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**CHARACTERISTICS OF THE CLINICAL EDUCATION
ROLE AS PERCEIVED BY REGISTERED NURSES
WORKING IN THE PRACTICE SETTING**

A thesis presented in partial fulfillment
of the requirements for the degree of
Master of Philosophy in Nursing
at Massey University

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1999

ABSTRACT

Although clinical education has long been acknowledged as the heart of nursing education, the role of the nurse lecturer in relation to the clinical learning experience of nursing students, is an area of long standing confusion and dispute. The many advances in technology, nursing science, and the professional role, have not been accompanied by substantive change in the approach to clinical education. Research to date has focused on the lecturers' and students' perceptions of the clinical education role.

This study describes the characteristics of the clinical education role as perceived by ten registered nurses working a practice setting. The participants in the study were employed by a Crown Health Enterprise which has for many years, served as a clinical practice agency for a department of nursing within an educational institute. All the participants were employed as registered nurses within the general medical and surgical wards.

A qualitative, descriptive and exploratory study was undertaken. Face to face, semi-structured interviews were used to obtain data. This was then analysed using thematic content analysis. Findings from the data revealed five characteristics of the clinical education role as perceived by Registered Nurses working in the practice setting. The clinical education role in its present form changes registered nurses relationship with their patients and changes their pattern of work. It requires good communication with nurse lecturers, preparation for the role, and needs to provide nursing students with the opportunity to learn.

ACKNOWLEDGMENTS

I am grateful for the help of many people with this work.

I wish to especially thank the ten registered nurses who participated in the study and so generously shared their ideas and experiences with me. Without their contribution this research would not have been possible.

I acknowledge the ongoing support and encouragement of my work colleagues at Wellington Polytechnic School of Nursing, Health and Environmental Sciences. I would also like to thank the Wellington Polytechnic library staff who have been so helpful in my literature searches.

Many thanks to Judith Moresi for her hard work in transcribing the interview tapes, sorting out computer glitches, and the presentation and printing of this thesis. A special thanks to my fellow student Sue MacDonald who participated in many discussions about our research, our doubts and our abilities. It is thanks to Sue that I had moments of clarity which enabled me to keep on writing.

Many thanks to my supervisor, Charmaine Hamilton, for her patient guidance, advice, and scholarly support during the process of writing this thesis.

Finally thank you to my husband for his encouragement, support and patience.

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Chapter 1

INTRODUCTION

Nursing is similar to the academic disciplines of medicine and law, in that nursing curricula are required to prepare students both educationally and vocationally. Graduates are expected to be able to care competently for patients with a wide range of needs and conditions in a range of settings. In order to provide safe beginning level nursing care new graduates should have achieved an appropriate theoretical knowledge on which to base their care and an ability to apply the practical skills necessary to implement that knowledge. Clinical education is the vehicle which provides students with the opportunity to translate theoretical knowledge into the provision of patient centred quality nursing care under the guidance of the clinical educator. Clinical education is the major component of pre registration nursing programmes. Via clinical education theoretical concepts learnt in the classroom are integrated into nursing practice and the student is socialised into the nursing profession.

Because nursing students in the practice setting work with real patients there is always an element of risk present in clinical education. As a consequence nurse lecturers¹, nurse practitioners, and students are constantly seeking the optimum safe method of clinical education. Research to date has, in the main, focused on the clinical nurse lecturer employed by the educational institution. The role of the registered nurse in clinical education has not received the same attention yet as Boyle's (1994) New Zealand research shows student nurses believe it is the registered nurses working in the practice setting who are their clinical educators, not the nurse lecturers. Boyle's research confirms Owen's 1993 findings that nurses in the United Kingdom believe the most effective clinical teaching is carried out by registered nurses in the practice setting. Currently the role of clinical educator in the education of pre

¹ Throughout this thesis the researcher will refer to a registered nurse employed by an educational institution as a nurse lecturer and a registered nurse working in the practice setting will be identified as a registered nurse or nurse practitioner.

registration nursing students is not clearly identified. It is not clear whether the role belongs to the nurse lecturer or the registered nurse in the practice setting. Most importantly it is not clear who is responsible for the student during their clinical placement.

Ives and Rowley (1990), in their research, sought to evaluate how registered nurses in the practice setting were coping with their role changes following the transfer of pre registration nursing programmes into the tertiary sector in Australia. From this study they identified the need to ask the registered nurses working in the practice setting their ideas and views relating to clinical education.

Significance of the study

The absence of any significant body of literature regarding nurse practitioners' perceptions of the clinical education role has created a role ambiguity that both nurse lecturers and registered nurses working in the practice setting find difficult. It is hoped this study will begin the process of clarifying the situation for nurse lecturers and registered nurses working in the practice setting.

Aim

The aim of this study is to describe the characteristics of the clinical education role as perceived by registered nurses working in the practice setting.²

The researcher's interest in the study

The researcher's interest in this study derived from her considerable experience as a clinical nurse lecturer working with students in the practice setting. Over many years it became apparent to the researcher that the role played by the nurse practitioner in clinical education had evolved in different ways in different wards. In the researcher's experience this creates significant and ongoing challenges for all involved in the clinical education of student nurses. This situation seems to have come about as a consequence of nurse

² When referring to nurses in general the pronoun she will be used, as in New Zealand the majority of registered nurses are female.

lecturers and nurses practitioners uncertainty about the nature of the clinical education role in the New Zealand setting. The researcher hopes this exploratory, descriptive study will provide the impetus for further research into this complex subject.

Organisation of the thesis

Chapter 1 introduces the thesis. **Chapter 2** presents the historical background and current concerns about clinical education in nursing are outlined. **Chapter 3** explores the literature in relation to the registered nurse and nurse lecturer's role in clinical education. **Chapter 4** examines the research methodology, planning and implementation of the research process used. **Chapter 5 - 9** presents an analysis of the data identifying the characteristics of the clinical education role as perceived by registered nurses working in the practice setting. **Chapter 10** Discusses and integrates the five characteristics of the clinical education role and the implications for nursing. **Chapter 11** concludes the thesis.

Chapter 2

HISTORICAL DEVELOPMENTS OF CLINICAL EDUCATION IN NEW ZEALAND

From the introduction of nursing education in New Zealand to the present time, the context of clinical education in pre-registration nursing programmes has changed. This chapter identifies these changes.

Background to the study

Women as healers in New Zealand

Women have always been the main healers in European society. They delivered babies, rendered first aid, prescribed and dispensed remedies and cared for the, infirm and dying, both as a neighbourly service and as paid work (Bradley, 1989). Women were believed to have a distinct nature which gave them a special ability to nurture. They were also regarded by society as the guardians of morals. Every woman was a nurse by virtue of demographic isolation and a widespread belief that sickness could be better attended at home rather than in the public institutions which served the needs of the poor and destitute.

Mother - daughter apprenticeship in nursing practice

In New Zealand prior to the 1870s nursing was undertaken by missionaries and women settlers who learnt their nursing skills from experience and expediency. Nursing was taught by mother to daughter as part of female apprenticeship. As a new colony, population centers were small and widespread, and the first nurses, although untrained, took on the traditional role of health visitors, midwives, and district nurses, often travelling on horseback over rough terrain to reach isolated communities (Booth, 1997). Nursing took place within the family and the home with women caring for family and friends. Even with the establishment of the early hospitals the sick continued to remain at home nursed by wife/mother, neighbourly women, or a community 'nurse'

who through need became experienced in providing medical and nursing services (Rodgers, 1985).

Early development of hospitals

As the population grew hospitals were slowly established throughout the country. Even after the construction of these hospitals conditions were primitive and remained so for many years. The total staff consisted in some cases of just two people, a Master and a Matron, who together ran the hospital to the best of their ability. In most cases the Master and Matron were a husband and wife team assisted by a wardsman or male assistant, who worked in the male ward and was also responsible for the maintenance of the hospital grounds (Orchard, 1997). By 1881 a few qualified nurses were being employed by hospitals, but the majority of nursing was carried out by untrained staff.

By 1883 a special report on hospitals showed few nurses were employed, and the hospitals were in very early stages of development (Orchard, 1997). Following the passage of the Hospitals and Charitable Aids Act, 1885, hospital conditions appeared to improve with better sanitation and equipment. The quality of care given, especially to the destitute and the poor also appeared to improve. As hospitals evolved in New Zealand, concerns developed over staffing, the quality of people recruited and the retention of staff. One way of recruiting better staff was to offer a training course (Burgess, 1984).

Influence of Nightingale nurses on clinical education

When she initiated her School of Nursing at St. Thomas's Hospital in London, England in 1860 Florence Nightingale formally began a process which was to change nursing education. This event saw the beginning of organised education of nurses. Nightingale recognised that nurses required a broad, general knowledge as well as being skilful in the delivery of nursing care. To this end, whilst most of the training took place on the job in the wards, trainee nurses were given lectures by doctors and the Matron and their work was

continually assessed by the senior nurse or the Matron (Rodgers, 1985; Booth, 1997).

In the 1870s and 1880s Nightingale nurses were arriving in New Zealand and taking up the positions of Matron in the larger hospitals. Their influence achieved desirable results. The male wards which were the domain of male attendants contrasted poorly against the clean female wards for which the Matron was responsible.

The 1886 Annual Report on Hospitals called attention to the fact that in female wards probationer nurses were learning their duties, taking the greatest possible interest in their calling which they had chosen for other than pecuniary means (Rodgers, 1985).

Introduction of nurse training in New Zealand

Formal nurse training in New Zealand began officially when in 1883 the first School of Nursing was opened. This was based on the Nightingale model. Miss Moore was appointed Matron to Wellington Hospital in 1882 and was responsible for implementing a number of changes, the most important of these being the introduction of training for probationers who were drawn from a 'high order' of society and supplanted the untrained attender of the sick (Rodgers, 1985). Regulations as to the training of a probationer were explicit (Rodgers, 1985). On the understanding that the woman would remain the length of one year she would receive nurse training which would be provided in the hospital. The probationer was under the control of the Lady Superintendent of the hospital who would ensure the woman remained sober, punctual, trustworthy, quiet, clean, orderly and neat. The standard of the training courses offered varied as they developed in different parts of the country and there was no legal protection of the title 'nurse', which meant that the public were still largely at the mercy of untrained practitioners (Burgess, 1984).

By 1895 there was an improvement in the standard of the training of probationers. Probationer nurses received tuition in 'scientific nursing skills', Assisting at surgery and observing complicated procedures were now seen as part of nursing training, along with the dressings, enemata, use of a thermometer, and observations of the sick (Rodgers, 1985). The mix of staff in public hospitals was also altering. Nursing staff consisted mainly of females who continued to usurp the position of the male attenders. Those males who still worked in hospitals, were appointed as dressers or porters, none of whom received nursing training (Rodgers, 1985). The length of training expanded to three years, the nurse being provided with lodgings, food, uniform and a small salary. During this period of nurse training the ward sister or matron were responsible for the clinical education of trainees in the wards.

With the apprentice model of nursing education, skills are learnt from observation of and working with others until the apprentice is able to carry out tasks unsupervised. Any theoretical basis is derived from practice, or from common sense, and although it may perpetuate custom and practice, it is at least realistic, and tailored practice to the circumstances in which it is carried out (Reed & Proctor, 1993).

Since 1922 student nurses' education has reflected the notion of ongoing clinical learning in hospital wards. Over time, this clinical learning has become purposeful and is now formalised as the clinical experience of today.

Grace Neil's influence on clinical education

In 1895 Grace Neill was appointed as Assistant Inspector to the Department of Hospitals, Asylums and Charitable Institutions of New Zealand. She consulted with nurses, doctors, and politicians, in the preparation of the Hospital Nurses Registration Bill which was presented to Parliament in 1901. The essence of the Bill was the basis of an address given by Grace Neill while attending the International Council of Women in London in 1899. In her address Grace Neil made it clear that the clinical component was to be taught in the ward by the

nurse practitioners. Her thoughts on nursing were centred on broadening the horizons of a nurse through education and learning.

The educational curriculum of hospitals should embrace a three year training. The first years [sic] teaching chiefly on ward work with the rudiments of anatomy and physiology. This teaching to be undertaken by Sisters or third year nurses under the Matron's supervision. The second year's course to include cooking, rudiments of chemistry, food values, etc. third year to include the training and teaching of juniors, and a foreign language (Rodgers, 1985).

The object of the Bill was not only to register nurses, but also to set standards for nurse training in New Zealand. Those who might register were required to receive three consecutive years training in a hospital and systematic instruction in theory and practical nursing, finally passing a state final examination (Rodgers, 1985).

In 1901 Dr. MacGregor stated that a Ward Sister's main duty was not to do the work herself, but to teach others how to do it (Rodgers, 1985). The Annual report of Hospitals of 1906 saw it as appropriate that probationers should be supervised by trained staff, the more senior the probationer the less need to have large numbers of trained staff (Rodgers, 1985). Historically Grace Neill and Dr. MacGregor established a pattern of clinical education by nurse practitioners which over time has become more formalised.

Introduction of regulations for schools of nursing

By 1908 a Consolidated Statute to the Nurses Registration Act appeared and with it the first nurses' regulations. The regulations gave conditions for training schools, attendance at lectures, introduced an elementary anatomy and physiology examination to be held during the term of training after the end of the first year and identified the course of instruction. The State Examination at the conclusion of the three years was to be in written, oral, and practical forms. Doctors featured largely as the approved teachers, with the Matron responsible for the probationers working a ten hour day in the performance of their duties. Tasks such as 'learning' to record observations made of patients

were learnt by observing the nurse one step above. It was she who gave the probationer a list of tasks and saw that they were performed to her satisfaction (Rodgers, 1985).

As an unknown author writing in Kai Tiaki in 1922 observed good education requires organised teaching.

How often when a new hospital is opened we hear that 'probationers' must be obtained, because 'other services can't be afforded'. So probationers enter for three years-in the expectation of receiving an education in nursing, plus a living, for their services. Good education is only possible with material, equipment, and organised teaching. The two latter are commonly lacking. Instruction, pupils soon find, is a side issue-teaching one of the numerous duties of an over worked matron and a medical officer with little time-perhaps with little taste for it. (Nursing Education, November 1922)

Hospital schools of nursing

As hospital schools of nursing became established their main emphasis was on the practical nurse. The nurse required knowledge in order to perform practical skills. The annual reports of the training schools for the early period of the 1920s highlighted the differences in training that hospital schools of nursing were offering. The smaller hospitals presented a limited number of hours of theoretical instruction, while most larger hospitals gradually extended both the hours and refinement of the topics (Rodgers, 1985).

In the early days of nurse training in New Zealand, student nurses were the work force in hospitals, and were paid an apprentice type wage. Their task was to follow the orders of the medical staff and carry out the practical work under the guidance of a few registered nurses. Hospital training programmes offered little in the way of integrating theory and practice. Nursing was seen primarily as practice with a little education (Harker, 1995). Technical training of nurses was to be acquired in the wards and was perceived as an important part of a Ward Sister's duty (The ward Sister, in Kai Tiaki October 1927, p. 211).

It is in the wards that the nurse must apply the lessons she learns in class. In the ward she requires individual teaching; in the ward the highest teaching and training power should be available. Yet it is rarely the case. The average sister - unlike others who undertake educational work - knows little or nothing of the art of teaching.... it is one thing to do good nursing, and another, and far more difficult thing, to do good nursing through pupil nurses.... Every Ward Sister should be a sister-tutor (Nursing Education, July, 1921, p. 135).

This identifies the clinical education role as belonging to the Ward Sister, acknowledging her as a Sister Tutor. It also signifies the Ward Sister as having the responsibility of teaching the trainees in the practice setting. It describes the dual roles of the Ward Sister as, of running the ward and ensuring safe patient care, and to ensure trainees under her supervision learn how to deliver safe nursing care.

Introduction of demonstration rooms within schools of nursing

In 1922 Miss McKenny at a nurses' meeting, read to the group her paper relating to nursing education and nursing practice:

The community cannot afford other than pupil nurses services but it should afford trained expert teaching for the pupils...Then might we begin to see in every training hospital, the nurses' laboratory, the nurses diet kitchen, the replica of a ward for practice, the students' library, as well as just a class room. And most to be desired of all, we might have the trained instructor (Nursing Education, November, 1922, p. 216).

Following this statement demonstration rooms became an accepted part of schools of nursing. Here students practiced their nursing skills under the supervision of trained instructors. Schools of nursing education were able to give the trainee nurses formal lectures and provide a ward like situation, in the demonstration room, for the trainees to practice their nursing skills. Both, in the classroom and demonstration room, trainees were taught by instructors within the schools of nursing. The introduction of the demonstration room within the schools of nursing provided the trainees with an introduction to the practical skills that would be required of them in the practice setting.

Previously these skills had been learnt from the nurse one rung higher up on the ladder of hierarchy.

In a paper presented at the Nurses conference by an unknown author in 1927 it was stated:

It has been suggested that probationers receive all their theoretical training in class rooms and practical demonstration rooms, as the Ward Sister is usually much too busy to devote any time to that work. Most of the practical training must be gained in wards where a capable sister must teach the real value of symptoms, treatments, etc., as applied to individual patients (Conference paper, 'The Ward Sister', October, 1927, p. 205).

Introduction of sister tutors

By 1927 the Ward Sisters lack of time to teach resulted in a general acceptance the student should receive all their theoretical knowledge and practical skills from Tutor Sisters working in the hospital schools of nursing. The role of Sister Tutor initially given to the Ward Sister now became that of the Tutor Sister, the person responsible for student learning in schools of nursing.

The first Tutor Sister was appointed in 1928. She was Miss West Watson who conducted the first Preliminary School in November, of that year, with a class of seven students. According to McDonald and Tulloch (1994), the Matron of St Thomas' Hospital had recommended Miss West Watson as a highly qualified nurse and keen educationalist. Initially the role of the Tutor Sister was to give preliminary instruction to the probationer nurses for a period of six weeks prior to being sent to the wards. Tutor Sisters worked in the schools of nursing separate from the wards, and had the responsibility of training the probationer nurses. Theoretical lectures were often the province of the doctors and practical classes the responsibility of the nursing tutor. Up until about the 1950s, medical staff continued to have a role in teaching and

examining the theory of nurses. The title Tutor Sister was to remain until hospital schools of nursing closed in the 1980s.

Clinical tutors

Over time Tutor Sisters assumed responsibility for the theoretical teaching in the classroom and Clinical Tutors became primarily responsible for supervising and teaching nurses in the wards. Clinical Tutors, always few in number, arose out of a perceived need to solve the evident problems of Tutor Sisters being unable to get sufficient time in the wards and Ward Sisters struggling to manage their ward work and the clinical education of student nurses. The purpose of the Clinical Tutor was to bridge the theory/practice gap by undertaking a teaching role in clinical practice (Clifford, 1993a). Clinical Tutors taught the practical components of nursing to students. They were often viewed as being of lesser status than Tutor Sisters. They visited wards to work alongside nurses especially junior nurses needing some guidance in their nursing practice. The role of Tutor Sister and Clinical Tutor were quite separate. Often a Clinical Tutor worked for a period of time in that position before they moved on to become a Tutor Sister. Nurse lecturers, within departments of nursing in educational institutions, may still be referred to as clinical tutors when they are in the practice setting.

Apprenticeship model of clinical education

Under the apprenticeship system of training, that prevailed for so long nursing students learned and refined their nursing skills on the job. For students, their primary clinical teachers were those on the next rung of the hierarchy. The Staff Nurse taught the third year, who taught the second year, who taught the first year. The Ward Sister's orders were the ultimate and were obeyed without question. Learning tended to be by trial and error, tradition, authority and sometimes by role modelling. Registered nurses working in the practice setting assumed responsibility for the teaching of students in the clinical area. Clinical staff set students tasks to do appropriate to their level of training, often teaching by example. Student learning depended on those nurses in the class

ahead of them and the level of expertise of the registered nurses on duty. If more senior nurses did not take an interest in students' learning requirements students often had to learn by trial and error. Clinical learning in this situation was unpredictable, with the responsibility for nurses clinical education falling randomly onto clinical tutors, other nurses working in the ward, and/or the Ward Sister.

During the 1960s, there was increasing concern about the training of student nurses despite the gradual improvements being made to meet their educational needs. High attrition rates of students began to cause considerable concern in government circles. The service demands of the hospital which involved shift work, often resulted in students being placed in clinical situations beyond their level of preparation. This combined with the pressure of study requirements contributed to the students stress and high student turnover (Burgess, 1984). Combined with growing employment opportunities for nurses outside of the hospitals in the areas of disease prevention and health promotion there was a desire to provide a common educational base for all nurses.

These factors led to the scrutiny of schools of nursing. Tutor Sisters were becoming disadvantaged by their lack of contact with their counterparts in other areas of education. In many schools of nursing the tutor-to-student ratio was unfavourable, and with several student intakes each year there was often little time for Tutor Sisters to carry out clinical teaching in the wards. A number of schools had difficulty recruiting and then retaining adequately qualified tutors. In the early 1970s only 29.7 per cent of tutors had the minimum qualification of a diploma from the School of Advanced Nursing Studies. With the pressures already mentioned, there were difficulties in keeping up with trends in nursing education (Burgess, 1984).

Development of a separation between practice and education

Over time separation between schools of nursing and the practice areas became greater and this created further problems. The knowledge, technology and theory explosion of the 20th century and the emergence of research-based, theory-linked nursing practice accelerated calls for the reform of apprentice-type educational programmes, which did not cultivate a questioning, rational attitude and critical thinking (Booth, 1997). As a result of these problems, there was extensive discussion and debate amongst nurses, health professionals and policy makers about the appropriate way to train nurses in an environment which was undergoing rapid and complex changes (Clare, 1991).

In 1970 the government appointed Dr. Helen Carpenter, to investigate and make recommendations to government about the most appropriate system of nursing education for New Zealand. In 1971 this culminated in the publication of 'An Improved System of Nursing Education for New Zealand'. In the publication Dr. Carpenter recommended that the overall responsibility and funding for nursing education be transferred to from the Department of Health to the Department of Education (Carpenter, 1971). This change saw the end of the apprentice-type education of nurses, where students were employed by the hospital authorities and received a salary during on-the-job training. In 1973 nursing education was moved from the hospital setting and transferred into the education sector.

In 1972, the then Department of Education, recommended that the supervision of nurses clinical training be carried out by nursing tutors employed by the teaching institute. It was considered that only with this method would there be any guarantee that the tutor's first priority was the training of students. At the same time the Nursing Council of New Zealand (NCNZ) designated 1500 clinical hours requirement for registration. These provisions apply today in the NCNZ Standards for Registration as a Comprehensive Nurse, October 1996.

A further recommendation of the Department of Health's Report on An Improved System of Nursing Education in New Zealand was that "the preparation of and career structure for tutors be examined with the objective of improving both". Dr. Carpenter had identified a serious problem relating to the educational preparation of Tutor Sisters. It was suggested that tutors, who had an interest, be encouraged to undertake a university degree or a Diploma in Education and financial assistance should be made available in a similar manner as for other teachers (Carpenter, 1971).

The 1973 transfer of nursing education into educational institutions

In 1972 the recommendation to educate nurses in the education sector was passed into legislation (Boyle, 1994). The reasons for the changeover to student-based learning were many but the most significant was the dissatisfaction with the traditional hospital-based training method. High attrition rates were a common feature of the traditional method and were seen by the government as costly (Department of Health, 1969). Practising nurses expressed the view that hospital based training was unable to prepare them adequately for their future role (Boyle, 1994). Comprehensive programmes were established in technical institutes. Nursing programmes were to cover a minimum of 3000 hours during three academic years (Burgess, 1984). The new programmes were designed to prepare nurses for practice in the psychiatric, psychopaedic, community, medical, surgical, maternal and child health areas, unlike the traditional programmes which produced nurses to work in narrower fields (Department of Health, 1988).

Since 1973, nursing education in New Zealand has undergone substantial changes. Students now have full student status within the general education system. Within the new comprehensive programmes, students carry out clinical nursing work in order to gain clinical experience. Nursing educational institutions are separated from the practice setting. Students visit the practice setting to gain their clinical experience. They are not, as under the traditional

training, members of staff whose education was incidental upon their meeting the service needs of the institution at which their training was based.

The aim of the transfer of nursing education

In 1973 nursing education was transferred to the education sector and students were enrolled at educational institutes to undertake a pre registration nursing programme. The overall aim of the transfer of nursing education was to meet the perceived educational needs of nurses who would work in a rapidly changing social, cultural and political environment of health care. Theoretical teaching and clinical practice in a variety of settings was to be coordinated to provide students with an educational background appropriate for a health service orientated towards the prevention of illness and the promotion of health. The emphasis on clinical experiences within a hospital was to change from task orientation to patient centred care, suitable for the student at a particular level of their experience and supervised by a nursing tutor (Clare, 1991).

It was planned that clinical experience would be supervised by a nursing tutor from a department of nursing within an educational institute, working directly with students in the practice area. Tutors were to supervise up to six first year students in a ward, working as a member of the ward team and answerable to the Charge Nurse for the quality of nursing care patients received. The tutor's level of nursing competence would be increased by contributing directly to the nursing care carried out by students, and the continuity of supervising students within one area of practice over a period of time.

With the change in the delivery of nursing education programmes a shift in responsibility for student learning occurred. Clinical education became primarily the responsibility of the educational establishment and nurse tutors were seen as having both classroom and clinical teaching roles.

In 1982 the Nursing Council of New Zealand, circulated a statement on nurse teachers' qualifications on entry to Technical Institute and Community College Departments of Nursing and to Hospital Schools of Nursing (Department of Health, 1988). In this document it was stated that nursing tutors employed after January 1985 would be required to have completed a university degree. Tutors already employed within the institute would eventually be required to gain a first degree. The Nursing Council did however acknowledge there were problems in implementing this, such as limited paid study leave and limited educational resources with only two university departments of nursing in New Zealand. Many nurse tutors did enrol and complete degrees.

Clinical education in the changing health services in the 1990s

Clinical education is a major component of the undergraduate nursing programme. In order to provide safe, beginning level nursing care, new graduates must have developed not only the theoretical knowledge on which to base their care but the practical application skills required to implement that knowledge. It is in the practice setting the nursing student has the opportunity to develop those crucial skills. The clinical learning environment will influence the development of student attitudes, psychomotor skills, knowledge and clinical problem solving abilities (Dunn & Hansford, 1997).

More recently there has been a change from Diploma programme to a Bachelor programme for pre-registration nursing in New Zealand. Within the transfer to a degree programme, the term nursing tutor changed to become nurse lecturer.

To meet the Nursing Council of New Zealand requirements for the completion of a Bachelor of Nursing degree the student must undertake 1500 hours of clinical practice. This experience is usually negotiated between the educational institute practicum coordinator and the liaison manager at the health care organisation. The number of student nurses for each clinical placement is negotiated several months before the students actually arrive for

their clinical experience. Charge Nurses and unit managers are then advised of the numbers of students they will receive from an educational institute. There is the practical difficulty of finding clinical experiences that correspond to classroom learning, and in settings where adequate clinical supervision can be provided by the staff and with patients who are not so acutely ill that their safety is compromised. This becomes a complex matrix when more than one department of nursing, within an educational institute, wishes to accommodate students within a single agency. The registered nurses working at the bedside do not normally have a major input into this process, but are required to work with the students when they arrive in their ward.

Nurse lecturers from the educational institute affiliated with multiple health agencies, may have a diverse geographical area in which to supervise their nursing students. The practice settings are not always places in which the nurse lecturer may have expert knowledge about the actual clinical area in which the student is based. Usually an attempt is made, however, to ensure that the lecturers do supervise in the areas in which they have some knowledge and they are able to cover the same practice setting each time they are supervising the students. Currently nurse lecturers may be expected to supervise between fifteen to twenty students on morning and/or afternoon duties. Due to the geographical constraints nurse lecturers often only have the time to deliver information or talk with students and therefore may not have time to become involved in the students clinical practice.

Escalating costs in both the health and education sectors have seen rationalisation on a large scale. In the health sector shorter hospital stays, high acuity, deinstitutionalisation and the growth of the community-based sector have changed the nature of the clinical experiences available for nursing students. Greater opportunities for independent nursing practice have become available (Boyle & Orchard, 1997). Nurses are now working alongside unregistered care workers in rest homes and the mental health area. The trend towards a changing pattern of health care was anticipated in 1973, the

lack of public resourcing was not (Boyle & Orchard, 1997). In the education sector, change has led to the emergence of a push to provide a seamless education system which is industry driven (Goff, 1989).

The move to degree preparation for student nurses and reduced staffing levels within educational institutions has placed increased demands on nurse lecturers. In order for some nurse lecturers to meet their teaching demands clinical teaching has become, by necessity, a lower priority, as clinical teaching time erodes into classroom teaching time. Nurse lecturers are spending less and less time in the practice setting teaching students. Their limited time in the practice setting is focussed on discussions or problem solving with students.

The Nursing Council of New Zealand requires that a nurse lecturer be available to students but not necessarily on site providing direct clinical teaching. For many nurse lecturers an issue of importance is how they can maintain currency of nursing skills while they are removed from the clinical environment. For hospitals an issue of economy is how to maintain staffing within the wards when students are present and requiring supervision from their registered nursing staff.

Clinical education 1994-1998

A significant change in recent years for nursing education has been the introduction of "contracting". Nursing departments, within educational institutions, now purchase clinical supervision from clinical practitioners employed as or by health providers. The number of placements currently available to nursing students in the traditional clinical areas such as hospitals is getting ever smaller. Hospitals with a reduced workforce, take fewer students. Community based services often find it difficult to absorb students into their daily work. These services are often profit driven and tend to take few students (Hallett, 1997; Carlisle, Kirk & Luker, 1997). In areas where there are very few registered nurses to act as role models, student preceptors are

often the most welcoming of students. This means that students are frequently placed over a range of specialised areas in small numbers i.e. one or two per placement.

Contracting for student access to services provided by the Crown Health Enterprises (C.H.E.) heralded the arrival of a market driven era of nursing education. The review of clinical education and training of health professionals carried out for the Health Reforms Directorate in 1992 costed registered nurses time and associated administration for C.H.E.'s when nursing students were learning in the practice setting. The cost was then moved from vote health and transferred to vote education. This combined with the purchaser/provider split between education and health has changed the relationship between nurse lecturers and nurse practitioners. In the past this relationship was based on goodwill. It is now shaped by commercial considerations (Boyle & Orchard, 1997).

The required clinical component of nursing education is expensive in terms of the hours of clinical teaching required. As funding decreases, nurse lecturers are being challenged to 'do more with less'. One of the greatest challenges for New Zealand educational departments of nursing in the next decade will be the adequate funding of clinical education programmes, the establishment of preceptor programmes for registered nurses supervising students, and identifying the clinical education role for both the nurse lecturer and the registered nurse in the practice setting. (Grealish & Carroll, 1998).

While nurse lecturers remain responsible for planning and supporting student's experience they now depend on clinical practitioners for access to, and the quality of, clinical experience. Nurse lecturers are required to be 'available' to students, to "support" them at all times during clinical hours (NZNC, Standard 6.5, 1996). Nurse lecturers need to be 'generalists', able to facilitate student learning over the many 'specialist' areas where students gain experience. Nurse lecturers who have clinical competence and credibility when they enter

teaching, have been found to experience resistance when they offer to work alongside students delivering care (Paterson, 1997). There is a national requirement for annual updating of nurse lecturers clinical skills in New Zealand but currency and level of expertise are often questioned by practitioners. Nurse lecturers themselves acknowledge that their clinical skills become limited in practice settings the longer they are 'in' teaching and they are adopting a link role to provide student support (Carlisle et al, 1997).

Because the role of clinical educator for pre-registration nursing students is ambiguous, it is not clear whether it belongs to the nurse lecturer or the registered nurse working in the practice setting. One consequence of this ambiguity is that teaching during students' clinical experience is increasingly being carried out by nurse practitioners (Boyle, 1994; Booth, 1997; Paterson 1997; Nehls, Rather, & Guyette, 1997; Carlisle et al, 1997). Nurse lecturers increasingly rely on the registered nurses working in the practice setting to be the clinical educators. While the situation has been formalised in the contracts, between the educational institutions and the C.H.E., contracts are not clear about who has responsibility for the clinical education role. It would however, appear that the registered nurses working in the practice setting have become de facto clinical educators. The role of the nurse practitioner and the nurse lecturer need to be clarified and integrated so that practitioners can be involved in curriculum planning and delivery, and lecturers can be involved in research which is clinically relevant (Nehls et al, 1997).

Summary

Nursing clinical education has developed historically since the arrival of women settlers in New Zealand in the early years of the nineteenth century. Nightingale nurses arrived in from London taking up the positions of Matron in hospitals and formalised the role of nursing. In 1973 nursing education moved from the Hospital Schools of Nursing to educational institutes and students became supernumerary in the practice setting. The move from the hospital training schools to departments of nursing within educational

institutes, refocussed nursing education on the process of learning. This learning was primarily facilitated by nurse tutors, who after the introduction of Bachelor Programmes in the 1990s became known as nurse lecturers, employed by the educational institution to supervise, encourage and assist students to learn.

Recent changes to government services in both health and education sectors have brought clinical training of health professionals into the philosophical debate which surrounds health service restructuring. Cost cutting in the health sector has meant, for some registered nurses, an increased workload as they continue to endeavour to provide nursing care to a standard acceptable to both their patients and themselves.

The purchaser/provider split between education and health has changed the relationship between nurse lecturers and nurse practitioners. In the past this relationship was based on good will. It is now shaped by commercial considerations (Boyle, 1994). Today's rapidly changing health care environment has necessitated many changes in the role of the nurse practitioner and nurse lecturer.

Chapter 3**CLINICAL EDUCATION
A REVIEW OF THE LITERATURE****Introduction**

During the last quarter of the twentieth century nursing has acquired new dimensions as a consequence of both the context in which it is being practised and the way it has been studied. With these new dimensions has come new terminology. In the international literature there are no universally accepted definitions related to the clinical education role. This poses problems when the context does not make clear the particular interpretation being used by an author. In order to ensure some consistency the researcher has chosen to utilise the most commonly accepted usage within New Zealand context.

Nurse lecturers are registered nurses employed by the educational institution and have classroom, management and clinical roles.

Nurse practitioners are registered nurses working in the practice setting, whose primary duty is to provide care to patients, but may also contribute to student learning in a number of ways. This may be as a role model, or as teacher and supervisor.

In the New Zealand setting the role of nurse practitioner and the role of nurse lecturer in clinical education owes much to individuals interpretation of the role and the context at any given point of time.

The term clinical supervision is currently used in nursing by nurse practitioners and nurse lecturers to describe their education role with students in the practice setting.

Clinical instruction has its foundations in the apprentice styled nursing training programmes prior to 1973. The term may still be used in the international literature and by some nurse practitioners to describe their teaching role.

Definitions of clinical teaching are, in the majority, very broad and non-specific. Clinical teaching is the type of teaching that occurs in the proximity of a patient in an individual or group setting. It is a dynamic process which takes place in a variety of sociocultural contexts.

Nursing education

Nursing is a practice based discipline with experiential learning in clinical practice areas comprising an overwhelming portion of a nursing student's education. Although all learning takes place within a social context, the context of clinical practice includes many more variables than the traditional academic setting (Fothergill-Bourbonnais & Higuchi, 1995). To be successful, registered nurses require problem solving skills, an understanding of the limits of the health care setting, and the theoretical knowledge to solve clinical problems. Lathlean (1992), described nursing as an occupation with fundamentally different views of its role, with education providing nursing students with an idealised theoretical view of nursing and the ward experience emphasising nursing as being about 'getting the work done'.

The potential for learning in a given clinical situation is directly proportional to the degree to which personnel in the situation accept students, the degree to which the personnel understand the total educational programme, and the quality of nursing care that is practised in the situation (Schweer, 1972). Learning in the clinical environment is dependant on a number of factors. These are the clinical environment itself, the availability of experienced registered nurses to supervise students, attitudes and motivation of those personnel involved in student learning, and the relationship between the educational institutions and the health care agency.

In preparation for sending students into the practice setting educational institutions have a responsibility to provide students with the opportunity to practice nursing skills. Neary (1997) considers that it is important that students have the opportunity to learn skills not only in the real situation, but also in simulation, so that the student has the opportunity to practice and test learning without fear of causing harm to a patient. Neary (1997) argues that it is often forgotten that students are not nurses, but in the process of learning to be registered nurses. It is suggested that students find it difficult on the wards without having been first taught some of the basic skills. Corkhill (1998) writes that while simulation of skills is important prior to practicing with patients, anecdotal reports from many new graduates consider that performing the skills in a laboratory is not really like using the skills as registered nurses; the model does not move and react in the manner of a patient, and it is still frightening for them as the registered nurse when they are confronted with the need for a skill they have not practiced on a patient while a student (Corkhill, 1998).

Weatherston (1981) acknowledges and supports the findings from the Briggs report (1972) that there is a need for coordination of education in the classroom and the service setting. It is argued that if the full potential for learning is to be realised within the clinical situation, staff who have an understanding of the learning process must be available to work with students. This may be achieved by having nurse lecturers within the clinical areas, or by having such a close liaison between clinical and educational staff, that control of clinical experience and consultation may occur easily.

With ongoing developments in nurse education and nursing practice Smith (1995) believes it is vital that nurse lecturers are active in the practice setting, promoting, supporting and evaluating change thus helping students put into practice their newly gained knowledge. As students progress through their education programme they encounter many different clinical settings. Transition from one ward to another whilst applying new theoretical knowledge to their nursing practice is difficult. Students have to meet new clinical staff,

learn their way around the ward and adapt themselves to the environment. The scope for the nurse lecturer to act in the clinical setting could be vast. The nurse lecturer could visit the ward frequently, providing support to both students and clinical staff, facilitating good practice and bridging the theory-practice gap. The nurse lecturer can be seen as the link between students and the clinical area (Smith, 1995).

Charlesworth, Kanneh, and Masterson (1992) believe the focus of nurse education must be the further pursuit of excellence. Nurse lecturers must contribute to the continuing development of nursing knowledge. Charlesworth et al. (1992), believe nursing is, and must remain a practice based profession: thus development and change should derive from, and be relevant to, practice. However there is the more crucial argument that when there are clinically credible and expert practitioners already in the clinical areas, the continual presence of nurse lecturers could be considered a doubling up of roles and resources. Should nurse lecturers be trying to displace the clinical practitioner as the role model for clinical excellence? (Acton, Gough & McCormack 1992).

According to Schön (1987) clinical practice provides a learning environment that is designed to enable students to put into practice knowledge they have already learnt. The aim of clinical practice is to extend the students' understanding of theoretical knowledge by testing it out in environments which simulate the real world. Schön explains that the practice setting is a virtual real world which represents essential features of a practice where students are able to experiment at low risk, at a level they are ready for, and are able to repeat many times as it is felt appropriate (Reed & Proctor, 1993). The concept of a virtual world, is one that mirrors reality, but is in fact a protected environment, and is very important when teaching students in the clinical area.

During the clinical focus of the education programme students encounter many different clinical settings. Applying new theoretical skills is difficult when students move between clinical areas. They may be keen to practise new

clinical skills acquired in previous placements but need to feel comfortable in order to implement these skills in their new clinical placement. Students need to develop the skill to adapt to constant change.

Clinical learning experiences refer to the totality of directed activity in which students engage in practice with consumers to meet health care needs. The clinical education of students is experiential in nature but not synonymous with a laboratory practicum. Clinical experience allows students the opportunity to see the textbook come to life and to practice skills under supervision. In addition clinical experience exposes students to the many roles of the nurse practitioner and socialises them into the profession (Augspurger, 1994). The clinical area is an important learning environment and the clinical teachers are seen by nursing students as a significant role model. Clinical teaching is the vehicle that provides students with the opportunity to translate theoretical knowledge into the learning of a variety of intellectual and psychomotor skills needed to provide patient-centred quality nursing care.

Nurse lecturers role

The role of the nurse lecturer has been interpreted in a variety of ways in different settings. Cave (1994) identified two aims for this role, one a clinical role, to identify and maintain standards of practice in a defined area, the second, an education role, to prepare and contribute to the educational programmes of students in relation to the theory and practice of nursing. Clare (1991) describes the role as one of an advocate for students, whereas Grealish and Carroll (1998) describe the role as working directly with students. Grotty (1993a) observed that nurse lecturers' perceive themselves in a liaison role rather than one of practicing in the practice setting with students. Clifford (1993b) describes the terms most frequently used by nurse lecturers when describing their clinical role as being, 'visits', 'liaison and support'. The term 'liaison' conjures up an image of a 'go between'. Lecturers seeing themselves as a link between education and service, or between the student and the ward staff working to build a 'relationship' that will facilitate student learning.

The roles and expectations of the nurse lecturer are described repeatedly in such terms as to 'foster and maintain the highest possible standards of nursing care', 'organise students' clinical experience', 'act as a bridge built between school and hospital' (Weatherston, 1981). Many nurse lecturers are committed, skilled nurses and lecturers. Their enthusiasm for bedside teaching, and their positive relationships with learners are impressive (Weatherstone, 1981). Clifford (1993a) believes that due to the diverse role of the nurse lecturer the individuals capabilities may be stretched to the full. She found from her research, in the United Kingdom, the nurse lecturer faces conflicts over meetings, the demands of a classroom, the management role and the clinical role. This is a problem that has recently arisen for some New Zealand nurse lecturers as they try to manage all three aspects of their role. This often leads to a conflict of interest as classroom commitments and management meetings tend to become the greater priority.

While few would question the importance of clinical teaching and learning in a practice discipline like nursing and the contribution of nurse practitioners and nurse lecturers to this learning, nurse lecturers have struggled to define what their role should be in the clinical area. Many currently adopt a 'one-dimensional role', that is they teach students and have little contact with the registered nurses in the practice setting (Owen, 1993). Some define their role as supervising the learning of their students in order to bridge the theory practice gap. Carpenito and Duesphol (1981) indicate that nurse lecturers have the responsibility for fostering educational opportunities in the clinical setting that will facilitate the preparation of a beginning practitioner. Infante (1986) believes the role of the nurse lecturer is to provide guidance from a strong conceptual and experiential base. She believes the nurse lecturer promotes learning rather than supervising or emulating practice. Such behaviours make the nurse lecturer a role model for teaching rather than practice. In contrast Infante (1986) writes that the nurse practitioner working in the various practice settings acts as a role model for students.

Many believe a major part of the lecturer's role is to monitor and maintain a satisfactory clinical learning environment. In order to achieve this the nurse lecturer will need to have current clinical ability and acceptance by the ward staff. Educational institutions require nurse lecturers to be involved in the practice setting, as well as develop and maintain an interest in research and publishing. However, it was found that the more involved nurse lecturers were in clinical work the fewer papers they published (Ostmoe, 1986). Thus creating another conflict within their roles and responsibilities.

The conflicting demands of the nurse lecturers role are such that is easy to get immersed in classroom activities and fail to respond proactively to the many changes in the practice setting that will shape the future (Clifford, 1993a). Morgan (1991) suggests that nurse lecturers are now charged with the responsibility for establishing education opportunities in the clinical setting that will facilitate learning.

Nurse lectures role in clinical teaching

In the absence of a universally accepted clinical education role, the clinical role of the nurse lecturer is generally assumed to be one of clinical teaching. The term clinical teaching is widely used, however its meaning is not always clear. Never-the-less White and Ewan (1991) conclude that most definitions of clinical teaching contain some reference to the translation of theoretical knowledge into practice.

The nature of the nurse lecturer's role in the clinical area has been an area of intense debate. Infante (1986) believes that the clinical role of the nurse lecturers is to provide academic guidance by setting the stage for clinical learning rather than to supervise practice. She explains that nurse lecturers are role models for teaching rather than practice and they serve as consultants to the practitioners, sharing with them their educational expertise so as to enhance the education of students. Osborne (1991) sustains this view when

she maintains that the move towards student-centred learning in nurse education has necessitated the need for lecturers to create the educational clinical environment within a practice setting that is conducive to student learning.

Alexander (1983) found that many nurse lecturers would like to free themselves of clinical teaching. A study by Jones (1985) aiming to establish factors which prevent lecturers carrying out clinical teaching, identified lack of control, a sense of conflict, stress and anxiety in the ward teaching situation, lack of peer support and an inability to plan ahead for such work. Also emerging from the study was finding that nurse lecturers felt they lacked time for clinical teaching.

A number of studies have reported the extent of the nurse lecturers involvement in the clinical area. In a recent study, Clifford (1993b) circulated questionnaires to 66 nurse lecturers to gather information regarding the nurse lecturers' clinical role. Forty questionnaires were returned and the results showed that the frequency and timing of lecturers' clinical involvement were not evenly distributed. Twenty per cent of respondents gave no indication of involvement in the clinical area. For others, the frequency of involvement ranged from daily to once every four weeks. It was also found that the time spent in each practice area varied enormously between respondents, with some spending up to a whole day, others spending hours or minutes (Lee, 1996). The reasons most often given by nurse lecturers for visits to the practice area concerned working relationships, liaison, and support of practitioners and student' (Clifford 1992). This study also found that although some nurse lecturers do work with students, this most commonly occurs with first-year students as it was perceived these students required more supervision. Clifford, (1993a), believes that there is a low priority to clinical teaching by nurse lecturers and an assumption that nurse lecturers are fulfilling a clinical teaching role is misleading. In exploring the nurse lecturers feelings about their current participation in direct patient care, Baillie (1994)

found that five out of ten nurse lecturers in her study did not participate in patient care at all and that lecturers felt uncertain as to whether clinical practice should be part of their role.

Clinical supervision

The move from a diploma level nursing programme to a degree level programmes, in New Zealand in 1994 has raised questions about the support and supervision of student nurses in the clinical setting. Barber and Norman (1987, p 56) define supervision as an 'interpersonal process where a skilled practitioners helps a less skilled or experienced practitioner to achieve professional abilities appropriate to her/his role'. At the same time they are offered counsel and support. Unfortunately due to the placement of large numbers of nursing students, especially in practice settings where care givers are employed, there are often not enough nurse practitioners to help supervise them with their nursing practice, let alone to familiarise themselves with the particular learning needs of each student. This is particularly the case when nurse practitioners are also expected to assess and evaluate the care needs of each of their patients, which arguably should take priority over the needs of the students.

Fowler (1996) believes that the theory of supervision and its subsequent model should address at least three areas. Firstly, it should describe the function of supervision within the practice of nursing. Secondly, it should identify the constituents of the supervisory relationship. Thirdly it should describe the process of the relationship. To enable the supervisory relationship to develop and work effectively in the areas of teaching and assessing, there needs to be adequate preparation of staff to ensure this. Fowler (1996) believes that the role of the supervisor is to ensure that relevant experience is provided so that the students can achieve their learning outcomes. Fowler also contends that 'supervisors to pre-and post registration students have a formal and well established role within the profession'. (Faugier and Butterworth 1993, cited in Fowler (1996), state that although clinical supervision has found its way into

the nursing vocabulary it has little impact on the reality of nursing practice or education. Within the literature there is an explicit assumption that clinical supervision will assist in the application of nursing theory to practice.

White, Butterworth, Bishop, Carson Jeacock and Clements (1998), conducted an exploratory study over an 18-month period to comprehend the experiences of nursing staff involved with clinical supervision. Their research showed that almost without exception none of the respondents had had any previous experience of an activity formally described as 'clinical supervision', either as a supervisee, or as a supervisor. However, some respondent reported a previous experience as a 'mentor', or as a 'counsellor', which they regarded as relevant. The need for appropriate educational preparation was a concern as most of the participants did not know about available models of clinical supervision and had set about it blindly and were making it up as they went along.

Butterworth and Faugier (1992) describe supervision as a dynamic, interpersonally focused experience which promotes the development of therapeutic proficiency. One of the primary reasons for all supervision is to ensure the safety and quality of the student nurses' work is of the highest standard in relation to the patients' needs. Following Butterworth and Faugier's (1992) exploration of clinical supervision Yegdich (1998) explored the concept of supervision within the boundaries of professional development and growth. These studies have focused on the registered nurse as the supervisor and also the supervisee. They did not explore the concept of supervision in the student and registered nurse relationship.

In New Zealand the model of clinical teaching used between and within educational institutions, range from the traditional model in which full responsibility for students' clinical supervision is taken by nurse lecturers, to a model that in which this responsibility is shared with registered nurses in the practice setting (Grant, Ives, Raybould & O'Shea, 1996).

Within the clinical supervision model often used in New Zealand pre registration nursing programmes, nurse lecturers may be known as clinical supervisors, and work with students in practice setting (Grealish & Carroll, 1998). Clinical supervision has been described by Wilson-Barnett, Butterworth, White, Twinn, Davies and Riley (1995), as an umbrella term which embraces the students' learning experience. Good communication is seen as being of central importance and the development of trust being necessary for an effective relationship between the registered nurse and the student. Bodley (1991) suggests that, support teaching and assessment are all important roles in supervision. The central importance of practitioners in the process of clinical teaching and supervision has resulted in the devolution of responsibility for this process from educational institutions to clinical areas. This has been evident by the changes in role from teaching practice to supporting the student in the clinical environment (Wilson-Barnett et al, 1995; Grotty, 1993a; Clifford, 1992).

Butterworth and Faugier (1992) are of the opinion that it is possible to find considerable literature on clinical supervision in professions such as psychology, social work, and counselling, but there is little of substance in nursing. Literature suggests that within the nursing profession, clinical supervision has developed in an ad hoc way, borrowing heavily from the therapy, counselling and social work professions (Butterworth & Faugier, 1992; Marrow & Tatum, 1994). Often it has been used in peer group support rather than as a formal process which can refine skills and lead to valuable improvements in patient care (Butterworth & Faugier, 1992).

In their exploration of the use and definition of the term clinical supervision in nursing, Butterworth and Faugier (1992) suggest the confusion in its use has been increased by the introduction of the terms 'mentor' and 'preceptor'. Butterworth and Faugier believe supervision should be seen as something that supports the total nursing workforce and discussed the need to recognise an

evolutionary change in the registered nurse to student if not nurse to patient relationship.

The assumption made by the Department of Education in 1972 that lecturers supervision of students' clinical education would ensure students' needs were given priority have been found to be flawed (Boyle, 1994). Infante's (1985) study demonstrated that lecturers experience a dilemma during clinical supervision because they continue to give priority to patient needs. Clare (1991) found, in the New Zealand setting, that nurse lecturers identified with the ward culture and failed to act as advocates for students. These findings may be partly explained by Paterson's (1997) research which shows that since 1973 nurse lecturers going into clinical areas are, and in fact have always been, treated as 'guests in the house' (effectively excluding students from 'insider' knowledge), a finding supported in the New Zealand setting by comments from Burgess (1984).

Theory - practice gap

Since the 1973 transfer of pre registration nursing programmes in New Zealand from hospitals to educational institutions, a total reform of student nursing education has taken place. The transfer of nursing education into educational institutions has over time created an artificial division between nurse lecturers and nurse practitioners, with each assuming more focused, specialist roles within their own domains (Booth, 1997). This reform has highlighted a gap between theory taught in the classroom and practice as it is encountered in the clinical area. This discrepancy between that which is taught in the nursing departments within the educational institutes and practised in the clinical areas is well documented (Hewison & Wildman 1996; Grotty, 1993b).

Historically, issues about theory and practice in nursing have been the preoccupation of nurse lecturers rather than of nurse practitioners (Lathlean, 1992). Now as the role of clinical educator has such a fundamental part to

play in students' clinical education the roles of both nurse lecturers and registered nurses working in the practice setting urgently need to be clarified and integrated.

If nurse lecturers are to work in the practice setting they need to be more aware of the clinical realities which affect the application of the theory taught by maintaining clinical contact through their clinical teaching of students. This helps overcome the gap between what is taught and what is seen in practice (Cave, 1994). An important role of the nurse lecturer is to educate students through tutorials in an attempt to link theory to practice. However good classroom theory and ward practice may not always correlate. As the hospital ward is an ever changing environment the nurse lecturer needs to keep up with the current changes (McCaugherty, 1991). An ideal, as described by Jarvis and Gibson (cited in Cave, 1994) is for nurse lecturers to guide the student in the application of theory to practice and also, assist in drawing out the theoretical implications from the practical experience.

Helping students improve the quality of care helps bridge the theory-practice gap and ensures nurse lecturers remain at the forefront of developments in clinical practice. Grotty (1993a) in her research on clinical role activities of nurse lecturers, found a very strong commitment of the respondents to a clinical liaison role. But they did not perceive their role to be one of teaching students through 'hands on care': they felt this was the role of the registered nurse in the clinical areas. One respondent in Grotty's study, stated that she put her clinical supervision as a low priority and at times found herself trying to avoid going out into clinical practice.

According to Smith (1995) the role of the nurse practitioner should be to provide educational support by facilitating good nursing practice and help to bridge the theory to practice gap. The nurse practitioner is a fundamental link between the students and the clinical area. If the profession acknowledges that theory is embedded in practice, some problems may be overcome.

Coates and Gormley (1997) support Smiths' belief and consider the quality of clinical nursing education is important. They suggest that nursing skills should be taught in the clinical area by practicing registered nurses, a recommendation also made by Nehls et al, (1997). Coates and Gormely (1997) point out that disparity between nursing theory and practice has a negative effect on patient care. Alexander (1982) also found that often theory taught in the classroom did not reflect practice, and suggests that students were unable to meet clinical objectives due to inadequate integration of theory with practice by the nurse lecturers a factor which gives value to Nehls et al. view.

The importance of practitioners' contribution to the preparation of student nurses' practice has been acknowledged in the literature (Grant et al, 1996). Howie (1988) supported registered nurses involvement in the supervision and teaching of students and suggests students' socialisation into the clinical area is largely dependent on the presence of effective role models. The effective role models were seen as the registered nurses working in the practice setting because nurse lecturers did not practice nursing or practised differently and as a result nurse lecturers advice was often disregarded (Clifford 1993b).

The problem of the theory - practice gap has been approached in a number of ways. Increasing the involvement of nurse lecturers in the clinical area was advocated as a means of improving the adverse effects of the theory-practice gap (Bradshaw, 1984). The argument underlying this suggestion was that as the bulk of the student's time was spent in the practice setting it follows that this is where their nurse lecturers should be. It was believed the integration of theory and practice could be achieved through the common link of a member of staff being present in the classroom and the clinical area (Hewison & Wildman, 1996).

Clifford (1993b) believes that there is a professional interest in the ways of linking theory to practice in the clinical learning environment. According to the

results of her 1992 study, a group of nurse lecturers saw the registered nurses working in the practice setting as being the most responsible for teaching students in their practice setting. Lathlean (1992) believes much of the research has recognised the ward Charge Nurse as the key person in the creation of a good environment for learning in the ward.

Traditional ward Charge Nurses were responsible for teaching student nurses within their wards. However Lathlean (1992) showed that Charge Nurses spent little time with students. Often students were seen as a pair of hands rather than learners, teaching was given low priority and potential learning opportunities were wasted (Lathlean, 1992). A number of reasons have been cited for the limited student teaching: these include the pressures of the work which made it difficult for charge nurses to devote adequate time to teaching and assessing, the inexperience of many Charge Nurses, the consequent lack of confidence in their teaching ability, and the general lack of preparation for this aspect of their role. The reduction in staffing levels has placed stress on the registered nurse in the practice area in which she has to care for patients, and supervise students during their clinical practice. This has resulted on occasions, in registered nurses either unable or unwilling to assist students in their learning and students feeling unwelcome and rejected (Booth, 1997).

Since nursing education has transferred from the hospital setting to educational institutions the problems associated with students' difficulties of bridging the theory to practice gap in the practice setting do not appear to have changed. It is one thing to say to clinical educators, 'you are expected to guide these students, to assist them in transferring theory into practice, to support them', and another thing for those clinical educators to operationalise what they have been told. A strategy is required in order to create, establish and maintain a clinical education role that benefits both the nurse practitioner working in the practice setting and nurse lecturers. A new approach is needed if practitioners are to obtain the skills to confidently and effectively help supervise and educate nursing students.

Clinical education is at the heart of all nursing education programmes (Ferguson, 1996; Lee, 1996). It therefore falls on the shoulders of the clinical educator to integrate theory and practice; provide an optimum learning environment; and structure learning experiences which facilitate the acquisition of the clinical learning skills.

Clinical teaching

Grealish and Carroll (1998) write that clinical teaching is the core of all nursing education and the role of the nurse lecturer appears to be implicit and 'hidden', resulting in a wide difference in the interpretation of the extent, purpose and nature of that role. This unresolved problem has led to the lack of a concerted effort in the provision of educational input in the clinical area. O'Shea and Parsons (1979) suggest that effective teaching is defined as those actions, activities and verbalisation of the clinical educator which facilitate student learning in the clinical setting.

However, there are practical difficulties finding clinical experiences that correspond to classroom learning, and in settings where adequate clinical supervisors can be provided by the staff and with clients who are not so acutely ill that the educator worries about their safety. The constraints within the practice setting may also impact on the learning environment. Knowles (1990) asserts that the learning environment should be physically comfortable; there should be mutual trust, respect and helpfulness, freedom of expression and acceptance of differences. Wong and Wong (1987) suggest that the practice setting may not meet these objectives due to the physical surroundings, institutional constraints such as dress requirements, difficult relationships with registered nurses, nurse lecturers and other students.

Dunn and Hansford (1997) undertook a study of 229 Australian undergraduate nursing students' perceptions of their clinical learning environment. While they state the need for clinical education to provide the opportunity to develop student attitudes, psychomotor skills, knowledge, and clinical problem solving

abilities as graduates, the study did not address the issue of whether or not clinical education provided the opportunity to develop these skills. The authors have tended to investigate the relationships and dynamics of the clinical experience, rather than skills performance (Corkhill, 1998).

Morgan and Knox (1987) utilised an instrument called the Nursing Clinical Teacher Effectiveness Inventory to determine the 'best' and 'worst' clinical educators as perceived by nursing faculty and students. Their study showed that being a good role model and encouraging mutual respect were the two most critical behaviours for the 'best' and 'worst' clinical teachers. Nehring (1990) and Kotzabassaki, Panou, Dimou, Karabagli, Koutsopoulou and Ikononou (1997) replicated the study by Morgan and Knox (1987). Their studies also identified being a good role model, enjoying nursing, enjoying teaching, taking responsibility for own actions were the most important characteristics distinguishing 'best' from 'worst' clinical educators. In both studies the 'worst' characteristics were not statistically significant. These studies have identified the need for nurse lecturers to be good role models for students but this is accompanied by a debate about whether clinically credible and expert practitioners already in the clinical areas should be the role models students need on which to base their development of practice. The emphasis on the need for good role model is well supported by the literature (Wong & Wong, 1987; Flager, Loper-Powers & Spitzer, 1988; Howie, 1988; Wilson, 1994).

Kirk, Carlisle and Luker (1994) undertook a Delphi survey of 300 nurse lecturers and a range of other clinical, managerial and educational staff in nursing and found that nurse lecturers have difficulty in developing a clinical role. They noted that although many of the nurse lecturers in the study thought it desirable to develop their clinical role, most saw it as unlikely as they would not be given the opportunity to do so. Other studies in the United Kingdom have identified similar problems with nurse lecturers trying to develop a clinical role. Clifford (1996) believed the situation was further complicated by

organisational changes in nurse education in which the goal posts keep changing. Jowett, Walton and Payne cited in Clifford (1996) indicated that nurse lecturers had difficulty in meeting the clinical demands of their role. The goal for clinical time for nurse lecturers in this study was half a day each week but they had difficulty in achieving this. A number of nurse lecturers in the study expressed concern about keeping up their own skill in nursing. Jowett et al.(1994) cited in Clifford (1996) noted that nurse lecturers were pulled in opposite directions' while trying to meet the academic and practical demands of their role.

How do nurse lecturers make sense of their different work roles? Clifford (1996) identified a number of factors she believes may be influential in the way nurse lecturers approach clinical education. Clifford revealed that organisational factors also appeared to make a difference in the nurse lecturer who had a smaller number of links to ward areas and therefore were more likely to exhibit a positive orientation towards clinical education (Clifford, 1996). She concluded that there may be a link between the lecturers perceived confidence in nursing practice and the confidence in clinical teaching, their preparation for the role and their perceived ability to influence the clinical environment.

Summary

Collectively the literature presented to date indicates the confusion and difficulties nursing lecturers face in fulfilling a clinical role. Few studies have focused on examining nurses practitioners experiences and perceptions relating to the clinical education role of students. The attention given to clinical practice within nursing and education suggests it is timely to consider the contribution of registered nurses working in the practice setting contribution to students' clinical education. This qualitative study therefore explores the perceptions of registered nurses working in the practice setting.

Chapter 4

METHODOLOGY

Introduction

A review of the literature identified a lack of research into the perceptions of registered nurses working in the practice setting regarding the characteristics of the clinical education role. The aim of this study is to describe the characteristics of the education role as perceived by registered nurses working in the practice setting. In this chapter the reader is introduced to the study design chosen to achieve this aim, the researcher's rationale for choosing qualitative research and the descriptive exploratory method. The scope of the research is described and the theoretical context of descriptive exploratory research in relation to the purpose of the study is identified.

Research study design

The purpose of research is to generate, discover, verify knowledge or to develop and test theory. The two traditions of research which have been evident in the development of nursing knowledge are quantitative and qualitative research. Quantitative research methods are usually highly structured and spelled out in advance of any data collection. The theoretical frameworks from which their hypotheses are derived are based on research that has been investigated and is not inferential (Field & Morse, 1985). Quantitative research methods focus on measuring the phenomenon which is under scrutiny, and on determining relationships between cause and effect.

Qualitative research is usually conducted to explore problems about which relatively little is known. Qualitative research methods have in part risen from the dissatisfaction with the ability of quantitative methods to produce nursing knowledge that is relevant to much of the world of nursing practice. Many situations in nursing practice are not well understood, and it is appropriate that research methods which serve to describe and understand aspects of practice are an important adjunct to the discovery of knowledge about nursing practice (Holloway & Wheeler, 1996).

A qualitative research design is one in which the researcher plans to observe, describe, compare, and analyse the characteristics, attributes, themes, and underlying dimensions of a particular group or situation (Seaman, 1987). Qualitative research is most useful when the researcher wishes to use the material found in narratives which describes the phenomenon from the participants' perspective. Often such methods involve the use of semi-structured interviews as a principle method of data collection. Semi-structured questions are contained in an interview guide with a focus on the issues to be covered. The sequencing of questions is not the same for every participant as it depends on the process of the interviews and the answers of each individual. The interview guide, however, ensures that the researcher collects similar types of data from all participants (Holloway & Wheeler, 1996).

Qualitative research investigates patterns of interaction instead of measuring variables. Qualitative researchers make narrative recordings of the phenomenon they are studying, and adopt a person-centred and holistic perspective to develop an understanding of human experiences which are important for health professionals. Through this approach nurses gain rich knowledge and insight about human beings (Holloway & Wheeler, 1996).

If the purpose of the research is to observe, describe, explore, and assemble new knowledge, a descriptive or exploratory design may be used (Seaman, 1987). Because little research appears to have focussed on the registered nurses' perspective's of the clinical education role in the practice setting, a qualitative descriptive research method allows the material to present itself through semi-structured interviews. The researcher has utilised the descriptive and exploratory approach which is qualitative in nature, to describe the perceptions of the clinical education role as described by a group of registered nurses working in the practice setting.

Descriptive research

Seaman (1987, p 18) suggests that with the 'descriptive design the researcher plans to either to collect new information of an unstudied phenomenon or to plan a new look at old data or old nursing routines'. The purpose is to obtain new knowledge by describing, comparing, and classifying observations and by inventing concepts to stand for what previously may have been unorganised or unrelated observations or data. Descriptive designs seek to describe accurately the characteristics of an individual, a situation, or a group and may determine the frequency with which the event occurs or, the frequency with which the event is associated with another. A strength of this method lies in its potential to give shape to previously unidentified and unorganised data and situations.

Polit and Hungler (1997) describe descriptive studies as having as their main objective the accurate portrayal of the characteristics of persons, situations, or groups and/or the frequency with which certain phenomena occur. Descriptive research studies are best suited when the phenomena related to the research needs a reality explanation on a descriptive scale to find meaningful and conceptual understanding which derives from the participants experiences (Wanasinghe, 1997). It is from this rich descriptive data the researcher begins to analyse the phenomenon being studied. In this endeavour it is the researcher's job to produce an account of how the participants see the situation or phenomenon (Melia, 1982).

Exploratory research

Because there does not appear to be any previous studies looking at the clinical education role as perceived by registered nurses working in the practice setting, this is an exploratory study. Seaman (1987) states that descriptive exploratory research is basic, in that it is essential for providing information upon which later studies can be built. Researchers who adopt this approach usually propose to describe a phenomenon. New knowledge emerges when the researcher describes the data, compares and classifies the

information to enable the identification of concepts and themes associated with the phenomenon being studied. Exploratory and descriptive research do not generate knowledge which is directly transferable to the broader community or to other contexts. The aim is to describe a phenomenon in the context in which it takes place.

Content analysis

The use of content analysis is a disciplined and systematic analysis of text and is a technique for analysing the content of written or spoken material (Seaman, 1987). The main aim in using content analysis is to identify the presence of patterns of recurring themes as the researcher analyses the interview transcripts line by line. Line by line analysis is accompanied by playing the interview tape recordings over and over and reading and re-reading the transcripts in order to get to know the data intimately (Burnard, 1991).

Thematic content analysis

The analysis of qualitative research usually begins with a search for themes or recurring regularities. The search for themes involves not only the discovery of commonalities across participants, but also a search for natural variation in the data (Polit & Hungler, 1997). In the final stages of analysis, the researcher strives to weave the thematic pieces together into an integrated whole. The researcher attends to not only what themes arise but also how they are patterned and extend throughout the entire interview or group of interviews. Themes are sometimes quite abstract and do not always 'jump out' of the interview (Polit & Hungler, 1989). The researcher needs to step back and ask 'what is this person trying to tell me?'. Often themes are concepts indicated by the data, rather than concrete entities directly described by the participants. Once identified, the themes appear to be significant concepts that link substantial portions of the interviews together. Often more than one theme may emerge from one interview (Field & Morse, 1985).

How does a researcher code for a theme? The researcher has to read and re-read the interviews in their entirety and then step back and reflect on the content. Important topics are then identified in the interviews and these topics or themes become the primary categories (Morse & Field, 1996).

Thematic content analysis can be done on the basis of a single interview for each participant which is appropriate for this study. The need for a single interview was due to two major constraints, constant change within the C.H.E. and restricted access to undertake nursing research.

Study Participants

The participants of the study were all drawn from a C.H.E which has for many years served as a clinical practice agency for an educational institute department of nursing. It is a policy of the C.H.E chosen for this study that all registered nurses who have completed two years of post registration clinical experience, provide role modelling and preceptorship to nursing students. This C.H.E was easily accessible to the researcher for the conducting of interviews.

All the participants in the study were employed as registered nurses within this C.H.E. in either the general medical or surgical wards. These two areas were chosen because during the academic year they regularly have year one, year two, and year three pre registration nursing students gaining clinical experience in the wards. Specialised wards such as oncology, post-natal, paediatric and women's health were not chosen for this study as they usually only have year three students placed in them. Private hospitals were not included in the study because they tend to have a registered nurse appointed to organise educational programmes for both new staff members and pre registration nursing students.

Registered nurses with a minimum of two years post registration experience were asked to participate in the research. This allowed time for the registered

nurses to have distanced themselves from being a student and therefore to be better able to reflect on the role of teaching students in their clinical setting.

Following permission from the General Manager of the Medical and Surgical Services and appropriate Ethics Committees to undertake the study, Charge Nurses on six wards were approached by the researcher to gain approval for the registered nurses in their ward to be invited by the researcher to participate in the study. The researcher spoke to each of the Charge Nurses, carefully outlining the proposed study. She explained that the interviews would be undertaken outside of the registered nurses working hours therefore not interrupting the registered nurses' working day.

Charge Nurses were asked for permission to display a poster outlining the proposed study and inviting those registered nurses interested in participating to contact the researcher. Each Charge Nurse approached agreed to the poster being displayed in the ward staff room. Three of the Charge Nurses showed an interest in the proposed study and were keen to have their registered nurses participate. The remaining seven were non committal but were happy for the Clinical Liaison Lecturer from the nursing department within the educational institute to place the poster on the staff room notice board. It was made clear by the researcher that the Charge Nurses were not expected to direct their registered nurses to participate in the study. It was to be left up to those nurse practitioners interested in volunteering to participate in the study to contact the researcher. This method was chosen in order to ensure no undue influence could be seen to be used by those in authority. Despite all these precautions one Charge Nurse told her registered nurses they were to take part in the study because she believed it was a worthwhile study relating to their nursing practice and supervision of students. No nurse practitioners working on this ward chose to participate in the study.

Profile of Study Participants

For this study the researcher proposed to interview twelve registered nurses who were currently working in the general medical and surgical wards with a minimum of two years post registration nursing experience.

Several interested registered nurses contacted the researcher but unfortunately they had only been registered as nurses for several months, therefore had little experience of working with nursing students for any length of time. These registered nurses were not included in the study. The lack of registered nurses with two or more years of clinical experience led to the researcher having some difficulty recruiting nurse practitioners to participate in the study, requiring a colleague to return to the wards several times to display new posters or uncover those that had been covered by other material.

After advertising for participants ten registered nurses voluntarily participated in the study. Two registered nurses contacted the researcher by phone, eight made contact when the researcher was in the practice setting supervising third year nursing students. The registered nurses showing an interest in the study were sent an information sheet outlining the proposed study, a question guide and a consent form. All of the participants were interested to know why the research was being carried out, the potential benefits for registered nurses working in the practice setting, and what the researcher proposed to do with the findings of the study. All believed they had a chance, through the study, to say how they felt about their clinical education role when students were placed in their wards. It appeared no-one had ever asked them how they felt about this and the impact it had on their nursing practice. None of the participants raised unanticipated issues of confidentiality and anonymity. On one of the wards six registered nurses identified they wished to participate. Subsequently four participated in the study. Two of the registered nurses were going on holiday for a short period of time and then moving to another ward and after discussion with the researcher elected not to participate. All ten participants

had been practicing as registered nurses for at least two years prior to the interview.

For this study the researcher had anticipated, on the basis of past experience as a nurse lecturer supervising students in the practice setting, that the participants would be Staff Nurses who currently worked with students during their clinical experience. In the event, because the poster asked for registered nurse participants, two Charge Nurses volunteered to be part of the study. Each justified their inclusion in the study by the fact they had until recently been Staff Nurses and worked with students in this role. Registered nurses working in the medical and surgical wards routinely work as clinical educators during students' clinical practice throughout the academic year. It was believed by the researcher, because this group of registered nurses were involved in the clinical education of students, they were the right people to ask about the characteristics of this role as they perceived it to be.

Four of the registered nurses were hospital trained, six gained their education through a Polytechnic programme. The age range covered 24 plus years. Work experience spanned two to twenty plus years. Five of the registered nurses were known to the researcher through previous activities, three had met the researcher briefly, two were unknown. All participants were working full-time when students were in their ward, with one nurse practitioner normally working part-time when students were not in the ward. At the completion of the interviews only registered nurses from five of the wards chosen for the study had elected to participate in the study.

Ethical Considerations

Approval Process

There were no identified risks to the participants providing that anonymity and confidentiality were maintained. Permission to carry out the study was obtained from the Massey University Human Ethics Committee and the Regional Health Authority Ethics Committee.

Conflict of Interest for the Researcher

An area of conflict of interest for the researcher was recognised and addressed prior to seeking ethics approval from Massey University Human Ethics Committee and the Regional Health Authority Ethics Committee. The researcher is employed as a nurse lecturer at a School of Nursing Studies in the same vicinity as the hospital selected for the study. The researcher had previously taught four of the participants during their nursing training, two years prior to the interviews, and had contact with three participants whilst supervising students in their wards eighteen months previously.

Consent of Participants

Informed consent was obtained from each individual registered nurse in a written form following an explanation of why the research was being undertaken, and the proposed use of the material gained through the interviews and the availability of the final document for them to read. Participants were given the opportunity to ask any questions at the initial meeting and the right for them to withdraw or have the tape recorder switched off at any time was reiterated.

Anonymity of Participants

Participants were given a name, different from their own, to ensure confidentiality on the audio tape and on their transcript. Only the researcher knew the names of the participants. Tapes were transcribed by a typist who was known to the researcher to be a reliable and trustworthy person. The transcriber had no contact with the participants and did not know the true identity of the participants. Any information given during the interviews that could identify either the participant or their place of work was removed from the transcript by the researcher. Tapes and transcripts were kept separately from each other in a secure place at all times. Only the researcher and the transcriber heard the tapes. Consent forms were kept separate from the tapes in a locked cupboard. Actual names of people and organisations were not included in the transcripts to ensure confidentiality.

Interview format and data collection

Face to face, in-depth, semi-structured interviews with ten registered nurses was chosen to elicit their personal experience of the clinical education role in the practice setting. The aim of the semi-structured interview is to give the participants some direction whilst obtaining their perceptions of the phenomenon (Holloway & Wheeler, 1996). Where possible participants were given an outline of the questions to be used five to seven days prior to the interview taking place. Two participants received their questions three days before their interview as they had been out of town and had not collected their mail. Interviews were undertaken out of the registered nurses working hours and away from their working area in a room used by the educational institution nurse lecturers within the hospital. Each interview was tape recorded, with permission having first been gained from each participant. The shortest interview took thirty minutes and the longest fifty minutes. The average length of time for the interviews was thirty to fifty minutes. None of the participants wanted a copy of their interview transcript, but three did request a summary of the final document to read.

The interview began with a request for a brief biography of the participants followed by three questions. Questions for the interviews were constructed in order to elicit information relating to the characteristics of the clinical education role. All the participants were asked the same three questions.

- Could you describe your role in the clinical education of student nurses?
- Could you explain the advantages and disadvantages of the present system of student nurses clinical education?
- Could you identify and discuss how you believe clinical education should be structured?

These three questions were asked to prompt the participants to describe their perceptions of their clinical education role, the problems they identify within the

present structure of the role, and how they believe this role should be structured in the future. It was hoped these questions would enable the participants to reflect and discuss their role at the present time. Further questions were asked if the researcher felt they were appropriate to clarify information relating to the characteristics of the clinical education role. All the interviews were carried out without any interruptions. One participant asked for the tape recorder to be switched off whilst a sensitive issue was being talked about and then the tape recorder was switched on again.

Each interview was tape recorded and later transcribed by a reliable professional typist who was familiar with transcribing from audio tapes. A confidentiality agreement form was signed by the typist prior to the transcribing taking place. When the transcripts and tapes were returned, the researcher listened to the tapes whilst reading the typed transcript on the computer. This allowed the researcher to make any necessary changes to the transcripts before copies were printed for analysis. In several instances the typist had attempted to correct the grammar and some words used by the participants, and had not included pauses or laughter in some of the interviews. All of the interviews were carried out within a period of three months.

Data analysis process

Using thematic content analysis the data in the interview transcripts was explored for recurring themes.

- Step 1.* each transcript was systematically and repeatedly read line by line.
- Step 2.* Recurring phrases were highlighted using a highlighter pen.
- Step 3.* Highlighted phrases were then examined closely to identify the themes within these phrases.
- Step 4.* Data from the individual study participants revealed there were a number of recurring themes.
- Step 5.* A list was made of recurring themes

- Step 6.* A list was made of the themes that were common to all the transcripts.

During the analysis stage the data were managed by a type of modified 'mind mapping'. This is a tool for organising thoughts and data into some manageable form. For this study a modified form of 'mind mapping' was particularly useful for managing the information from the interviews and organising it into a system. The 'mind mapping' process was used to identify the themes emerging in the interview data. Following each reading of the individual transcripts a different colour paper was used for the 'mind map'. Throughout the analysis process the maps were read and reread to clarify for the researcher, individual participants perceptions of the clinical education role. Individual mind maps for each participant were then collated and the themes identified.

Once the themes were identified they were grouped together under headings with the aim of reducing the number of statements and collapsing some of the similar ones into broader categories. Each category was put onto an individual piece of paper and a 'mind map' was then developed using the statements from the participants' interview transcripts to verify their authenticity. These 'mind maps' were also useful for quick referral when details of the interviews were required and to link data from the interviews.

Recurring themes identified

- Having students means an increased workload
- Nurses are not prepared for their teaching role
- Students keep our knowledge current
- Student are not prepared for their clinical practice
- Having students is in my job description
- Students change the nurse-client relationship
- The impact of student learning on patient care
- Tutors need to be involved in students' learning
- Staff nurses are not asked if they want to work with students

- The educational institution must take some responsibility for students learning

Like themes were highlighted and combined to create five main themes. Transcripts were then reviewed to ensure these themes were common to all the transcripts

Common themes

- There is a changed relationship with patients when student nurses are present.
- There is a changed pattern of work
- There needs to be good communication with lecturers from the educational institution
- Nurse practitioners need to be prepared for the role
- Student nurses need to be given the opportunity to learn

From these common themes it is possible to identify five characteristics of the clinical education role as perceived by registered nurses working in the practice setting

The 5 characteristics are:

- It changes the registered nurses relationship with their patients
- It changes the registered nurses pattern of work
- It requires good communication between registered nurses and nurse lecturers
- It requires registered nurses to be preparation for the clinical education role
- It requires the student nurse to have the opportunity to learn in the practice setting

Validity of the study

The findings of this study rest on the truthfulness of the recorded text of the interviews and the identification of themes identifying the characteristics by the researcher. The trustworthiness of the study relates not to the results of the study, but to how the process of the research was recorded, the events that took place, the steps that evolved and the thinking behind the whole process (Booth, 1997).

Summary

The choice of a qualitative descriptive exploratory research method for this study has been discussed. Issues relating to the recruitment of participants, interview format, ethical issues, and the collection and analysis of data have been outlined. A description is given of the participants and their reasons for inclusion in the study and any problems incurred in their selection. The process of data analysis and identification of themes has been discussed.

Participants in this study had at least two years post registration nursing experience in an acute medical or surgical ward. They work in complex and dynamic environments delivering nursing care to patients who are often very sick. All of the participants had worked with pre registration nursing students whilst they were in the practice setting. Despite this it appeared no-one had ever asked them how they felt about this and the impact it had on their nursing practice.

The next five chapters

Embedded in the themes are the tensions experienced by the participants relating to their role as a professional nurse within the health agency, a concern for patient care and a need to supervise students in clinical education. The identified characteristics of the clinical education role are discussed in the following five chapters. The sequence of these chapters does not represent any order of priority by the researcher or study participants.

Chapter 5

IT CHANGES THE REGISTERED NURSES RELATIONSHIP WITH THEIR PATIENTS

Introduction

The work of the nurse is dynamic and sensitive as nursing responds to the immediacy of the patient situation. During the nurses relationship with the patient there is a patterned interaction between patient and nurse which is essential to the outcome of the patient's experience (Christensen, 1990).

Contemporary nursing practice occurs in a complex environment that is constantly undergoing change. Not only are there technical changes of newer equipment and techniques, but there are organisational changes, structural changes, policy changes, and workforce changes (Booth, 1997). Each of these changes can cause an alteration in the role of the nurse in relation to the patient.

The introduction of short stay care, early discharge and day surgery has meant many nurse practitioners now have only a short period of time with their patients. In this environment the registered nurse needs to be able to rapidly create a positive relationship with the patient. This is difficult to achieve when patients are only in the ward for a short period of time. A positive relationship is necessary to ensure patients the best of care, maximise their safety, and ensure they are well informed of impending procedures and of follow up care required.

This relationship can be disrupted by the constant presence of another person. If students are present the patients have to be confident that they are safe and well supervised. The student, patient, nurse practitioner interaction is complex and difficult to manage well.

Nurse - patient relationship

One characteristic of the clinical education role is that it changes the registered nurse-patient relationship. Participants discussed how students took their time away from their patient care and how they often were a distraction for them when they were giving patient care. Students in some instances interrupted the registered-patient relationship when they broke into the nurse practitioners' conversation with the patient to ask what it is she is doing. Registered nurses working in the practice setting have a professional obligation to ensure their patients safety whilst at the same time endeavouring to meet the students learning needs. This can sometimes be difficult for the registered nurse working in an acute practice setting when at all times the registered nurse-patient relationship should be primary.

What you get your satisfaction out of quite often is the one to one relationship with the patient and it is stunted when you have somebody with you. You don't communicate in the same way, especially if they, the students, are immature.
(Frances)

This difficulty is increased when a student is present. It is further increased when the student lacks maturity, experience, or is tired.

Frances found that some students lacked maturity and were unable to understand when it was appropriate to ask questions and when to keep quiet. This was especially difficult when she was doing something quite complex with a patient necessitating her to carry out the procedure in a way different from the text book because of the patients' unique situation. Student lack of maturity may also be a concern for patients when discussing personal issues with a student constantly present.

Occasionally you will get the sort of inappropriate statement when you want them to be quiet really. *(Frances)*

Students asking questions at inappropriate times can disrupt the nurse practitioner concentrating on her patient care.

Frances believed it was also quite hard to inspire students when they were tired or when she was busy. She described how a student coming to the ward tired and not able to work effectively with her whilst she is giving patient care disrupted her relationship with the patient.

You may have someone who has worked two part time jobs and would rather be in bed today, and you are trying to inspire them to something you are doing. *(Frances)*

Students questioning the registered nurse inappropriately or being too tired to work effectively interferes with the nurse practitioners communication with their patient because the student requires attention. This can create a difficult situation especially given the short time the registered nurse may have to establish a good working relationship with her patient.

So you are not just focusing on your patient and often nurses find that frustrating. *(Frances)*

Frances did not feel the students were experienced enough to understand the importance of the relationship between the registered nurse and the patient. They did not always appear to think before questioning her nursing practice in front of the patient.

I had a student who made me feel like the student. I said please do not give her to me again. She kept saying to me in front of the patient 'why aren't you doing this?' and 'why are you doing that?' You know how you order things in your mind, and what she said was perfectly valid, but I had chosen to do it a different way. *(Frances)*

When the registered nurses were working with a student they needed to ensure students were able to deliver a safe and competent standard of nursing care to patients.

It's overseeing their knowledge and their safety, and my own safety, and it's hard work. *(Lesley)*

Jane was also aware of keeping the patient safe. She discussed how nurse practitioners are becoming more and more accountable and responsible for

their patients' nursing care and the difficulty of being responsible for student learning.

As nurses we are becoming more and more accountable. We are accountable for the student and their practice. *(Jane)*

When nursing students are placed in a practice setting they are supernumerary. Their focus is on learning at the bedside. This can cause a conflict of interest for the registered nurse whose main focus of attention should be her patients. Participants strongly acknowledged their personal responsibility to maintain patient safety but also acknowledged that they identified a responsibility to ensure that the students were safe to give patient care. Inevitably the quality of student support and teaching given by registered nurses will be influenced by the more pressing patients demands.

The Staff Nurse's focus is split between the patient and the student, so you are not focusing just on your patient and often nurses find that quite frustrating. *(Frances)*

When students provide nursing care to patients the registered nurse is generally accepted as being responsible for the patient and the care they receive from a student. Participants believe that patient safety must be carefully monitored when a student is delivering that care. Nurse practitioners recognised students were in the practice setting to practice and learn clinical skills.

When you are working with somebody you want to keep quite close to you so you can see what they are doing. *(Louise)*

When the ward is so busy and you have a patient going flat and patients coming back from theatre, sometimes you actually forget you have a student because you know you have to get the job done for the patient. So the student has to run behind you. *(Kate)*

Lesley described how when working with a student she felt there was always a need to be looking for risks to patient safety and a need to ensure that standards of patients care were maintained.

Patient care I feel is at risk sometimes having a student. You are constantly looking at factors of safety, patient care, nursing standards when you have a student. *(Lesley)*

Clare described how when she worked with students she had to continually ensure patient safety by making sure the student was able to carry out nursing procedures such as a shower without the patient being left undressed too long and becoming cold.

When they go to the shower have they taken everything with them. Making sure they are not leaving the patient stark naked and shivering. *(Clare)*

Participants experienced conflict managing the interactions between the many dimensions of the clinical education role. They discussed the problem of managing the relationship with the student and the patient whilst ensuring patient safety. Participants believed nursing in busy acute practice settings compounded the element of safety particularly

In an acute area patients come and go very quickly and may be acutely ill. Nursing is time consuming and complex in acute areas. The changing acuity of patients being admitted to the hospital wards often means the registered nurses do not have the time to teach and supervise students well. The clinical education role takes time and energy away from the more demanding role of delivering acute nursing care.

When a registered nurse comes on duty she needs to first familiarise herself with her patients and plan how she will meet their needs. Then to this she may have to add the student and their learning needs.

You get hand over on Monday morning, the student is there, you may or may not have been on days off, you don't really know what's wrong with your patients until you have read all the notes and by then you want to get stuck in because things are beginning to happen and you may not be able to touch base properly with the student until half way through the first day. *(Frances)*

Frances has described an important part of the nurse practitioners role when they come on duty as assessing their patients' nursing needs. The registered nurse needs to spend time reading the patients notes and identifying their patients requirements. They may not have time to assess both students or their patients' requirements effectively. On one hand the nurse practitioner is responsible for her patients, and on the other hand has a responsibility to meet students' learning requirements. Through no fault of her own it would appear that in some situations the nurse practitioner is unable to successfully meet the needs of both patients and students.

I am one of the most senior nurses on our ward so I get the big cases, you know that they have got all the different pumps and drains and tubes. And then I will also have a student and I find it unfair because I am focusing on what I have to do at that time. *(Kate)*

In this situation Kate has identified the complexity of her nursing practice, her need to concentrate on performing the technical skills which require her full attention. Having a student in this situation prevented her focusing on the patient and the nursing care they require from her. Responding to the students learning needs interrupted this activity.

Mary believes the ward situation is where a student learns about patients' conditions and how to nurse them.

On a general medical ward which is, I think, a very good learning setting, you could pick up someone who you could go through nursing cares together and get used to them over the next few days. Just good hygiene and turning stuff and basic things like that. Put a lot of time and energy into it and learn about why you are doing it and then get onto conditions and CHF [Congestive Heart failure] would be a good one. Talk about the symptoms you can see in a person who is short of breath and has swollen ankles, and the drugs they are on. So you can really think about why you are doing it and sort of give perfect nursing care together as a way to learn together. *(Mary)*

In this situation Mary has outlined an ideal learning opportunity for the student. Her focus is not on whether it is appropriate for a patient in heart failure to have a student practicing their nursing skills on them when they are so sick.

Paula also believes the student needs to practice on real patients in order to learn nursing skills. In the student-patient relationship it is generally accepted by students and patients that they can practice on patients because this is the way student nurses learn the complexities of nursing practice.

They need the opportunity to practice on real live patients.
(Paula)

When the registered nurses are really busy with their patients they may not have the time to concentrate on the student's learning needs. In this situation participants believed they should be able to call a lecturer to come and work with the student, therefore freeing the nurse practitioner to care for her patients.

I think they see the Polytech tutors are not involved enough, they [registered nurses] feel because of the workload they are expected to do anyway, a student can be a severe hindrance. So I think they feel the tutor should be more involved. (Sam)

In particular Jane felt strongly she should be able to call the lecturer in to work with the student when she was too busy with a patient.

We are working hard and we have our patients to think about and to have an extra stressor is sometimes too much to ask for. (Jane)

Involving the nurse lecturer she felt, would ensure the student would continue to have the opportunity to learn rather than being left on their own in the ward whilst the registered nurse was busy. However, if the lecturer becomes more involved in working with a student they are a second person to disrupt the nurse-patient relationship. Even if the lecturer only spends a short period of time with the patient it requires the patient to adjust to a new relationship.

All participants stated their belief that their patients must come first. They saw themselves as registered nurses employed to nurse people who needed their expertise and that students came second in any situation. When they were busy it was easy for them to forget that they had a student with them. It was easier for them in such situations to give the student tasks to do in order for them to get on with their work. In reality the registered nurses felt they should have the time to stay with the student and supervise what they are learning and explain things to them but the patients and their care must come first.

The prime responsibility of the nurse is to the patient, so I mean, if it means the student misses out on something then so be it. The patient is paramount. *(Sam)*

Sam was quite clear on the registered nurses' professional responsibility towards the patient receiving good nursing care. This sometimes becomes difficult for the registered nurse to achieve when she has a student trailing after her. A student could also be a hindrance to the registered nurse distracting her from her patients, especially if the student required a lot of supervision, asked a lot of questions, or did not know how to work within the ward team.

If you are flat tack with five patients and you've got a difficult patient the student doesn't learn because you are concentrating on your patient and what you need to be doing for the patient. *(Louise)*

In this situation there is conflict of interest for the nurse practitioner who on one hand has a responsibility to the patient, and on the other hand is aware of the responsibility to teach the student. If the registered nurses are not allocated less patients to care for then the student will not remain their main focus during the duty because the patients needs will always come first.

If your primary focus is actually your patients, which it is, not your students, then they are getting sidelined if you have more things on, which is not good for their learning. You don't tell your student things because you are pushed. *(Mary)*

This statement by Mary is supported by Jane who feels registered nurses are becoming more and more accountable and responsible for nursing care while also being responsible for student learning.

Mary described an incident when she had a patient go into septic shock. Because she was so busy with the patient she could not explain to the student the emergency procedure used when a patient collapsed.

The Polytech tutor came into the ward and I sort of told her briefly how frustrated I had been and she said to me to make sure the student saw the CV line book about CV line management, and I thought it was really dumb because I thought I should tell her about septic shock and we should have gone over the signs and symptoms and reinforced what she had seen and the far more important emergency management stuff....It was very hard because I did not have time to go over either of those things, and I wish the tutor could have. She could have stayed. *(Mary)*

In this description Mary illustrates the lack of registered nurse and nurse lecturer collaboration in a difficult situation resulting in the student missing out on a valuable learning opportunity. It also demonstrates how Mary put the patients' immediate needs before those of the student. She recognised the patients' need of her time and nursing ability to ensure a safe outcome of the situation. Due to disruption to her work, and the need to catch up and complete this work, Mary was unable to spend time discussing with the student what had taken place. She felt if the registered nurse and nurse lecturer could have worked together both herself and the student would have felt better about the urgency and suddenness of the patients' situation.

Kate found that students took her away from her patients because she had to constantly stop and show them how to do things. The consequence of this is the patients did not remain her first priority.

I think it is unfair that we actually have to show them how to do things because it does take a lot of time out of our day when we're organising patients discharges. It takes our time away from our patients. *(Kate)*

If the registered nurse has to stop and explain things to a student and this is done in front of the patient this may cause the patient some distress.

Like you have two patients, two students and have two major operations and you teach them. *(Kate)*

In this situation the nurse-patient relationship becomes distorted because the nurse practitioner has introduced two students into the relationship. Negotiating the patients nursing needs and the students' learning takes an enormous amount of the registered nurses skill and time in a busy ward.

I still find two students very demanding. It depends on the students and their capabilities. Some are good and it is quite manageable, but at times it has been quite unmanageable. *(Clare)*

Clare and Kate have the difficult task of dividing their time between the two students and their patients who have been to theatre and require individual attention.

Nurse-student relationship

During the students time in the clinical setting they form a working relationship with the registered nurse to whom they are allocated. This relationship mainly depends on the registered nurses willingness to work with a student and teach as they give nursing care.

I do a lot of direct teaching, like this is how we do this. A lot of stuff they just pick up off us from watching our interaction with people....As for the hands on stuff letting them do stuff and talking them through it. *(Louise)*

In this situation Louise has interrupted the nurse-patient relationship by taking the student along to observe her as she interacts with the patient. Her focus has moved from her patient to the student as she explains what she is doing or lets the student carry out the nursing procedure whilst she watches. It is during the registered nurse and students' time together that their relationship develops. The students learning needs may be met but the patients' needs for

total concentration by the nurse practitioner on the task she is carrying out may not. The presence of the student can distort the nurse-patient relationship merely by being the third person within the relationship.

One way of overcoming this is to give the student tasks to do. Two participants questioned the value of giving a student a task to do if there is no follow up on how they have done or what they have learnt, although it was believed to be a good idea to give some of your routine jobs to a student if you were busy.

A student who has limited nursing abilities will require more of the registered nurses time as they are shown how to perform the nursing skill. This is time taken away from the patient or the patient has to wait during the nursing procedure for the registered nurse to explain what she is doing.

Clare explained that from her experience, first year registered nurses learning their role as a staff nurse and care for acutely sick patients, find it hard to work with a student for the whole duty. Whilst they are developing their role as a registered nurse their main focus has to be their patients as well as developing an understanding of their own capabilities in delivering safe nursing care. The situation is further complicated if the registered nurse herself is inexperienced.

So you are getting a first year staff nurse who is still actually learning suddenly getting a young student. She cannot cope work wise. *(Clare)*

Clare was aware the student only spends a few weeks a year in the hospital setting. She had experienced third year students arriving on the ward who had never worked in a hospital through their training. Therefore the student could not use knowledge previously learnt in similar situations when needed.

The students are not getting hospital training and experience and cannot cope with the situations. *(Clare)*

Although Clare could understand the need for the student to experience nursing in the community she was not convinced this experience enabled a new graduate to work in acute wards and cope with nursing sick patients.

Louise believed some students may experience culture shock when working in the ward and coming face to face with very sick people.

It is hard enough coming into a strange environment with a whole lot of people you don't know, a culture you don't know, with sick people who have tubes everywhere. *(Louise)*

Clare acknowledged that for some students entering the ward can be difficult for them especially if they are first years students entering nursing straight from school. When they enter a busy medical ward, they will not have developed the knowledge and expertise required to work effectively with a registered nurse and her patient.

Remember that a lot of these students come straight from school into a very busy medical ward, which is quite a frightening experience for many of them to come into. *(Clare)*

Many students entering the acute practice setting for the first time can experience culture shock.

Summary

This chapter focused on the nurse-patient relationship which become altered when a student entered the relationship. The registered nurses relationship with her patients is primary but it is often disrupted when a student is involved. She then has to incorporate the student into her workload and her relationship with the patient. This is not always an easy task especially if the student is tired or asks inappropriate questions through a lack of maturity.

Registered nurses discussed their concerns about how the student presence could alter this relationship. There are difficulties in the nurse-student relationship due to the need for the patient being the registered nurse's main priority especially if they are acutely sick. In this situation the registered nurse

is unable to give the student her full attention. Patients may also have difficulty in developing a relationship with the nurse practitioner because the student works with the registered nurse and becomes the third person in the relationship. Registered nurses teaching students in front of the patient may exclude the patient from the relationship.

Chapter 6

IT CHANGES THE REGISTERED NURSES PATTERN OF WORK

Introduction

Before students arrive at their clinical placement letters from the educational institution have preceded them providing the ward with students names, dates, a brief outline of the intended learning outcome plus the days and hours students will be present in the ward. This information is then used to guide the patient allocation process (Boyle 1994).

In the practice setting in which the participants work, a registered nurse's normal pattern of work relates to the allocation of a number of patients to care for at the start of their duty. Each ward has a 'work' book which is filled out by either the Charge Nurse, or the senior registered nurse in charge, for the following morning and afternoon duties with nurse-patient allocations.

A registered nurse may be allocated five or six patients for the duty. Students' names are usually included as part of this process. Usually each registered nurse has a mixture of the sickest and more complex patients, who require large amounts of nursing time, as well as patients who require less of the registered nurses time. Registered nurses, during the duty, care for their own group of patients and help each other with difficult tasks when asked as well as oversee the nursing practice of less experienced registered nurses. On both morning and afternoon duties, the nurse-patient allocation takes place before the registered nurses receive the patient report from nurse practitioners working the previous duty. Students are usually in the room when the registered nurses read the report of their patients and find they have been allocated a student for the duty. The allocation of a student to a registered nurse is not always negotiated by the Charge Nurse before the student arrives in the ward. Both the registered nurse and student may arrive on duty to find they have been allocated to each other. The registered nurse and student are

often allocated extra patients as it is seen there are two pairs of hands to do the registered nurse's allocated workload.

When registered nurses plan their work for the duty they plan their time between their patients after considering patient's nursing care and treatments, time for meal breaks and time for documentation in their patient's notes. Within this plan they manage any unplanned interruptions by other health workers, telephone messages, talking to patient's relatives, participation in team meetings, and dealing with any acute situations that may arise.

When students are in the practice setting they are either assigned to a registered nurse and help to care her patients, or the student is assigned patients and then works with the patient's registered nurse. If a student is allocated more than one patient this could mean they could have to work with more than one registered nurse. Only one practice setting in this study assigned patients to students.

This study finds that registered nurses perceive their workload is increased when a student is present. The allocation of a student is often accompanied by one or two extra patients being added to the registered nurse for the duty. The registered nurses workload is further increased when she has to stop and teach students as well as ensure the student practices safely. During the course of the duty the registered nurses' patient may become more ill requiring her full attention. Within the course of the registered nurses duty she may also have to find the time to speak with the nurse lecturer about the student's progress.

Participants explained that when allocated a student for the duty their normal work pattern became disrupted. Several participants stated that they were not usually asked if they wanted to work with students. Poor consultation between the registered nurses and their Charge Nurse about the allocation of students prior to the student arriving in the ward caused some negative feelings towards

their education role. For Lesley, in particular, the lack of discussion about student allocation between the Charge Nurse and registered nurses was an area of concern but she felt powerless to change the situation because other registered nurses were not prepared to take a stand on the issue. For Lesley the allocation of a student meant a hugely increased demand on her time and disrupted her normal pattern of work. The only way Lesley believed the situation would change would be by saying no to having students or moving to another ward.

To change that system, you could change it, I am prepared to change it by saying no not to have any more students.
(Lesley)

Louise felt supported by her Charge Nurse but explained that it was pretty much taken for granted that the registered nurses on her ward would work with students. Although the registered nurses could ask not to work with a student, the Charge Nurse had an expectation that the registered nurses would unless there were exceptional circumstances which made it undesirable for either the student or the registered nurse. Often this expectation was difficult to cope with following a long stretch of shifts or if registered nurses were only able to work with a student for a day or two and then changed shifts. If any registered nurses did not want to work with a student because of tiredness or a personality clash they could discuss this with the Charge Nurse and where possible the student would be allocated to another registered nurse.

It is pretty much taken for granted that you will work with students. The charge nurse knows who likes to have students and who doesn't. (Louise)

The assumption that the registered nurses could supervise and educate students during their clinical practice experience plus be given an increased workload was seen as un-realistic benefiting neither the student nor the patients receiving nursing care. Often this meant that when the registered nurses were really busy it was easiest to give the student tasks to do as this

kept them busy and enabled the registered nurse to get on with her own workload as they felt they needed to put the patient first.

Many registered nurses they did not know until they arrived for the duty that they were going to be working with a student.

We just have our allocation book with all our patients in and it will say whether you are with a student or not. We don't really get asked, the Charge Nurse sees it as our job. You know, in our job description. *(Kate)*

Kate stated that in her ward the Charge Nurse gave them some warning that students were coming to the ward but that they were expected to work with them. They were not actually asked if they wanted to have a student as the Charge Nurse believed that as it was in their job description they would be expected to take on a student.

Frances felt that many registered nurses did not really mind having a student. She believed registered nurses could however become tired of working with students. She believed a problem for registered nurses was that their teaching did not appear to be recognised by the hospital manager, Charge Nurse, or the nurse lecturers.

It's not so much they mind having a student, it is just expected. *(Frances)*

Sam, Lesley, and Frances spoke of some registered nurses in their practice areas who had refused to take students because they were not prepared to take on an increased workload especially if they were tired or had been working a long stretch of duties. From their own experiences registered nurses were, in most cases, willing to take a student for the duty, with some of their colleagues appearing quite enthusiastic about this, but other registered nurses were not.

People are going to say no and then suddenly the student will be left in the lurch. *(Lesley)*

Stating whether or not they will take a student for the duty is not always dealt with tactfully.

Sometimes it's done in front of the student, not very tactfully, other times people will sort it out before students arrive, everyone gets a bit worn down I think. (*Frances*)

The participants were aware of the negative attitudes towards students and most tried to sort out these feelings before the student arrived on the ward. Frances acknowledged that it was unfortunate for students to arrive on the ward and hear the registered nurses discussing who wanted them for the duty. This occurred in her practice area quite frequently because unfortunately there was no formal recognition by the Charge Nurse of those registered nurses who enjoyed working with students. Often the less experienced registered nurses did not feel confident about sharing their knowledge and skills with students and so would refuse to work with a student. The more senior registered nurses sometimes refused to take students when they were tired of having students in the ward and were also expected to orientate new staff nurses to the ward. One participant had been orientating new staff for four months and was tired of continually explaining to new registered nurses and supervising their delivery of patient care.

Very occasionally somebody will come up to me and say "please could I not have a student this week, I have just had enough". (*Sam*)

The ward Sam worked on had a number of registered nurses in their first year of registration working there. This meant that those registered nurses on duty who had more than one year of experience as a registered nurse were expected to always take the students to work with them. This group of registered nurses were also called upon to orientate new staff members over a three month period. It is perhaps understandable that the registered nurses with whom Sam works become 'fed up' with always having a second person incorporated into their workload.

The reduction in nursing staff levels, caused by cost cutting of the C.H.E., has placed stress on the registered nurses to take an increased patient workload, and also supervise student learning. From the participant's perspective a major issue and concern for them related to the increase in the volume of their workload when they were allocated a student for the duty and the consequence need to alter their pattern of work. Having a student for the whole duty requires the registered nurse to be continually overseeing their application of knowledge and nursing practice. In order to facilitate students' learning the registered nurses believed they ought to be allocated an appropriate number of patients, relevant to the students' learning needs, with time to explain the theoretical knowledge behind the nursing skills they are required to carry out.

The institution doesn't help that by allocating [the allocation of patients] if you have one student you must be able to have six patients. There is a thinking behind that if there is two you, you must be able to handle twice the amount of work. It is actually the opposite. You should be allocated three patients say, and then my time can be given to the student.
(Lesley)

Several participants believed that their workload should go down as supervising a student during their clinical learning, takes valuable time. Mary also described how her workload was increased when she was allocated a student for the duty.

Sometimes when you have a student you get more patients because they think, oh, you have got a student and I think we should have less. (Mary)

Lesley explained how the registered nurses' problem of their workload increasing when students were in the ward would only change if the system changed, and this was not likely to happen. In the ward Lesley worked in it was known by the registered nurses that if they allocated a student their workload would go up despite this issue being discussed by the staff with their Charge Nurse. Lesley believed the Charge Nurse had to be committed to having students in the ward plus ensuring they were exposed to the right

learning situations rather than just sent off to work with a registered nurse for the duty.

It's just a known fact, if you are going to have a student you have more patients. *(Lesley)*

Whilst for some of the participants the number of patients they were allocated for the duty did increase when they had a student with them, this did not apply to all. Three participants believed that although their workload did not increase in size it did increase because the amount of their time spent focusing on the student's learning needs and ensuring their safety to practice and teaching them their skills took a lot of their time and slowed them down. It appears from the participants' descriptions that it was not recognised by lecturers, Charge Nurses and unit managers that working with and supervising students, actually slowed the nurse practitioner down. Increasing the registered nurse's workload therefore made it harder for them to complete their allocated workload.

Frances also experienced an increased workload when students were in the ward and believed, like Mary and Lesley, registered nurses working with students should be allocated less patients. A decreased workload would enable the registered nurse to spend time explaining procedures to students rather than focusing on getting the job done.

It is not like they give you a reduced workload because you have a student, if anything you are likely to have more. *(Frances)*

Paula also explained when allocated a student that the registered nurse's workload was increased due to the registered nurse being slowed down within her routine work pattern.

Having a student makes a huge increase in the workload. *(Paula)*

However, on Paula's ward the registered nurse was allocated fewer patients because it was recognised the registered nurses were actually slowed down

by having students, especially if the student was in their first year of the programme. It was recognised by her Charge Nurse that having a student increased the registered nurses workload. Once again the Charge Nurse of the ward had an expectation that the registered nurses would work with students unless they were extremely tired or were new graduates. The Charge Nurse did recognise that some registered nurses needed a break from students.

Clare was unusual in that she did not have a pre-allocated workload when she worked with a student. She mainly worked with first year students. At the start of each duty she picks the patients she thinks are appropriate for the students' learning requirements. She has arranged to do this with her Charge Nurse and the other registered nurses. The other registered nurses in the ward were happy for her to do this because it meant they did not have to work with first year students.

A huge amount of patience is needed and I think this is why the young staff nurse cannot cope with the first year students because they do not have the patience, let alone the time, to devote to them whereas I am not taking a patient load. I have time because we look at the book and say right we will take three or four patients. *(Clare)*

Although Clare said she was able to pick the number of patients she would have for the duty she still believed she was slowed down as she helped the student learn to give patient care safely.

Well, if it gets really busy, unfortunately the student just has to follow and watch. *(Clare)*

Kate described how she believed she was slowed down when working with a student. Her duty was disrupted when allocated a student as her time was often spent showing students how to carry out nursing procedures or supervising the student carrying out the procedures.

We are actually slowed down by having students and it can be quite exhausting sometimes. *(Kate)*

As a senior nurse practitioner Kate was often left in charge of the ward on the Charge Nurse's day off. She often took a patient load plus a student but found it hard to combine the three roles.

So you are in charge of the whole ward. You have to help the nurses if they have a difficult patient and you also have a student following you around and its hard to explain everything and why you are doing everything when you have so much going on around the ward. *(Kate)*

This time spent with the student slows the registered nurses down and takes their time and focus away from their patients and is disrupting to the ward routine.

It does take a lot of our time out of our day and it sets us back, you know when we are organising patient discharges. *(Kate)*

These examples describe how the pattern of work is changed for both Paula and Kate when they are allocated a student. Even though Paula was given fewer patients she described the registered nurses as being slowed down despite their being two people doing the work. The registered nurses frequently has to stop and explain procedures, or stay with a student and supervise their nursing practice. Other times she needs to keep checking to see that the student has carried out each task given to them.

From Helen's perspective the registered nurse's workload did not go up when students were in the ward because students were not thought to be members of staff and fully competent to contribute to patient care. She did believe though, that working with a student did increase their workload.

Our workload does not go up but having a student makes a difference to the load and this is not taken into account as far as the staff loading goes. *(Helen)*

When the registered nurses were busy with their increased workload, they did not feel they had the time to teach students and supervise their practice. The

clinical environment is a changing and diverse learning environment for the students to enter, necessitating the participants to divide their attention between students and patients.

The participants accepted that they are expected to work with a student but were aware that their tiredness and heavy workloads did not always make them feel positive towards students. This did not create the best learning environment for students. To work with a student was time consuming requiring extra effort and energy by them which increased their workload. To be a good role model to students the registered nurses identified a need to have the time to actually show ways of delivering good nursing cares.

Well it's very tiring....It is quite wearying when you have to spend the entire day explaining what you are doing and why you are doing it. *(Frances)*

Working with a student who is totally disinterested in being in the ward, made it hard for the registered nurse to keep a focus on the students learning needs. In reality a lot of a registered nurses work relates to washing people, walking them and making their beds, not the dramatic emergency type of nursing students may view on television and expect to see in the ward.

When we are so busy we cannot explain things properly so students can pick up bad habits from us because we can do things very quickly and maybe the student does not see the important points. *(Kate)*

This concern described by Kate related to her not having the time to sit down and explain things properly such as unusual dressings carried out in her ward. This meant that when she was really busy the student may not understand what she was doing especially if she was taking short cuts because she had done that particular dressing many times.

When the registered nurse was busy the student may be sent off to carry out a procedure without the registered nurse having the time to check that they can

do it safely and competently. This she believed could result in students picking up bad habits from the registered nurse's own practice and trying to do tasks they has not actually practiced before.

A lot of the students haven't heard of what we do, so that's quite difficult because we have to go back and explain everything. *(Kate)*

Kate describes her ward as a specialised area and this makes it difficult for the student to understand the type of surgery many patients receive. Because she has to stop and explain what she is doing she is slowed down with her work. This may also prevent her from having time to help the other registered nurses if they need help with a patient's treatment.

Mary described working with a student as:

I think a student to me is like having another patient or so. At the end of a long stretch of duty it is actually very tiring to have the extra energy I reckon that is required to put into a student on top of what you are putting into your patients. So you can get tired of it. *(Mary)*

For Mary a student not only meant an extra workload but also an increased responsibility not only for her patients but for the students' learning. She found this hard to accept, especially when tired and lacking the energy she required to put into a students' learning on top of what she is putting into her patient's cares. Participant's tiredness, especially at the end of a long stretch of duties, was not they felt, recognised by the Charge Nurse, colleagues, hospital managers or the nurse lecturers. This they felt tended to push their goodwill too far.

A comment by three of the participants highlighted the fact that they believed that students were entering the practice areas without enough skills to enable them to work effectively as a member of the ward team. This was seen as a disadvantage for the students. The participants believed that they were teaching the practical skills in the wards and this was actually the nurse

lecturer's job. Ideally prior to commencing their clinical practice students are required to practice skills in the clinical laboratory, achieving an acceptable level before they enter the practice setting.

We find a lot of them don't have any basic skills whatsoever, like even the basic taking the blood pressure, so we have to teach them. *(Kate)*

A lot of clinical time is spent learning skills that they should probably already know. *(Louise)*

I think before students go into practice they should spend time in the practice suite at Polytech learning basic techniques, how to wash a patient, how to give an injection, so when they get to the ward they can make a bed. *(Lesley)*

The participants indicated they believed that the departments of nursing within the educational institutes should send students into the practice setting with an adequate level of nursing skills in order for them to participate in the delivery of patient care. Students had arrived in one practice area not understanding what a blood pressure was, what different pressures were telling them and unable to take a patients blood pressure. Other students had been unable to carry out simple basic nursing procedures.

I have to teach them simple things like how to make a bed, how to wash their hands. Polytech I believe doesn't teach it. *(Clare)*

In this instance the Clare was trying to ensure, for her own peace of mind, that students would at least acquire some basic nursing skills whilst working with her. Students worked with Clare at all times learning how she gave patient care and carrying out simple procedures for themselves once she felt they were able to complete the procedure safely. This took an immense amount of her time and was very demanding when there were more than two students allocated to her at one time. Clare was not allocated the sickest patients but was often given patients requiring a lot of time and attention. Sometimes she felt

It is very demanding because it is not always easy with two students, to be watching both at the same time, to have both occupied and interested in what you are doing and sharing my jobs with them. *(Clare)*

The participants said they were quite happy to have the students in the wards but in some cases the student were unable to read and understand nursing reports as well as write patient's reports, so one of their criteria was that students should be able to do this. Several registered nurses believed that students should be able to read a nursing report and note the relevant information and at the end of their duty write a ward report for the patients they had been caring for. They should also be able to chart recordings.

A lot of new students and new graduates have trouble writing reports. *(Helen)*

Nurses are coming through unable to read and write. *(Lesley)*

Paula, Kate, and Helen described how they believed students should arrive on the ward with their learning objectives clearly written so the registered nurses knew what the student needed to learn. Kate believed this would save the registered nurses time trying to find out what the student needed to learn

It would be good if they came with objectives written about what they want to learn *(Kate)*.

It really concerns me that students come with no clear objectives for that particular setting. *(Paula)*

They don't tell you what their objectives are and I think they need to. *(Helen)*

A perception was that for some students it appeared to be left up to them to decide what they wanted to learn in a particular practice setting. A problem arises for the registered nurses when the students do not know what it is they need to learn and their learning needs seem vague and woolly. The participants believed that due to the pressure of their workload they did not always have the time to sit down and explain things to the students plus sort

out their learning objectives, which should have been sorted out before they arrived in the practice setting.

It would be lovely if we had time to begin to sit down with the student, I mean that's a universal problem with nurses actually, to sit down and with the student first for half an hour and figure out what they are trying to learn....I mean it would be ideal if you could sit down and have a discussion first of all and say right now we are going to go off and read the notes and look after these patients and we'll try and do what you wanted to do. *(Frances)*

Frances explained that she believed nursing was a 24 hours a day job and no one gives registered nurses the time to sit down and discuss how they are going to care for their patients. They have the hand over from one duty to another where information relating to patient care is briefly discussed, but further information for the nurse practitioner is gained through working with the patient and reading their charts. From Frances' experience the duty may not proceed as expected as many unplanned events could change her workload at any time. For the registered nurse allocated a student to work with they do not have built into their working day the time to sit and carefully plan the students learning for their time in the ward.

I mean in terms of getting your work done, that sounds negative, but if you want to make the most out of any learning experience you can't just do it, you have to talk about it afterwards, perhaps plan for next time you do it, you know to sort of go through the learning cycle. *(Frances)*

Mary discussed that when she was busy she did not have time to focus on the student or help them work through any problems they may have. Because she had an increased workload she often had to take over the patient care which meant the student was often sidelined which was not always good for their learning.

When you are busy you are more likely to take over because you actually do not have time to be with the student which is no learning for them really. *(Mary)*

Mary indicated that she sometimes did not tell her student what she was doing or what was happening because she was too busy.

Clare found having students put a huge demand on her when she supervised year one students and she could understand why other registered nurses on the ward were not willing to work with this group of students. Clare perceived the other registered nurses as not having enough patience let alone the time to spend on supervising year one students learning.

There is a lot of demand put on me. A huge amount of patience is needed. *(Clare)*

Participants described how they worked with the students during the different stages of their programme. Year one students required a lot of the registered nurses time and expertise as they showed the students how to perform basic nursing skills.

Year one are more time consuming than year three. *(Kate)*

One participant totally worked with year one students' nursing practice during their placement to ensure the students learnt to give safe, appropriate nursing care. Another preferred students to follow her around for the first few days to get used to the ward whilst observing her nursing practice before they were then left to perform simple nursing tasks for patients by themselves. It was up to each individual registered nurse to assess the student and their abilities before they gave them any responsibilities.

Basically you have them follow you around for the first couple of days, getting them used to the ward and then allowing them to perform procedures and organise patient care. *(Jane)*

Jane stated that if the student was quite good they would get a lot more out of their clinical placement but if she believed them not to be good then they spent their time following her around. A good student was perceived to be one who had lots of initiative, and did not need to be instructed all the time.

You have to gauge where they are at really, everything is new, just watching and getting used to patients, how to talk with them. *(Mary)*

Students who had previously worked as enrolled nurses, and year three students who were motivated and showed initiative, demand less of the registered nurses' time because they are able to take their own patients and be responsible for their nursing cares with minimal supervision.

Helen described working with a first year student whom she believed was a sensible student, able to ask questions when it was appropriate. But the student had had to work with Helen constantly because she had been taught only a few skills prior to starting on the ward, so required quite a lot of supervision. Helen believed this approach took quite a lot of her time plus she had to keep stopping and to explain what she was doing because she knew the student did not understand what she was doing and why.

It really depends on the student whether I have to work with them all the time, or just some of the time. It's up to them a lot and what year they are. *(Helen)*

Sam believed it was important for registered nurses on the ward, as a group, to have time to reflect on their nursing practice and their teaching of students'. Only by having time to sit down and discuss any problems associated with these two very different roles could they make any changes to benefit themselves and the student.

We don't actually have the opportunity to actually reflect on our nursing practice as a ward group. *(Sam)*

Sam has described the lack of opportunity for the registered nurses in this ward to get together and reflect on their nursing practice because students are in the ward.

Summary

The registered nurse's workload was discussed by the participants in relation to their allocation of a student for the duty, a disruption to their normal work pattern, being slowed down by students requiring large amounts of their time.

Increasing the registered nurses' workload changes the pattern of work by giving them the responsibility of more patients as well as ensuring the student practices safely. Added to this students sometimes arrive on the wards unprepared to perform basic nursing skills. This further slows the registered nurses down as they make time to supervise the students nursing practice while they learn the skills. Disrupted relationships and patterns of work make the clinical education role an added burden for busy registered nurses working in the practice setting.

Chapter 7

IT REQUIRES GOOD COMMUNICATION BETWEEN REGISTERED NURSES AND NURSE LECTURERS

Introduction

Each nurse lecturer who is responsible for students while they are in the practice setting liaises with the registered nurses working with students, in particular the Charge Nurse. The form this liaison takes varies from nurse lecturer to nurse lecturer because each acts independently to interpret this responsibility.

Normally a nurse lecturer is available on a pager visiting many different areas to see students. It is intended that the nurse lecturer withdraws from the practice setting over the three year programme so that by the last semester placement, in year three, the student is practicing independently from the nurse lecturer and works solely with the registered nurses (Boyle 1994).

Because there is a lack of clarity about the role of clinical educator it is essential to maintain regular and good communication between registered nurses and nurse lecturers. This process is, however, complex because the registered nurses' increased workload, as a result of having a student, means they have less time available to meet with the nurse lecturer. This means that both the registered nurse and nurse lecturer may not actually get to speak to one and other about the student's progress or any problems the registered nurse has identified. This situation does not enable good communication between the two groups.

Within the present structure of supervising and teaching nursing students in the practice setting, there appears to be a preference, by nurse lecturers and students, for nurse practitioners currently working in the practice areas to undertake this role. This is due to structural changes within the departments of nursing in educational institutions, resulting in a reduction of nursing lecturers

being available to supervise students during their practice placements. This shortfall of nurse lecturer availability has meant when students arrive in the wards registered nurses have picked up the role by default.

The nurse lecturer's role in clinical education was discussed by all participants. The perception, that there was a lack of communication between the registered nurses and the nurse lecturers, caused some concern for the participants as they saw this as effectively giving some registered nurses permission to carry out the clinical education role in a superficial manner and without any accountability.

Participants perceived nurse lecturer as either visiting the student to have a talk with them in private or coming to take the student away from the ward for a period of time. These talks were described as being secretive, causing an air of mystery about them, as they excluded the registered nurses and Charge Nurse from participating in any discussion relating to student progress or problems.

Registered nurses communication with nurse lecturers

Participants believed there is a serious lack of communication between nurse lecturers and registered nurses working in the practice setting. Participants were not fully aware of the nurse lecturer's role in the students clinical learning but believed nurse lecturers should spend longer periods in the practice settings working with the students. Jane feels she should be able to consult with nurse lecturers about any concerns with students. She did not appreciate nurse lecturers coming in to the ward and taking students away.

I mean a lot of the clinical educators come down and say "how's John going". We go 'Oh yes he's doing all right', and then they are taken away. Unless the RN speaks up and says well no actually they are not doing very well at all, but I mean nine times out of ten no one is going to say that because it is more trouble than its worth. (Jane)

Nurse lecturers were described as popping into the ward to visit their student, often without actually communicating with the Charge Nurse or the registered nurse practitioner working with the student. Not one of the participants described a nurse lecturer actually undertaking nursing tasks with students

I think oh yes, here is the tutor popped in for a few minutes, but the time spent with the student is not enough and it tends to be discussion time as to how the student is going but it is not the hands on stuff. *(Paula)*

As nurse lecturers commitments to their classroom teaching increased their time in the practice setting has slowly decreased. Over time this has, in some cases, led to nurse lecturers becoming out of date with their nursing practice skills and consequently, when they do go into the practice setting they feel even more out of date which in turn leads to nurse lecturers visiting the practice areas less and less.

Louise explained how there needed to be more nurse lecturer input in the wards especially with students in their first or second year of training. Louise was aware that some nurse lecturers were more comfortable in the practice setting than others, enabling them to be involved in student learning.

You have got the Polytech on one side and the hospital on the other and there needs to be some link greater than just the students themselves. *(Louise)*

Louise was aware of the nurse lecturer who liaised between the two agencies, coming into the ward regularly but still believed the registered nurses needed more nurse lecturer input when the student was actually in the ward working with the registered nurse. Louise described this input as the nurse lecturer working in the ward for one day with the student and their registered nurse. This would enable the registered nurse to discuss the students progress with the lecturer. What Louise said she believed registered nurses really wanted was to be able to talk to the nurse lecturer, get to know the nurse lecturer,

and be able to discuss their teaching role especially if they had never worked with a student before.

I definitely think there could be more tutor input in the first year. And it is as much for the staff nurse as it is for the student in that you have got a new staff nurse who has never had students before, or even one who has, it is nice for the nurse to know the students are learning what they need to learn or you seem to be teaching this person well. *(Louise)*

Paula described how she believed if the in-house communication with the lecturer and the student was formalised by regular meetings any issues arising could be easily addressed before they became major problems.

It doesn't happen at the moment, you get a two minute corridor conference if you are lucky. The student may get more but the staff working on the ward don't get more than that, unless there is a particular problem and you request it and then I am sure it would be available but it seems a bit ad hoc at the moment. *(Paula)*

Paula believed that if the nurse lecturer had the skills required to work in an acute practice setting then they would be made welcome in her ward, but in reality believed it was unreasonable to expect anyone who was not working in the area on a daily basis to keep up with the changes taking place. Paula believed that realistically, nurse lecturers could not be current in their practice for all the wards where they had students. This should not though prevent the nurse lecturer communicating with the registered nurse working with the student.

What I would like to see is designated meeting times between the lecturers and the staff nurse working with the student, where there is time to address the issues and put the three heads together. *(Paula)*

Participants also believed that they needed guidance from the nurse lecturers on what they were teaching the students.

If the lecturer met with the nurse and the student as a threesome. If you met for ten minutes and just discussed through a few things that you had gone through during the day and she could, because you are in the teaching role as a tutor, you could pick the eyes out of a clinical experience a wee bit from the teaching point of view, a little more than a staff nurse. It would be a way of on the job teaching the staff nurse how to teach. *(Frances)*

Although Frances believed registered nurses were responsible for students' clinical education the role of the lecturer should be one of a support person for the nurse practitioner by showing them how to teach students if they are unsure, and being there if any problems occur which the registered nurse may not feel able to cope with.

The issues related to the time spent by lecturers in the practice setting, both in terms of their clinical proficiency, supportive role for students, and their relevance to student learning appear to be areas causing some degree of concern for the registered nurses participating in the study.

We need to keep in touch with the tutors more. It would be quite nice if we could have more to do with the tutors ourselves. If the three of us could sit down and set out objectives so that we knew where we were going, the student knew where they were going and when the tutor arrived to come in and see what has been happening and to ask us how the student is doing. *(Kate)*

This comment reflects Kate's need for regular communication with the lecturer. The need for clarification of the students' learning needs, and acknowledgment of her contribution in this process.

There is no real liaising between the tutors and the staff nurses who are buddied with the students. I feel they are my responsibility for the time they spend there, but there needs to be more tutor input. *(Helen)*

Clare and Mary described how they believed when the ward was really busy the registered nurse should be able to ring the nurse lecturer and say they need some help to supervise the student.

The staff nurse should be able to ring the tutor and say please I need some help. *(Clare)*

Clare identified a lack of communication between registered nurses and nurse lecturers. She was aware that the nurse lecturer came to the ward to speak with the student but had very little contact with lecturers herself. She believed the nurse lecturer should talk with her about the students progress or any problems that had arisen within the students practice. She presumed nurse lecturers were happy to leave students under her supervision, but apart from the students themselves and her Charge Nurse, had received little feedback from nurse lecturers

She [nurse lecture] comes up, speaks to the student, as far as I am aware, says 'is everything all right', and they say 'yes we are fine', and that is about it. *(Clare)*

Jane understood that the nurse lecturer could not be in the ward all the time with students.

The tutor cannot be there all the time with the student because they have got so many....it has to be a combined effort....it would be good if you could consult with the tutor. *(Jane)*

Mary on the other hand described the nurse lecturers as just quickly coming in to the ward to see a student. This can be interpreted as causing an air of mystery as to what these talks consisted of and perhaps raising an issue for the registered nurses of a hidden agenda that did not include the nurse practitioner.

The tutor just comes in quickly, from what I see, and has a chat to the student and goes again so you are not really part of the picture. *(Mary)*

The registered nurses do not like it when the students are withdrawn from the practice setting by lecturers without consultation with them. They believe

because they have the primary clinical education role they should be involved in all conversations with students re their clinical work.

Participants described the nurse lecturers coming into the ward to talk with students but were not sure what was the purpose of the talks. They felt they would prefer the nurse lecturer to talk with them. They believe this would help them understand how they could help the student learn and inform the nurse lecturer what the students were actually learning and any problems they felt the students were experiencing in their practice. Open communication between nurse lecturer and registered nurse would prevent the feeling of secrecy surrounding the lecturers' visits to the wards by the registered nurses and enable them to feel valued for their contribution towards students learning.

I think there is a big role for tutors coming into the ward and asking students what they are doing, going over things as they come up....The tutors don't ask the Staff Nurses what they think would help students learning that day....I guess I would have to find out what they are asking the students because if we work in together it would be good. *(Mary)*

From Kate's perspective

A disadvantage is that we do not see the tutors. *(Kate)*

Kate believed that the nurse lecturers should be helping students in the wards especially in setting out their learning objectives, checking to see if they are achieving their objectives and being a resource person for explaining the learning opportunities in the ward. To enable the nurse lecturer to do this they would need to spend time with the registered nurses in the ward becoming familiar with the different routines and procedures.

There needs to be clear communication between the registered nurses working with the students and nurse lecturers to clarify the roles of each so that they are able to fulfill the roles effectively. At present these practitioners perceived the role of clinical education and supervision as now belonging to

them, with the nurse lecturer coming to the ward to talk with students and acting as a liaison person for the student. If the perception is right there needs to be a much closer liaison between the registered nurses and nurse lecturers to ensure that students learning, both in the classroom and practice area, ensure their clients receive safe nursing care.

Kate described how she believed that nurse lecturers should be working with students in the ward especially during their first week in the ward. From her own experience of being a student she understood that students sometimes felt safer asking their nurse lecturer questions instead of their registered nurse because students often felt silly asking nurse practitioners simple questions. She saw the nurse lecturer's role as orientating students to the ward procedures and layout, plus being a support person, a job that took precious time for registered nurses keeping them away from their patients.

I think the first week a lot of time should be spent with the tutor. Just showing them the layout of the ward and the routine and how to do the basic paging, doing a simple admission, basic skills. *(Kate)*

Communication is hampered by the registered nurses belief that the responsibility of clinical education has moved from the nurse lecturers to the registered nurses working in the practice setting. Participants saw themselves as the experts in the practice setting and therefore the ones to facilitate student learning and the involvement of the nursing lecturers was for some a low priority.

In the last year and a half, I have seen a reduced availability and presence of tutors on the ward giving their experience, showing their knowledge and showing students the right and wrong way to do things. I am sure that it used to be that the tutor used to come in and have an allocated number of students and worked as a team with the rest of the ward to educate and train students. Maybe the role of the nurse lecturer needs to be redefined. *(Lesley)*

One participant described how the registered nurses working in their practice area would prefer that the nurse lecturer be more involved in the student's clinical education. This was not believed to be out of inherent laziness but because they saw nurse lecturers as deficient in carrying out the role. In this particular practice setting the lecturers were not perceived as being involved enough with the registered nurses and students. Often the registered nurses were managing large workloads plus supervising a student. The presence of the nurse lecturer involved in the students learning would enable the nurse practitioner to focus on her patients knowing the student was being supervised in their delivery of nursing.

I think the need for the tutors to closely liaise with whoever is in charge is extremely important. I think tutors coming in and going out of the ward, or the clinical setting is totally inappropriate. They need to make themselves known, they need to develop some sort of relationship with whoever is in charge, they will get far better responses from the staff if they become known around the ward. Certainly if they put down their bag and take off their coat that would make a huge difference. *(Sam)*

It was perceived by one participant that the relationship between the registered nurses and the nurse lecturers was not close enough despite attempts being made by them to rectify this. Frances believed the educational institution had the overall responsibility for organising and managing the clinical teaching.

To make sure that things are set up and if the staff nurse has hassles accessing things that are needed for teaching so there is somewhere for her to go besides a charge nurse who is not actually focused on the student. The tutors come and talk to the student but there isn't any actual support for the staff nurse who is doing the teaching. *(Frances)*

Sometimes the registered nurses want to talk to the nurse lecturer about things other than student issues. This would be especially helpful for the less experienced registered nurses who manage the clinical education of students. Participants explained that they believed nurse lecturers need to be available

and willing to communicate with the registered nurses working in the practice setting.

Six of the participants had gained their nursing education through a nursing programme within an educational institution. This, they believed, enabled them to identify the nurse lecturers when they visited the practice area to see students. They were aware that the registered nurses not familiar with the local department of nursing, were disadvantaged because they were unsure who the nurse lecturers were therefore could not consult with them on issues relating to the students' learning.

I am sure that it used to be that the tutor used to come in and have an allocated number of students and worked as a team with the rest of the ward to educate and train those students. I would like to see that back again. *(Lesley)*

The participants all recognised the importance of their contribution to students learning. They were aware that students had meetings with their nurse lecturer but could not understand why they were not included in the meetings.

Jane discussed the need for better communication between the nurse practitioners and nurse lecturers.

It would be good if you could consult with the clinical tutor and just say I think they need more of this, or I think we need to teach them more of that. *(Jane)*

The purpose of students being in the ward is to enable them to link theoretical concepts learnt in the classroom into their nursing practice. Nursing lecturers needed to be aware of the clinical realities which affect the application of the theory they teach.

Paula explained the ideal situation for her would be nurse lecturers skilled in the skills specific to the ward and working with students, but in reality understood that it was impossible for the nurse lecturers to keep up with the

changes taking place and the registered nurse was therefore in a better position to do this.

Lesley was concerned about the lack of the nurse lecturers presence in the ward for both the student and the registered nurse.

I thought we had a lack of tutor coverage when I was a student. We have had three or four sets of students through this year and we have maybe seen the tutor twice. What is that? Is that an indication of a tutor over extended with the amount of students they have in the hospital? Do they believe the students don't need coverage? *(Lesley)*

Paula did believe, from her experience, that nurse lecturers did not feature in the students learning in the practice setting.

Generally the tutors are not seen as being of relevance in clinical teaching of the students. *(Paula)*

Paula explained that on her ward registered nurses had taken on board they were the clinical educators and did not see a way of changing this so they lived with the system.

None of the participants believed the nurse lecturers actually taught the students in the clinical area. They did believe, though, that the nurse lecturer should be accessible when needed and when necessary a resource person for both the student and the nurse practitioner.

Part of the communication problem between the registered nurses and nurse lecturers is caused by the lack of clarity about responsibility for the clinical education role.

An issue identified by eight of the participants related to who had the responsibility for ensuring learning opportunities were available for students in the practice setting. Although they understood that nurse lecturers could not be in the wards all the time they still believed the education institutions had the

overall responsibility of ensuring the availability of student learning opportunities.

Frances talked about how, somewhere in the recent change in nursing education, the responsibility for the clinical education of students in the practice setting has moved from the lecturers to the registered nurses.

Somehow the responsibility has been put on staff nurses with no kind of real consultation, it has just slowly slid over.
(Frances)

This comment relates to Frances' understanding that when pre registration nursing programmes began, nurse lecturers worked in the wards with a group of students, taking a workload and working as a team member in their delivery of patient care. Gradually, over time, nurse lecturers have spent less and less time in the practice setting leaving the registered nurses to teach and supervise student learning and acquisition of skills. Frances was unsure of when or how the clinical education role became the responsibility of the registered nurses but was aware that she had not been prepared for the role. This highlights the lack of consultation between the health and education agencies.

Participants believed that the responsibility for students clinical education belonged to both the educational institution and the hospital managers. They could understand that the nurse lecturers could not be in all the wards at the same time as they were required to supervise large numbers of students each day. They also believed that they should be able to sort any student problems out with their Charge Nurse and call in the lecturer if the problem continued. They saw themselves as the expert nurse practitioners with a professional responsibility to teach students.

The responsibility day to day when they are on the ward is the nursing staff but the overall responsibility is, and should be, the Polytechs to ensure they are learning enough and the right things, and are competent in those things. *(Louise)*

Mary believed both the registered nurse and nurse lecturer had the responsibility but there needed to be better communication between them.

I think it is OK for the staff nurse to have responsibility, but I think also the tutors should have some responsibility as well. Its quite nice if they can work together. *(Mary)*

Helen on the other hand believed there should be more liaising between the two institutions with the educational institution taking a large share of the responsibility.

I think the main responsibility I would have to say is the Polytechs responsibility for the clinical education. Perhaps 60/40 or a 70/30 type set up where the Polytech is more the main responsibility. *(Helen)*

Jane also believe it was a shared role because in reality the nurse lecturer could not be in the ward all the time with the student.

It is a responsibility, it's in the job description that we do train students. I don't think it is our responsibility if a student is having a lot of problems. That has to be a combined effort, we are working hard and have our patients to think about. *(Jane)*

Clare preferred to have trained nurse lecturers from the educational institution be responsible because she believed registered nurses lacked the time to teach students. This related to her experience of students arriving on the ward unable to perform basic nursing tasks without supervision from their nurse practitioner. This she felt was especially hard for registered nurses with limited post registration experience or who might be lacking confidence in their role as a nurse practitioner in a busy ward.

On the other hand Frances saw the registered nurse as the expert to teach students but still believed the educational institution had the overall responsibility for student learning.

The responsibility has to lie with whoever is formally responsible. I think nurses have the responsibility for doing that in the clinical area. I think whoever they are training with is responsible for their formal learning and passage through their programme. (*Sam*)

Although Sam accepted that the educational institution has the ultimate responsibility for students clinical education there still remained the registered nurses responsibility of ensuring students were exposed to the right learning opportunities.

I think in actual fact the most realistic thing for the teaching is to use the staff nurses because they are the experts in that area. There is no way that your Polytech tutor can keep up comfortably with everything that is happening in every area in the hospital. (*Frances*)

Although Frances saw the registered nurses having the responsibility for students' clinical education there still remained the overall responsibility of the educational institution to organise and manage the teaching by registered nurses. Frances explained that registered nurses had enough hassles with understanding what they needed to know in order to teach students. Louise also believed the responsibility of the day to day learning in the ward remained the responsibility of the nurses but the educational institution had the responsibility of ensuring students were learning appropriate skills and were practicing competent nursing care.

Helen and Lesley also supported the idea that the educational institutions had a greater responsibility for students clinical education.

I think the Polytech needs to pick up some responsibility here. I put it down to 70% Polytech and 30% institution. (*Lesley*)

Lesley explained the educational institutions had 70% of the responsibility for students' clinical education because the student is there for 3 years and the Polytech wants to pick up and be funded for students to an acceptable level in

a degree course so they have the responsibility to educate the student. On the other hand the institution wants to have a good quality registered nurse come through the system, they also have to pick up a marginal amount of responsibility. Ultimately Lesley believes there is a shortfall in responsibility as neither institution takes responsibility. An outcome of this was that Lesley believed students pick up their own education when in the practice setting.

From Paula's perspective both institutions should have the responsibility of the clinical education role.

I think it needs to be joint venture between the polytechnic and the clinicians. *(Paula)*

Jane also thought that the clinical education role should be a combined effort because realistically she understood that nurse lecturers could not be in the ward all of the time. Both Jane and Paula thought that if the nurse lecturer and registered nurses were communicating effectively then the role could be a partnership using the strengths of both groups. If students was causing concern in the practice setting then both the registered nurse and lecturer should be able to discuss this and work out a solution to benefit the student.

The sense of being valued for ones contribution is an important factor for registered nurses working in the practice setting and supervising student learning. If registered nurses and nurse lecturers are able to communicate in the practice setting the nurse practitioners may begin to feel valued for their contribution in students clinical learning. Dissatisfaction with their preparation for their teaching role was frequently expressed. It would appear from the participants perspective that nurse lecturers are distancing themselves from clinical practice.

Summary

At the present time it is not clear who has the responsibility for the clinical education role and this needs to be clarified between the educational institutions and the C.H.E. From the study participants perspective it appears that some of the problems relating to the clinical education role could be overcome with better communication between registered nurses in the practice setting and nurse lecturers from educational institutions. Nurse lecturers appeared to have a low-profile in the practice setting, because they were not seen to be actively involved in students' learning. When nurse lecturers visit the practice setting the visits were student focused, and did not always include discussion with the registered working with the student.

Chapter 8

IT REQUIRES THE REGISTERED NURSE TO BE PREPARED FOR THE CLINICAL EDUCATION ROLE

Introduction

Registered nurses employed within educational institutions are normally prepared for their teaching role for both in the classroom and in the practice setting. Registered nurses working in the practice setting do not have this preparation. Nurse lecturers know and understand the nursing curriculum currently being delivered. Registered nurses in the practice setting do not know the curriculum. They do have identified in their job description their contribution to students learning in the practice setting but are not given any preparation for the role.

Registered nurses working in the practice setting are required to add the clinical education role onto their normal, often heavy, workload. These registered nurses need to know what exactly is required of them in order to optimise student learning while monitoring patient safety.

The term preceptor is now being used to describe a variety of roles. In this situation it refers to a role related to the clinical education of student nurses. In other situations it may refer to the preparation of inexperienced registered nurse by one with greater experience. Preceptors may be regular ward staff who add a preceptorship role to their work or they may be experienced registered nurses employed specifically as preceptors.

Preceptor workshops have been offered to registered nurses working in the practice setting free of charge by the educational institutions. The aim of these workshops is to introduce and explain the nurse's role in supervising students learning. Unfortunately only a few registered nurses have been able to attend these workshops. Apart from the preceptor workshops there has not been any

other formal preparation for registered nurses to supervise and teach student nurses in the practice setting.

Preparation for the role

Most participants believed that they needed guidance from the nurse lecturers on what they were teaching the students to ensure they were meeting the students learning needs. One participant, however, stated she did not believe that the nurse lecturers were relevant in the students clinical learning because all the clinical teaching was being done in the wards by the registered nurses.

Despite the often complex and sometimes stressful practice settings in which the participants worked they understood that monitoring their own expertise in clinical practice was important in order for them to work with students. This expertise enabled them to provide what students needed to learn but they sometimes did not have the time or energy to facilitate student learning. From the participants' perspective's they believed the clinical education of student nurses was part of their role as it was in their job description, but several appeared to gain little satisfaction from the role as clinical educator.

Registered nurses working at the C.H.E. with a minimum of nine months in current practice in the wards where this study was carried out, have in their job description a brief outline relating to their role in students' clinical education. The outline is very brief and vague, and gives little guide as to how to accomplish it. It does not indicate how the nurse practitioner will be prepared for the role or if there is a choice of undertaking the role.

It's in the job description that we do train students. *(Jane)*

Teaching students is discussed briefly in the registered nurses job description, and can be seen to direct the nurse practitioners to teach, but may not encourage them to do so as a professional responsibility.

The participants said their lack of preparation to undertake the role of supervising students, hindered their ability to efficiently support student learning. Registered nurses in the practice setting are unable to clearly identify their role in students' clinical education and feel they require more preparation and support from education. They are unaware of the competencies that the students are expected to achieve during their time in the practice area. All of the participants were unsure of what is expected of them in relation to their role of supervising students in the practice setting. This is not surprising, given that expectations have not been clearly defined by the nursing institutions (Ives & Rowley, 1990). None of the participants felt adequately prepared for their teaching and supervising role.

I don't really know what the Polytech is expecting of us really. I haven't had any formal teaching I don't really know what they are expected to learn while they are on our ward. *(Helen)*

As Helen was unsure of her teaching role she found it easier to cope by referring back to her time as a student eight years ago. She felt this was all fine for some situations, but believed she lacked the relevant current theoretical knowledge and knowledge of the style of students learning. There was a gap in the registered nurses' knowledge that did not make them feel entirely comfortable with their teaching role. This did not give the participants confidence to teach or make the job any easier

I was just given a student. *(Louise)*

Louise also found when she was given a student, she had to refer back to her time as a student to try and remember what a student needed to learn.

Louise believed all registered nurses in her ward, with at least eight to nine months post registration experience, would work with students during their practical experience. It was perceived by her Charge Nurse that registered nurses needed this time to learn their role without the added responsibility of students.

Sometimes registered nurses in their first year of registration were expected to supervise students, partly due to a lack of more experienced nurse practitioners being on duty at the time, and partly due to them being more willing to supervise students. Although they have gained their nursing education through a comprehensive nursing programme, the role of supervisor is very different from the role of a student.

Responsibility for preparing the registered nurses for the role of teaching and supervising students was seen as belonging to both the educational institution and the hospital management.

It would have been quite nice to have begun with a teaching programme, something that made the role official. *(Frances)*

Four participants believed they picked up the role from working with their colleagues and the help they received from their Charge Nurse. Clare felt she had learnt the role over the period of time she had worked with students. She also said her Charge Nurse had been very helpful in assisting her to work out the best way to approach the role.

It was hit and miss to start with. I had to work out what I felt was important from what I was seeing with the Polytech nurses coming into the hospital and there appeared to be huge gaps. So I had to work out what I felt and I had a talk with my Charge Nurse. I think you have to remember that I am a state registered nurse, I am not a teacher and I have never had any teaching experience. *(Clare)*

Louise discussed how she felt supported by her Charge Nurse, who frequently acted as a resource person if they were experiencing problems with a student, had encouraged the registered nurses to attend preceptor workshops offered by an educational institution, and she knew she could decline to work with a student but generally the nurse practitioners were expected to work with students.

The Charge Nurse is quite often involved, talking things through, "How shall I approach this, would this be OK". We spend a lot of time talking with her about teaching students especially if they are struggling. *(Louise)*

Help was usually only sought if the registered nurse was experiencing problems with a student as they believed they just got on with the job. In some cases the problems were not resolved, just pushed to one side. The role taken by the participants seems to be based mainly on their goodwill and founded on what they had experienced as a student themselves. They felt that the role was a bit hit and miss until they were able to sort the role out for themselves, often after talking with their Charge Nurse.

Sam was concerned that the lack of adequate preparation for registered nurses to undertake their clinical education role often left them feeling unable to be effective teachers plus manage their increased workloads.

I think they see themselves as deficient as far as the role is concerned. *(Sam)*

Several participants admitted to not knowing the nursing curriculum being taught in the school of nursing and therefore were not sure of the boundaries of their teaching role.

I have no idea how things are being taught at Polytech and how I should be responding as a staff nurse taking these students, so maybe I am not the best person to have them because maybe I don't really know where they are at and what is happening. They have got theorists now that I have never heard of and journalising that I am not quite sure about. *(Mary)*

I am not really in touch with what, perhaps, the Polytech is teaching and how they are teaching it nowadays. *(Helen)*

Two participants said they were unsure of the current nursing curriculum as there had been several changes in the last few years. There seemed to be a gap between what the registered nurses thought the students were being

taught, partly from their own experiences as students, and what they believed was actually being currently taught to students. They were not aware of curriculum changes and theoretical models used by the educational institutions.

Paula believed nurse practitioners should be prepared for the role of teaching students rather than each registered nurse deciding how this should be done. Setting a standard of teaching practice would hopefully make registered nurses accountable for what they teach students.

I think they have taken on board as their role and this is the way it is and don't see any way of addressing that, so they live with the system. But they need that extra preparation for the teaching skills side of it and certainly to be made accountable to know that they are accountable for ensuring that whatever needs to be covered is covered. They can't just do it on an ad hoc basis. *(Paula)*

Participants believed the lack of preparation did not foster a professional desire to teach students they were allocated and it did not give the registered nurses the confidence to teach and assess students which they believed was part of their role. Preceptor work-shops, run by the educational institutions, offered to registered nurses were accepted as a first step in enabling them to understand the role of teaching and supervising student nurses' clinical learning.

I have had no proper instruction of what I should be doing, and no teaching in the role of doing it, apart from attending one preceptors day, which was held here at the hospital and was three years too late. *(Clare)*

By the time Clare had attended a preceptor study day she felt she had already, by trial and error, worked out a teaching role for herself. Clare said she would have liked to talk through with lecturers her role so they knew what she was doing. She did not know what was expected of her or what the students were learning in the classroom so she could apply this in their practice.

Lesley saw a role for preceptors to take on the responsibility of teaching and supervising students during their time in the ward. This would relieve the nurse practitioner from undertaking a teaching role as well continue to give nursing care.

We should have preceptors in the ward to pick up and have under their wings students for a set amount of time. The preceptive staff nurse that picks up the training of students should be paid by the Polytech and the C.H.E. and should dedicate their time to the student. *(Lesley)*

Louise had not attended any preceptor workshops because she had been on night duty each time they were offered.

I haven't been to one but I think they are a really good initiative. *(Louise)*

She did discuss how several registered nurses in her ward had attended and found the workshops had definitely made the teaching role clearer for them. Louise believed this helped the registered nurses become more aware of what their responsibilities were, the responsibility of the student and the educational institution.

Two participants said the registered nurse's attendance at the preceptor workshops depended on whether the Charge Nurse valued the contribution they made to student learning and would therefore relieve them from their practice to attend the one day workshop run by the departments of nursing with the educational institutions. The two participants had been unable to attend the workshops. Attendance for some registered nurses required them to do so on their day off.

I wouldn't imagine the Charge Nurse will give anybody the time off to go. She doesn't see it as part of the nursing work. She doesn't see the relevance of a day at Polytech. *(Lesley)*

Lesley was quite disheartened by the lack of support from the Charge Nurse to send registered nurses to the preceptor workshops being offered for those interested in attending.

Because the Charge Nurses have to pay the staff nurse to go then they are not actually keen to send people. It's costing the company \$140 or whatever the gross pay of a staff nurse is to send our nurses to the Polytech to be taught how to teach your students. Now it is possible, I suppose, for staff nurses to choose to go on their day off because it is free.
(Frances)

Frances was aware that the C.H.E. had also run preceptor workshops for registered nurses who were orientating new staff members. Nurse practitioners were keen to attend these workshops and Charge Nurses were willing to give them the time to go. This reflects the different attitudes to staff requirements and those of students enrolled in a nursing programme.

Frances believed there should be some formal recognition of their teaching role:

I think the person doing the teaching should have some formal recognition as such and some formal responsibility. You know, something that's just a bit more accountable for what they teach students. (Frances)

Frances discussed the possibility of several people who wanted to work with students each taking a turn of having a student. Because supervising students is tiring work taking turns would enable other registered nurses to have a rest from students.

You know 'not good old so and so, she will take the student'. I mean they may be very nice but good old so and so is not particularly accountable for what she teaches the student.
(Frances)

This would prevent registered nurses who disliked working with students, or were tired of them, being allocated a student.

I mean some people are good teachers and some people aren't. It is detrimental to a student if they have a bad experience with an RN so it is only fair they have a good education. *(Jane)*

Several participants were aware the registered nurses did not receive any formal recognition for their clinical education role from either the hospital managers or the educational institutions.

I want to reduce the amount of time I have with students unless things change. I am happy to train them, but things have to change. There has to be recognition of the job I am doing, the amount of work I am doing and follow up consultation with the lecturers. *(Lesley)*

I certainly feel that there should be some acknowledgment of the role not just an automatic assumption. Whether it's financial, whether is a piece of paper I don't know, but whatever there should be some recognition of their role. *(Sam)*

Sam explained that registered nurses are expected to teach students but receive no reward either financially or even in many instances any recognition from either institutions of their added responsibility when working with student. This was summed up by Lesley who believed both institutions should be working as a team.

I think there needs to be recognition of the staff nurses that are picking up the students and the effort they are putting into doing it. *(Lesley)*

Paula also described the need to reward registered nurses for their teaching role. Attending free preceptors workshops in work time was one way of achieving this. She also felt this was fine in an ideal situation but on her ward they were short staffed so the registered nurses were unable to attend the sessions.

Lesley was concerned that the lack of lecturers coverage of students appeared to leave the registered nurses in the ward little choice of teaching and supervising student learning.

Just a lack of teamwork, just a lack of communication between the Polytechnic and the Hospital. (*Lesley*)

Mary's concern related to the lack of feedback for registered nurses and believed it could be done better to ensure nurse practitioners understood the complexities of their teaching role. She believed only with feedback were registered nurses in a position to change their teaching styles for each level of student coming to the ward and saw this as the lecturers responsibility.

It's not very good for you, it means as a staff nurse you are not getting any feedback about your role either and about what the tutor expects of you and whether you are doing a good job, because I guess if Polytech wants us to do a better job we need to be getting feedback. (*Mary*)

All of the participants discussed their lack of their preparation for the role they were expected to undertake. This did not appear to enhance their motivation to continue to supervise student learning within the practice setting.

It's like we are the tutors with the clinical skills and it's like we don't actually get paid for that. You know it's noticed in our income. (*Kate*)

Support, teaching, and assessment are all important facets of the registered nurses role when teaching students. If the registered nurses are not aware of the nursing curriculum and content, and have not been informed of the competencies expected of the students, then they are not in a position to teach appropriately (Booth, 1997).

Summary

The participants reported that the lack of preparation to undertake their clinical education role, seriously hindered their ability to support student learning. If the registered nurses are not aware of the nursing curriculum and content, and have not been informed of the competencies expected of the student, then they are not in a position to teach appropriately or to assess the students progress.

Chapter 9

IT REQUIRES THE STUDENT NURSE TO HAVE THE OPPORTUNITY TO LEARN IN THE PRACTICE SETTING

Introduction

The clinical area has always been regarded as an important learning environment for students and one of the strengths of the pre registration nursing programme has been the continued use of 'hands on' practice-based clinical experience. Nursing students are placed in the practice setting to enable them to learn by doing real world work (Schön, 1987). This requires close supervision from the registered nurse. Which registered nurse works with the student is determined by the Charge Nurse. When students are in the practice setting they are not considered as having staff member status, but are considered to be supernumerary. They are therefore dependent on the registered nurse for their learning as they have no right of access to patients without them. In order to learn students need to have access to the clinical area, access to good role models, to registered nurses with the time to work with them, and to registered nurses knowledgeable about their educational needs and to be able to work with patients.

The registered nurses who facilitate this experience by supervision, guidance, assistance and monitoring greatly influence the students' learning. In these roles, they can give students a realistic view of nursing practice. Registered nurses are therefore an important component of the learning process for nursing students.

The acceptance of the clinical education role seems to depend on whether registered nurses see it as an integral part of their nursing role or as a separate and additional responsibility. Many C.H.E's have the task of student teaching included in the job description of registered nurses with more than one year post registration nursing experience. The Standards for Nursing Practice of the New Zealand Nurses Organisation (1993) also identifies

registered nurses as having a responsibility for fostering the development of students into the nursing profession.

During the students' clinical placement both nurse lecturers and nurse practitioners are responsible for facilitating students' learning. At the same time as the nurse practitioners supervise the students practice they help the students acquire nursing knowledge and skills. This aspect of their role depends in part on fluctuations in their workload. Many nurses see teaching students as part of their professional responsibility to pass on their knowledge.

All of the participants believed the clinical education role is an essential role. Several participants gained satisfaction from teaching students. Jane saw her teaching role as a sharing of her knowledge with students, a role she really enjoyed.

Its good to have a student to be a key preceptor or buddy for a student and I think the students quite like it too....You have to put back in what you have taken out so that's fair enough....I personally like it. I find it really tests your knowledge and it is quite challenging, but its enjoyable you know and its quite refreshing that you have to wonder why I am doing this and then you have to explain. *(Jane)*

Yes, I do enjoy it. I enjoy teaching Polytech students. *(Lesley)*

Jane and Lesley's comments illustrate the registered nurses' positive attitude to teaching, valuing the student as a learner, and a willingness to participate in the individual learning needed for students.

Several participants believed new graduate nurses liked to work with students. Lesley could understand why new graduates liked to work with a student because they felt they understand what the student needed to learn.

You can see how the first and second year new graduates likes students because they know what Polytech wants, they know the objectives, and they know how the system works. *(Lesley)*

Paula, working in a busy surgical ward, however, believed that new graduates were not the best nurse practitioners to work with students because they have not found their feet as new registered nurses coping with what they have to do in their eight hour-shift. Their knowledge is only at a beginning level.

I have read a lot of literature which suggests that the best person to work with the student is someone who has recently been in that position, but I think six months is too soon and I think ideally they need that first year to find their feet themselves. But unfortunately given our workforce at the moment if you can find someone that has been around for two years to give continuity might be difficult. *(Paula)*

Lathlean (1992), described nursing as an occupation with fundamentally different views of its role, with education providing nursing students with an idealised, theoretical view of nursing, and the ward experience emphasising nursing as being about 'getting the work done'. Clinicians need to take an active role in the education of nursing students but educators also need to remember they have to keep in touch with the reality of the practice setting.

The role as I see it, I think is providing the environment and the socialisation in our particular setting is a very important part. The linking of theory to practice, understanding the ward culture. *(Paula)*

Jane believes students should go into hospitals as this is where they learn the technical skills of nursing, how nurse practitioners relate to each other, and to their patients. However she does not describe students learning to communicate with patients.

It is good for them to come in to see actually what a hospital is all about and what roles are different. You learn fluid balance charts or you learn about writing notes, they can actually see that being put into practice and they learn about different staff relationships with other people and see RNs working together with patients. *(Jane)*

There are attributes of nursing practice that make it more complex and varied, in comparison to any theoretical descriptions. A text-book or classroom

description of nursing care can never be quite the same as the real world experience. Clinical education by the registered nurse enables the student to capture the psychological and social dimensions of each patients care. People react as individuals to the stress of illness and hospitalisation and if they come from a particular social setting they may have characteristic attitudes and opinions, which the student needs to understand and learn (McCaugherty, 1991).

We are responsible for what we teach them for what they learn, how much they learn, and how well they learn. We can teach them the basics really if we want to with the sloppy habits that some of us have got, or we can teach them well and to a higher standard and obviously what we teach them is going to reflect in the nurses we get in the future so it works to our advantage to teach them well and teach them to a high standard. Teach them to ask questions, to use initiative and not be afraid of talking to the doctors. *(Louise)*

Because of the multi-contextual nature of the environment, the learning experience can be positive, exciting, challenging and stimulating, or it can be negative, frustrating, intimidating and stressful (Booth, 1997). From the participants' perspective they believed their workload and attitude towards students could strongly influence student's learning.

Frances believed that the registered nurses increased workload, the high acuity of patients in the ward, and a high expectation of the amount of knowledge each student has, did not always mean the student was in the best situation to learn.

I don't think the student nurses get an entirely fair deal all of the time. *(Frances)*

This comment relates specifically to students on the ward where Frances works. There had been a rapid staff turnover and the system of buddying new staff meant that a large proportion of a registered nurse's time is spent either with students or with new staff members. This made it difficult for the registered nurses to move between new staff members and students and also

keep their focus on the student and their learning needs. Because students do not 'belong' to the ward their learning needs are not always the registered nurses' first priority. The need to orientate new registered nurses will often take priority, leaving students unsupervised or waiting around until someone was free to notice them.

The knowledge that each staff nurse has and passes on to the student is vital for their learning. I find that most of our staff nurses have a different degree of knowledge and it is hard to quantify how much, or what, the student is picking up. Each staff nurses' quality of the education given to the student differs. *(Lesley)*

Participants were concerned about the lack of accountability each registered nurse had to what they taught students. With the reduction of nurse lecturers time in the practice setting registered nurses are left to teach students in a way they feel is appropriate. For some registered nurses this may mean they may choose to have very little input into student learning. Jane believed students should have a good education whilst in the practice setting but was aware that not all students experienced this.

It can be detrimental to a student if they have a bad experience with a RN so it is fair they have a good education. *(Jane)*

Louise and Mary described one of their colleagues telling a student to go and take the blood pressure of every patient in the ward, because she felt this was what the student needed to learn.

I worked with someone who made their student go and do blood pressures on every single person in the ward with a manual blood pressure thing and she felt it was really important that the student learnt the skill and could do it and repeat it right around the ward. The student spent hours doing that. *(Mary)*

We had a student recently who spent a whole morning with a nurse doing blood pressures. We would hope that when people come to the ward they are able to go and take a set of obs. by themselves. *(Louise)*

The presence of students who are required to participate in, as distinct from, observe care is disruptive. In the situations recorded by Mary and Louise the registered nurse set the student the task of carrying out a nursing skill over and over again because she believed this was the best way to learn the skill. The student has carried out her wishes and in doing so disrupted a number of nurse-patient relationships by going from patient to patient taking their blood pressure. The student did not have time to form a relationship with all the patients in the ward but patients were expected to accept the student coming in and performing a nursing task on them.

The patients' rights to privacy and consenting to a student practicing skills on them have not been considered by the registered nurse allocating the routine work to the student. When a patient enters the hospital they may be aware that it is a teaching hospital and therefore may encounter nursing students performing nursing tasks on them. However having a student giving nursing care is different from a registered nurse giving the care.

Several participants described part of their clinical education role as being a good role model for students. Role models are essential for the development of a theory of practice, and for professional development. Learning in the practice area occurs in many ways, one of the most powerful being observational experience. Many social behaviours are learnt as a result of observing registered nurses practice nursing in everyday situations. In seeking a professional identity students progress from imitating the registered nurse's role to adapting behaviour to suit new situations. Ideally the registered nurse in the practice setting, acting in a supportive role, becomes the students' role model (Howie, 1988).

Mary, Kate and Louise described their primary teaching role as that of being a role model, showing students how registered nurses work on the ward. Through this students learn how nurse practitioners plan their duty, how they cope with problems that happen unexpectedly. It was also about educating

them on what nurse practitioners were actually doing, talking about what was wrong with patients and how the drugs and nursing care all fit together.

I think we are one of the main role models for clinical skills.
(Kate)

I think my role is one of role model to them....showing how we act as nurses on the ward and how we interact with patients. I think it is about teaching skills to the students and supporting them and observing them, also educating them on what we are actually doing and talking about what is wrong with people. (Mary)

They need to know what the nurse does and how we do it. A lot of the teaching I do is direct teaching like this is how we do this. Letting them do stuff and talking them through it.
(Louise)

These comments describe how the participants believe they participate in student teaching. To enable students to learn by acting as a role model, showing them the work nurse practitioners engage in, their interaction with patients, and supporting students as they learn their nursing skills were perceived as an important part of the registered nurse's clinical education role.

Helen described how she preferred to mainly look at the practical aspects of nursing because she knew that the student learnt a lot of theory in the classroom. She saw her role as linking the theory to practice in a ward setting.

Basically, what I like to do is show or teach with the student and mainly look at the practical sides of nursing because I know a lot of the theory is done at Polytech. I really try and put, hopefully, what they have learnt in theory first at Polytech into practice in a ward setting. (Helen)

Louise was aware that students could not learn all they needed to know in the classroom therefore the role of the nurse practitioner was to teach the students the basic techniques of nursing cares.

My main role is to fill in the gaps from Polytech. *(Louise)*

Paula saw her clinical education role as filling in the gaps from what the student learns in the classroom and providing a reality check for students to understand what nursing was all about. Kate preferred to have the student follow her around for their first week on the ward whilst she explained the routine of the ward, showed them how she liked procedures carried out, where the equipment was kept. Kate believed working with a registered nurse enabled the student to understand how nurse practitioners carried out procedures the student had not learnt in the classroom. When Kate believed that they understood the ward routine she left them to carry out a few procedures on their own.

In order for students to get the best experience from working with their registered nurse they need to be motivated. From the practitioners' perspective, the students' attitudes often influenced their acceptance by the registered nurse they were working with. Students who appeared motivated and wanted to learn were more likely to obtain more practical experiences as the registered nurse gave them more responsibility. Those who were not well motivated were often left to follow the registered nurse around and just observe her perform her nursing cares.

Sometimes it is hard, especially if they seem to be a pain more than a help or always asking to go home. The ones that aren't enthusiastic. Depending on how I am feeling, sometimes I just think oh well you can't be bothered well I won't be bothered, I will just let you do, I will tell you what to and you can go and do it and I will just double check that you have done it, or I will follow you while you do it. But I think, well, it's your learning, you know, if they are not enthusiastic about it whatever, it's them that's going to suffer not me.
(Kate)

When students showed little enthusiasm or a lack of interest in gaining any experience the registered nurses saw them as a hindrance to their own work. Student interest or reaction to their clinical placement had an impact on the relationship with the registered nurse they were allocated to work with. If the

Charge Nurses have to keep using the same registered nurses for each group of students coming to the wards then the registered nurses like Kate may well express their feelings towards students.

Student competence became a major issue for participants. Their lack of preparation to perform nursing tasks often meant valuable time had to be spent showing students how to perform these tasks.

Student's lack of preparation for their clinical practice was identified by Kate and Lesley as a hindrance to the student's learning. This also interfered with the registered nurse's work as they were not clear just what is was the students needed to learn. She did not want to spend time teaching students to carry out nursing procedures she believed should have been learnt in the classroom.

Sometimes they say they have to sit down and do some study, but they are just reading a book or whatever and I think OK you can do that, that's choice, its your loss. But yet again it depends on how I am feeling as well if I can be bothered with them. *(Kate)*

Practitioners saw third year students as being easier to work with, usually requiring less of their time in explaining what needed to be done, and becoming a valuable member of the ward team by the end of their clinical experience, and eventually contributing to patient care and the workload allocated to them.

If the student is quite good then they will probably get more out of the placement because they will be allowed to do a lot more and be trusted, and if they are not too good then they spend the rest of the time following you around. *(Jane)*

Students are different and arrive in the practice setting with different learning needs, abilities, and motivation. Sometimes this knowledge the student brings to the ward needs to be acknowledged by the registered nurses. However

Lesley and Paula describe how they believe it is left up to the student to decide what it is they wish to learn during their time in the clinical placement.

I think the student on their own back picks up a fair amount of their education. They are supported in a way by Polytech, because that is where they do their learning, and they are supported even less by the C.H.E....I would say students were picking up their own education. *(Lesley)*

Students tell me that it is up to them to decide what they are going to be learning. *(Paula)*

These two comments describe situations where students have been left to decide their own learning objectives without any apparent guidance from their lecturer. It also indicates that it appears to be up to the students to ensure they have the opportunity to learn. This raises the question whether students have enough knowledge to make such decisions without academic support and if they have been prepared adequately to enter the practice setting.

Sam discussed how students working with a nurse practitioner were able to see registered nurses in action. They would see the good registered nurses and the not so good nurses practice, good role models and not so good role models. In an ideal situation on the ward students would be exposed to the very best nurse practitioners but Sam was quite aware that was unlikely ever to happen. In reality each registered nurse had their own professional standard of nursing practice so students would always meet different levels of competency in the nurse practitioners they worked with. Despite this Sam believed registered nurses had a professional responsibility to teach students.

I certainly believe there is a professional responsibility to teach and to foster professionalism in nursing and that as [is] part of what they are doing in the ward situation. The staff seem to accept that having students is part of their lot in life. *(Sam)*

Although registered nurses have a responsibility to teach Sam was aware that there were sometimes disadvantages for students. Unfortunately students do

not always get to see what they need to and they only get told what the nurse practitioner chooses to tell them or has time to tell them.

Students need to gain self confidence in the practice setting as they try to master new techniques, skills, and role expectations. Students are able to build their confidence as their ability to function as useful members of the ward increases and by experiencing success in the clinical area. This self confidence depends on the availability and willingness of the registered nurses to answer their questions, show them new procedures, or make them feel they are not just a pair of hands to do all the registered nurses' jobs because they are too busy to work with a student.

The ideal learning situation for me would be where the staff would have a minimalist workload that was hand picked for what it would give the student depending on where they were at in their programme. So on a general medical ward which is, I think, a very good learning setting, you could pick patients that you could go through their nursing cares together, just good hygiene, turning patients and skin care, basic things like that and put a lot of time and energy into it.
(Mary)

Mary believed students' learning depended a lot on people's own values, on what they think a student should be learning.

I like the idea of students working alongside a registered nurse who wants to have them there and can act as a support person. *(Mary)*

Mary referred back to her own student nursing experience where a group of students worked in a ward with a lecturer. Although this was a useful experience it did not in her view reflect the real world of nursing. Mary was aware that students sometimes need to just watch what the nurse practitioner is doing in order to understand how the nurse deals with the situation. Sometimes students required support from their registered nurse when they were involved in patient care and had to feel safe to ask for the support. Mary was very aware that this support was often lacking for students.

There has to be an element of non-threatening teaching for students. *(Mary)*

If the student is at a stage in their training where they are not quite sure of what they are doing they can be really disadvantaged if the nurse practitioner is too busy to spend time with them. They will be unable to participate in a lot of nursing activities because the nurse practitioner is too busy with her patients to have the spare time to explain things to them.

If you are flat tack with five patients and you've got a difficult patient the student doesn't learn because you are concentrating on your patient and what you need to be doing for the patient and the student gets kind of lost on the way. *(Louise)*

This statement describes how the students' learning cannot always be the registered nurses first priority if the nurse practitioner has a workload to get through.

I feel I lack time with students. *(Mary)*

Kate and Louise describe the advantages of working with a student.

An advantage is that having a student keeps us on our toes, it helps us realise what we know and what we don't know with them asking us questions. Keeps us thinking why are we doing things. *(Kate)*

Its definitely an advantage for the nursing staff to have somebody questioning your practice a lot of the time. That's really good for us. *(Louise)*

Frances believed that students' questions helped keep registered nurses' knowledge current as the more the nurses access their knowledge the easier it is to share it. For registered nurses not used to accessing their knowledge they tend to forget all that they know.

You are used to accessing it if you have to share it, whereas it gets a bit buried if you are not sharing it with somebody regularly. *(Frances)*

As for the nursing staff I think the general feeling is that we enjoy having students. I think in the clinical setting they are often disadvantaged by the business of the ward at the time therefore they don't get to participate in a lot of things, because teaching students takes a lot of time and if the nurse is busy with a patient, obviously the student is the one to miss out. *(Louise)*

From the participants' perspective, the students' attitude to clinical practice made a big difference in their acceptance by the registered nurses. Students who were motivated to learn and seek out new learning opportunities were more likely to be accepted by the staff and included within the ward team. First year students took up a lot of the registered nurses time as they had to explain everything that they were doing. This group of students could not be left alone to get on with tasks given to them.

Registered nurses are employed by the C.H.E. to work rostered and rotating shifts. Registered nurse working shifts make continuity of the nurse-student relationship difficult. Several participants discussed how registered nurses' changing shifts during the students' clinical placement, did have an affect on the students' learning. Each time they were required to work with a different registered nurse they had to evaluate what was expected of them and satisfy the nurse practitioner they were competent in their practice. If a student had to work with several different registered nurses in one week their learning could be compromised as they keep proving their clinical abilities to each nurse practitioner.

A problem is not following through with a student as I'm doing ams. and then change to pms. so the student has me for two days then goes to someone else and I think it takes a few days to get a rapport with your student and if you change shifts you both loose it and the student has to start all over again. *(Mary)*

The C.H.E. requirement of providing effective staffing levels over the 24 hour period, means the student may seldom work with the same registered nurse throughout their clinical experience

It would be good if the student was on the same shifts as your shifts. If you could have the same student for one or two weeks at a time then you could get to grips with the whole sort of care of a workload and what it involves. *(Helen)*

Helen's statement related to her working with students who worked a shorter duty. Often students leave the ward before the patient's nursing notes are written, late drugs are given out, and the sickest patients are settled for the night. During this time many nursing procedures are still carried out which could involve students plus teaching them how to give a verbal report to the oncoming night duty staff.

They are disadvantaged by the fact that the nursing staff do rostered and rotating [shifts] so it's hard to get any continuity in your teaching. *(Louise)*

Both Helen's and Louise's comments demonstrate the lack of continuity that can make it difficult for the registered nurses to organise learning opportunities and assess student learning. For students having to keep changing to different registered nurses means they have to prove their capabilities, be observed by the nurse practitioner whilst carrying out some procedures, and therefore not actually move forward in their learning. This, the participants believed, slowed down the students' clinical learning. What students therefore do become good at is interpreting what each nurse practitioner likes, working under close supervision, and not actually learning how to time manage their workload.

One ward did not allocate students to one particular registered nurse. Each student was expected to follow through a patient during their placement on the ward working with different registered nurses. It was hoped this would enable the student to work with a variety of registered nurses but retain the continuity of being allocated the same patients each day. This way of allocating students was decided upon by the Charge Nurse in an effort to prevent students being stuck with a 'bad' registered nurse for more than one duty.

I actually think there is some value for them moving between different staff members, and as things stand at the moment that is what they have to do. (*Sam*)

In Sam's ward there were not enough experienced registered nurses working on the ward to work with the students. Unfortunately students were learning from different inexperienced nurse practitioners who themselves were learning to cope with their new role, that of a registered nurse on a busy ward. Ideally the student should be able to work with the same registered nurse

You have got to have a lot of patience and a good sense of humour. (*Paula*)

Paula believed that a registered nurse sometimes needed a sense of humour to enable them to cope with students who did not always want to be in the ward.

Summary

There appears from the study participants to be several constraints surrounding the students opportunity to learn in the practice setting. Shift work disrupts student learning and their relationship with the registered nurse as they encounter several nurse practitioners during their time spent in the practice setting. In order for students to gain the best experience from working with the registered nurse they require adequate sleep prior to coming to the ward and need to be motivated to learn from the registered nurse. Educational institutions have a responsibility to ensure students are adequately prepared to work in the practice setting. A lack of preparation hinders the students learning as well as slowing the registered nurse as she stops to show the student basic nursing skills. All this suggests student learning is haphazard at the present moment.

Chapter 10

DISCUSSION OF FINDINGS

Introduction

This chapter draws together material from the previous chapters and discusses registered nurses perceptions of the characteristics of the clinical education role. The findings from this study indicate a number of unfortunate aspects of the present role. The current clinical nursing education role as perceived by the ten registered nurses is not conducive to good clinical education or practice. In its present form it disrupts relationships and adversely affects the registered nurses' management of her work. Its a role characterised by inadequate preparation and poor communication. Nor does it encourage the registered nurse to focus on student learning.

There have been significant organisational changes in hospitals in the past 20 years. In particular the turnover of patients has increased dramatically and because of early discharge policies and advances in medicine and surgery the majority of hospital in-patients either require a great deal of nursing care, or stay so briefly that relationships with nursing staff are transitory. In addition the care of patients often has a high technical component so that cardiac monitors, intravenous pumps, and central venous lines are now commonplace, not only in areas defined as high technology, but in general wards.

The changing pace and nature of nursing has implications for registered nurses supervising students in their clinical practice (Merchant, 1992). When students work with real patients, there is always an element of risk involved and therefore some anxiety for the registered nurse whose primary focus must always be their patient. Maintaining patients safety is a fundamental professional responsibility. The clinical education of student nurses should never compromise patient safety. It therefore requires well planned and supervised clinical experience in the practice setting. Nursing needs to develop strategies that nurture the personal and professional development of

registered nurses working in the practice setting and educate students into the professional role of nursing.

The age of entry into pre registration programmes has evoked much discussion among registered nurses who question students ability to cope in what are perceived by many registered nurses to be complex nursing relationships. Students are able to enter pre registration nursing programmes at a minimum age of 18 years, usually moving from school to an educational institution. On entry to a nursing programme some students have not acquired the maturity necessary to understand the importance of the registered nurse-patient relationship. They do not recognise when it is appropriate to keep quiet or withdraw from a situation or discussion. It is unclear how nurse lecturers or registered nurses can overcome this lack of maturity because maturity is something acquired over time. Students could be given scenarios in the classroom outlining current clinical situations but in reality this can never be the same as the real clinical situation.

Students gaining their nursing education in educational institutions have not had the same immersion into the nursing culture as registered nurses working in the practice setting. They enter each clinical placement as a visitor and novice, often unable to follow patients through their hospital stay, and sometimes having to work with a different registered nurse each day. Their learning depends greatly on the registered nurse they work with. If the registered nurse excludes them from their patient interactions the student will not learn how or when to ask appropriate questions. Student learning is not solely related to the practical skills of nursing. It is also how to interact with patients, answer their questions, maintain patient confidentiality and develop a professional identity with nursing. Dreyfus and Dreyfus (1996) make a useful distinction between the level of skilled performance that can be achieved through principles of nursing and nursing learnt in the classroom, and situation judgement that can be gained only in the real situation.

It appears from the data that the participants see New Zealand registered nurses as having a central role in the student learning process. This is in line with overseas trends. Wilson-Barnett et al. (1995) report that this role is becoming more dominant and there seems to have been a shift in responsibility of clinical teaching and supervision away from the nurse lecturers to the registered nurses working in the practice setting. Howie (1988), suggests students socialisation into the practice setting is largely dependent on the presence of the registered nurse as an effective role model. However, various writers have expressed their concern about putting the responsibility of clinical education on registered nurses working in the practice setting (Lee, 1996). Webster (1990) cautions that even though registered nurses make an important contribution to the supervision and teaching of students, one must recognise the many difficulties facing them. She argues that nurse lecturers need to share the clinical education responsibilities so as not to demoralise the registered nurses and thereby lose their cooperation.

The acceptance of the clinical education role by participants seems to depend on whether they saw it as an integral part of their nursing role or as a separate and additional responsibility. The C.H.E. has a requirement for student teaching included in the job description of registered nurses with more than one year post registration nursing experience. However, nowhere does it explain how the registered nurse should carry out the teaching or how they should be prepared for the role. Registered nurses who were often in their first year of registration were still expected to supervise students because they were either on duty when the students were in the ward or because it was thought they would know what the students needed to learn during their placement and therefore it would be easier for them to work with them.

Charge Nurses are notified by the educational institute the dates of students arriving in the ward. Ideally the Charge Nurse should be able to allocate the students to those registered nurses who are not working long stretches of duties or carrying a heavy patient load. In reality this is difficult to achieve.

Some registered nurses described their teaching role as tiring. They found it difficult to keep explaining what they were doing, and why they were doing it to students. This was especially hard when they had worked for more than seven days at a stretch only to find when they arrived on duty they had been allocated a student for the duty. This is not the ideal teaching/learning situation for either the student and the registered nurse.

In acute medical and surgical wards patients are usually in the ward for a very short period of time and the nurse-patient relationship needs to be established very quickly to ensure the best outcome for the patient. A concern for the study participants was the disruption to fragile nurse-patient relationships and change in these relationships when they worked with a student. This disruption occurred when inexperienced students took the registered nurses attention away from their patients, often becoming a distracter just by their presence or by interrupting the registered nurses' conversation with their patient. The students presence may affect the trust and effective communication between the registered nurse and the patient. This becomes more difficult for both the registered nurse and patient if the student, because of inexperience or immaturity, does not have the insight to withdraw themselves from the conversation or situation. Sometimes the student may suddenly be asked to leave the room or told to 'be quiet' which is not beneficial to the patient, student, or the registered nurse.

To work with a student means registered nurses are in the role of 'buddy' or role model as they guide, motivate, challenge or support students, whilst they continue to deliver their expert nursing care to often very sick patients needing their time and full attention. In fact they are doing two very difficult and demanding jobs. The registered nurse faces the challenge of teaching the student the practical aspects of nursing practice whilst also teaching them the importance of assessing each nursing situation and withdrawing when necessary.

During their three year pre registration programme students are required to work under the direct supervision of a registered nurse. However, if the registered nurse becomes too busy with her work, it appears from the participants' comments, some registered nurse's give basic nursing tasks to students. Although several participants felt guilty about this practice they understood why this practice occurred as it enables the registered nurse to get on with their care of patients. It appears that these tasks are carried out unsupervised which is a cause for concern both for the patient, and the institution. When patients enter hospital they may expect to receive expert nursing care from registered nurses but according to the participants perceptions often receive care from an inexperienced student working with minimal supervision.

Sending students off to carry out nursing tasks unsupervised also disrupts the nurse-patient relationship as the student may be unknown to the patient. Registered nurses can justify their reason for doing this but perhaps need to reflect on the patient and identify what is best for them in this situation. If the registered nurse values her relationship with her patients and wants the best outcome for them, working with the student and not sending them off to do nursing tasks, would assist the patient to include the student in their relationship with the registered nurse.

There is evidence that the registered nurse's contribution to students' clinical education provides a much needed opportunity for students to learn and reflect on clinical practice as delivered in the 'real world by real nurses'. It appears however, that this learning may be at the expense of the patient's privacy. Students' need to learn by doing and communicating with registered nurses raises, questions about a patient's right to expert nursing care from registered nurses. When patients enter a public hospital it is perhaps too often assumed by registered nurses and nurse lecturers that patients understand it is a teaching hospital where students will carry out some procedures on them. Patients need to be asked if they are willing to allow a student to practice their

nursing skills on them especially if the student is performing this for the first time. None of the study participants mentioned asking patients if they were willing to have a student carry out their nursing procedures. This is of considerable concern, as ideally, this permission should be obtained before the student arrives at their bedside with the registered nurse.

Registered nurses themselves disrupt the nurse-patient relationship in several ways. The registered nurse explaining their nursing practice in front of the patient to a student can undermine the patient's confidence in the care they are receiving. From the findings in the data it appears that registered nurses sometimes forget the patient when they are explaining nursing procedures to a student. The patient becomes 'hidden' within the relationship. Technology is being used more often in nursing so it is natural the registered nurse needs to explain this to the student. What both the registered nurse and student need to remember is that when the patient is very sick it may not always be in the patient's best interest to overhear all the technical details surrounding their care.

The disruption to the nurse-patient relationship could be minimised by the same registered nurse and student working together each day. This would mean the student and the registered nurse would work the same duties during the student's placement in the ward. This would enable both the registered nurse and the student to develop a relationship whereby the student would learn appropriate behaviour when with patients. Registered nurses do act as role models for students, so excluding the student from the nurse-patient relationship does not teach the student how to professionally develop a relationship with a patient. Careful introduction of the student to the patient by the registered nurse will also enable the student to be included into the relationship. This would entail the patient giving their consent to the student being present and undertaking the nursing cares they require.

Within the nurse-student relationship one factor which requires greater consideration in planning for clinical education is the experience the student brings with them to the practice setting. Mature age and enrolled nurses bring different qualities, expectations, and abilities to the practice setting which separate them from younger and less experienced students. These students were perceived by several participants to require less of their time, especially if they were in their third year. They were able to assess each situation and act appropriately, knew how to communicate with patients and perform nursing skills. Less time spent teaching a student at the bedside would enable the registered nurse to focus on her other patients.

Registered nurses' rostered duties may not enhance the nurse-student relationship or ensure continuity in student learning as most registered nurses were unable to work with a student for more than a couple of days. This, they believed, slowed down the students' learning as each time the student changed registered nurses they had to re-establish themselves. A longer period of time with each registered nurse would ensure the student had the time to develop the skills associated with being a registered nurse. This would also enable the registered nurse to plan a learning programme for each student, supervise their learning over a longer period of time, and set achievable and realistic objectives for each students level of expertise. This would have the possibility of hastening the students understanding and application of theory to their practice. Students would begin to become part of the nursing and health team furthering their confidence and contribution to the delivery of nursing care to a group of patients (Gillingham, 1997). When students change registered nurses they are confronted with new philosophies and or nursing practices (Pateman, 1992).

A further constraint to the participants' clinical education role related to how having a student allocated to them for a duty disrupted their normal work pattern. When students are not in the ward registered nurses have usually developed a pattern to their work which becomes disrupted when they work

with a student. Their workload is increased because it is generally believed by the Charge Nurse, allocating the nurse-patient load, that there are two pair of hands to get through the work. With this increase in workload it is difficult for the nurse practitioner working with the student to achieve an acceptable level of student competence through support and guidance in their nursing practice.

Teaching a student was perceived as time consuming and hard work because the registered nurse not only had the role of educating the student but was often allocated the sickest patients and allocated one or two more patients. Generally the registered nurses were given a workload of six patients plus a student and found it was too much work for one registered nurse to cope with in a duty. Because of this the some of the registered nurses' believed that the student did not get an entirely fair deal and in many cases picked up a fair amount of their own learning. It is not acceptable for a patient to take second place because the registered nurse has to concentrate on the student's learning needs. Nor is it acceptable for students being responsible for their own learning in the clinical situation.

The registered nurses in the study recognised that they are slowed down when they work with a student. It is preferable that the registered nurse be given a few appropriate patients to care for. This would enable the student to learn from the registered nurse as they together carry out nursing cares. This would also give the registered nurse time to teach the student how to care for the patient effectively, and give the student the opportunity to learn without the anxiety of holding the registered nurse up whilst she explains things to them.

The clinical learning environment should positively influence the development of student attitudes, psychomotor skills, knowledge and clinical problem solving skills (Dunn & Hansford, 1997). The registered nurses working in the practice setting are the gatekeepers and guides to learning opportunities and a link between the educational and clinical environment (Dunn & Hansford,

1997). Registered nurses who work in practice settings in which students undertake clinical learning experiences should therefore be adequately prepared for this responsible role. However learning in the practice setting is dependent on a variety of factors, the clinical environment, the student attitude to learning, and the willingness of the registered nurses to work with students.

For registered nurses allocated students not only does their normal work pattern change but it may also affect their relationship with their colleagues. Participants of this study described the experience of registered nurses feeling negative towards students when they went on duty and found they had been allocated a student for the duty. This negative feeling stemmed from knowing they would have an increased workload for the duty, role conflict in the registered nurse-patient, registered nurse-student relationship, lack of preparation for the role plus the responsibility of ensuring the students were safe in their delivery of nursing care.

Wilson-Barnett, et al. (1995) believes that the atmosphere in the clinical area was very important in order for students to feel supported. When registered nurses work together and are motivated and satisfied, students in particular feel supported. Fowler (1996) believes that in order for the supervisory relationships to develop and work effectively in the areas of teaching, there needs to be adequate preparation of staff to ensure this. Registered nurses who are keen to provide good care, have positive attitudes to nursing and are also aware of their responsibility to students and to share their knowledge. In contrast when registered nurses are unhappy or feel overburdened students are seen as another 'rod' for their back and their negative attitudes provide a negative experience for the students. Therefore a new approach is needed if registered nurses are to obtain the skills to confidently and effectively help supervise and educate students.

Several participants discussed the need for the introduction of preceptor workshops to prepare registered nurses to become a 'buddy' to the students

would be a first step in professionally acknowledging the role they have previously been carrying out. They did not discuss what they believed the workshop should teach them. Marrow and Tatum (1994), write that supervisors would benefit from a more clearly defined role with respect to student supervision. This could be achieved through attendance at preceptor workshops, through registered nurses sharing their knowledge and own practice when supervising students, and their reflection on their current practice and its significance on student learning.

In the preceptor model, registered nurses working in the practice setting provide on-site supervision and clinical instruction for students. Students have the advantage of working with motivated, skilled clinicians with an adequate knowledge of the workplace policy and procedures. Myrick (1991), believes the use of preceptors for student teaching is fraught with inherent problems among them being the possible lack of teaching ability of the preceptor. A further constraint for the development of the preceptor model relates to the funding for the preparation and implementation of preceptorship models. In New Zealand financial support for the development of the preceptorship model would need to be negotiated between educational institutions and health agencies (Grealish & Carroll, 1998).

Support for registered nurse preceptors in the form of preparation for the role has been identified in the literature as essential in to the success of preceptor programmes. Dilbert and Goldenburg (1995) propose that preceptors are more likely to be committed to the preceptor role when there are worthwhile benefits, rewards and supports. Important components of preceptor training include teaching/learning strategies, principles of adult education, communication skills, values and role clarification, assessment of individual learning needs and evaluating students' performance (Dilbert & Goldenburg, 1995). Motivation is identified by participants as the most important attribute required to be a good preceptor for a student. The motivation of preceptors is often assumed to result from increased intellectual stimulation and

responsibility which are believed to be reward enough in themselves. However, the problems of trying to fulfill two roles at once, teacher and practitioner, have been identified as problematic and many practitioners believe that is neither fair nor practical to offer the preceptor no tangible reward for fulfilling the preceptor role (Burke, 1994).

If the criteria used to select the preceptors is not clearly explained, it leaves open the question of how standards will be maintained as unsuitable people may be selected as preceptors on the basis of their clinical experience. A good preceptor needs to be motivated, have good communication skills, be approachable, and be able to demonstrate good nursing care. Some registered nurses have a problem of sharing knowledge. For some precepting is perceived as being time wasting as they could be looking after their sick patients instead of taking time to explain things to a student. Therefore selection and preparation for the role of preceptor should ensure the right registered nurse undertake the role.

The development of the preceptor role for registered nurses, some feel, would enable them to understand how to become an effective clinical educator when working with students. Inviting registered nurse preceptors into the educational institutions to become familiar, through workshops, with the pre registration nursing curriculum, teaching strategies to promote student learning, developing a sense of belonging, would help create a bridge between education and practice. However this alone will not change the fact that the responsibility for students' clinical education is not accepted by either the C.H.E or the educational institutions. Nor would it help make clear who currently has primary responsibility for clinical education in the practice setting.

Continuing to teaching students under the present system is not acceptable to the participants. Their perceptions were that if they were to be the clinical educators then they needed to be adequately prepared for undertaking this role with both the educational institutes and the C.H.E., ensuring workshops

were made available within working hours for those registered nurses interested. Participation should be voluntary and not put upon them by their Charge Nurse. They believed that not all registered nurses were necessarily good teachers or role models, and for a student to work with a registered nurse not interested in their educational development may prevent the student from learning from that particular setting.

Instead of the registered nurses role of clinical educator being ad hoc as at present it should be professionally recognised by the service managers and the educational agencies. This professional development offered to preceptors could be reflected in nurses' career pathways, a position the registered nurse applies for as a clinical educator for students.

Good communication between the educational institution and the health care agency was perceived as being of central importance by the participants. Communication skills on the part of the nurse lecturer were described as being an important factor in establishing the trust of the nurse lecturers and the registered nurses' willingness to work with students. Communication between the registered nurse, student, and nurse lecturer was identified as being important for all concerned in managing any issues or problems identified, understanding the clinical education role of both the registered nurse and nurse lecturer, and ensuring the student maximises all learning opportunities.

The participants identified several ways in which they believed communication could be improved. These included discussion of students' learning outcomes, an understanding of the nursing curriculum, nurse lecturers making themselves known to the registered nurses, open communication which encourages questions for clarification, feedback for the registered nurses relating to their teaching performance, and dealing with problems and disputes which may arise.

Participants identified problems communicating with the nursing lecturers. They described the need for time to be spent by the nurse lecturers in discussing with them students progress, the strengths and weaknesses of students and how to manage their education role particularly in the area of the students' clinical assessments. Nurse lecturers were perceived as 'popping in' to talk with students. The registered nurses wished to be included in discussions with students about their progress during their time in the practice setting. Several participants saw the lecturers role as being solely a support person for the student, with little liaising with the registered nurses actually working with the student.

Some study participants believed the nurse lecturers should be available to assist them to develop their own skills of clinical teaching and supervision. This they believed would help them increase their confidence and direct them how to manage an increased workload, acutely ill patients while supervising students learning and development of nursing skills. Carlisle, Kirk & Luker (1997), wrote that debate to whether nurse lecturers should act as support for clinical staff in their clinical teaching role has extended over a number of years. It would appear from this study that the registered nurses would welcome support and encouragement from nurse lecturers. It would appear from this study participants were comfortable in their clinical practice but believe academic support from lecturers would enable them to more confidently continue with this role. It is however questionable as to how much time realistically a nurse lecturer can spend in each practice area they visit, liaising with the registered nurses. The area of relationships with registered nurses in the practice area and nurse lecturers warrants further inquiry, both from the practice area and the educational sector.

From the participants perspective there was a general consensus that the role of the nurse lecturer need not entail the actual delivery of patient care. This related to several perceived barriers such as patient privacy, disruption of the nurse-client relationship, and nurse-student relationship and the issue of the

nurse lecturers clinical competency. They saw the nurse lecturer in the role of a 'visitor' or a liaison person in the ward rather than as a participant in the students' clinical learning. As Clifford, (1993), writes this it is perhaps from this perspective that the term 'guest in the ward' was coined by Jones (1985). The term 'liaison' also noted by Jones (1985), conjures up an image of a 'go between'. 'Visit' and 'liaison' however are not mutually exclusive, for a short visit can do much to help in the liaison role. Nurse lecturers may be seeing themselves however, as a bridge between education and practice working to build a relationship that will facilitate student learning.

When nurse lecturers visited the practice areas they did appear to be supporting the student during their brief visits by checking for any problems the student might be experiencing, and to check they had completed their objectives. Two participants described specifically asking the nurse lecturer to come into their practice area to help sort out problems associated with a student causing them some concern relating to safety to practice and a poor attitude. Together they were able to supervise the student carefully but the registered nurses believed better communication between themselves and the nurse lecturer would have surfaced the problem student sooner.

The role of the nurse lecturers and their links with the practice areas was discussed by all participants. Their reactions were divided about their expectations of the clinical education role they perceived belonged to the nurse lecturer to have. One participant believed quite strongly that nurse lecturers were failing in the role of clinical education for students, as it appeared that students picked up their own learning within a very busy and sometimes unsupportive practice area. Some participants felt that when registered nurses were too busy to work with students they should be able to expect that a nurse lecturer would come into the ward and become the clinical educator for the student. In this situation the nurse lecturer would only have a role in students' learning when the registered nurse is busy. This raises issues relating to the clinical practice skills of lecturers, how current can their practice

be, and whether the lecturers feel competent to give safe nursing care within the boundaries of all the technical equipment required for that care.

As nursing programmes have evolved in the educational institutions nurse lecturers have had to make their first priority their classroom teaching yet are still expected to be able to teach students in the practice setting without actually practicing. The decrease in the nurse lecturers' clinical practice time has led somewhat to a reduction in their clinical competence. Cave (1994) argues, that essentially this is due to nurse lecturers being too far removed from practice. This has caused an artificial division between theory and practice and has led to the deskilling for some nurse lecturers. This deskilling has been aggravated by the number of specialist areas in which nurse lecturers are required to supervise students, and the question of whether they are, or can be, clinically competent and credible in all those areas (Booth, 1997). This leads to the question as to whether nurse lecturers can teach effectively in the practice setting. The registered nurse working in the clinical area is accustomed to remaining in one setting or one type of setting whilst the nurse lecturer must move through a number of settings and perhaps never achieve a high degree of comfort in any of them (Infante, 1986).

It is important to consider whether the nurse lecturer should teach and supervise students in the practice setting. It is clear from the perceptions of the study participants that most nurse lecturers are currently undertaking a clinical liaison role not a clinical teaching role (Lee, 1996). However from recent studies by Jeffree (1991), Grotty (1993a), Clifford (1993b) it appears that the nature of a nurse lecturer's liaison role is also problematic. It is ill defined and open to different interpretations. Most importantly, the studies have drawn attention to the issue of why many nurse lecturers do not regard teaching and working with students as part of their role in the practice setting (Lee, 1996).

Issues related to the time spent by nurse lecturers in the practice setting, both in terms of their clinical proficiency, supportive role for students, and their relevance to student learning, appear to be causing considerable concern for the registered nurses participating in this study. The point at which nurse lecturers cease to be active and effective in clinical work needs further exploration. As Clifford (1994), observes registered nurses enter the field of education as expert clinicians, yet their role as a nurse lecturer in education does little to further develop their clinical expertise, leading to a progressive distancing from the practice area.

Participants described the need for students to enter the practice area able to perform clinical skills. A common statement by the participants was their ward was a specialised area. Many practice areas have a high acuity level, sometimes a high technical requirement, which means registered nurses do not always have time to teach basic nursing skills. They did not believe they should be required to teach these. In their view students should enter the practice setting with sufficient nursing skills to enable them to perform beginning level nursing practice. This was perceived as the educational institute responsibility to ensure students could perform at this level with minimal supervision.

Clinical skills preparation for practice should be taught, practiced, and assessed in the skills laboratory before students enter the practice setting. This may require departments of nursing valuing skills acquisition and developing simulated situations relevant to the practice areas students enter. However, in the current era of economic reforms and financial constraints the cost of the students use of materials in the skills laboratory are a part of the cost of pre nursing programmes. Nurse lecturers are aware that students' spending more time in the skills laboratory has the potential to increase student fees, which in itself is a contentious issue for lecturers and students.

As Neary (1997) argues, it is often forgotten that students are not registered nurses, but in the process of learning to be registered nurses. Students find it difficult enough entering each new practice setting without the added stress of not being able to perform basic nursing skills. It is apparent there needs to be a much closer liaison between the nurse lecturer and the registered nurse to ensure that clinical skills are integrated within the classroom content relevant to each year of the nursing programme in order for the student to be well prepared for working in the practice setting. The student role of supernumerary learner also needs to be clarified, as at present, students are often seen to be a useful pair of hands when the registered nurses are very busy. This means the student is often caught between the work ethic and wanting to be integrated into the ward team, and the educational philosophy of the school with emphasis on making sense of theoretical knowledge in the clinical area.

Students are arriving in the wards without their learning objectives written. This was perceived as part of the educational institutes responsibility to ensure students were adequately prepared to practice in the clinical area. Nurse lecturers were seen as having the responsibility to ensure students are able to set their learning objectives in order to achieve the required level of competence required to successfully complete the pre registration programme. Corkhill (1998) maintains that students fulfilling learning objectives during their clinical practice can be difficult when the registered nurses in the practice setting have different objectives from those outlined by the educational institutions. Ideally the supernumerary status of the student should enable them to take advantage of learning opportunities available which may differ from their pre written objectives. The effectiveness of the practice setting as a learning environment is dependent not only on the skills of the registered nurse but also the interpretation of professional practice presented to the student.

At the core of the debate is the question of responsibility for teaching of clinical skills, which are necessarily part of competency within the nursing profession. It appears from this study that this responsibility has not been fully accepted by either the educational institutes or by the C.H.E.'s who have a contractual agreement to make available clinical placements. Within this contractual agreement there is a cost involved whereby the educational institutes pay for student access to each C.H.E. The acquisition of both academic and clinical skills hold equal importance in the preparation of the competent practitioner (Carlisle et al, 1997).

Unfortunately the role of supervising students' clinical learning, as described by the study participants, appears to have been imposed upon them without any consultation with the nurse lecturers or hospital managers. For some registered nurses supervising students has become a contractual duty and not a professional commitment to prepare students to enter the workforce as registered nurses. Registered nurses choosing to supervise students do so with a different perspective on the educational process of educating students, in order to prepare a good quality professional nurse at the end of their programme. Certainly the participants in this study were very aware that in some cases the heavy workload of registered nurses meant they had less time and less desire to support students.

Participants appeared to view their clinical education role as part of their registered nurses role and the majority gained some satisfaction from teaching students. However, if the health care funding difficulties continue, and staffing levels continue to fall, the work and teaching demands on registered nurses will increase. This could possibly lead to a decrease in the value placed upon teaching and the development of resentment to the added burden of teaching students (Grealish & Carroll, 1998).

Whilst the education of students remains the major responsibility of the educational institutes, the registered nurses working in the practice setting do

have considerable input into that education. As the role of the registered nurse in the clinical education of students seems to be taken for granted, and the role of the nurse lecturer is unclear, current preparation for the clinical education role is unsatisfactory. Formal boundaries and clear responsibilities and accountabilities for the registered nurse and nurse lecturer roles in clinical education urgently need to be developed.

Implications for nursing

The restructuring which has taken place throughout New Zealand society over the last decade is affecting nursing practice and nursing education in significant ways. On the one hand it is offering new opportunities for nursing to promote autonomous practice, but on the other hand it is exerting increased pressure for nursing to provide a service which is effective and efficient in economic terms (Boyle, 1994).

The required clinical component of nursing education is expensive in terms of the large number of teaching hours required. As funding decreases, nursing lecturers are being challenged to 'do more with less'. One of the greatest challenges for New Zealand departments of nursing in the next decade will be the adequate funding of clinical education programmes (Grealish & Carroll 1998).

Today's rapidly changing health care environment has necessitated many changes in the role of the registered nurse and conflict arises between economic efficiency and nursing's commitment to maximise the quality of students clinical education. Teaching by registered nurses in the practice setting raises questions about the integration of practice with theory and the values being taught during clinical experience. In the past it has not been until the student graduated that the employer became the 'moderator of the role of the registered nurse' (Porter-O'Grady, 1997).

Staff shortages, casualisation of the workforce, and lack of resources means learning for the student in the practice setting is not always appropriate. This may require the educational curriculum to increase the students time in their experiential learning in order to gain knowledge and confidence in performing nursing care. In the classroom the student is unencumbered by real crisis, students can synthesise their knowledge, be questioned about how they would proceed, and be asked to explain their rationale (Grealish & Carroll, 1998). Patient care can be explored in the context of various organisational, ethical, and emotional aspects. And students can help one and other to seek answers, examine alternatives, and project outcomes, thus enhancing their professional practice. Students would be taught methods to encourage and enable them to transfer knowledge to the practice setting (Packer, 1994). This would ensure students could perform nursing skills. The task of the nurse lecturers' in experiential learning is to teach the essential nursing skills and to prepare the student to recognise when being confronted with new and bewildering nursing procedures (Wharton, 1985). This would reduce the need for the registered nurse taking time out the already increased workload care to teach basic nursing skills to students.

Duxbury (1995), believes registered nurses in the practice setting need knowledge and the ability to put knowledge into practice. Participants discussed how their lack of preparation to undertake the role of clinical education hindered their ability to fulfill the role and therefore support student learning. This perception is supported by Wilson-Barnett et al. (1995), who believe support, teaching and assessment are all important facets of the supervision role by registered nurses.

In the present climate of nursing practice and nursing education, both the registered nurse and nurse lecturers role in clinical education is erratic, problematic, ill defined and open to interpretations. Following the transfer of nursing education into educational institutions little preparation was given to registered nurses in the practice area regarding their clinical education role.

Over time registered nurses have interpreted the role as they perceive it to be, either from their own experience as a nursing student, from discussions with nurse lecturers, or as guided by their Charge Nurse. While registered nurses in the practice area are able to identify the characteristics of the clinical education role they were not able to clearly define that role.

This study shows that there is confusion within the practice setting about the role of the registered nurse and nurse lecturer in the clinical education of student's. This reflects the confusion already demonstrated in the literature. Most importantly, the study has demonstrated the need to clearly define and attribute the clinical education role.

Service providers and education need to accept some responsibility for developing a clinical education role that benefits both the registered nurse and nurse lecturer, as well as focusing on the student learning needs, and the patients nursing care needs. This will require a long overdue major overhaul of the present system. Tinkering will not improve the situation but it may temporarily solve the fundamental problems caused by the lack of clarity about the role of the registered nurse and the role of the nurse lecturer.

Summary

This study demonstrated that the clinical education role as perceived by registered nurses working in the practice setting, is unclear and poorly defined. As a consequence it is being created by registered nurses and nurse lecturers in an ad hoc manner that compromises patient care and student learning.

The conflicting demands of the nurse lecturers role in the classroom and nurse practitioners in the clinical area are such that it is easy to get immersed in the day to day provision of service and fail to respond proactively to the many changes that will shape the future. It is crucial for nurse lecturers, nurse practitioners, and those involved in developing professional and organisational guidelines for teaching practice to undertake a review of the management of the clinical work of nurse lecturers and nurse practitioners in the future.

Chapter 11

CONCLUSION

The collection of data for this study began out in 1997 and concluded in 1998. This study aimed to determine the characteristics of the clinical education role as perceived by registered nurses working in the practice setting. To achieve this a qualitative, descriptive, and exploratory method was used in the study to gather the data. Ten registered nurses with a minimum of two years post registration nursing experience, working in the acute medical and surgical wards were interviewed using semi-structured interviews. The analysis of the data revealed five common themes emerged describing the characteristics of the clinical education role.

Embedded within the five characteristics are the issues and tension surrounding the clinical education role for the participants. Communication and workload issues combined with the lack of a clearly defined clinical education role mitigate against optimum patient care and student learning.

The health care system within which registered nurses practice and student nurses gain their clinical experience, has also changed and continues to change. Health care cut backs, higher acuity levels of patients, casualisation of nursing staff, and rapid discharge of patients have led to a change in the registered nurses work pattern as they strive to give a high quality of nursing care to often very sick patients.

Along the way, delivery of nursing programmes have also changed. This has resulted in staff cut-backs both within the practice settings but also in the educational institutions. For nurses working in the practice setting their focus remains clinically-based and relating to their patients. Nursing lecturers on the other hand have to divide their time between teaching in the classroom and supervising students in the practice setting. With increased classroom commitments lecturers are less and less able to spend great lengths of time in the practice setting. The challenge currently facing lecturers is to find ways of

working with registered nurses in the practice setting, to share each other's knowledge and expertise as each group works towards ensuring student learning and patient care remains a high priority.

There is a need to create new models of clinical education for nursing students, which will keep pace with the continuing financial constraints and changing hospital environment. This may entail departments of nursing developing simulation in the clinical laboratory to expose students to the complexity of nursing skills, and to develop their nursing expertise in the perceived 'basic nursing skills'. It is obvious from this study student nurses need to be better prepared before they enter the clinical areas. This may require departments of nursing to re-focus the time students spend in skills laboratories and ensuring the learning is relevant and current to the practice areas they enter. It must be remembered though that it is not possible to teach all nursing skills in this environment.

As a degree of competition for clinical placements already exists. Traditional boundaries between the clinical work of junior doctors and nurses are also being redrawn in public hospitals providing clear pressures for increased registered nurse contribution within the health team. The implication of this is registered nurses will begin to have less time to supervise students within the present ad hoc system currently being used between education and practice. How much longer will it be realistic in the future for nurses in the practice setting, employed by a C.H.E to be afforded the time to give to the teaching of nursing students. Nurses within the new market-led health service may not continue to see the educational of students as a justifiable priority or responsibility.

Without a clear definition of the clinical education role and its associated responsibilities and accountabilities registered nurses and nurse lecturers have pragmatically developed and accommodated individual interpretations of the role which takes into account the issues at the moment. While this solution

solves day to day operational problems it ultimately results in more confusion which in its turn is responded to by a new pragmatic and ad hoc solution.

This approach needs to be curtailed. Good clinical education should be seen as an enabling relationship between nurses whereby a nurse practitioner and nurse lecturer is accountable to the students to help them to practice to the best of their ability. Clinical supervision should be facilitative and empowering for both the registered nurse and the student, set within a framework of accountability for both groups. Further New Zealand strategies need to be explored and developed. Most importantly current problems need to be urgently addressed by educational institutions and health sector agencies to ensure patients receive optimum care and students the optimum learning experience.

Limitations of this study

This study was carried out in one C.H.E and the results from the study relate to the registered nurses within this C.H.E. The small scale and nature of this study prevents the findings being generalised. It is acknowledged that nursing students also enter private medical and surgical hospitals for their clinical experience. A further study could include the registered nurses working within these hospitals as they also supervise students in their clinical practice.

APPENDIX 1



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**FACULTY OF
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**DEPARTMENT OF
NURSING AND
MIDWIFERY**

The Characteristics Of The Clinical Teaching Role As Perceived By Registered Nurses Working In A Practice Setting

INFORMATION SHEET

Thank you for your interest in the proposed research which aims to identify and describe the characteristics of the clinical teaching role as perceived by registered nurses working in the practice setting. My name is Stephenie Orchard and I am doing this research for my Masters Degree at Massey University. As well as studying at Massey University I am also a Registered General and Obstetric Nurse and I am currently involved in teaching in the degree programme at Wellington Polytechnic. Charmaine Hamilton senior lecturer in the department of Nursing and Midwifery at Massey University is my thesis supervisor.

Research has focused the student and nurse educators perceptions of the clinical teaching role. As yet there does not appear to be any research on the registered nurse perspective of the clinical education role in the practice setting. Your participation in this study will contribute to our knowledge of clinical education from a practitioners perspective.

The objectives for this research are to:

- identify and describe the characteristics of the clinical education role as perceived by registered nurses working in the practice setting.
- describe the advantages and disadvantages of the present system of clinical education as perceived registered nurses working in the practice setting.
- identify who registered nurses believe fulfill the clinical education role at the present time.
- ascertain who registered nurses believe should be responsible for clinical education.
- determine who the registered nurse practitioners believe the preferred clinical educator is in the practice setting.

If you are interested in participating, you will be invited to a meeting with the researcher to ask any further questions you may have about your participation in the study. As well, you will be asked to sign a consent form if you wish to

take part in the study. You will be involved in two interviews, each lasting about 60 minutes. The time and place will be at your convenience. Each interview will be audio taped, with your permission, and the transcript will be given to you to verify that the statements are an accurate reflection of what you said.

If you decide to take part in this study you have the right to withdraw from the study at any time during the research. You also have the right to refuse to answer any particular question. Anonymity will be adhered to in the write up of the thesis and any publications arising from this. You will be allotted a pseudonym name that only you and I will know. This is to protect your identity. As each transcript will need to be typed up by a professional typist. That person will be required to sign a confidentiality agreement.

The information gathered is to be used to further nurses knowledge of the clinical education. The findings will be used for my Massey University thesis, conference presentations, publications in nursing journals, and in nurse education. A summary of the findings will be given to you when the thesis has been written.

Please do not hesitate to phone me for more information.

If you wish to be part of this study please contact me at the following address:

Stephenie Orchard
Department of Nursing, Wellington Polytechnic
Phone (04) 801 2794 ext. 8757
Fax 801 2796
Home Telephone Number 4793 916

If you wish to contact my supervisor Charmaine Hamilton regarding this research, you can contact her at the following address:

Charmaine Hamilton
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APPENDIX 2

The Characteristics Of The Clinical Teaching Role As Perceived By Registered Nurses Working In A Practice Setting

CONSENT FORM

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I understand I have the right to withdraw from the study at any time and to decline to answer any particular questions.

I agree to provide information to the researcher on the understanding that my name will not be used without my permission. (*The information will be used only for this research and publications arising from this project*).

I agree to the interview being audio taped. I also understand that I have the right to ask for the audio tape to be turned off at any time during the interview.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signed:

Name:

Date:



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APPENDIX 3

The Characteristics Of The Clinical Teaching Role As Perceived By Registered Nurses Working In A Practice Setting

Confidentiality Agreement (Typist)

I agree that the tapes I am to transcribe contain confidential information.

I agree to maintain confidentiality by not disclosing any aspects of the tapes or typed transcripts with any other person, apart from the researcher for the sole purpose of clarifying content.

No other person will have access to the tapes or typed transcripts while they are in my care.

Tapes, transcripts and the computer disc will be returned to the researcher as soon as they are finished with

Signed:

Name:

Date:

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