights

- The need for more nurses has increased the number of student and newly qualified nurses

- Traditional clinical supervision and preceptorship are not sustainable
- The Dedicated Education Unit does not work for health services with multiple education partners
- The health service led, Clinical Clusters Education Model, provides a viable alternative to support learning for higher student numbers
- Learning circles present a useful change management strategy

Keywords

Collaborative Clusters Education Model, student, clinical learning, facilitation, nursing education

INTRODUCTION

In Australia, near the end of the 20th century, as nursing education was moving from hospitals into the university, two models of clinical education dominated – supervision and preceptorship (Grealish & Carroll, 1998). In one health service in southeast Queensland, Australia, the sustainability of the supervision model was threatened by a looming nursing shortage (Snavely, 2016). The numbers of students and newly qualified nurses coming into the service were rising (Health Workforce Australia, 2014), and the supervision model, where one university-appointed facilitator works with six to eight students, required significantly more facilitators. However, the facilitators were difficult to recruit from health services areas that were already facing a shortage of experienced nurses.

In 2013, the preceptorship model was piloted in one area of the health service. While the trial was found to produce satisfactory learning for students and newly qualified nurses, the costs associated with training and support for model implementation and maintenance were considered too high for full implementation across the organisation. The need for a clinical education model that could provide access to appropriate learning experiences through preceptors or buddies, as well as provide ongoing support for each group, students, newly qualified nurses, and staff nurses who support learning, was required.

The provision of clinical education for nursing students continues to present challenges for health service organisations internationally. Innovations in clinical education for students have been underway since the turn of the century (Grealish & Carroll, 1998; Edgecombe et al., 1999; Mulready-Shick et al., 2013), and the learning needs of newly qualified nurses are increasingly considered to be important for health services (Duchscher, 2009). The role of the experienced registered nurse as a ‘learning guide’ or buddy is considered pivotal in providing access to appropriate learning opportunities for students and newly qualified nurses (Henderson & Eaton, 2012). However, the burden of supporting

learners to make sense of their experiences, while managing a full workload of patient care responsibilities, is challenging for experienced nurses (Henderson & Eaton, 2012). A model for clinical education that can (1) position the learner to access appropriate practice experiences and (2) provide academic facilitation to support the learner to make sense of practice experiences was required.

Positioning the learner to access appropriate practice experiences is a key feature of the preceptorship model (Grealish et al., 2014; Myrick et al., 2010). This model draws upon apprenticeship theory, in particular Vygotsky's (1978) Zone of Proximal Development, which suggests that learning should be matched with an individual's developmental level. This theory informs the practice of scaffolding learning, where clinical experiences are matched to the students' development level (Spouse, 1998). The preceptor learns more about the learner's abilities through a close working relationship and identifies practice experiences that can afford learning (Edward et al., 2017). However, preceptors often are inadequately prepared on how to foster learning in relation to the specific learning needs of students and newly qualified nurses (Henderson & Eaton, 2012).

Once learners have access to experience, they require a teacher to assist them to make sense of those experiences, to help them shape their professional identity (Blaka & Filstad, 2007). The presence of the academic teacher or supervisor is a key strength in the supervision model (Grealish & Smale, 2011). The supervisor is focused on monitoring knowledge and analytical skills development in the clinical setting (Grealish & Carroll, 1998). However, as more supervisors are recruited directly from the practice setting rather than the university, they report less confidence about the significant learnings from practice in relation to the students' academic programme (Mather, McKay, & Allen, 2015).

A third model, the Dedicated Education Unit (DEU), has emerged to address the shortcomings of earlier models. In the DEU model, there are two modes of learning support:

clinicians provide access to learning experiences in the workplace and nurse academics facilitate learning from experiences. While these roles can cross over in various iterations of the model, there is general agreement that clinical wards or units are dedicated to placements by only one university (Edgecombe et al., 1999; Mulready-Shick et al., 2013). One advantage of the DEU model is that a strong relationship can develop between the health service and university in the ward context; clinicians become much more confident about the levels of performance expected for each stage of the students' program (Grealish & Smale, 2011). The DEU model also provides for students from each level (first, second, and third year) to experience their placements at the same time, in the same ward. The co-placements provide new opportunities for peer-learning (Bail et al., 2014) as well as the potential to increase ward capacity to host more students.

While there is growing research to indicate that the DEU model is feasible and provides greater collaboration (Moore & Nahigian, 2013) and significant learning gains (Mulready-Shick et al., 2013), the requirement for a dedicated relationship with one university is more difficult in a time of nursing shortage. To meet the expected shortage of nurses, universities have increased student enrolments and require more health service placements. As such government health services are required to partner with several universities to ensure adequate placement experiences are available. While some universities might adopt a two or three day per week attendance pattern prescribed in the DEU model (Gonda et al., 1999), other universities continue to use the block placement or five-day per week model. Further to this, each university has unique clinical learning requirements for its students, confusing staff nurses who want to engage students in practice the 'right' way (Grealish & Smale, 2011). Another educational model was required to support health services to confront these complex challenges.

In this project, nursing education leaders in one health service collaborated with university colleagues to develop a clinical education model that promoted the benefits of the DEU model - without the requirements for single university partnership and specific patterns of clinical attendance. The program aimed to support clinical learning for nursing students and newly qualified nurses in multiple wards, outpatient units, and community health services across the organisation. This paper reports on the feasibility of an emergent clinical education model, as reported by the facilitators who carried primary responsibility for model implementation.

METHODS

This descriptive qualitative study aimed to provide a summary of facilitators' perspectives of implementing an emergent clinical education model, known as the Collaborative Clusters Education Model. In the descriptive qualitative approach, data are interpreted to provide insights into a phenomenon, without the strong traditions associated with phenomenology and grounded theory (Polit & Beck, 2018).

This study was set in one metropolitan health service in southeast Queensland, Australia. The health service operates over multiple campuses across the city, with one tertiary level hospital, a regional hospital, one specialist surgical service and several community-based services.

Intervention

The Collaborative Clusters Education Model (CCEM) was structured to: (1) position the learner close to the registered nurse to enable access to practice experiences and (2) provide regular opportunities for learners to make sense of experiences individually, and in small groups, with a clinical facilitator. The CCCEM relies on the facilitator role, an experienced registered nurse who has undertaken education in work-based learning. The

facilitators work in clusters of three to four facilitators, sharing responsibility for a group of 36 to 50 learners within a geographic area constituting five to seven wards or work units. The facilitators were hospital appointments, funded by the university, and provided clinical leadership through supporting learners to be active participants, and supporting clinical nurses to include learners into their complex workplace (See Table 1).

[Insert Table 1 here]

Preparatory activities included presentations to the senior nursing executive about the new model and the expected outcomes and visits to each of the nursing unit managers to brief them on the new model and possible implications. To prepare for the transition to the CCEM, two masterclasses were provided to facilitators. The first focused on the need for new approaches to organisational learning and development to support the health services ambition to be world-leading in clinical care. A range of clinical education models to support student and newly qualified nurses to learn in the workplace were reviewed, and the DEU model was examined critically for strengths and limitations. The second masterclass focused on specific strategies to support learning from practice such as Socratic questioning, shared critical reflection, and practice handover.

During the first six months of the implementation phase, a third masterclass was held for all facilitators. In this masterclass, a clinical facilitator familiar with the collaborative model shared her experiences and provided strategies for working with nurses to support learning and how to gather data about performance. How to use this data to inform assessment and feedback was also shared.

The connection with higher education providers was maintained in two ways. Firstly, a facilitator coordinator was appointed to manage the facilitator team. The coordinator

worked closely with academic partners to establish the placement experiences, focused on operational matters. Secondly, the coordinator met weekly with the facilitators in a team meeting to monitor student and newly qualified nurse progress and identify learning and other issues. Information regarding student progress was shared with the higher education providers in weekly reports, with urgent issues discussed by telephone. The coordinator is a key element in the model and acts as a boundary object between the hospital and higher education provider (Berry 2011), keeping open lines of communication, establishing expectations and negotiating when problems arise (Henderson et al., 2010). Workshops for registered nurses on how to engage students in practice and provide feedback were held monthly.

Implementation - Reference Group

The CCEM implementation was led by a Reference Group, using the principle of co-design. This principle incorporates the input from 15 individuals with different expertise and perspectives, who collaboratively work together to generate solutions to problems using iterative processes (Gagliardi et al., 2016). Members of the Reference Group included nursing students, newly qualified nurses, facilitators, nurse managers, academics and educational researchers. The Reference Group was Chaired by the Director for Nursing and Midwifery Education for the health service. The Reference Group met monthly over a six-month implementation period. O'Neill and colleagues (2011) suggest that the improvement process should be iterative - including regular meetings of key stakeholders and consideration of data that are systematically collected during the period of implementation - and should take local conditions into account in the design.

The Reference Group identified three ways to monitor the feasibility of the CCEM. Firstly, feedback from students on placement, routinely collected as part of the universities' quality monitoring was shared with the Reference Group. Secondly, members of the

Reference Group were encouraged to share their anecdotal experiences or those of colleagues to provide insight into how the CCEM was being accepted. Thirdly, the facilitators were invited to meet in a learning circle to share their experiences and make recommendations to improve the model and/or its implementation. This paper presents the third group of findings, the facilitator discussions held in a learning circle format.

The Reference Group discussed the findings, considering contextual as well as operational matters, to determine whether the information coming to the meetings was related to the CCEM implementation or other factors. Decisions about actions, immediate, short and long term, were confirmed in the meeting and followed up at future meetings.

Data collection

To facilitate the gathering of information about the implementation process, the facilitators were divided into three groups. Each facilitator was invited to participate in three learning circle discussions for their group, held over a five-month period. The learning circle approach was selected because of its effectiveness in providing a safe place for individuals to share their concerns and work collaboratively to shape possible solutions (Walker et al., 2011). Each learning circle was facilitated by an academic from a local university, who was not involved in the CCEM but was a member of the research team (VF, JS, EG).

The findings from each of these learning circles were summarised by the academic leader at the meeting, confirmed by the participants through a written record, and then submitted to the Reference Group for consideration. The Reference Group used information from the learning circles, as well as anecdotal reports from each of the stakeholders at the meeting, to continually modify the model and the support structures to enable implementation.

Data analysis

The discussion summaries were subjected to content analysis (Graneheim & Lundman, 2004) to understand the transition process and make recommendations for model

development. Analysis was undertaken manually by the first author and independently validated by two other team members (LA, TvM). Recommendations from the Reference Group were validated with facilitators at a workshop held in January 2016 and implemented in 2016.

Ethical considerations

There were risks to the facilitators as their roles underwent significant change. It was important to engage them in the process of change, and to learn about the operational limitations of the CCEM. Given that the facilitators were employed by the health service, it was important to have the academic outsiders facilitate the learning circles. All meeting summaries were de-identified, with only the academic's name, as the researcher, reported. This process for monitoring the implementation was approved by the organisational Human Research Ethics Committee as a quality activity (HREC/16/QGC/169).

FINDINGS

The process of introducing the CCEM required stakeholder participation in the Project Reference Group meetings and attendance at workshops and learning circles. Overall, there was good engagement overall in the project, with at least 70% attendance at the Project Reference Group meetings and, with one exception, regular facilitator engagement with the learning circles.

The timing and summarised key points for each learning circle were mapped in relation to the timing of the Reference Group meetings and staff training (see Table 2). While the timing of the learning circles and reports did not directly match the Reference Group meetings, consideration and discussion of the learning circle meeting summaries was a standing item on the Reference Group meeting agenda. As the information from the learning circles came to the Reference Group, recommendations for change were developed. Members

of the Reference Group agreed to delay making significant changes for the first six months of the implementation.

[Insert Table 2 here]

Following analysis of the learning circle summaries, it was agreed that three activities emerged as critical to the process of transition for the facilitators. These were (1) align stakeholder expectations with the new model, (2) clarify roles and responsibilities within clusters, and (3) develop strategies for collecting information about student performance.

Align stakeholder expectations

During the early phases of the transition, clinicians and students were unsure about the model and how students would be supported and assessed. The health service employed almost 9,000 staff and was distributed geographically across the city, making it difficult to inform staff in all areas about the change in this relatively short period. Facilitators reported that there was a mismatch between stakeholder expectations and what the model provides for students (Learning Circle [LC]1: Meeting [M]1).

As the facilitators became more experienced in the model, they began to recognise the importance for access to different types of experiences depending on the students' level of education. For example, facilitators noticed registered nurse expectations for enrolled nurse students were not realistic when the enrolled nursing students arrived on the ward for placement following year three undergraduate nursing students (LC1: M2). Early in the implementation phase, some facilitators reported that higher education providers were unclear about who to contact regarding specific student matters (LC2: M1) but this was quickly resolved by making the facilitator coordinator the point of contact for operational matters with external stakeholders.

Clarify roles and responsibilities

Facilitators noted that in some ward areas, the responsibility for who works closely with the students was difficult to negotiate (LC3: M1). The negotiations were considered to be more challenging for experienced facilitators than those who joined as part of the new CCEM. This was attributed to the combination of the registered nurses' familiarity with the individual facilitator and their lack of awareness of the change, leading to their subsequent surprise regarding their new responsibilities for engaging students into the work team (LC3: M1).

There was confusion among facilitators, registered nurses and nursing unit managers regarding which nurses could be buddied with a student. Facilitators reported that some nurses would not buddy with students on the [incorrect] assumption that they (the registered nurses) had not completed the preceptorship program (LC1: M2). After several months of implementation, facilitators reported that more ward staff were buddying with students, and including students in their day to day work, but there were still occasional negotiations with some registered nurses and nursing unit managers regarding the facilitator role (LC1: M3). However, even when ward staff buddied with students, facilitators reported that some students experienced lack of access to experiences as the registered nurse was too busy to support the student to undertake a procedure (LC3: M3). This registered nurse behaviour was partially attributed to not knowing the students or their capacity due to continuous partnering with different students (LC3: M3).

Some facilitators reported initiating in-service programs about the CCEM, clarifying roles and responsibilities in their local work units (LC2: M2). The value of communication between the facilitators and students, ward staff, ward managers, other facilitators and the facilitator manager was emphasised as critical to the successful implementation of the model (LC2: M3).

Develop strategies for gathering information about student performance

Assessment of student performance emerged as an important issue in the implementation period. Facilitators reported discovering students who were underperforming late in the placement (LC3: M1), with limited time to provide formative feedback, and raised issues about how to manage students' progress in the course. Experienced facilitators relied heavily on direct observation of practice to gather information and found the large numbers of students overwhelming (LC1: M2), making it difficult to continue this practice (LC2: M1). In one cluster of four facilitators, they approached this problem by sharing the responsibility for student assessment between the team, providing information gathered on the students to each other (LC3: M2) in electronic journal records. These records were held in an e-folder on the data drive and only accessed by the facilitators. Students were informed that all four facilitators were collecting information about their performance and this enhanced the process of performance assessment.

Although most nurses liked to work with students, many did not know what type of information should be collected in order to make judgements about the students' level of performance (LC1: M2). As the facilitators became more experienced in gathering information, they began to work with registered nurses in the wards to assist with the provision of formative feedback on performance directly to the students (LC2: M3).

DISCUSSION

The decision to implement the CCEM across the organisation was opportunistic, recognising future resource limitations with the clinical supervision model. However, the process for the transition provides important information for other health services interested in leading clinical education for novice nurses as they transition into the profession. The facilitators' focus on three activities, aligning stakeholder expectations, clarifying roles and

responsibilities, and developing strategies to gather information about learner performance, were important, and possibly critical, to the ensuring the feasibility of the model.

In the transition described here, regular meetings with stakeholders through the Reference Group and the collection of facilitators' perspectives and ideas through learning circles reports provide a good framework for implementation. The learning circle approach was useful because facilitator concerns were not only raised, but facilitators were also engaged in developing solutions. While learning circles have demonstrated effectiveness for peer learning (Walker et al., 2011), the use of learning circles as part of change processes is worthy of further investigation.

The co-design approach, using a Reference Group, provided a space for useful debate and discussion about the emerging features of the CCEM. However, while most stakeholders were represented in the change process framework, the consumer voice was not. Health service consumers experience care from nursing students (Eskilsson et al., 2015), and their perspective needs to be directly incorporated into future change processes. Similar to reports on the governance changes required for the DEU implementation (Owen & Grealish, 2006), the Reference Group was essential to debate philosophies of learning, negotiate changes in processes, and commit resources to enhance the model.

For the facilitators, the work to align the perspectives of multiple stakeholders who were affected by changes to the clinical education model was considered challenging and yet critical to successful implementation. Facilitators worked closely with stakeholders within the different wards and areas of the hospital system, laying the foundations for future discussions about learning within the unique context of each setting. As the CCEM emerged in practice, the facilitator was well positioned to undertake activities recognised as fostering a learning culture. Open discussion with ward staff, to help local teams understand students' capabilities and learning needs and preparing information that is helpful to academic partners

are consistent with activities that support a workplace learning culture (Henderson et al., 2011).

The transition to the CCEM presented challenges for those most closely involved in workplace learning in regard to their roles and responsibilities. Early in the change process, the role of the coordinator as the key contact point for higher education providers proved to be a positive process to support communication about students and their learning experiences. As the change progressed, it became evident that not only were students learning but all participants in the process were learning how to make the CCEM work in practice to meet the needs of multiple stakeholders. In order to increase clarity around responsibilities, the information about the CCEM was shared in a brochure and poster that were widely distributed across the health service. A student limitations policy was introduced where what students could not do (limitations) was prescribed and generic guidelines for what students could do were based on their expected levels of participation and the criticality of the work, consistent with recommendations by Grealish and Smale (2011). The policy and guidelines are now used by facilitators to negotiate access for work activities within each of the localised work units. Clarification of roles and responsibilities appears to be continually negotiated in models that engage a community of clinicians, such as the DEU (Bail et al., 2014). As with the DEU model, a formal meeting process for local site (ward) negotiations and re-negotiations may be required for the CCEM.

By far the most challenging concern for experienced facilitators, who had worked in the traditional supervisory model, was the generation of additional strategies to gather information about student performance. While direct observation of practice was still used, there were fewer opportunities to observe students in action. Using information about students gathered in small group discussions or debriefs and soliciting reports from nurses, patients and families were other ways of gathering information that began to emerge. For

example, the use of existing data systems to share journal accounts of students' performance between facilitators in one cluster was a creative strategy. While there is a dearth of literature on *how* data are collected to inform performance assessment, facilitators were encouraged to share their strategies in a Masterclass on collecting and processing information for assessment. Further research into the specific techniques used to gather evidence to inform a judgement about performance is required.

As the project continued, the facilitators shifted their focus from the individual students to the work team, supporting registered nurses in how they can assist students and newly qualified nurses to learn from practice. The provision of continuous training to nurses has been effective in developing a learning culture (Henderson et al., 2012). Concepts that were most helpful to nurses appeared to be scaffolding of experiences (Spouse 1998) and the related Partner-Learn-Progress method (Henderson et al., 2006). One area that could be developed is the provision of group supervision to nurses in clusters, which has been reported to improve nurse confidence and student learning (Anderson et al., 2013).

During the implementation, the focus was on feasibility – how the model works in practice. Further research into the model, and its overall effectiveness and efficiency, as well as further research to discover the elements that are critical for implementation is recommended. To enhance research into the CCEM, a regular symposium is proposed, open to education providers and other health services. The inclusion of consumers in the program and as part of the audience is also proposed so that new lines of inquiry into the model's operations can be explored.

In summary, the implementation of the CCEM was overall a successful transition, noting the significance in undertaking this type of change across a large and geographically distributed health service. The CCEM focuses on transition to practice, and the benefits for newly qualified nurses require further investigation. The learning circle approach to engage

the key implementers in critique and generating solutions provided good information to assist with tailoring the CCEM and how it was implemented. The learning circle approach is a flexible work-based pedagogy that may offer further opportunities for application to transform work practices. Sustainability of the CCEM will require continual investment in: training (Masterclasses), nurse training, and orienting students to the model. As time passes, and students who experienced the CCEM return as newly qualified nurses, there will be further opportunities to sustain the model, much like what has been experienced in the DEU (Mulready-Shick et al 2014).

Limitations

This account of managing an organisation-wide change to the delivery of clinical education support has presented a small body of evidence on feasibility. While the change process was unique to one health service in one Australian jurisdiction, the themes emerging from the learning circle discussions identified important considerations for others attempting such widespread organisational change.

CONCLUSIONS AND RECOMMENDATIONS

The CCEM has emerged as a clinical education model to support the transition to practice that enhances the clinical learning environments in localised work units, within a distributed health service. It provides two levels of support to learners – access to clinical experiences and opportunities for discussion to make sense of those experiences. The CCEM model emerged theoretically over 20 years ago and is now proven to be feasible in practice. Further research into how (1) students, newly qualified nurses and staff learn in localised work units and (2) practice pedagogies, such as learning circles, support learning from, as well as evolve and improve, practice is required.

REFERENCES

- Anderson, C.S., Danielsson, A., Hov, R., & Athlin, E., 2013. Expectations and experiences of group supervision: Swedish and Norwegian preceptors' perspectives. *Journal of Nursing Management* 21 (2), 263-272.
- Bail, K., Hodgson, D., Merrit, A., Gibson, J., Taylor, J., Grealish, L., 2014. The Canberra Dedicated Education Unit. In K Edgecombe & M Bowden (eds). *Clinical learning and teaching innovations in nursing: Dedicated Education Units building a better future*. Springer-Verlag, 79-89.
- Berry, L.E., 2011. Creating community: strengthening education and practice partnerships through communities of practice. *International Journal of Nursing Education Scholarship* 8 (1), Article 9.
- Blaka, G. & Filstad, C., 2007. How does a newcomer construct identity? A socio-cultural approach to workplace learning. *International Journal of Lifelong Education* 26 (1), 59-73.
- Duchscher, J.E.B., 2009. Transition shock: the initial stage of role adaptation for newly graduated Registered Nurses. *Journal of Advanced Nursing* 65(5), 1103-1113.
- Edgecombe, K., Wotton, K., Gonda, J., & Mason, P., 1999. Dedicated Education Units: 1 A new concept for clinical teaching and learning. *Contemporary Nurse* 8 (4), 166-171.
- Edward, K., Ousey, K., Playle, J., & Giandinoto, J., 2017. Are new nurses work ready - the impact of preceptorship. An integrative systematic review. *Journal of Professional Nursing* 33 (5), 326-333.
- Eskilsson, C., Carlsson, G., Ekebergh, M., & Horberg, U., 2015. The experiences of patients receiving care from nursing students at a Dedicated Education Unit: a phenomenological study. *Nurse Education in Practice* 15(5), 353-358.

- Gonda, J., Wotton, K., Edgecombe, K., & Mason, P. 1999. Dedicated Education Units: 2 An Evaluation. *Contemporary Nurse* 8(4), 172-176.
- Graneheim, U.H. & Lundman, B. 2004. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today* 24 (2), 105-12.
- Grealish, L. & Carroll, G., 1998. Beyond preceptorship and supervision: a third clinical teaching model emerges for Australian nursing education. *Australian Journal of Advanced Nursing* 15 (2), 3-11.
- Grealish, L. & Smale, L.A., 2011. Theory before practice: implicit assumptions about clinical nursing education in Australia as revealed through a shared critical reflection. *Contemporary Nurse* 39 (1), 51-64.
- Health Workforce Australia, 2014. Australia's Future Health Workforce – Nurses Overview. Commonwealth of Australia: Canberra. Downloaded 28 August 2018: [https://www.health.gov.au/internet/main/publishing.nsf/Content/34AA7E6FDB8C16AAC257D9500112F25/\\$File/AFHW%20-%20Nurses%20overview%20report.pdf](https://www.health.gov.au/internet/main/publishing.nsf/Content/34AA7E6FDB8C16AAC257D9500112F25/$File/AFHW%20-%20Nurses%20overview%20report.pdf)
- Henderson, A., Alexander, H., Haywood, A., Stapleton, P., Cooke, M., Patterson, E., Dalton, M. & Creedy, D.K., 2010. Promoting and providing expert guidance in work-intensive clinical settings. *Vocations and Learning* 3 (2), 141-156.
- Henderson, A., Briggs, J., Schoonbeek, S., Paterson, K., 2011. A framework to develop a clinical learning culture in health facilities: ideas from the literature. *International Nursing Review* 58 (2), 196-202.
- Henderson, A. & Eaton, E., 2013. Assisting nurses to facilitate student and new graduate learning in practice settings: What 'support' do nurses at the bedside need? *Nurse Education in Practice* 13(3), 197-201.
- Henderson, A., Twentyman, M., Eaton, E., Creedy, D., Stapleton, P., Lloyd, B., 2012.

- Creating supportive clinical learning environments: an intervention study. *Journal of Clinical Nursing* 19 (1-2), 177-182.
- Henderson, A., Winch, S. & Heel, A., 2006. Partner, learn, progress: a conceptual model for continuous clinical education. *Nurse Education Today* 26 (2), 104-109.
- Mather, C.A., McKay, A., & Allen, P., 2015. Clinical supervisors' perspectives on delivering work integrated learning: a survey study. *Nurse Education Today* 15, 625-631.
- Moore, J. & Nahigian, E., 2013. Nursing student perceptions of nurse-to-nurse collaboration in Dedicated Education Units and in traditional clinical instruction units. *Journal of Nursing Education* 52 (6), 346-350.
- Mulready-Shick, J., Flanagan, K.M., Banister, G.E., Mylott, L., & Curtin, L.J., 2013. Evaluating Dedicated Education Units for clinical education quality. *Journal of Nursing Education* 52 (11), 606-614.
- Mulready-Shick, J. & Flanagan, K., 2014. Building the evidence for Dedicated Education Unit sustainability and partnership success. *Nursing Education Perspectives* 36 (6), 287-293.
- O'Neill, S.M., Hempel, S., Lim, Y., Danz, M.S., Foy, R., Suttorp, M.J., Shekelle, P.G., & Rubenstein L.V., 2011. Identifying continuous quality improvement publications: what makes an improvement intervention 'CQI'? *BMJ Quality and Safety* 20 (12), 1011-1019.
- Owen, J. & Grealish, L., 2006. Clinical education delivery – A collaborative, shared governance model provides a framework for planning, implementation and evaluation. *Collegian* 13 (2), 15-21.
- Polit, D., Beck, C.T., 2017. *Nursing Research: Generating and Assessing Evidence for Nursing Practice 10e*. Wolters Kluwer: Philadelphia.
- Snavey, T., 2016. A brief economic analysis of the looming nursing shortage in the United States. *Nursing Economic\$* 34(2), 98-100.

- Spouse, J., 1998. Scaffolding student learning in clinical practice. *Nurse Education Today* 18 (4), 259-266.
- Vygotsky, L., 1978. Interaction between learning and development. *Mind and Society*, 79-91.
- Walker, R., Cooke, M., Henderson, A., & Creedy, D., 2011. Impact of a learning circle intervention across academic and service contexts on developing a learning culture. *Nurse Education Today*, vol. 31 (4), pp. 378–382.

Table 1. Example activities for Facilitators in the Collaborative Clusters Education Model (adapted from Grealish et al, 2014)

Acknowledge complexity of the workplace	Support learners to be active participants	Support clinical nurses to include learners
<p>Prepare learners for the learning context through information provision and briefing/ orientation sessions, being frank about what opportunities are (and are not) available.</p> <p>Support learners to set learning goals that are consistent with what the placement experience can afford.</p> <p>Recognise teachable moments as they arise and use this to stimulate further learning.</p> <p>Provide opportunities for learners to repeat practices in different situations to develop confidence and recognise the influence of context.</p> <p>In debriefing or classroom activities, encourage learners to share their experiences and think forward to other contexts in which this learning might apply.</p> <p>Conduct workshops on negotiation theory and practice for staff to support learner participation in clinical experience.</p>	<p>Provide a useful orientation to the nature of the work and values in that community of practice.</p> <p>Encourage learners to work in peer groups, across years if possible, so that they can experience support from other learners and discuss what they are learning and experiencing with each other – reduce a reliance on ‘teachers’.</p> <p>Encourage staff to avoid consistently explaining practice – let the learners do the explaining.</p> <p>Ask comparative questions where the experience is compared to past experiences and possible future experiences.</p> <p>Ask evaluative questions that require deep thought about value, quality and equity.</p>	<p>Brief the staff about the learners’ abilities (based on year group) prior to each placement.</p> <p>Provide examples of appropriate and inappropriate work delegation to learners based on their level of development.</p> <p>Develop team models of care that hold learners to account for specific nursing work.</p> <p>Coach staff on appropriate delegation, including how to follow up.</p> <p>Coach staff on how to provide ‘on the spot’ feedback on learner performance.</p> <p>Coach staff on recognising learners who require greater support, e.g. closer facilitator support or learning contract.</p>

Table 2. Learning Circle Meetings in the context of other activities

July: M1	Masterclass 3 – Outsider experience of the CCEM		
	<u>LC 1 (n=4)</u> Clarify aim of meeting Mismatch in students' expectations Clinical facilitator role not clear Difficult to let go of 1:1 teaching Focus on communicating with stakeholders Using the orientation day to discuss changes with students	<u>LC 2 (n=4)</u> Seek clarification on the model and their role Mismatch between stakeholder expectations Need to be clearly identified – uniform Recommend clinical facilitators conduct staff workshops Recommend a brochure	<u>LC 3 (n=5)</u> Identifying students who are underperforming too late in the placement Nurses' expectations of supervision need to be managed Inconsistencies in nurses available to work with students Students are more accountable Recommend a new name for the clinical facilitator
August	Reference Group meeting 1 – clarify role of the Reference Group		
September: M2	Reference Group meeting 2 – consider M1 meeting summaries		
	<u>LC 1 (n=4)</u> RNs struggling to support EN students RN expectations of students is higher than the students can deliver Responsibilities for student assessment are not clear Clinical facilitators sharing a student group developing ways to communicate e.g. shared journal Large student numbers are overwhelming	<u>LC 2 (n=6)</u> Need more guidance on facilitation – a set of principles Seeking greater engagement with ward staff	<u>LC 3 (n=1)</u> Clinical facilitator developing confidence RN feedback is inconsistent in quality Need more information on how to assess students indirectly

October	Reference Group meeting 3 – consider M2 meeting summaries		
November: M3	Reference Group meeting 4 – discussion of M1 and M2 summaries and generate recommendations		
	<u>LC 1 (n=5)</u> Increasing understanding of various roles Clinical facilitators looking for strategies on how to support RNs to support workplace learning Confusion between clinical facilitator and other staff in the ward Find ways to support RNs to provide feedback to students	<u>LC 2 (n=5)</u> Note RNs are involving students much more in the ward activities Note the upcoming changes in the competency standards for the RN Clarify the purpose of feedback: informal or formal, formative and summative Note improving communication between stakeholders	<u>LC 3 (n=4)</u> There is a mismatch between stakeholder expectations and what is provided in the model Rotating rosters for RNs reduce consistency for students and newly qualified nurses Collecting information about the students – identifying sources Need in-services for RNs on feedback
December	Reference Group 5 – agreement on recommendations for change		
January	Reference group 6 – discussion of M3 summaries and finalise recommendations		
	Full meeting E2P CFs – consider findings and recommendations		

M=Meeting; LC=Learning Circle; CCEM =Collaborative Clusters Education Model; E2P CF=Entry-to-Practice Clinical Facilitator; RN=Registered Nurse