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## **Facilitating learning in clinical practice: Evaluation of a trial of a supervisor of clinical education role**

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### **Facilitating learning in clinical practice:**

#### **Evaluation of a trial of a supervisor of clinical education role**

##### **Abstract**

**Background:** Learning through practice is enhanced when clinical environments support registered nurses to teach students.

**Aim:** This paper assesses the contribution of a supervisor of clinical education (SCE) employed to assist registered nurses partner with students and facilitate their learning during the clinical practicum.

**Design:** A record of the activities of the SCE; and a survey completed by students about the value of activities of the SCE.

**Data Collection:** Information was collected about how the SCE was utilised by staff and students through a self-report diary. A survey was used to collect feedback from students about the contribution of the role following an eight week clinical practicum.

**Data Analysis:** Themes were derived from the self report diary. Descriptive statistics were performed on the student feedback survey.

**Setting:** Students were placed across three medical wards and three surgical wards in a large 700+ bed tertiary referral hospital in South East Queensland, Australia.

Results: Two major educational needs were requested by registered nurses and students.

These were: 'filling the gap' around actual and perceived knowledge deficit of the Registered Nurse and/or student; and utilising clinical practice 'episodes', often when resources were stretched, as teachable moments. A third lesser need was to assist Registered Nurses encourage learning accountability and motivation within students.

Student feedback ( $n=21$ ) identified that the facilitator assisted through direct teaching and supervision; students did not report that the facilitator contributed to enhancing the learning partnership between the registered nurses and students.

Conclusion: The supervisor of clinical education successfully interacted with students to optimise their learning, however, there was limited success in developing registered nurses skills and abilities in engaging with students.

Implications for Practice: To further develop registered nurses clinical teaching skills a diversity of strategies, both within and outside of the role of supervisor of clinical education, is needed.

Key words: clinical learning, supervisor of clinical education, student, clinical placement, clinical teaching

Words: 300

### **What is already known about this topic**

- Clinical placements are a vital part of students learning to make sense of theoretical knowledge
- The relationship between the registered nurse and the student is a crucial factor in student learning during clinical placements
- Ambiguity and confusion exist around the roles that support education during the clinical practicum

### **What this paper adds**

- Identification of two key learning activities rated by students as valuable during the clinical practicum
- Evidence that in the acute care sector registered nurses working with students prefer to handover responsibility of the student to a nurse with education experiences rather than embrace the opportunity to learn simple activities that increase their ability to teach during episodes of clinical practice.

## **Facilitating learning in clinical practice:**

### **Evaluation of the role of supervisor of clinical education**

#### **Introduction**

Nursing is a practice based discipline. The supervision of clinical practice as part of the educational preparation for nursing registration is therefore a key consideration for nursing programs. Internationally nursing has moved from a mostly apprentice-based system to a university program (Reid, 1994; United Kingdom Central Council, 1999). Optimising the value of the clinical practicum component of the program is essential with this shift in the educational preparation.

The literature clearly identifies students needs during clinical practicum, namely students need to be effectively assimilated and develop a relationship with the registered nurse and the team of clinicians so they are encouraged to actively observe, and participate through asking questions about practice (Eraut, 2003; Jaye & Egan 2009; Twentyman *et al.* 2006; Henderson *et al.* 2006; Clarke, Gibb, Ramprogrus 2003S; Levett-Jones 2005); second, registered nurses need to be effective role-models who can guide and supervise students performing skills, and assist students make sense of their knowledge through asking questions of the students (Billett, 2003; Orland-Barack & Wilhelem, 2005; Henderson *et al.* 2010). However there are organisational impediments to achieving these needs. A parallel body of literature recognises difficulties such as increasing numbers of students being placed (Rodger *et al.* 2008), a perception by staff that teaching is a burden (Clark &

Henderson 2005), and inadequate understanding and preparation of the clinician for the teaching role (Brammer 2006; Eaton *et al.* 2007). For example, if nurses see the students as another pair of hands they will delegate simple hygiene activities to the student rather than directly supervise a student perform a complex skill or engage in patient interviews or education sessions where appropriate.

Internationally within the nursing profession many positions have been created to address these difficulties that potentially curtail student learning in the workplace. These positions require effective communication skills to liaise with staff about student learning needs and also to interact directly with the students. Interactions with staff and students vary depending on the role. These include preceptor, mentor, clinical guide, link tutor, clinical facilitator, work-based educator and clinical co-ordinator (Lambert & Glacken 2005; Dickson *et al.*, 2006; Henderson *et al.*, 2006; Mulholland *et al.*, 2006; Andrews & Roberts, 2003; Smith & Gray, 2001). A consistent imperative for these positions is to assist the partnership between the registered nurse and the student as it is largely the registered nurse (RN) with whom the student works for the duration of a shift or shifts that is instrumental in shaping student learning (Brammer, 2006; Clarke *et al.*, 2003).

A teaching role is clearly acknowledged in the professional practice of all registered nurses: In Australia, the Australian Nursing and Midwifery Council competencies state that registered nurses “contribute to the professional development of self and others” (2005,p.4). This necessitates that where appropriate nurses teach others – this includes student nurses, new graduates, and other health disciplines. The Canadian Nurses

Association specify that registered nurses provide constructive feedback to colleagues (eg peer assessment) as one of 44 requisite competencies (Canadian Nurses Association, 2009). Nurses who are cognisant of this responsibility and accordingly facilitate the learning of others contribute to the creation of clinical learning environments where all staff become involved in developing others (McNamara 2007; Henderson 2010).

There are real benefits to be gained if collectively all nurses are involved in teaching. This is particularly relevant given increasing numbers of student nurses and therefore greater demands for learning opportunities in the clinical practice setting. To achieve these ends a supervisor of clinical education (SCE) has been proposed to assist clinicians develop collegial relationships and acquire skills in guided learning such as demonstrating and role-modelling (Henderson *et al.* 2010). These roles arguably contribute to a culture in practice settings where clinicians facilitate learning as part of their workload, without being burdened by teaching and assessment requirements.

There is a paucity of empirical research linking many of the roles to their contribution to the student experience of learning (Bray & Nettleton, 2007; Lambert & Glacken, 2005). Given the cost of positions to support clinical learning that is, the role is solely responsible for optimising clinical learning and therefore does not carry a patient load (eg in the case of a clinical facilitator refer Wellard *et al.*, 2004; Dickson *et al.* 2006; or work-based educator refer Mulholland *et al.*, 2006), it is important to ascertain and clarify their contribution to scholarship.

This paper reports on the specific activities and outcomes of the proposed role of a supervisor of clinical education (SCE). Trial of such a role was deemed important given the need to enhance RNs ability to engage with students and support their learning in clinical practice settings. In Australia, these positions are usually funded by the university so that student learning opportunities during the clinical placement are maximised. As explained the role is specifically to support RNs facilitate student learning in the practice setting and therefore does not carry a patient load. Outcomes of the role are sought through student feedback.

### **Aim**

This paper assesses the contribution of a supervisor of clinical education (SCE) employed to assist registered nurses (RNs) to partner with students and facilitate their learning during the clinical practicum.

### **Method**

This study reports on the activities conducted by a SCE intended to optimise student learning experiences. A survey was completed by the students at the completion of the clinical practicum to provide feedback about their perceptions of assistance.

The clinical supervisor: The SCE assisted engagement between the RNs and the students. They are selected because of their experience in facilitating learning in practice and their

ability to be readily accepted by ward staff. A SCE is positioned across two to three wards where they are located for the duration of the shift. The aim is to develop staff behaviours to enhance student learning opportunities, however, the SCE could be 'paged' to another ward area when needed promptly to deal with a specific issue. Student performance was not assessed by the SCE in this study. The SCE worked with the RNs while they partnered students during the evening shifts, i.e. 13:00-21:30 for a whole semester of study from July to December 2007. A semester, equivalent to one 6 month study period comprised eight weeks of clinical practice when the students were placed on the wards for two shifts.

The students: There were 27 students in the second half of the year July – December 2007 completing their first year of study of a Bachelor of Nursing in the acute clinical wards where this study was undertaken. Students had previously spent two days per week for 8 weeks in the acute clinical setting in the first half of their first year. Supervision was similar – however it had not been evaluated. The 27 students were rostered fairly evenly across two shifts – morning and afternoon, therefore the facilitator only ever worked with a maximum of thirteen RNs who were partnered with the students, during any one shift.

Setting: The students were placed across three medical wards and three surgical wards in a large 700+ bed tertiary referral hospital in South East Queensland. The medical and surgical diagnosis of patients in these areas included: general medical, endocrinology, hypertension, transplants, upper gastrointestinal, gynaecology, hepatobiliary, and colorectal. Nursing staff care for approximately 4 to 6 complex care patients, namely

patients who require management of multiple infusions and polypharmacy. The skill mix of staff in each ward area was typically mostly registered nurses (RNs) who were supported by a Clinical Nurse (registered nurse with expert knowledge); there were also a smaller number of enrolled nurses (a diploma course completed in 18 months). While there was mostly a RN workforce in a number of these areas up to one third of the staff were within their first twelve to eighteen months after graduation.

The activities of the supervisor of clinical education (SCE): During each shift the SCE met with the RNs about student rostering, and provided suggestions about how staff could welcome students. The SCE made contact with the RN and student about twice per shift, and was contactable via pager when located in other wards. Identification by the SCE of teaching activities was achieved primarily through 'ad hoc' interactions during informal visits; namely, learning needs became apparent through the SCE asking the RN or student impromptu questions about their practice. The informal teaching episodes were designed to role-model to RNs how to facilitate student learning and also enhance student clinical knowledge.

When conducting informal teaching episodes the SCE would clearly establish with the RN and the student their existing knowledge and identify learning need areas. Where possible conversations between RNs and students were guided by the SCE to assist RNs develop their teaching skills. Depending on the activity, eg placing ECG leads or inserting a naso-gastric tube the SCE usually demonstrated in a mock situation, separate from the patient, then the procedure was clinically executed by the student under the

supervision and guidance of the RN or the SCE, if the RNs did not have the necessary confidence or insufficient time to supervise the student. Following any procedure a debriefing session was conducted, that is, time away from the immediate clinical situation to answer any questions, provide feedback, and encourage students to reflect on the situation. The time period for such activities ranged from 10 to 45 minutes, depending on the complexity of the activity and the learning needs of the RN and student.

### **Ethical considerations**

The findings about the activities of the SCE were derived from diarising by the SCE. The diarised information was anonymous – it recorded the nature of the work of the SCE.

Ethical guidelines were adhered to in how the author documented the nature of this work:

Neither the names of the clinical areas nor the names of the students or staff were recorded. Ethical practice was maintained in relation to the discussions between the researchers, that is, any observed incidences that may have involved ‘poor practice’ were followed up in a professional and ethical manner in accordance with registration and licensure.

The feedback obtained was via the standard form where participants anonymously rated aspects of their learning experience during the clinical practicum. The feedback form has been approved by the Hospital Ethics Committee where the students were placed for the clinical practicum.

## **Data collection**

Two forms of data were collected about the activities of the SCE. A diary where the specific work of the SCE was documented, and a student survey providing feedback about the impact of the clinical facilitator.

*Self-report diary:* The SCE was given guidance in the nature of the information that should be recorded. The type of assistance, interactions and requests during each shift were recorded over the eight week period. It was maintained by the SCE who was one of the researchers. This was also discussed and reviewed by another researcher to ensure clarity of meaning.

*Survey:* Student feedback collected via a survey based on the Clinical Learning Inventory developed by Chan (2001, 2002) at the completion of the eight weeks. The survey, trialled previously, comprised ten questions about how students perceived the value of the SCE (refer Table 1). Responses were recorded using a 5 point likert scale: A score of (5) for Strongly Agree and ranging to (1) Strongly Disagree.

## **Data Analysis**

*Self-report diary:* The raw data from the diary was read and re-read by the researchers to identify common themes. Themes were explored around content of learning activities and RN requests (Miles & Huberman 1994). Exploration of the data identified that there were dominant themes around educational needs of RNs.

*Survey:* Descriptive statistics were used to analyse the collated responses of the feedback survey.

## **Findings**

*Self-report diary:* An analysis of the activities that the SCE engaged grouped into three categories. These groupings were:

- i. 'Filling in the gap' around actual and perceived knowledge deficit of the RN or student;
- ii. Utilising clinical practice 'episodes', often when resources were stretched, as teachable moments;
- iii. Learning accountability and motivation.

### *'Filling in the gap' around actual or perceived knowledge deficit of the RN or student*

The most prevalent educational need that the SCE was required to address was a perceived or actual knowledge deficit by the RN and the student around a particular clinical activity. The allocation of students to graduate or junior nurses meant that the RN either had never performed the skill or did not have the confidence to competently demonstrate the skill to the student nurse. If the SCE had not been present then the RN would have had to seek assistance from a more experienced staff member to perform these activities. The SCE was able to draw these situations as learning activities for both RN and students. These occasions included: commencement of a Graseby Pump on a palliative care patient, Naso-Gastric Tube insertion, setting up of a femoral line insertion

and Indwelling catheter (IDC) insertion. The need for the SCE to demonstrate these skills to the RN and student was largely because of the skill mix present during the shifts when the students were rostered. The advanced practice and knowledge of the SCE further assisted the RN as good teaching techniques were role-modelled.

*Utilising clinical practice 'episodes', often when resources were stretched, as teachable moments*

Learning opportunities were maximised through the SCE 'being available' when 'teachable moments' arose. There was limited teaching time in the busy clinical units, and consequently reduced opportunities for students to 'practise' in the real world on actual patients. The SCE assisted through the provision of time so that the student could be guided through performing their first Electro-cardiograph, medication administration, including sub cutaneous and intramuscular injections in the clinical area.

While the RN working with the student can manage their workload, the student as a novice can take a substantial amount of additional time to perform these same skills. RNs are often working alongside students constantly for the eight weeks when students are on their clinical placement, therefore, relieving the RN to directly supervise this activity can impact significantly to assist the time management of the RN. Although the RNs actively sought minimal assistance from the SCE the verbal feedback from the RNs to the SCE indicated that such assistance reduced the stress that RNs felt in 'getting the work done'. Less stress may have helped strengthen the RN-student partnership.

*Learning accountability and motivation*

The SCE explained to the RNs that students are also accountable for their learning. RNs found it challenging to accommodate variations in student knowledge. The SCE focused on two areas: firstly, they continually updated the RN on student's scope of practice that expanded during the semester; and secondly they encouraged the RNs to assist the student to become 'agentic' learners (Billett & Pavlova 2005). When obvious learning opportunities were not present the SCE provided examples to the RNs about how students can drive their own learning, for example, revising patient assessment in conjunction with actual patient histories, and then engaging with patients to learn about this history. Registered Nurses appreciated advice and guidance in how to facilitate student learning.

*Student feedback:* Out of the 27 students, 21 students returned the survey [78% response rate]. Means were calculated for the response to questions on the survey.

A summary of the responses is provided in TABLE 1, with a mean score calculated.

INSERT TABLE 1 ABOUT HERE

Scores overall are high which is common when seeking feedback in these situations. Despite these high scores it is the clustering of questions around the highest and lowest scores that are most informative. Students responded most positively to the questions about the role of the SCE in directly enhancing their learning. Of further interest however, is that while the students perceived positive relations between themselves and the SCE (questions pertaining to these areas scored above 4.5) they did not view the SCE's strength in improving relationships between themselves and the RN they were partnered

as high. The questions pertaining to whether the SCE strengthened the relationship between the student and the RN buddy or the unit staff were the only questions that scored below 4.5.

The SCE was successful in directly interacting with the students to address education needs. The efforts by the SCE to engage the RN and student was not as successful.

### **Limitations**

The findings from this small study are, in part, positive. The specific recommendations are particularly relevant to the context as described in this study. For example, some of the issues relate to the actual staff skill mix where the students are located.

The evaluations of the student experience are overall quite high. Evaluations about satisfaction are usually high, however, the different responses about the value of direct assistance provided to students by the SCE in contrast to the responses about the success of the SCE in guiding RNs to engage with students were quite distinct.

### **Discussion**

Teaching is an integral aspect of RN work. Exploration around how to develop the teaching role of the RN through roles such as a SCE is imperative. This evaluation of piloting a different role such as a SCE offers insights to the strength of factors that can mitigate against these new roles.

The key purpose of the SCE role is to assist the RN in a fundamental aspect of student learning namely, to engage the student within a community of practice (Henderson *et al.* 2010). As explained in this trial the SCE actively worked to improve the relationship between RNs and students. Through informal interactions the SCE role modelled to the RNs, specific clinical tasks and problem solving together with learning strategies such as open questioning. This initiative helped prepare RNs to interact with students and facilitate their learning (Brammer 2006; Eaton *et al.* 2007).

Demanding workloads (Rodger *et al.* 2008), together with the extra time that is needed for students to actively participate (Billett 2003) makes time for teaching a challenge. Arguably this is why RNs expressed relief to the SCE that a break from the student assisted in 'reducing their stress'. Unfortunately this was different from the intent to enhance RNs ability to engage and foster student learning. As identified more work needs to be explored around how this facilitative role of a SCE can encourage greater engagement and collaboration between the RN and students rather than 'relieving stress' for the RN.

The appreciation that RNs conveyed about the value of interactions verified that the SCE role could have further focused on feedback and reward as the impression was that this role in supporting students is largely 'taken-for-granted'.

Students need to be encouraged to think about and reflect on tasks (Orland-Barack & Wilhelem 2005). Clinical facilitators and educators are not always available and RNs can easily assist students to question, however further exploration both outside of and within the SCE role is needed to assist all nurses to contribute to teaching in the practice setting. Dynamic learning environments are needed if students are to graduate as competent health professionals. Roles, such as, the SCE can be instrumental in assisting staff to engage learners as part of their practice. Exploring the value of advice, recognition and reward are worthy if the SCE is to better guide and motivate RNs to teach in practice.

## **Conclusion**

The SCE role can be powerful in their assistance to staff when RNs do not have particular skills. It is evident that the use of a SCE can add value to the clinical setting in addressing education needs and thereby maximising learning opportunities for students during practicum experiences. Employment of a SCE helps students' make sense of practice in clinical contexts. Further exploration around how to improve the working relationship between the RN and student is still needed, as it is the RN who is in the most significant position to enhance student learning experiences and ensure the sustainability of positive clinical practicum experiences.

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TABLE 1: Mean scores of ratings of the clinical facilitator

<b>QUESTIONS (1-10)</b>	<b>MEAN (n=21)</b>
The Clinical Facilitator successfully orientated me to the hospital, staff and emergency procedures.	4.1
The Clinical Facilitator encouraged me to engage and reflect on my own practice.	4.5
The Clinical Facilitator made it clear what I had to do to be successful in the clinical setting.	4.5
The Clinical Facilitator promoted positive reflection between my buddy nurse and myself.	4.3
The Facilitator showed genuine concern for my progress and needs.	4.8
The Facilitator assisted in my interactions with unit staff to ensure that I was provided with timely and constructive feedback.	4.3
The Clinical Facilitator, through negotiation with the unit staff, helped me achieve my learning goals	4.5
The Facilitator managed the group in a way that helped me learn.	4.6
The Facilitator assisted me with identifying learning experiences that were appropriate for my needs.	4.7
Overall Rating of Facilitator	4.7