Clinical Facilitation in Nursing:

Does it meet re-entry and refresher students' expectations?

Ms Helen Hughes, BNg

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Faculty of Medicine, Nursing and Health Sciences

Flinders University of South Australia

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SUMMARY

The aim of this study was to explore how effectively three models of clinical facilitation used to support students undertaking either a Re-entry or Refresher nursing program met their expectations. Re-entry (RE) and Refresher (RF) nursing programs are intended to prepare currently, or previously registered nurses to return to practice, and have been conducted by two teaching hospitals in South Australia since 2001. The three clinical support models used are 1) the Program Clinical Facilitator – Primary Hospital model, 2) the Program Clinical Facilitator – Off site model, and 3) the Local Facilitator – Remote Hospital model. The model used for each student is determined only by their clinical placement location.

Examining the appropriateness of using clinical facilitation as a model to support RE/RF students is valuable for four reasons. First and foremost, using a clinical placement support model designed for undergraduate nursing students, for either qualified, or previously qualified nurses' needs to be questioned. Secondly, whilst RF programs are not regulated per se as students are registered nurses, RE students are no longer registered, and therefore programs require accreditation by appropriate regulatory bodies. This distinction is important in the context of role responsibilities for clinical support and assessments, and for emphasising the importance of quality assurance processes in monitoring assessment of competence. Thirdly, in times of economic and fiscal restraint it is valuable to explore the validity of using a clinical support model, which some argue, is not economically sustainable (Mannix et al. 2006; Sanderson & Lea 2012), and exhibits major flawes (Andrews & Ford 2013). Lastly, and in support of the former points, the RE/RF student is considered a valuable human resource in times of workforce shortages (Durand & Randhawa 2002; National Nursing and Nursing Education Taskforce 2005; Asselin, Osterman & Cullen 2006; Elwin 2007; Long & West 2007; McMurtrie et al. 2014), thereby justifying research into this student cohort and development of a broader, and deeper understanding of concepts related to RE/RF students, in particular their clinical learning needs and support preferences.

In this exploratory study, a three stage qualitative interpretative approach was used to maximise both the richness of the data, and capture the diverse expectations and experiences of the clinical support students expected and received. A purposive sampling method was used to recruit study participants. A short demographic questionnaire and three focus groups were used to collect data. Two focus groups were conducted with students enrolled in a RE/RF program delivered in 2011. Focus group one explored students' expectations of the support they anticipate needing from the clinical facilitator, and focus group two reflected on how their experience matched their expectations. A third focus group explored the concepts raised by the student participants with clinical facilitators who provide support to RE/RF students while on placement. Data from all three focus groups was examined using a three stage thematic analysis approach. Analysis

indicated RE/RF students expected the clinical facilitator role may include activities grouped into four themes: a) guide their learning; b) facilitate clinical assimilation; c) provide advocacy and; 4) support. Focus group two and three reviewed these themes and identified whether students' expectations were met.

This study's finding highlighted four main points and provides direction for further research. Firstly the finding suggests RE/RF students were self-directed in achieving their learning and relied less than they expected on the clinical facilitator for their learning. Secondly, RE/RF students expected the clinical facilitator would play a role in their clinical assimilation and role transition; however, this was not the case for all students, particularly at satellite hospitals. Thirdly, the expectation that clinical facilitators would advocate on their behalf, both as an individual and learner was also not met in every situation. And Lastly, RE/RF students' expectations and needs being met were influenced by availability and accessibility of the clinical facilitator. Given these findings, and in recognition of the need to support the reintegration of RE/RF students into the workforce, further research exploring this student cohorts' learning needs and support preferences would seem appropriate.

Declaration

"I certify that this thesis does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by a person except where due reference is made in the text"

Helen Louise Hughes

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ABBREVIATIONS AND GLOSSARY

Definitions provided in the following glossary are not intended to be the definitive meaning of the term. The intention is to clarify and contextualise terms which are often ambiguous or modified to suit individual contexts. The definitions provided below are a lexicon of terms used in the context of the Re-entry and Refresher Program discussed in this thesis.

Clinical Facilitator (CF): The definition of Clinical Facilitator varies. In the context of the Re-entry/Refresher programs in this study, the clinical facilitator may be known as the Program Clinical Facilitator, or the Local Facilitator. A clinical facilitator is a registered nurse who is appointed to support Re-entry/Refresher students during their clinical placement. It is important to emphasis the role of the clinical facilitator varies according to student need, model of clinical facilitation used, and clinical setting. The CF may be required to provide support through debriefing, assist with student learning, or provide clinical support and/or information to clinical staff regarding the program and assessment processes.

Clinical Placement: The component of a health professional's education that is undertaken in the clinical setting. In this study, the Re-entry/ Refresher Programs clinical placement may be undertaken in a variety of venues including metropolitan or country hospitals, private hospitals, or aged care facilities.

Clinical Privileges: The Executive Director of Nursing of a health service is accountable for the standard of care delivered to patients in their health service. After meeting an organisation's set criteria, 'Clinical Privileges' are granted to Clinical Facilitators, not employed by the health service. These privileges give Clinical Facilitators the authority to support and supervise students in the clinical setting of the health service.

Clinical Supervisor (CS): In this study, the title "Clinical Supervisor" will be used to identify the registered nurse (RN) who is working directly with the student in the clinical setting. This term is interchangeable with that of "buddy", "allocated RN", "supervising RN" and "preceptor". Their role is to supervise, direct, assess, support and provide feedback to the student during the allocated shifts, while the student plans and delivers care to patients. This RN is also directly accountable for the care delivered to the patient/patients being cared for by the student under their supervision.

Local Facilitator (LF): 'Local Facilitator' is the title given to the RN, employed by and nominated by the health service to take responsibility for supporting Re-entry/Refresher students during their clinical placement. This RN is not program staff, but is nominated by the health service to take responsibility for supporting Re-entry/Refresher students during their clinical placement. The local facilitators are members of the local clinical staff and are nominated for the role by the local nursing management, without input from the Re-entry/Refresher program staff and are generally not supernumerary. As with the Clinical Facilitator, the role of the Local Facilitator varies according to the clinical setting. The Local

Facilitator is responsible for providing support to the RE/RF student (both academically and psychologically) and for assisting other clinical staff working with the student. They may or may not be responsible for either participating in, or taking complete responsibility for, assessing the competency of the RE student against the National competency standards for the registered nurse.

Local Facilitator - Remote Hospital (LF-RH): The term 'Local Facilitator – Remote Hospital' refers to the facilitator used to support students undertaking clinical placement at alternative health sites which are not affiliated with the primary hospital. This may include private or non-government facilities or, country health services. Students undertaking clinical placement in any of these health services are supported by a local facilitator remote to the program's primary hospital (LF-RH).

Preceptor: The definition of 'Preceptor' varies. It may be used by some individuals to identify the "clinical supervisor", "buddy", "allocated RN", or "supervising RN" who works with, and, supervises the Re-entry/ Refresher student. In this thesis 'preceptor' will be used to describe a designated person from the ward who is responsible for supporting the student throughout their placement on the ward.

Primary Hospital (PH): The 'Primary Hospital' is the site that delivers the Re-entry/Refresher program. Students attend workshops and may undertake clinical placements at this site. Both the Program Coordinator and Program Clinical Facilitator are based at the primary hospital.

Program Coordinator: The 'Program Coordinator' is the Nurse Educator responsible for all aspects of the Re-entry/Refresher Program development, evaluation and delivery. Their role includes curriculum development and review, administrative and management tasks, teaching, assessment of academic activities, and, supporting and guiding Clinical Facilitators and Local Facilitators in their role. Whilst they are not directly involved in the supervision of students in the clinical setting, they are responsible for the planning and provision of supervision, and/or remediation, or additional clinical support as required.

Program Clinical Facilitator (PCF): The 'Program Clinical Facilitator' is an RN employed by the health service delivering the Re-entry/Refresher Programs. Their role is to provide clinical facilitation (as defined above) to student undertaking clinical placement in the primary hospital as well as other hospitals affiliated with the primary hospital.

Program Clinical Facilitator – Primary Hospital (PCF- PH): The term 'Program Clinical Facilitator – Primary Hospital' refers to the model used to support students undertaking clinical placement in the primary hospital. This role is performed by the Program Clinical Facilitator.

Program Clinical Facilitator – Satellite Site (PCF-SS): The term 'Program Clinical Facilitator – Satellite Site refers to the model used to support students undertaking clinical

placement at alternative health sites but which are affiliated with the primary hospital. This role is performed by the Program Clinical Facilitator employed by the primary hospital and is supernumerary.

Remote Hospital: In this thesis the term remote hospital is used to identify a hospital or health service that is not affiliated with the primary hospital. This may include private or non-government facilities or, country health services. Students undertaking clinical placement in any of these health services are supported by a local facilitator (LF).

RN Refresher Nursing Student (RF NS): A refresher nursing student is a person who is registered with the Nursing and Midwifery Board of Australia as a registered nurse. The individual undertakes the RN Refresher Program to develop a level of competency that will enable them to seek employment in their selected area of contemporary practice (Callaghan et al. 2009; SA Health 2014 p 187).

RN Refresher Program (RF): A RN Refresher Program is a program delivered to currently registered nurses wishing to return to work after a break, or up-skill and move to either the acute or aged care sectors. The refresher program discussed in this thesis is delivered over 14 weeks (SA Health 2013b).

RN Re-entry Nursing Student (RE NS): A re-entry nursing student is and individual who previously held registrations as a nurse, and who undertakes the RN Re-entry Program to develop a level of competence that will enable them to again meet the registration requirements of the Nursing and Midwifery Board of Australia (SA Health 2013a).

RN Re-entry Program (RE): An RN Re-entry program is an accredited program delivered to individuals who have been previously registered as nurses, and who wish to gain reinstatement to the register with the Nursing and Midwifery Board of Australia. The re-entry program discussed in this thesis is delivered over 19 weeks (SA Health 2013a).

Satellite Hospital: In this thesis the term ‘satellite hospital’ is used to identify a hospital that is affiliated with the primary hospital under the governance of the same local health network, but located at a different site. The context of this thesis there is one primary hospital and two satellite hospitals. The two satellite hospitals, are located five and eighteen kilometres from the primary hospital. RE/RF students attending clinical placement at either of these hospitals are supported by the program clinical facilitator (PCF-SS).

CHAPTER 1 – INTRODUCTION

In South Australia both Re-entry and Refresher programs are offered to individuals who are or have previously been registered as nurses, and who want to return to the workforce. The Registered Nurse Re-entry (RE) program provides a learning program for individuals previously registered as nurses to develop competencies that will enable them to meet the registration requirements of the Nursing and Midwifery Board of Australia (NMBA) (SA Health 2013a). The Registered Nurse Refresher (RF) program provides a learning program for currently registered nurses to develop competencies that will enable them to seek employment in their selected area of practice (SA Health 2013b). Both the refresher and re-entry programs run twice yearly, and whilst each program has specific practical, academic, and assessment requirements, these programs have been designed to be delivered concurrently with one student group. For literary convenience these programs will now be referred to as the RE/RF programs throughout this thesis.

In 2001 the South Australian Department for Health and Ageing (known as SA Health) commenced providing RE/RF programs to provide pathways for both registered and previously registered nurses to return to the workforce. With state government funding the twice yearly program, conducted in two major teaching hospitals continues to provide an entry point for up to 80 individuals to gain employment as registered nurses across a broad range of health settings. A close working relationship, and some shared administrative processes between the two program coordinators, ensures program content and delivery remains consistent, despite being managed independently by the relevant local health networks. These programs are now entering their 14th year of delivery.

The RE/RF programs consist of theoretical and practical (clinical placement) components. Program content and assessment is designed to suit the particular student cohort. RE programs are designed to provide individuals who were previously registered as nurses, with the opportunity to develop and collect evidence of competency which will facilitate their re-registration as a nurse. The RF program is a modified version of this program designed to assist currently registered nurses (therefore deemed to already meet the National Competency

Standards for the Registered Nurse) develop competency in the acute care setting.

Academic and clinical assessments are undertaken by both student groups. In the RE program assessment processes require the student, program and ward staff to evaluate if a student's knowledge, skills and attitudes meet the National Competency Standards for the Registered Nurse (SA Health 2013a). The RF program academic and clinical assessments are designed to allow students gain or refresh skills related to their specific clinical context. Assesements provide the RF student with evidence of their competency in these clinical skills and knowledge.

Academic activities undertaken by students during both programs are assessed by the program coordinator. RE students are required to complete more academic activities than RF students, to satisfy regulatory requirements related to the National Competency Standards for the Registered Nurse. Clinical performance, and therefore competency, is routinely assessed and documented by clinicians in the clinical placement setting not attatched to the program. Program staff have little, or no influence, at the local level as to who completes the assessment of clinical skills, however, it is expected that a senior member of the ward will complete the formative and summative assessment documents which provide evidence of competency as benchmarked against the National Competency Standards for the Registered Nurse. The clinical faciliator attached to the program, may if required, undertake assessment of activities if staff are unavailable to complete an assessment task, but this is in the manority of cases, and they are generally not involved in the summative or formative assessment of the RE student. An exception to this case may be in the facilitation model referred to as the Local Facilitator - Remote Hospital (LF-RH) model where the local facilitator may be the person responsible for all aspects of clinical support and assessment of either a RE or RF student.

All students are required to attend six days of workshops, and complete 150 hours of online learning modules. The distinction between the re-entry and refresher programs exists in the required number of academic activities undertaken and the duration of supernumerary clinical placements and reporting of successful program completion. The refresher students, who are still currently

registered, are required to complete 200 clinical hours and 13 academic activities. Re-entry students, whose registration has lapsed, are required to satisfactorily complete 300 clinical hours and 20 academic activities as benchmarked against the National Competency Standards for the Registered Nurse. Clinical placement occurs in one of the SA Health services, or non-government agencies or aged care facilities. Upon successful completion of the academic and clinical components of the program RF students are awarded a certificate of completion (non-graded pass) RE students who are assessed as competent at the completion of the program (as benchmarked against the National Competency Standards for the Registered Nurse) are required to submit evidence of competency to the Australian Health Practitioner Regulation Agency for consideration by the NMBA. This application for reinstatement to the register by the student is supported by accompanying evidence of competence which is provided to Australian Health Practitioner Regulation Agency by the RE program coordinator.

Evaluation of educational programs is an important component for ensuring quality assurance and improvement. All of the RE/RF students are asked to complete two online evaluations of their respective programs. The first evaluation is completed at the conclusion of the workshops, and prior to clinical placement. The second evaluation is undertaken upon completion of the full program. In recent years it has been noted that students frequently comment on the variability of clinical support offered to them during their clinical placement.

The RE/RF programs use clinical facilitation models to support students during their supernumerary clinical placements. Clinical facilitation in its varying forms is a contemporary model of clinical support used both nationally (Andrews & Ford 2013) and internationally (Rowan & Barber 2000) to support nursing students in the clinical setting. Providing a standard definition that accurately describes clinical facilitation is difficult, as it has been contextualised by education and health service providers to suit individual contexts. Variations in the application of clinical facilitation may include, but is not limited to, partnership arrangements between health services and education providers where the clinical facilitator supports students and preceptors (Sanderson & Lea 2012), employment arrangements or secondments (Sanderson & Lea 2012), or roles which require direct clinical supervision responsibilities (Andrews & Ford 2013).

Clinical facilitation as a model of supervising nursing students appears more easily defined by its principles than its application. Clinical facilitation can loosely be defined as a process by which an experienced registered nurse provides support to both nursing students and the clinical staff responsible for supervising the students during clinical placement (Sanderson & Lea 2012). Underpinning educational principles of clinical facilitation arose from work undertaken by Carl Rogers, whose model placed students at the centre of the learning experience (Cross 1996), and is founded on adult learning principles. There is a shared responsibility for student learning though a partnership between the clinical facilitator and clinical staff. Banning (2005) emphasises Gregory's (2002) concept that the facilitative method of teaching and learning "teases out previous learning and helps students 'make sense' of experience in relation to real world events" (Banning 2005 p 504). With this concept in mind it is easy to see the appeal of the concept of clinical facilitation as a model for nursing students.

The RE/RF programs at the centre of this thesis uses three different models of clinical facilitation to support students during clinical placement. Whilst it was the aim of this study to explore the experience of RE/RF students supported by both clinical and local facilitator within the context of all three models used in the RE/RF program, student placement arrangements prevented this. As no student was facilitated by a Local Facilitator during this study, data relating specifically to this model was not collected. Program staff made reference to LF model during focus group three thereby validating its inclusion in this thesis. For literary convenience and clarity the three models will be identified as

1. Program Clinical Facilitator – Primary Hospital (PCF-PH) model
2. Program Clinical Facilitator – Satellite Site (PCF-SS) model, and
3. Local Facilitator (LF) model.

Model one (PCF-PH) is used to support students undertaking their clinical placement in the primary hospital which delivers the RE/RF program. Model two (PCF-SS) is used to support students undertaking their clinical placement in clinical settings belonging to the same local health service as the primary hospital, but located at a different site. Model three (LF) is used to support students undertaking clinical placements in private, aged care or regional

facilities. The primary role of the clinical facilitators is to assist the student's socialisation to the clinical work place, foster a positive learning environment, undertake clinical teaching and assessment identify and manage underperformance, and liaise with program and clinical staff when supporting the student.

Whist all three models aim to support RE/RF students during their placement there are key differences in the models. In the first model, PCF-PH the role of clinical facilitator is undertaken by an RN employed by the primary hospital, with experience working in the clinical areas of the hospital. During the RE/RF students' clinical placement the role of the PCF-PH is supernumerary to the ward staff who are primarily responsible for providing bedside supervision to students. Additionally, the PCF participates in the delivery of workshops and study days with the program coordinator, prior to students' clinical placement. The second model, PCF-SS also involves facilitation by the PCF in a supernumerary role, but is delivered to students undertaking placement in satellite health care services affiliated with the primary hospital. In this thesis these hospitals will be referred to as satellite services. These hospitals/health services belong to the same local health network. In this arrangement the PCF-SS generally visits students weekly unless otherwise requested by staff or students. As a general rule, the PCF-SS does not take on a clinical teaching or supervising role as they are not located at the site. The clinical supervision and bedside teaching role is performed by the supervising RN commonly referred to as the preceptor. Depending on clinical placement allocation, the individual PCF may be responsible for up to 15 students across two to three sites, performing both the PCF-PH and PCF-SS roles concurrently.

Students on clinical placement outside of the local health network, in private or non-government facilities, or country health services are supported under the third model referred to as a Local Facilitator (LF). For the purpose of this thesis these hospitals and health services will be referred to as remote hospitals. The LF is a member of the local clinical staff and is nominated for the role by nursing management without input from the RE/RF program management. Unlike the PCF who is employed as a supernumerary support person by the program, the LF role is generally undertaken by an individual in addition to their usual clinical responsibilities and without supernumerary status. While it is expected that the

LF be an experienced senior registered nurse, no educational prerequisites or training is required for their appointment to the role. No formal training is provided to support the LF in this role, however, a brief role description document is provided (see Appendix 1). Principally, the student support role they are required to undertake is the same as the PCF. The LF may be responsible for one student from the RE/RF program, and concurrently may also have responsibility for learners in other programs. It is possible that apart from submission of written evidence of clinical performance, there may not be any communication between the LF and program staff prior to, or during, clinical placement unless there was a significant concern about the RE/RF student's performance.

Why choose this topic?

Quality clinical placement and student outcomes are reliant on effective relationships (Henderson, Heel & Twentyman 2007; Prideaux, Worley & Bligh 2007). At its most complex level, the student is at the centre of many relationships whilst undertaking clinical placement (Prideaux, Worley & Bligh 2007). The responsibility for supporting and assessing students is not 'black and white' and this is of particular importance in the context of the RE student, who whilst possibly skilled and knowledgeable is not registered. Today, undergraduate and RE/RF nursing students are a transient part of the clinical service, attending placement in a wide range of settings connected to the education providers, through memorandums of understanding or affiliation agreements rather than employer/employee responsibilities. At its simplest, this relationship is a triad between the student, the health service's clinical staff who support the student during their clinical placement, and the education provider's representative, the clinical facilitator. With the student at the centre of the relationship, this shared responsibility for a student's learning relies upon the effective collaboration and shared ownership of a student's learning by all members of the triad (Henderson, Heel & Twentyman 2007; Prideaux, Worley & Bligh 2007). Personal experience supervising and facilitating undergraduate students left me reflecting on the model of clinical facilitation and whether it fostered relationships in this triad to its maximum potential. When changing my role from clinical facilitator of undergraduate nursing students to program coordinator of the RE/RF program, natural progression led me to consider the

effectiveness of clinical facilitation in the context of the RE/RF student experience.

It is known that quality clinical learning is essential in enabling nursing students to graduate as competent professionals (Gabb & Keating 2005) and that quality clinical facilitation enriches clinical placements for nursing students (Andrews & Ford 2013). Banning (2005) explains that the educational strength of "facilitation" is that it allows the learner to take previous learning, such as the theory learnt in a classroom environment, and place it in the context of its practical application(Banning 2005 p 504). This allows the learner to make sense of what they do in the clinical setting. I have undertaken many educational support roles including nurse clinician responsible for supervising undergraduate, refresher and re-entry students, undergraduate nursing clinical facilitation and more recently RE/RF program coordinator. It is these experiences that have prompted my reflection on how we support our nursing students, and ways in which we may improve clinical placement support. In my role as program coordinator of the RE/RF programs I found myself questioning if the problems I experienced and observed as a clinical facilitator and preceptor of undergraduate nursing students could be expected with the RE/RF nursing students. I wondered what the experience of the RE/RF student was when supported by any of the three different models, and whether the broader educational concept of facilitation, of allowing students to make sense of prior learning in the context of the real world actually occurs. Furthermore, I wondered if the application of a primarily undergraduate support model served the needs of the unique group of qualified practitioners re-entering or refreshing their clinical skills.

From personal observation and in conversation with RE/RF program students I began to question the effectiveness of the application of the undergraduate clinical facilitation model, and recognised the potential variation in the quality of the clinical support provided as a result of clinical placement allocation and the different models of facilitation used. Anecdotally, students who undertook clinical placement in the PH and facilitated by the PCF generally felt better supported than their peers who were supported by either the PCF-SS or LF in other hospitals. This is understandable given the variations in the clinical facilitation models. Firstly, students in the primary hospital have access to their clinical facilitators five days a week, whilst those at either satellite or remote hospitals

are not guaranteed their level of access to their support person. Secondly, as a permanent member of the hospital staff, the PCF has the opportunity to develop strong relationships with the clinical staff who work with the students and ready access to the program coordinator. The benefits of this clinical facilitation model did not appear to be consistently afforded to students, especially those supported by the PCF-SS and LF models.

Whilst students supported by the PCF-SS at the affiliated hospitals had the advantage of a skilled, supernumerary facilitator, they appeared to lack some of the other benefits of the PCF-PH model, in particular facilitator availability, clinical teaching and supervision opportunities, and clinician-facilitator relationships. Due to facilitator-student ratios, rostering complexities and number of sites to be visited, unless specifically requested, visits to students in the PCF-SS model are generally limited to once weekly at pre-arranged times. These planned visits might be at the time when students were in need of support, or, may be inconvenient due to the dynamic nature of the clinical setting. Whilst students and clinical staff, could contact the PCF-SS and arrange meetings or additional support, this lack of accessibility and flexibility appeared less than ideal, particularly if there were performance concerns or interpersonal problems. Anecdotally, weekly visits were generally used for debriefing and discussing clinical competencies, and not for teaching or supervising. The lack of familiarity with the clinical areas, ward processes and routines, and clinical staff appears to discourage any opportunity for clinical teaching or supervision by the PCF-SS, with responsibility for this falling solely on ward staff regardless of clinical pressures. It also seemed apparent that the PCF-SS did not appear to interact with clinical staff at the same level as they did with staff at their own hospital.

Similarly, students attending clinical placement outside of the local health network, appeared to have be disadvantaged by the LF model also. The LF is provided by the clinical unit or hospital without financial remuneration from the RE/RF program. Unlike tertiary education sector - health service arrangements, the RE/RF program – health service arrangement is one of benevolence. Clinical units accept responsibility for accommodating the role of the LF within the context of their daily business without financial support. Given this structure, staff taking on the role of LF are at risk of being overburdened or under-prepared for their role, potentially reducing the quality of support provided to students.

This study aims to explore whether clinical facilitation models used to support students undertaking Re-entry or Refresher programs meets their expectations. In recognition of both the possible differences between the RE/RF student learning needs, and the identified differences in assessment and regulatory requirements it would have been ideal to have been able to compare and contrast between the student cohorts. However, due firstly to the infrequency of the program which is only held twice yearly, and secondly, to the small number of students which participate in either program this was not feasible. It was for these reasons it was decided to combine the RE/RF students into one study cohort.

As a practiced based profession, the opportunity to maximise learning in the clinical setting cannot be underestimated (Twentyman, Eaton & Henderson 2006; Henderson & Tyler 2011). The largest group of nursing students undertaking clinical placements are undergraduate nursing students. Whilst there is national (Mannix et al. 2006; Croxon & Maginnis 2009) and international research (Pollard et al. 2007; Williamson et al. 2011; Struksnes et al. 2012) exploring clinical support models for undergraduate nursing students they are not the only nursing students to attend clinical placement. How best to facilitate the learning of other non-undergraduate students currently receives little attention by researchers. Decisions on how best to facilitate the clinical learning of non-undergraduate nursing students appears to be made on assumptions of research of undergraduate nursing students' needs and experiences. Given the uniqueness of each individual student, student groups, and the complex nature of the clinical learning environment, the acceptance of a ubiquitous clinical support model may be inappropriate. With predicated workforce shortages (Franklin 2013), understanding the learning needs of the RE/RF nursing group will assist those developing curriculum and ensure appropriate models of support are developed.

Thesis Structure

This thesis is presented in six chapters. This chapter, chapter one, firstly introduced the topics of refresher/re-entry programs and the importance of clinical facilitation in these programs. Secondly, it detailed the current clinical facilitation models used to support RE/RF students in South Australia and, its evolution from a model commonly used for undergraduate nursing students. Thirdly, this chapter had positioned my interest in the topic, and lastly, justified the worth of researching the topic.

Chapter two will present a comprehensive literature review examining the current and relevant historical literature. The first section of the literature review examines the current and relevant historical literature discussing the re-entry or refresher students and associated programs. Section two discusses the evolution, and application of clinical facilitation models. The third and final section of the chapter highlights the gaps in the literature examining the clinical facilitation of the RE/RF student.

Chapter three provides details of the chosen methodological framework used for the study. It outlines the study design including participant recruitment and data collection, management and analysis. This chapter explains the two phase data analysis process used to examine the data, and discusses the process adopted to optimise the trustworthiness of the study.

The findings chapter, chapter four, presents my interpretation of the data in four themes, and relates the results back to the focus of the research, which is an understanding of the clinical facilitation expectations of RE/RF students. It also raises a secondary finding of possible influences on RE/RF students' expectation of the clinical facilitator during clinical placement.

Chapter five revisits the key findings of the study, discusses the implications which result from the findings of the study, and makes suggestions for further research related to the findings. Study limitations will also be examined, in particular, the associated implications and management of my multiple roles as RE/RF program coordinator, researcher, and focus group facilitator.

The sixth and final chapter draws the thesis to a close presenting concluding statements and recommendations for practice and future research.

Following the chapters are the appendices referred to throughout this thesis. These appendices include ethics documents, participant recruitment documents, demographic questionnaire, focus group questions and data analysis results.

CHAPTER 2: A REVIEW OF THE LITERATURE

Introduction

The purpose of this chapter is to examine the literature related to the support and supervision of the RE/RF student during clinical placement. Whilst there is a growing body of research examining support during clinical placement, including clinical facilitation of undergraduate nursing students, very little appears in the literature about the clinical support needs of the RE/RF student. Given the paucity of literature examining the RE/RF student in either the clinical setting, or their support requirements, the literature review has been broadened to consider more than just the support of the RE/RF student to provide a context of this unique cohort. For this reason the literature review is divided into three sections.

The first section of the literature review examines the current and relevant historical literature discussing re-entry or refresher nursing programs. This approach is then repeated in section two, for the review of the literature which examines the evolution, and application of clinical facilitation models. The third and final section of the chapter highlights the gaps in the literature examining the clinical facilitation of the RE/RF student and clarifies how this study contributes to increasing what is known on the topic of clinical support of the RE/RF student.

Re-entry and Refresher Search Strategies

The aim of this literature review is to consider the clinical facilitation model in the context of the RN RE/RF program student. Given the lack of consistency in terminology used in the literature when referring to the re-entry or refresher student and associated programs, a series of searches were performed in three phases. Phase one sought literature in the academic databases, phase two searched the internet, and phase three searched for secondary references identified from the literature located in phases one and two.

Phase one consisted of two steps. The first step used the selected primary search terms in combinations in recognised academic databases, while step two used the same search terms individually in the same databases. Phase two repeated the steps used and the search terms used for phase one, but included the use of the Google search engine. The aim of this second step was to locate grey literature examining re-entry and refresher nursing students or programs.

Phase three was performed after the literature obtained from phase one and two searches was reviewed. During this review, less common terms used to describe re-entry and refresher nursing students or programs, and secondary references, were identified and then sought to add to the literature for review.

Phase one, step one consisted of four targeted searches of the primary terms "re-entry nurse/program" or "refresher nurse/program" with "clinical facilitation" using academic resources. The searchers were performed using the FindIt@Flinders search engine (Flinders University 2014b).This search engine permits the search to retrieve literature from any of the universities library catalogue and online resources including databases, e-books, newspapers, hard copy books, conference proceedings and Flinders Academic Commons (Flinders University 2014b). This series of four searches resulted in the identification of 183 articles. Review of the abstracts indicated that only two articles were marginally related to the topic of re-entry and refresher students. One article examined the return of medical officers (Varjavand, Novack & Schindler 2012), while the other promoted a program returning nurses to age care (Mather & Marlow 2012). Both these articles were reviewed later with the other articles to identify alternative search terms and identify secondary references.

Phase one, step two, examined the search terms "re-entry" and "refresher" in combination with "nurse" and "program" without clinical facilitation within FindIt@Flinders search engine. From this search 62 items were found. These were either journal articles or dissertations. All these documents were reviewed for relevance and rated as either of primary relevance (n=24) or secondary relevance (n=38). The documents evaluated as of primary relevance were filed for inclusion in the literature review, while those rated as secondary relevance were used for gathering background information, but not included in the literature review.

Phase two repeated the steps used for phase one but this time using the Google search engine. The aim of this search strategy was to locate grey literature and identify alternative search terms to the key words already identified. Results from these searches found re-entry program brochures and information (for example see Deakin University 2013; Australian College of Nursing 2014), Australian federal and state government reports discussing re-entry for health professions

(Office of the Chief Health Professions Officer & Department of Health Perth 2008; Workforce Development & Leadership Branch NSW Health 2007), national regulatory nursing and midwifery organisation consultation papers (Australian Nursing and Midwifery Accreditation Council), and employment advertisements and workshops for clinical facilitators.

Phase three, the final stage of the literature search was undertaken during the review of literature sourced in phases one and two. This search strategy was used to locate additional secondary references as the reviewed literature produced valuable secondary references. Due to the confusion and ambiguity in terminology used to describe both the RE/RE student and programs, this phase was an opportunity to search for any new search terms that emerged in the literature.

Literature Review - The Re-entry and Refresher

This section of the literature review will present the concepts which emerged from the literature discussing RE/RF programs and students. Recognising that the RE/RF students have different learning needs to enable them to return to practice, the aim of the review was to tease out, and differentiate between re-entry and refresher programs, however this was difficult. The lack of clarity and inconsistency in the terminology used to describe programs and participants has been recognised by McMurtrie et al. (2014). The indiscriminate use of vernacular to describe both registered nurses and individuals who were previously registered as nurses, such as “refresher” “inactive” or “re-entry” without clarifying students registration status, made it impossible at times to confidently determine which student cohort were being discussed. Whilst some of the literature leads the reader to make assumptions about the specific student group, and program aims, ambiguity in the language risks inaccuracy in interpretation. For this reason all RE/RF programs and students discussed in the literature review will be considered as one group, the RE/RF student group.

Performing a literature search highlighted the dearth of research examining the RE/RF student in the context of clinical support models used in RE/RF programs. Given this, the literature review filters were broadened to include all articles, irrespective of age, where RE/RF programs or students were the key subject. This identified a total of 84 documents for initial review. Articles included both

national and international academic articles, and government reports. Whilst some research focussing on RE/RF students and programs has been undertaken by Australian and UK researchers, the majority of academic articles have emanated from the United States of America. Some articles related to other groups of RE/RF students including enrolled nurses, mental health nurses, medical officers and allied health professional. This literature was reviewed with the purpose of identifying secondary resources and underlying principles of the learning needs of qualified health professionals, but will not be included specifically in this review.

As there is a paucity of literature exploring the support models for RE/RF students, this section of the literature review will offer firstly, a background to the development of RE/RF programs, secondly, an overview of program designs, outcomes, and models of support, and lastly an insight into the RE/RF participant, as evident in the literature. It is expected that an examination of these concepts will assist in developing an understanding of the unique learning, and support needs of this student group.

Background

Whilst little may be known about the RE/RF student, or the effectiveness of supported models used during clinical placement, it is not because RE/RF students and programs are a new phenomenon (Elwin 2007). The earliest reference to the RE/RF program or student appeared in the American literature as early as 1930 (Belock 1983). In a 1952 American Journal of Nursing article an uncredited author highlighted the growing number of refresher courses for qualified nurses across many states of the United States of America (Anonymous 1952). This article also references a Japanese hospital which was also delivering refresher programs at the time (Anonymous 1952). These courses were designed as a recruitment strategy to return “inactive nurses” back to the workforce (Anonymous 1952) and were generally specific to the individual recruiting hospital (Belock 1983). Participants undertaking these courses were often required to accept employment in the hospital providing the refresher opportunity (Anonymous 1952). The nursing literature indicates RE/RF programs continued to be conducted between 1960 and 1970 (Belock 1983) in the United States of America providing individuals with an opportunity to refresh their practice (Pearce 1962; Curran & Lengacher 1982; Alden & Carrozza 1997).

Programs offered a blend of clinical and theoretical components, and provided the chance to develop the skills required of the "modern nurse" (Pearce 1962 p98).

Between 1980 and1990 refresher programs or "Nursing Update" courses (Ferris & Brown 1992 p 220) were continuing to be delivered to enable qualified nurses to return to practice for the benefit of the workforce (Alden & Carrozza 1997). The return to work was considered a valuable recruitment strategy (Curtis & Schneidenbach 1991), and courses ensured inactive nurses were competent to practice in the changing clinical environment (Kalnins, Phelps & Glauber 1994).

International and national literature indicates RE/RF programs have been conducted primarily for two reasons. Firstly, these programs have been delivered to provide support to nurses to enable them to return to practice during times of workforce shortages (Durand & Randhawa 2002; National Nursing and Nursing Education Taskforce 2005; Asselin, Osterman & Cullen 2006; Elwin 2007; Long & West 2007; McMurtrie et al. 2014). In the America literature, the delivery of RE/RF programs, has historically correlated with the ebb and flow of the recruitment needs of health services (Belock 1983; Sharp & Frederick 1990; Ferris & Brown 1992). Secondly, in recognition of the dynamic changing role of the nurse and the healthcare settings, programs have provided nurses with pathways to update their skills and ensure they are safe practitioners in contemporary practice (Bellack 1995), or assist them transition from one area of practice to another (Asselin, Osterman & Cullen 2006; Borgfeld 2014).

Whilst these two reasons remain equally valid today, a third justification for offering RE/RF program now exists. This is the need to meet regulatory requirements of nursing governing agencies. The evolution of nursing as a profession has increased the need for nurses' practice to be effectively regulated by appropriate governing authorities. The provision of accredited RE/RF programs provide professional regulators with a guarantee that returning clinicians are competent to practice in contemporary health settings (Bellack 1995; Elwin 2007; Borgfeld 2014).

The advancement of nursing as a profession and the technological and medical progress of healthcare in the later part of the twentieth century added a greater complexity to the need to deliver RE/RF programs. There is evidence that some

individuals undertaking RE/RF programs had not practiced up to 20 years (Kelly 1980). Some regulatory agencies, both in the United states of America (Belock 1983) and Australia (Nursing and Midwifery Board of Australia 2010) recognised that individuals who had not practiced as nurses for a period of time may not be competent to practice without undertaking a RE/RF program.

As more regulatory agencies identified the need for greater governance over registration and recency of practice, pressure for regulatory changes meant the ad hoc delivery of programs needed to be standardised. This was to ensure individuals had programs available to them which would allow them to update their knowledge and gain the new skills required to be competent and meet registration requirements (Belock 1983). These changes meant that RE/RF programs were now more than just a recruitment strategy.

The reasons for individuals opting to undertake RE/RF programs differ. Prior to the nursing profession's recognition that ensuring patient safety required nurses to maintain and demonstrate competency, and currency of skills and knowledge, nurses nationally and internationally, could retain their registration simply through paying their registration fee (Young 2000). In more recent times there were additional reasons for an individual choosing to participate in RE/RF programs. Firstly, persons who have allowed their registration to lapse may be required to complete a RE program to reregister as a nurse (Macdonald & Freise 1989; Bellack 1995; Borgfeld 2014). Secondly, some nurses who remain registered may be directed by their regulatory authority to undertake a RF program prior to being permitted to practice. Thirdly, registered nurses who have taken a short break, may undertake a RF program to ensure they remain competent to meet practice standards (Nursing and Midwifery Board of Australia 2010) and increase employability. Lastly, some nurses opt to complete a RE program to assist them change from one practice setting to another (Asselin, Osterman & Cullen 2006; Borgfeld 2014).

Little is written about the RE/RF experience in UK, either current or historically. What is evident however is that, like other countries, the British health service and regulating agencies firstly, experience workforce shortages (Durand & Randhawa 2002), and secondly, recognises the need for nurses to demonstrate competency before returning to work after a break. RE/RF programs are viewed

as a part way to addressing both these problem. As a result of this need to ensure individuals returning to the nursing workforce were competent, the British nursing regulatory body, the Nursing and Midwifery Council placed RE/RF programs under the control of the professional's regulatory agencies and government health services in 2010 (McMurtrie et al. 2014).

In American, where the terminology is more ambiguous, it is more difficult to distinguish between the program pathways for licensed nurses and individuals whose nursing license has expired. Re-entry programs (this may or may not include both RE/RF student groups) have been offered by hospitals (Kalnins, Phelps & Glauber 1994), universities (Lee 1988) and both hospitals and colleges in collaborative ventures (Phelps & Morice 1992). As is the experience in Australia, American nurses are now required to provide greater evidence of competency to practice, and individuals who have allowed their registration (licence) to lapse, are now required to undertake a reinstatement course (Bernardo 2011) which are specific to the state in which they intend to practice.

Program Design

RE/RF program designs have reflected the progression of the nursing profession. The earlier RE/RF programs were designed to assist people who were generally women, gain the confidence to return to the individual hospitals that needed a workforce, and were delivered in an uncoordinated approach (Young 2000). These programs generally offered upskilling through lectures and on the job training (Young 2000). The evolution of the nursing profession and adoption of appropriate contemporary education theory including active learning and adult learning principles has been noted in RE/RF program design (Elwin 2007). The shift from program delivery by health services to higher education providers was first noted in the 1980s (Curran & Lengacher 1982; Belock 1983; Ferris & Brown 1992). This allowed RE/RF programs to align with the current model of undergraduate nursing education, and recognises that whilst nursing is a practiced based profession, academic and professional development is of equal importance.

In Australia RE/RF programs have been delivered both by the health services, (Bassett & Nissen 2010), registered training organisations Sydney (Adventist Hospital & San College of Education 2014), professional organisations

(Australian College of Nursing 2014) and the tertiary sector (Flinders University 2014a). The delivery options for RE/RF programs are currently under review by the NMBA, and it is anticipated that RN re-entry programs will no longer be delivered by health services not affiliated with tertiary education providers. (Nursing and Midwifery Board of Australia 2014), whilst refresher programs may be delivered by a variety of education providers.

Elwin (2007) emphasises that successful learning for RE/RF students is not just about the acquisition of new knowledge through independent learning, clinical observation and experiential learning, but is also about the integration of past knowledge and experiences into their current context. To achieve this both earlier and contemporary RE/RF programs have included theoretical and practical components (Curran & Lengacher 1982; Kalnins, Phelps & Glauber 1994; Andre & Hall 1999; Hammer & Craig 2008; Bassett & Nissen 2010; McMurtrie et al. 2014). In the past it appears programs have commonly run between six and 16 weeks (Kelly 1980; Curran & Lengacher 1982; Brown & Waddell 1988; Curtis & Schneidenbach 1991; Ferris & Brown 1992; Phelps & Morice 1992; Andre & Hall 1999; Borgfeld 2014), with some programs being branded as fast track (Burns et al. 2006), or intensive courses (Andre & Hall 1999). The program at the centre of this study offers a 14-19 week program for re-entry RNs and 9-14 weeks for a refresher RNs (depending on whether they choose to complete their programs full time or part time)(Bassett & Nissen 2010).

As mentioned previously the reported RE/RF programs have been designed to include both theoretical and clinical components and vary in length and delivery (Andre & Hall 1999; Borgfeld 2014; Brown & Waddell 1988; Burns et al. 2006; Curran & Lengacher 1982; Curtis & Schneidenbach 1991; Ferris & Brown 1992; Kelly 1980; Phelps & Morice 1992). The theoretical component has been reported as being provided through traditional didactic classroom teaching (Curtis & Schneidenbach 1991; Phelps & Morice 1992), simulated case studies (Curtis & Schneidenbach 1991) and online e-learning models (Borgfeld 2014), or combinations of both (Bassett & Nissen 2010; McMurtrie et al. 2014). The reported hours of the theoretical component has varied between 34 and 170 hours (Curran & Lengacher 1982; Brown & Waddell 1988; Macdonald & Freise 1989; Curtis & Schneidenbach 1991; Ferris & Brown 1992; Phelps & Morice 1992; Bellack 1995; Elwin 2007; Borgfeld 2014) with earlier programs planning

their programs around what nurses “absolutely need to know” (Curtis & Schneidenbach 1991 p 36) whilst contemporary programs are designed to meet a set of competencies standards as defined by nursing regulatory bodies (Bassett & Nissen 2010).

The shortage of nurses in rural areas encouraged some program designers to develop “self-study” options with flexible start dates for individuals in rural areas unable to attend structured programs in metropolitan areas (Bellack 1995). Rural and remote students in the program in this study are required to attend the didactic sessions, however following completion of the workshops they are able to complete all other components online and do not have the flexibility in program start dates.

Outcomes

Measuring program outcomes has primarily been associated with employment outcomes (Kelly 1980; Carpenter-Connell 1984; Ferris & Brown 1992; Kalnins, Phelps & Glauber 1994; Bellack 1995; Alden & Carrozza 1997; Blankenship, Winslow & Smith 2003; Hammer & Craig 2008; Borgfeld 2014). These studies have reported that RE/RF programs adequately prepare RNs to return to practice and that employment and retention data is used as a measure of success.

Program Staff

The specific roles of individuals employed by education providers and health services to deliver RE/RF programs discussed in the literature is confusing. The use of local terms such as faculty or academic staff (Andre & Hall 1999; Cundall et al. 2004; Davidhizar & Bartlett 2006), coordinator (Hawley & Foley 2004; Huggins 2005), nurse educators (Cundall et al. 2004),instructors (Kelly 1980; Curran & Lengacher 1982; Curtis & Schneidenbach 1991; Cundall et al. 2004), staff educators (Curtis & Schneidenbach 1991), clinical instructors (Brown, L & Waddell 1988; Ferris & Brown 1992; Hawley & Foley 2004), clinical teaching assistants (Andre & Hall 1999) preceptors (Andre & Hall 1999; Cundall et al. 2004; Davidhizar & Bartlett 2006) mentors without role definition is problematic. The absence of specific details on roles does not enable differentiation between responsibilities of individuals within the team, and their responsible within the RE/RF program.

While there is ambiguity in job titles, and role responsibilities for program staff, the literature is clear in identifying the valuable characteristics required by program staff in preparing RE/RF students to return to practice. A 1988 study of re-entry students suggested that the relationship between staff and re-entry student should be not authoritarian – more of a consultant or advisor role (Lee 1988). The role of the program staff in the success of the RE/RF program was reported in the literature as early as 1991 (Curtis & Schneidenbach 1991). This was further supported in a study by Hall and Andre (1999) who emphasised the importance of RE/RF program staff consciously demonstrating behaviours which foster a relationship of trust. This trust was established by a "*philosophical approach taken by…staff [which] included emphasising commonalities, volunteering self-disclosure, displaying…commitment and motivation to teach such a group, and providing ready and early support for students*" (Andre & Hall 1999 p 240). Other reports highlighted the collegial nature of the teacher student relationship likening it to a mentorship or peer support approach which was acknowledged in the program evaluation as one of its strengths (Curtis & Schneidenbach 1991).

Student Support

The support offered to RE/RF students during clinical placement was not commonly reported in the literature. The use of a clinical support model of facilitator/instructor to a group of students was reported by (Bellack 1995; Bassett & Nissen 2010). Others studies reported using program staff in collaboration with health service staff who acted as preceptors or mentors (Bellack 1995; Andre & Hall 1999; Blankenship, Winslow & Smith 2003; Cundall et al. 2004; Davidhizar & Bartlett 2006; Borgfeld 2014).

Preceptorship models have been commonly used as a model of clinical support for both undergraduate and postgraduate nursing students in Australia (Ford, Courtney-Pratt & Fitzgerald 2013). As with clinical facilitation, the preceptorship model as reported in the literature, has been adapted to suit a variety of settings and organisations and, lacks consistency in meaning and terminology. The terms preceptorship and preceptor can be used to describe a formalised arrangement (Health Workforce Australia 2010) or, more loosely, to describe a RN who is supervising a student over one or more shifts (Monterosso & Zilembo 2008; Smedley, Morey & Race 2010). An example of the former by Health Workforce

Australia (HWA) defined preceptorship in very general terms as “the process through which existing nurses and midwives provide support to newly qualified nurses and midwives” (Health Workforce Australia 2010 p 48). HWA use Nash’s (2007) definition of preceptor which allows for broad interpretation to include both undergraduate and RE/RF nursing students, clarifying a preceptor is “generally a practising registered nurse providing individual clinical supervision/teaching on a 1:1 basis” (Health Workforce Australia 2010p 48).

The less formalised preceptor model places the emphasis for learning and teaching on the individuals rather than a model of support. To illustrate the lack of clarity, and blending of support model concepts, Walker et al. (2013) describe a support model, defined by HWA (2010) as a combined facilitator/preceptor model, but commonly described as a facilitation model of support. In this model the student is “buddied” with a registered nurse in the clinical area on a day to day basis, with overall responsibility for the student accepted by the clinical facilitator (Walker et al. 2013). Henderson and Eaton (2013 p 197) concur with the various nomenclatures, and clusters the terms such as buddies, preceptors and mentors into the category of “learning guides” to allow for ambiguity of roles and titles in adaptions of support models.

There is consensus that the preceptorship models have foundation principles which include “a one-to-one relationship” (Callaghan et al. 2009; Croxon & Maginnis 2009; Luhanga et al. 2010; Ford, Courtney-Pratt & Fitzgerald 2013) and are arranged between an experienced nurse and a nursing student, or junior nurse (Croxon & Maginnis 2009; Smedley, Morey & Race 2010) for a determined time (Smedley, Morey & Race 2010). The preceptor generally accepts the responsibility for supporting the preceptee in addition to their clinical work (Croxon & Maginnis 2009).

In preceptorship models where the student and clinician work together consistently, the student can “rely on that nurse for feedback, guidance, and modelling of professional practice” (Callaghan et al. 2009 p 249). This arrangement of the preceptorship model develops a trusting relationship, ensures consistency of feedback, and provides students with a real world view of nursing and an opportunity to consolidate their practice (Callaghan et al. 2009 p 247). In this application of the model there is an assumption that the preceptorship takes

place over an identified period (Ford, Courtney-Pratt & Fitzgerald 2013), and the preceptor is skilled in facilitating student learning, with an understanding of adult learning principles, and has accepted the role readily. The term preceptor may also be used by some formally or informally to identify the registered nurse buddying (McMurtrie 2014) the student in the clinical area in models such as the clinical facilitator model. This is often the case in the program discussed in this study, and to begin to consider the appropriateness of a support model for a student group, it is important to have some understanding of the demographics and characteristics that may be typical of the group.

The participant

To begin to appreciate the best way to support RE/RF student during their clinical placement it is necessary to understand the nature of the person who would complete an RE/RF program. RE/RF students share many similarities with their peers, but equally, demonstrate variability in their demographics. This is true of the research undertaken both in Australia and overseas.

Reports on the characteristics of RE/RF students indicate that the majority are female (Brown, L & Waddell 1988; Lee 1988; Bellack 1995; Andre & Hall 1999; Long & West 2007; McMurtrie et al. 2014). Hammer and Craig (2008 p 364) suggest that RE/RF students are usually at a "transitional point of their lives", with a change in personal situation or family arrangement. Whilst another similarity appears to be age, it is also a demographic statistic that shows great range. Whilst research shows the largest proportion of RE/RF students have been aged between 40 and 50 years of age (Brown, L & Waddell 1988; Curtis & Schneidenbach 1991; Alden & Carrozza 1997; Long & West 2007) students have been as young as 24 years of age, and as old as 65 years of age (Curtis & Schneidenbach 1991; Borgfeld 2014).

This diversity in demographic is also demonstrated in the time students undertook a RE/RF program after gaining initial nursing qualification, and the type of qualification gained. Students completing RE/RF programs may have attained their initial nursing qualification relatively recently, or many years prior to starting the program (Belock 1983; Brown, L & Waddell 1988) and with variety of years of nursing experience.

One Australian study showed that students in enrolled in RE/RF programs may have been qualified three to 32 years prior to undertaking the program (Andre & Hall 1999). More recently, students who completed the RE/RF program had obtained their initial nursing qualification between two and 33 years prior to completing the program (SA Health Refresher Program 2014). For some RE/RF students, the time between registration and completing the RE/RF program was spent in the profession. A study by Borgfeld (2014) highlighted this variability of experience reporting that some individuals commenced a RE/RF program with between 11 and 25 years of nursing experience (Borgfeld 2014). The professional and educational qualifications of the RE/RF cohort may also vary widely. Firstly, with the changes to the educational approach to nurse education, RE/RF cohorts may include individuals with certificate, diploma, bachelor, master or even doctorate qualifications. Whilst this diversity may not have been demonstrated in early American studies, later literature indicates that individuals undertaking RE/RF programs may have trained in a hospital or have a qualification gained in a tertiary institution (Andre & Hall 1999). It also appears reasonable to assume that in contemporary programs, these foundation nursing qualifications may also be accompanied by other nursing and non-nursing qualifications given many RE/RF students are returning to nursing after pursuing other professional interests. Given this potential broad range of educational and professional experiences in a RE/RF student group, it is not surprising that the literature highlights the point that individuals who enrol in RE/RF programs return to practice with a diverse range of skills and knowledge (Curtis & Schneidenbach 1991; Borgfeld 2014).

It is evident from the literature that people, who choose to return to work by way of a RE/RF program, do so for personal and professional reasons. Personal reasons may include economic necessity and/or financial benefit (Curran & Lengacher 1982; Brown, L & Waddell 1988; Curtis & Schneidenbach 1991; Ferris & Brown 1992; Phelps & Morice 1992; Bellack 1995), or due to the change in women's role in society (Curran & Lengacher 1982; Brown, L & Waddell 1988; Bellack 1995). Alternatively some individuals may be required to return to the workforce due to changes in personal circumstances (Brown & Waddell 1988; Curtis & Schneidenbach 1991; Ferris & Brown 1992; Bellack 1995). Professional reasons for undertaking a RE/RF program may include responding to recruitment

drives (Brown, L & Waddell 1988; Bellack 1995), taking the opportunity to change their area of practice (Brown, L & Waddell 1988; Curtis & Schneidenbach 1991; Borgfeld 2014), or to update their skills (Macdonald & Freise 1989; Curtis & Schneidenbach 1991; Phelps & Morice 1992; Kalnins, Phelps & Glauber 1994; Bellack 1995; Andre & Hall 1999). Some nurses may also use the program to address regulatory requirements, such as recency of practice (Borgfeld 2014), or, to gain registration in a country where they did not gain their initial registration. (Brown & Waddell 1988; Macdonald & Freise 1989; Bellack 1995).

Research suggests that RE/RF student share similar personal characteristics. Regardless of age, students demonstrated a high motivation to undertake their respective programs (Curtis & Schneidenbach 1991; Hammer & Craig 2008) with some displaying excitement at the challenges ahead, but acknowledging they may be overwhelmed by the process (Lee 1988). This enthusiasm and commitment has been demonstrated with some students prepared to travel significant distances daily, or relocate for the duration of the program (Brown, L & Waddell 1988).

Some literature also suggests the RE/RF students are a "special needs group" (Andre & Hall 1999 p 239). They experience great levels of anxiety and may have poor self-esteem (Andre & Hall 1999; Durand & Randhawa 2002; Elwin 2007) and have unrealistically high expectations of themselves (Andre & Hall 1999). They are also concerned they may no longer be able to perform the role of the nurse in a contemporary setting (Kelly 1980) and are fearful that they may experience difficulty being accepted by ward staff in the clinical area (McMurtrie et al. 2014).

Despite their personal concerns and anxieties, what is evident in the literature is that RE/RF students are motivated learners (Curtis & Schneidenbach 1991; Hammer & Craig 2008). Ensuring that educational approaches harness this motivation and supports RE/RF students' learning is complex, particularly with the shift from teacher centred learning to student centred learning and, adult learning principles. Hammer and Craig (2008) highlight the significant fact that many students undertaking such programs are at "transitional points of their lives" (2008 p 364) and reminds readers of the need to balance a structured and

interactive learning environment with the unique needs of the learner (Hammer & Craig 2008 p 359).

In summary, RE/RF programs have been discussed in the literature, primarily as a strategy for addressing workforce shortages (Asselin, Osterman & Cullen 2006; Durand & Randhawa 2002; Elwin 2007; Long & West 2007; McMurtrie et al. 2014; National Nursing and Nursing Education Taskforce 2005). In the current context, RE/RF programs also provide individuals with opportunities to comply with regulation requirements and maintain competency. As shown, to date little is known about the RE/RF student and their learning needs and how best to support them in the clinical environment. What is known is that this cohort has some unique and distinctive characteristics that should be considered when planning programs and clinical placement requirements. The next section of the literature review will examine what is known about the model of clinical support used in the RE/RF program at the centre of this study, clinical facilitation.

Literature Review – Clinical Facilitation

The purpose of this section of the literature review is to consider the clinical facilitation model in the context of the RN RE/RF program student. As the terms used to describe the various models of clinical facilitation, and the title of clinical facilitator has been adapted over time to suit a variety of organisational situations and needs, a wide range of terms was included in the initial search to ensure relevant literature was identified. Key terms used in included “clinical facilitator”, “facilitator”, “clinical teacher”, “education facilitator’, clinical supervisor, and “preceptor”. Literature was then reviewed for relevance and alternative key terms.

As with earlier searches no specific literature examining clinical facilitation as a support model for RE/RF students was located. Whilst some literature identifies the use of preceptors to support RE/RF students, little understanding of the effectiveness of this support model was gained from the literature reviewed. Firstly, the literature available does not have clinical support as a theme that has been developed to any depth of understanding, and secondly, the variability of terminology and models made it difficult to evaluate the precise model used. For this reason this section of the chapter will consider clinical facilitation in a broader context. It will firstly explore the evolution of clinical facilitation as a model of

support for nursing students, secondly it will examine what is written about the concept of clinical facilitation, and lastly, it will consider the role of the facilitator and its place as a model of support in the current nursing context.

The Evolution of clinical Facilitation

Traditionally, practice based professions such as nursing have relied on apprenticeships style education. This model relied on clinical staff supervising students who were part of the workforce (Råholm, Thorkildsen & Löfmark 2010). The migration of nursing education to the tertiary sector in the 1980s necessitated a change in the way students were supported during their clinical placement (Walker et al. 2013). Responsibility for clinical support during clinical placement was no longer a singular, organisational responsibility. Current literature indicates that there have been some difficulties in the transition to this bipartite approach to nursing education (Walsh & Jones 2005). Contemporary nursing literature demonstrates the interest in examining, and, defining suitable models required to meet stakeholder and students' needs and expectations (Lambert & Glacken 2004; Mallik & Aylott 2005; Mannix et al. 2006; Croxon & Maginnis 2009; Henderson & Tyler 2011; Mackay et al. 2014).

New models need to traverse the complexities of a partnership approach (Mannix, Wilkes & Luck 2009; Sanderson & Lea 2012) with shared organisational responsibility for student learning in the clinical environment (Burns, I & Paterson 2005; Courtney-Pratt et al. 2012), and fit with the higher education sector's adult learning principles (Lambert & Glacken 2005). The professionalisation of nursing meant that competent completion of tasks was only one element of clinical performance, and, the development of critical thinking skills was equally important (Lambert & Glacken 2005). It was also recognised that learning environments, that is the clinical setting, with all its social complexities, needed to foster and enable students to develop a deeper and more meaningful understanding of their profession's theory and how it applies to their practice to develop into competent practitioners (Cope, Cuthbertson & Stoddart 2000 p 851; Henderson 2011).

Nursing students were no longer a workforce, but were supernumerary with the primary focus of their clinical placement centred on their learning and the consolidation of knowledge (Mannix, Wilkes & Luck 2009). This was a distinct

shift from the previous apprenticeship model with a “take for granted” attitude that effective learning occurred through a student’s experience and exposure as part of the nursing workforce (Mannix et al. 2006).

The need to accommodate individual education and health organisational needs, changing economic environments, workplace pressures and the rapidly changing clinical environment drives the need for clinical support models to evolve and advance (Budgen & Gamroth 2008). As models evolve and new approaches and support roles were developed, confusion surrounding terminology and differences in application began to occur. Such new models included clinical facilitation (Rowan & Barber 2000; Ellis & Hogard 2003), dedicated education units, (Wotton & Gonda 2004; Moscato, Nishioka & Coe 2013), cluster models (Bourgeois, Drayton & Brown 2011) and team leader models (Walker et al. 2013). These models have evolved to suit organizational and educational requirements blurring models and the shared use of terms to describe personnel with different roles and responsibilities, creating confusion for students and staff. Some researchers recognizing this problem are choosing to group the different variations of models under the term “clinical supervisors” (Health Workforce Australia 2010; Mackay et al. 2014) in an attempt to reduce confusion.

The clinical facilitation model evolved in the early 1980s (Beckett & Wall 1985) and has been used to bridge the new shared responsibility by education and health care sectors for clinical education of nursing students. Various applications of the model have been used by universities and health services to support nursing students both nationally (Bassett & Nissen 2010; Sanderson & Lea 2012; Andrews & Ford 2013), and internationally (Rowan & Barber 2000), and is still used today (Mackay et al. 2014). In some models clinical facilitators worked directly with students at the point of patient care (Rowan & Barber 2000; Sanderson & Lea 2012), whilst other clinical facilitators act in a link or liaison capacity rather than adopt a hands on teaching role (Bourgeois, Drayton & Brown 2011).

Burrows (1997) in her concept analysis of clinical facilitation emphasises a common occurrence in the literature, that the term facilitation is open to a wide variety of uses and interpretations. Despite the title and the model, what does remain constant however, is the fundamental concept of the clinical facilitator role

as someone who enhances the learning a student takes from the clinical environment (Rowan & Barber 2000). Burrows (1997 p 401) indicates this occurs through the partnership developed between the facilitator, and the learner. This relationship is based on mutual trust and uses critical reflection to optimise the students learning (1997 p 401)

The Concept of Clinical Facilitation

The concept of clinical facilitation in the context of nursing education evolved from the work of Carl Rogers (Beckett & Wall 1985; Cross 1996; Lambert & Glacken 2005). In educational facilitation, the approach is student centred (Beckett & Wall 1985; Lambert & Glacken 2005). This approach was significantly different from the earlier hospital based training system which was teacher directed (Lambert & Glacken 2005), which relied on the principle that learning would occur through exposure rather than purposeful critical reflection.

The shift from the teacher centred model to a model which emphasised the student as a learner, and not as the primary person responsible for the delivery of the health service, aligned with the shift to adult learning principles and the facilitation model of enabling a student to take responsibility for their learning. The role of the teacher, now became more of a facilitator of learning, requiring different techniques and skills such as “stepping in or stepping back” (Dickson, Walker & Bourgeois 2006 p 420) to ensure a successful blend of encouraging critical thinking and skill development in their students whilst maintaining patient safety (Dickson, Walker & Bourgeois 2006). Getting the correct mix of both art and science to achieve this, for both clinical facilitators and “buddies” working with students, continues to be a challenge and explains the ongoing research interest in this area for undergraduate nursing students.

The Role of the Clinical Facilitator

The role of the clinical facilitator is complex with significant accountability (Mannix et al. 2006), compounded by role ambiguity (Lambert & Glacken 2005). Whilst actually defining the role of the clinical facilitator may be difficult due to the numerous models and role variations, research indicates there are some general characteristics common to most clinical facilitator roles. Andrew and Ford (2013) argue that the role is non-prescriptive with a degree of autonomy and flexibility. From the literature review, at a conceptual level, it appears possible to categorise

the role of the clinical facilitator into three broad categories of responsibility. Firstly fostering of relationships and learning environments (Dickson, Walker & Bourgeois 2006; Waldock 2010), secondly to provide leadership though supporting students and clinical staff both clinically and professionally (Dickson, Walker & Bourgeois 2006; Waldock 2010; Henderson & Eaton 2013), and thirdly management and administration tasks (Bassett & Nissen 2010).

Clinical Facilitation in the Current Australian Context

In Australia clinical facilitation is used as a model of supporting students during clinical placement by both universities and health services despite identified shortcomings in some applications of the model. Andrew and Ford (2013) raise concerns regarding the common use of casual staff to fulfil the role of clinical facilitator; inconsistencies in educational qualifications required of individuals undertaking the role, ambiguity of role requirements, and poor preparation of clinical facilitators for their role (Andrews & Ford 2013). Other researchers highlight the cost and suggest the model is not economically viability or sustainable (Mannix et al. 2006; Sanderson & Lea 2012).

What the Literature Tells Us

In undertaking this literature review three main themes emerged. Firstly, there is a need for registered nurses and individuals previously registered as nurses to have access to quality RE/RF programs to enable them to return to practice as competent and confident nurses. Secondly, quality clinical learning is essential for all nursing students and the model of support provided to students can profoundly influence the clinical learning that occurs. Lastly, that whilst researchers are generating new knowledge regarding the best ways to support undergraduate nursing students in the clinical environment, little is reported about how to best support RE/RF students in the clinical environment.

The first dominant theme to arise from the literature is that quality RE/RF programs benefit nurses, health delivery services, regulatory agencies, and ultimately patient care. It also illustrates the uniqueness of RE/RF student, and the need for programs to be developed in response to the uniqueness. Providing individuals with quality programs which include well supported clinical learning opportunities allows them to upskill, return to the workforce, or be reinstated to the register, as competent practitioners. There is a plethora of literature that also

emphasises the value of RE/RF programs in providing health services with a valuable source of skilled clinicians quickly with an ability to meet the increased demand for nurses at times of shortage. More recent literature illustrates the importance of quality RE/RF programs in providing regulatory agencies with accredited pathways which ensure clinicians are competent to practice.

The relationship between quality clinical support and student learning in the clinical environment was the second major theme to emerge from the literature review. It is evident from the literature that nursing academics recognise the importance of the learning that occurs in the clinical environment and the role effective support plays in enhancing or disabling this learning. The role that effective clinical support contributes to quality clinical placements cannot be understated. Developing a model to meet the needs of students, education providers, clinical facilities which are financially economical and sustainable, and supported by sound educational principles remains challenging. This ongoing search for an ideal model has resulted in current models, such as clinical facilitation, being adapted and modified to suit the needs of multiple stakeholders. This has led to a blurring of models, and lack of clarity in terminology and roles, making effective and precise evaluation and comparison of models difficult.

The third theme to emerge, by omission rather than availability of evidence, is that whilst literature examining support models continues to grow, it is limited to the undergraduate nursing programs. Despite the literature acknowledging the need to support RE/RF students to return to the workforce, and the importance of facilitating clinical learning, research examining the two as one concept does not appear in the literature. It is reasonable to assume that the RE/RF student, given their previous nursing experiences, knowledge, and life experiences may have different learning and support needs to that of undergraduate nursing students. Some research has demonstrated the uniqueness and diversity of the RE/RF student and considered the needs for programs to acknowledge this, but developing an understanding of their support needs during clinical placement has not been a focus of research.

What is evident is the diversity of the RE/RF cohort. Some participants are returning after easing of family commitments, others are wishing to move from

one area of nursing to another, such as from aged care to the acute care setting, while others are returning to clinical nursing after illness or pursuing other careers paths (Hall & Andre 1999). Whatever the reason for their return to their profession, the RN RE/RF program student returns to the clinical setting with an assumed history of nursing competently in the clinical environment, and, a wealth of knowledge gained from personal and profession life experiences. With this in mind, selecting the most suitable model of clinical support needs further research.

Summary

This chapter has demonstrated that there is no significant research examining what model of support is best for RE/RF students during their clinical placement. It has presented what is known about the RE/RF student from the literature available and discussed the programs which have been developed to assist them return to practice. It has also explored the clinical support model known as clinical facilitation, and identified that there are shortfalls in many applications of the model. It has also revealed that researchers acknowledge these deficits and there is interest in addressing these – but to date this has only been addressed in the literature only in the context of undergraduate nursing students. This literature review demonstrates the paucity of literature examining the RE/RF student in the clinical setting, and the need to recognise that the RE/RF student may have different support needs to that of the undergraduate nursing student. Therefore, this research study aims to contribute to the sparse body of knowledge examining RE/RF students' learning needs, by exploring what they expect in way of clinical support, and if the current models of clinical facilitation used meet those expectations.

The following chapter offers details of the methodological framework chosen and rationale for the choosing this particular approach and ethical concerns associated with the research are clarified and addressed. It also explains the recruitment and selection of study participants and the collection and management of the associated data. This chapter also explains the two phase data analysis process used to examination the data and discusses the process adopted to optimise the trustworthiness of the study.

CHAPTER 3: METHODOLOGY AND APPROACH

Introduction

This chapter will discuss the methodological framework chosen to explore the whether the support model of clinical facilitation meets the expectations of RE/RF students undertaking clinical placement. It outlines the study design including, participant recruitment and data collection and management. This chapter also explains the two phase data analysis process used to examine the data and will discuss the process adopted to optimise the trustworthiness of the study.

Study methodology

The first step in choosing a research approach is to ensure a methodology is chosen that suits the aims of the study and question being asked (Schneider, Whitehead & Elliot 2007). The question fundamental to this study is whether the clinical support model commonly referred to as "Clinical Facilitation" meets the expectations and needs of the refresher & re-entry student. Central to this question are the concepts of the "individual" and "expectations". Expectation can be defined as "a strong belief that something will happen or be the case" (Oxford Dictionariesa 2014). Individual can be defined as "characteristic of a particular person (Oxford Dictionariesb 2014). Psychologists tell us an individual's expectations develop over our life time and are formed as a result of experiences and what are taught (Bonds Shapiro 2012).

From previous experience the RE/RF student group have demonstrated significant diversity in educational, professional and personal qualities. Any research approach should, therefore, provide an opportunity to capture the uniqueness of the RE/RF student, and the potential diversity in clinical facilitator expectations and experiences. Therefore a qualitative approach was considered the best fit for this exploratory study on expectations and experiences.

Six demographic questions were included in this study to collect participants' details including age, gender, years in nursing, nursing qualification, and whether they had been supported by a clinical facilitator.

When planning which research methodology to use, consideration was again given to the diverse background of potential research participants and how best to maximise the richness of the information this could provide. It was important

to ensure that the chosen approach maximised the opportunity to capture the wide variations of views and experiences that were possible. Variation in the potential participant group could include, but not be limited to, age, gender, nationality, work experience, nursing education/training, time away from the workforce or profession, and educational background. It was felt that all these potential variables would provide a group that brought with them a broad range of experiences and expectations of a clinical facilitator. It was decided to approach this study by way of a qualitative interpretative approach, as this methodology allows the researcher to "describe, explore and generate meaning within a social or practice context" (Schneider, Whitehead & Elliot 2007 p 25). A qualitative interpretative approach acknowledges and uses the premise that people are complex beings who bring unique meaning and perspectives to any given situation according to their individual realities (Schneider, Whitehead & Elliott 2007).

After deciding on the research approach and methodology it was necessary to determine the most appropriate means for data collection. Focus groups were used as the primary source of data collection as focus groups are valuable in providing an opportunity to explore individuals' thoughts and perceptions of particular experiences and phenomena (Liamputtong 2009). Focus groups were chosen for data collection for the following three reasons. Firstly, the dynamics of group interactions can result in added insight and richness of information that would otherwise be gained through individual interviews (Schneider, Whitehead & Elliott 2007). Discussions within a group setting can nurture reflective processes by others upon the contributions of group participants. This reflection has the potential to generate deeper consideration of the concepts and promote further contributions to the discussions, perpetuating the generation of new data that would not have arisen in an individual interview. It was expected that participants in this study would have such a diversity of personal experiences and expectations of clinical facilitation that group discussion, and the resulting deeper reflection, would be particularly beneficial. The value of this knowledge generation from focus group methodology may be particularly useful in the post clinical placement focus group between individuals who had experienced different models of clinical facilitation. It was also thought that the use of focus groups, given the use of different facilitation models within the program, may

enhance discussions and the depth of data generated (Grudens-Schuck N et al. 2004).

Secondly, as primary researcher and program coordinator, I was aware of a potential real or perceived power imbalance between researcher and participants. Minimising the discomfort for participants by having them together should maximise participation and contribution to topic discussions. Individual interviews, where a power imbalance is present is not only unethical but also compromises the quality of the research. Liamputtong (2009) suggests focus groups offer researchers an opportunity to explore sensitive issues, or, provide marginalised individuals an opportunity to be heard. Whilst the exploration of clinical facilitation may not be believed sensitive, nor RE/RF students considered a marginalised group, an approach which may be suitable for collecting authentic data in such situations, may be appropriate for a study where there may be either a real or perceived power imbalance between the researcher and participants. All efforts were made to reassure potential study participants that their participation and contributions were voluntary, confidential, and would not influence the individual's program results. It was felt that the use of focus groups as an alternative to individual interviews may be less threatening to willing participants. It was also thought that individuals may feel uncomfortable discussing their personal views and experiences which may reflect negatively on program staff, or processes, directly with the program coordinator and that offering them the group environment of focus groups may help them feel supported. It was possible that individuals may also feel reassured if others had similar experiences.

Thirdly, the decision to use focus groups was made for reasons of convenience and expedience. Aware that many of the RE/RF students were under pressure from competing demands, such as work, family and study, the need to reduce the time burden was apparent. For the program coordinator focus groups would be logistically easier. Study participants could attend the two focus groups scheduled during the program workshops, eliminating the need for making special arrangements. The first focus group was scheduled at the conclusion of the block intensive which they were required to attend. Similarly, students were required to attend a group debrief at the conclusion of clinical placement as a

component of the RE/RF program, so the second focus group was scheduled following this, allowing for the commitment of concurrent attendance.

Describing focus groups as “form of group interview” (Kitzinger 1995) fails to acknowledge the key strengths of this data collecting approach over interviews, group or otherwise. Marczak & Sewell (2014) define a focus group as “as a group of interacting individuals having some common interest or characteristics, brought together by a moderator, who uses the group and its interactions as a way to gain information about a specific or focused issue”. Whilst this definition highlights the active role of the moderator (McLafferty 2004), the interaction between participants, and the importance of a commonality between participants, it does not highlight the significance of the interactions of the individuals in the group in generating richer data, and a potentially deeper understanding of the subject at the centre of the research (Schneider, Whitehead & Elliott 2007). McLafferty (2004) illustrates this point in her review of the literature summarising their aim as “the purposeful use of interaction in order to generate data (Merton et al. 1990, Kitzinger 1996, Morgan 1996).

The generation of rich material in focus groups relies on the participants interacting with one another, rather than with only the researcher as occurs in interviews (Schneider, Whitehead & Elliott 2007). This encourages the participants to explore and clarify their views with others (Kitzinger 1995) potentially leading to new contributions being made to the discussion. This generation of further discussion may enhance the depth and breadth of the data offered. This definition is also unsuccessful in illustrating the shift in control of the discussion from researcher to participants that occurs in focus groups. The use of open ended questions by the moderator provides the opportunity for group members to take discussions in unforeseen directions (Kitzinger 1995) and is an appropriate approach given the researcher is interested in the students’ experience of clinical facilitation (Silverman 2010).

Deciding upon the use of focus groups to collect data lead to the question of overall design. Consideration was given to the objective of this study which was to explore clinical facilitation of the RE/RF participant. This led to the decision to approach data collection using three focus groups. Two focus groups were used to collect data from RE/RF students and one focus group was used to collect

data from the clinical facilitators supporting the RE/RF students. The focus groups targeting RE/RF students are identified as focus group one and focus group two. Focus group three refers the focus group run with the RE/RF clinical facilitators. It is important to note here that whilst focus groups were run with both students and facilitators, the primary interest of this study is the experiences of the RE/RF students. The reason for including a clinical facilitator focus group was to add context and provide a broader perspective of clinical facilitation as a model. The decision to hold separate focus groups for the clinical facilitators and strudels was made for two reasons. Firstly it was a concern that if clinical facilitators were present at the first focus group, it may influence their behaviour when supporting students during the clinical placement. Secondly, it was felt that incorporating the clinical facilitators in the post clinical placement focus group may possibly affect the willingness of the RE/RF students to provide accurate accounts of their experiences.

Ethics approval

An ethics approval for a qualitative research project examining clinical facilitation of RE/RF students was sought and granted from the Flinders University and Southern Area Health Service Social and Behavioural Research Ethics Committee and is included as Appendix Two . Support from the Executive Director of Nursing and Chief Executive Officer of the Health Service delivering the program was also obtained and is included as Appendix Three.

Specific ethical matters arose as a direct result of the aims of the study and specific sampling approach required to undertake this research. The primary intentions of the study were to explore issues directly related to RE/RF students' experience of the clinical facilitator model, and its ability to provide effective clinical support during clinical placement. The design of the study required the use of a sample consisting of individuals enrolled in such a program. As there are limited RE/RF programs offered, and the students needed to be actively enrolled in a program, there were related implications due to the nature of the relationship between the researcher and indiviudals participating in the study. These ethical matters were also considered when preparing the proposed focus group planned for collecting information from the clinical facilitators who support the students. Whilst this was not the primary source of data collection for the study, the implications of the relationship needed to be considered.

In the dual role as primary researcher and program coordinator there were ethical concerns to consider. Firstly, as primary researcher and RE/RF program coordinator, a perceived or real power imbalance could be present for both students and clinical facilitators. As program coordinator I was responsible for assessing and grading students' academic work. I was also the direct line manager for the clinical facilitators employed for the program. Identifying these concerns enabled careful planning of recruitment and data collection processes to be undertaken. This ensured that irrespective of whether an individual participated in the study, their program results, or employment situation would not be affected. A second consideration was the maintenance of confidentiality as there may be perceived burden or risk to the participants by their sharing of perceptions and opinions. Information sought from the study related to their expectations and experiences of clinical facilitation during the program they were participating in, therefore individuals agreeing to participate in the study would need to be assured that information obtained would remain confidential.

Participant recruitment and selection

As the aim of this study was to examine clinical facilitation expectations of the RE/RF participant a purposive sampling strategy was used to recruit study particpants for all three focus groups. For data to be of value to this research topic, study participants needed to be able to reflect on clinical facilitation of RE/RF students. Purposive sampling is the deliberate selection of study partipants who meet specific criteria related to skill set, knowledge or experiences (Schneider, Whitehead & Elliott 2007). This careful selection maximises the opportunity for the research to gain the specific information required.. Therefore this study required sampling individuals who have either been a RE/RF student, or, had facilitated RE/RF students.

Purposive sampling was used for this study targeting RE/RF students undertaking clinical placement supported and clinical faciliators engaged in providing the support. Students enrolled in the July 2011 RE/RF program and their clinical or local facilitor were the sampling group of interest that fitted the criteria for this study. This ensured the information obtained from the study participants related to the experience of either being a RE/RF student supported by a clinical facilitator, or, a failitator of RE/RF students. As discussed later in this thesis, the criteria for focus group three was later expanded to allow recruitment

of clinical facilitators who had previously facilitated RE/RF, but not specifically the present group, due to low numbers of available clinical facilitators.

The study design required a focus group to be conducted with students before they commenced clinical placement, which occurs in week six of the progam. For clarity, this pre clinical placement focus group is identified as focus group one. Depending on the level of interest from RE/RF students in particpating in the study, and given the recommended size for focus groups is six to ten participants (Schneider, Whitehead & Elliott 2007), consideration was given to running two focus groups to enable all those interested an opportunity to contribute to the study. Recuitment began at week one of the program there were 12 RE/RF students enrolled in the July 2011 program, consisting of three re-entry students and nine refresher nurses. The students were appoached as a group by the researchers' supervisor during a workshop held in the first week of the program. The researcher was not involved nor present at this recruitment session to minimise coercian and to ensure students did not feel obliged to participate, and, felt free to ask questions. During this session, students were informed of the project, its purpose and approach, the date and time of the first focus group and, offered the opportunity to ask questions of the supervisor. A copy of the Letter of Introduction (Appendix 4), Information Sheet (Appendix 5) and Consent Form (Appendix 6) were provided to the students. Students willing to participate were asked to notify the resercher, or the researcher's supervisor, by the end of the week to give an indication of potential participant numbers. Prior to focus group one, two refresher and one re-entry students withdrew from the program. This reduced the possible paticipation numbers to nine.

Given the project aimed to explore whether clinical facilitation meet the expectations of the RE/RF student, recruitment for the second focus group targeted only RE/RF students who participated in the first focus group. At the conclusion of focus group one, particpants were reminded of the researcher's plan to run a second focus group after the conclusion of their clinical placement. Arrangements for contacting potential participants regarding confirmation of dates, venue and times were dicussed. This focus group was timed to correspond with the completion of their clinical placement and program. For clarity this focus group is referred to as focus group two.

Recruitment of clinical facilitators for focus group three was undertaken at the completion of the student's clinical placement. This was deliberate with the aim of reducing the influence of the study on the clincial facilitators' behaviour, and/or interaction with the students, during their clinical placement. The number of clinical or local facilitators engaged in the program, and therefore fulfilling the purposive sample criteria, was dictated by the student group size and clinical plcacement allocation. Due to the low number of students undertaking clinical placement at the time of the study (n=9), the potential focus group participants, was limited to one clinical facilitator. As this was not congruent with focus group methodology, it was decided to also invite a person who had held the role of RE/RF clinical facilitator previously. It was felt given this person's experience with the current model they would potentially add valuable contributions. This focus group with RE/RF facilitators is referred to as focus group three.

Data collection

A total of three focus groups were conducted: two with students and one with facilitators, and one demographic questionnaire was used to collect data. The short online demographic questionnaire (see Appendix 10) was completed by the RE/RF student participants. The questionnaire collected data relating to age, gender, length of time qualified as a nurse, nursing education, where their qualification was gained, and whether they had been previously supported in a clinical placement by a clinical facilitator before. As this data was only a supplementary data source for comparison against findings in the literature, only a brief reference is made to it in the findings chapter.

The primary source of data collection was the focus groups. Focus groups one and two, conducted with students from the RE/RF program, aimed to explore clinical facilitation from the perspective of the student. Data collected from focus group was used to explore the expectations of the RE/RF student, of clinical facilitation, as a model of support during their clinical placement. Focus group data was planned to provide insight into whether the expectations expressed in focus group one were meet. Focus group three was designed to collect data related to the RE/RF Clinical Facilitators' experiences of supporting RE/RF using the three models used by the program. All focus groups were conducted using a similar approach. Focus group three, which examined clinical facilitation from the

view point of the facilitator was conducted by a different moderator, and therefore will be discussed at the end of this section.

Focus groups one and two – RE/RF students

Focus group one was held during program time for ease of attendance for participants. Focus group two was held after all students had completed all academic and clinical requirements of the program, and just prior to completion of the program. Both student focus groups were held at the venue where the program was delivered. Focus groups one and two were moderated by the primary researcher, and were audio recorded for professional transcription. The room was set up to allow the group to sit informally around a table, with light refreshments provided, so as to foster a relaxed environment. A short two minute introduction addressing the purpose of the focus group, research topic, focus group format, confidentiality requirements and rights and responsibilities of the participants was provided by the moderator. An introduction to one another was not required as the group had spent approximately six days together and knew each other. Group consensus about confidentiality and respect was established to create a safe and supportive environment. Individuals were assured that their identity, name or work place would not be identifiable from the data collected, and as such they would not experience invasions of privacy or embarrassment.

Six of the nine RE/RF students enrolled in the July 2011 program participated in the first focus group (FG1). The focus group participants consisted of one RE student and five refresher students. Of the six who attended this focus group, four were allocated clinical placement at the primary hospital, and two were attending clinical placement at satellite hospitals. There were no focus group participants who were allocated to a remote hospital. The three students declining to participate did not provide reasons for their decision.

Four of those who participated in focus group one participated in focus group two at the completion of the program. Three of this group had attended clinical placement at the primary hospital and one had attended a satellite hospital. The two who did not attend the second group did so for differing reasons. One student withdrew from the program after focus group one was conducted, but prior to commencing clinical placement. Attempts to email this student following their withdrawal were not successful in gaining a response. The other participant

who did not attend the second focus group completed the program early to accommodate the need to relocate her family interstate before the second focus group date. They were therefore geographically isolated to participate in the focus group and not contactable.

The focus groups were conducted within the anticipated content discussion and time durations. It had been anticipated that both focus groups would run for approximately 60-90 minutes each. In reality both groups ran for approximately 70 minutes. Focus group one was organised around seven questions which are shown in Table 1. As a novice researcher I have listed the planned question and the transcript of the actual questions as asked. The purpose of this is to demonstrate adherence to processes which enhance rigor and acknowledges limitations of the study. This will be discussed further in the limitations section of the discussion chapter of this thesis.

Table 1: Focus Group One Questions

Planned questions and actual questions asked in focus group one.		
1.	Planned	Have you had a clinical placement in the past that has used this model for clinical supervision and if so, can you reflect on your experiences? (10 minutes)
	Actual	Have you had a clinical placement in the past where you have used this model before as your clinical supervision? If so, reflect back on that experience.
2.	Planned	What other models of support have you experienced during clinical placements and, were they positive? (10 minutes)
	Actual	Have you experienced any other models of clinical support?
3.	Planned	What kind of clinical support do you believe will be of most value to you during your clinical placement? (10 minutes)
	Actual	Back to the point of the refresher re-entry, do you think, what are your feelings about what you're going to need as a clinical support? What are the things that are going to be most important to you while you're at clinical placement as a refresher re-entry nurse?
4.	Planned	What aspects of your clinical placement are worrying you most? (10 minutes)
	Actual	What's worrying you most all about your clinical placements? What's causing you anxiety? What are the things that worry you?
5.	Planned	What kind of support do you believe will be of most value to you during your placement, and from who do you expect that support? (10 minutes)
	Actual	This question was asked in several ways over the discussion So who do you expect to get the most support from to overcome those areas, you perceive either rightly or wrongly, areas you are going to struggle with? So where do you seek your primary support from?
6.	Planned	When considering both your clinical placement, and learning needs, what does the term "Clinical Facilitation" mean to you? (10 minutes)
	Actual	So when considering your clinical placement and learning needs, what does the term Clinical Facilitator mean to you.?
7.	Planned	How are you feeling about your upcoming clinical placement and what are your expectations of your clinical facilitator? (10 minutes)
	Actual	Would you day it is a secondary role, the facilitator to your clinical placement, is that how you see it?

Focus group two did not have scripted questions. The moderator provided an overview of the themes that had emerged in the first focus group (see Table 2) and wrote these on the whiteboard for the participants to reflect on throughout

the discussion. The aim of this was to confirm firstly, the accuracy of the first focus group transcript, and secondly, the meaning that had been attributed to the data during the early stages of analysis. The provision of this information also offered a starting point for the focus group discussion. Clarification of the term "clinical facilitator" was provided, and then the moderator asked the opening question of "bearing in mind that these were your ideas, how did the refresher re-entry program facilitation meet your expectations?" The focus group was then allowed to flow with the moderator taking opportunity to develop points of interest, clarify meaning through questioning responses to participant, and refocus the group on the topic when required, using the terms written on the whiteboard as prompts.

Table 2: Focus Group Two – Themes

Engagement	Variation Shared Expectations Initiated Expected/ unexpected Impact on ward membership
Roles	Debrief Feedback Goal Setting Planning learning Resource person Scaffolding learning Problem solving
Advocacy for Learning	Negotiating ward culture Self-agency/empowering self Conflict resolution direction Humanness versus task focus
Relationships	Self Ward Staff Education staff

Focus Group Three – RE/RF Program Clinical Facilitators

Focus group three was run after the program had been completed. The aim of this focus group was to examine clinical facilitation of the RE/RF participant from the view point of the facilitators. The RE/RF program uses three models of clinical facilitation to support the students, and the model used is dependent on the site where the clinical placement is undertaken. Due to the low number of students undertaking clinical placement during this study the potential focus

group participants was in principal limited to one clinical facilitator. This clinical facilitator supported nine students across three sites, one being the primary hospital, and the second and third being health services affiliated with the primary hospital under two of the three potential models; Program Clinical Facilitator – Primary Hospital (PCF-PH), and Program Clinical Facilitator – Satellite Site (PCF-SS) models. No Local Facilitator (LF) was used during this program and therefore was not available for recruitment to participate in this study. As a focus group relies on the dynamics of a group and the discussions and reflections that emerge from the group, an invitation to participate in the study was offered to the clinical facilitator who has supported students in the preceding RE/RF programs. This clinical facilitator had also provided support to RE/RF students across multiple sites under both the PCF-PH and PCF-SS models.

Focus group three was conducted with two clinical facilitator participants, the researcher and was moderated by the primary researcher's supervisor. It was deemed important to have the focus group moderated by a person external to the program and its staff due to the professional relationship between the researcher and the clinical facilitators. The moderator gave a short explanation of research topic, focus group format, and confidentiality assurances, before commencing the discussion which lasted approximately 71 minutes. The moderator asked the clinical facilitators ten questions that had been formulated collaboratively between the researcher and moderator prior to the group meeting (see Table 3). The tenth question was designed as a statement and provided the clinical facilitators with a brief overview of the expectations raised by the RE/RF students in focus group one and two. Reflecting on these concepts from the perspective of clinical facilitators occupied the remainder of the focus group. The researcher's perspective was sought for clarification and input when requested by the clinical facilitators and/or moderator.

Table 3: Focus Group Three Questions

1	What do you see as the role of the clinical facilitator?
2	How do you see the difference between your role as clinical facilitator and the people who work with these students in the ward?
3	How clear are you on your roles and responsibility? Do you feel that this particular role is clearly outlined in what's expected as opposed to how it just evolves?
4	What are the positive aspects of your role? What things do you really enjoy?
5	Are there any negatives about the role? What are they
6	Have you ever felt the support you are able to offer is limited by the scope of the role? Why?
7	Do you feel your role is structured with enough support?
8	Do you get the same satisfaction in your role of supporting students on other sites? Why is this?
9	So if there was anything that could be done to improve the role of the facilitator for re-entries, refreshers at the moment what would that be?
10	The focus groups run with the students raised concepts related to the role of the clinical facilitator. These included advocacy for students' learning, empowering/self-agency, debriefing, performance monitoring and feedback, and planning their learning. How does this fit with how you see your role?

Upon completion of each focus group, audio files were submitted to a professional service for transcription. Audio files and transcriptions were stored on a secure server attached to the health service associated with the study to satisfy ethics requirements and maintain participant confidentiality.

Data management

All focus groups were recorded with a digital recorder and professionally transcribed into text. Focus group one was noted to be of particularly poor quality due to low volume and poor clarity making transcription difficult and incomplete. Much of the transcript passages were either missing text, marked as unclear by the transcriber, or appeared inaccurate in the given context. These problems were satisfactorily rectified by reviewing both the audio and transcript together and correcting or entering the text to ensure transcript accuracy. As researcher and program coordinator I had developed a close personal

relationship with all participants in the focus group. This familiarity with the individuals made it possible to confidently interpret and correct the majority of omissions in the text. This review also provided an opportunity to allocate an anonymous code to each individual. Participants were identified as “interviewee” only with no individual anonymous code attached to each participant. The established relationship between the researcher and study participants enabled the confident checking of the audio against the transcript. Interviewees in focus group two were then allocated the same code as was allocated to them in focus group one.. This was done as it was felt that being able to match pre and post clinical placement responses to participants may enhance findings, and possible allow deeper meaning to be attributed to the data and themes which may emerge.

Whilst there were still some gaps in the transcript of focus group two, the lessons learnt from focus group one ensured the recordings from focus group two was of a higher quality. This had been achieved by the use of new recording equipment, and taking more care with the placement of audio equipment and seating of participants. Gaps in the text of the second transcription were only due to background noises such as chairs moving and soft voices. There was also lack of clarity in regards to where some responses began and finished, and attribution of responses to different individuals. These deficits were again addressed, by the researcher who moderated the focus group, comparing the audio recording against the transcript. This allowed the text to be corrected, and ensured the transcript accurately reflected what was said by a participant. The transcription of focus group three was also checked for accuracy, and apart from inconsistencies in the identifiers used for the participants, moderator and observer the text was representative of the audio. This was easily rectified by the researcher prior to analysis.

The data collected by the demographic questionnaire was achieved using an anonymous online questionnaire tool via a secure government learning management system. The data was then transcribed by the researcher for use in the review of literature relating RE/RF program participants. Data was de-identified and stored along with other research data, in a locked office.

As a researcher there is an obligation to ensure ethical management of data. This means ensuring participant confidentiality, and, secures storage of all records and data (Schneider, Whitehead & Elliott 2007). Maintaining participant confidentiality was achieved firstly by ensuring participant details were stored appropriately, and secondly, that data gathered from the focus groups would not be attributed to any particular individuals participating in the study. The first step, confidential storage of participant details was easily achieved by maintaining electronic files on a password protected computer, or, in the case of hard copies, in a locked office, accessible only to the researcher. Participant details and allocated identifiers, designed to assist the researcher with analysis, were stored separately, and disposal of documents has been by either shredding, or through the use of government confidential waste bins.

However, in respect to the second element, a remedial step was required to ensure that data emanating from the focus groups could not be attributed to the individual participating in the discussion. Whilst focus groups one and two used the term “interviewee” as a substitute for the name of the participant, focus group three transcript inserted names of participants on some occasions, thereby compromising participant confidentiality due to low numbers. This was corrected by the researcher, when the transcript was reviewed against the audio prior to coding. During this process the two participants were allocated an individual number. The transcript was de-identified and the individual’s allocated number inserted in lieu of their name ensuring participant confidentiality and assisting preparation of data for analysis.

Data Analysis

In performing qualitative data analysis, it is the researcher’s goal to “capture, understand and represent participants’ perceptions and meanings *through and in* their own words” (Ruona, 2005, p 234). In this study data analysis was undertaken firstly, by interpreting the data from the demographic questionnaire, and then secondly, by using a three phased thematic analysis approach, to review the data collected from the three focus groups with the aim of developing an understanding of how well clinical facilitation meets the needs of the RE/RF student.

In qualitative research, data analysis can occur at different stages of the study, but generally, it takes place at one of three stages of the project (Schneider, Whitehead & Elliott 2007). These stages are – simultaneous analysis of data with the data collection processes; upon completion of all data collection processes, or staged to correspond with specific data collection activities (Schneider, Whitehead & Elliott 2007). In this study the data analysis process was most closely aligned with the simultaneous analysis approach. This approach, commonly referred to as the "constant comparative data analysis" (Schneider, Whitehead & Elliott 2007) suggests data collection and analysis processes occurs together, but at varying stages to suit the researcher and study design, aims and timelines.

In this study, collection of data commenced with the demographic questionnaire, followed by focus groups one, two, and three, which were run at various times through the study. Data analysis also occurred at these different stages of the study and was performed in three distinct phases.

The first phase incorporated a primary review of focus group one data and the identification of themes related to participants expectation of the clinical facilitation support model in the context of the RE/RF. This examination of the data was performed by the researcher and supervisor independently to ensure rigor, and was undertaken prior to the running of focus group two. The timing of this analysis allowed for the themes identified from focus group one to guide the preparation of questions and discussion in focus group two. The categories identified during this process are noted in Table two.

The second phase of analysis commenced after focus group two data had been collected. This process involved returning to focus group one to re-examination and refine themes identified in the first round of data analysis. These themes, or meaningful categories (Ruona 2005), were then used to guide the second stage of phase two, which was the analysis of focus group two. This phase also incorporated the analysis of the data collected in the demographic questionnaire (Appendix 10). This analysis was a simple process of collating specific details related to age, gender, nursing education background and exposure to clinical facilitator models of support. The final phase, phase three was the analysis of

focus group three in the context of the themes that has arisen from the analysis of focus group one and two.

All focus group data was analysed using a thematic analysis method. Thematic analysis is a process by which the researcher examines the raw data to extract meaning to develop meaningful categories or themes (Ruona 2005). This process requires a "deliberate, considered systematic" (Schneider, Whitehead & Elliott 2007 p139) approach from the researcher, which allows them to consider, compare, reconsider and re-compare the data, or data set to establish meaning that can be categorized. In this study the strategy used by the researcher commenced with reading the transcripts, identifying and coding points of interest, arranging similar codes into groups, which were then formed into categories or themes. The results of this analysis were then discussed with the research supervisor before a second cycle of coding was undertaken which allowed for themes and codes to be refined. The reviewing of codes and themes by the research supervisor was in part, recognition of the researcher's limited experience in analysing qualitative data, and an acknowledgement for the need to demonstrate rigour, given any researcher brings to the analysis process, their own view of the world. Who the researcher is, their personal experiences, beliefs, and prejudices colour the lenses through which they interpret the data before them (Ruona 2005). This process and its place in ensuring rigour is examined in more detail in the following section.

Rigour

For the results of any research study to have value and be seen as credible and stand up to examination and scrutiny, and demonstrate trustworthiness. The criterion by which research is evaluated is referred to as rigour. Liamputtong cites rigour is the "means by which we demonstrate integrity and competency, a way of demonstrating the integrity of the research process. Without rigour, there is a danger that research may become fictional journalism, worthless, as contributing to knowledge" (Tobin & Begley 2004 p 390 as cited in Liamputtong 2009 p 20).

The term rigour is traditionally associated with quantitative research (Schneider, Whitehead & Elliott 2007). The equivalent in qualitative research is "trustworthiness" (Schneider, Whitehead & Elliott 2007) which relates to the "rightness/correctness" (Schneider, Whitehead & Elliott 2007 p 148) of the

research results. Demonstrating “trustworthiness” requires the researcher to use a set of criteria to support their findings. Frameworks exist to support qualitative researchers in their endeavour to gain credibility in their research. Schneider et al (2007) suggest that there are six broad approaches or options that researchers can use to provide validity to their research methodology. One of those positions is “Position 5 – each study develops suitable, justified criteria.” (Schneider, Whitehead & Elliott 2007 p 149). This popular viewpoint (Schneider, Whitehead & Elliott 2007) provides researchers with the flexibility required by the qualitative paradigm suggesting criteria include an audit/decision tail, member checking and peer analysis, as adequate methods for ensuring research quality (Schneider, Whitehead & Elliott 2007). It is this position, and its three elements which will be used to consider the rigour of this research study.

The first element, an audit or decision trail, is a record of the research study design planning, sampling, data collection and analysis processes (Schneider, Whitehead & Elliott 2007). Effective management of these details contribute to the “trustworthiness” of the research by ensuring evidence of processes are transparent and available for scrutiny. In this study these processes have been examined and critiqued by both the supervisor and co-supervisor. All stages of the study – planning and preparation, focus group delivery, data analysis and reporting of findings - have supporting electronic or written documentation. Electronic records are stored on a secure server, and written records are maintained in the researcher’s office. This thesis presents a detailed account of the research process and decision trail.

Member, or participant checking, is the second element of position 5 (Schneider, Whitehead & Elliott 2007), which strengthens the “trustworthiness” of a study. Firstly this allows the researcher the opportunity to ensure that data collected is accurate prior to commencing analysis. This is particularly important in cases such as focus group one, where there are gaps in the data, or, inaccuracy in the transcription from one medium to another. Secondly, and of equal importance, member or participant checking, allows the researcher to check their interpretation of the data and, the meaning they have attributed to the data. In the case of this study the process of member checking occurred at the commencement of focus group two. The researcher identified the themes which emerged from focus group one and discussed the associated meaning attributed

to the themes seeking confirmation of the interpretation of the discussion that had taken place in focus group one.he third element of position 5 is peer analysis checking (Schneider, Whitehead & Elliott 2007). In the case of this study, the regular instruction and critiquing of study methodology and data analysis by the experienced supervisor and co-supervisor satisfies this criteria.

Apart from the elements of "trustworthiness" argued within the context of the above framework, there are two other aspects that add strength to the study's validity. Firstly, the research is being conducted as part of a structured and supervised high research degree program ensuring that even as a novice researcher, process related to collecting, managing, analysis and reporting of research findings are of an acceptable quality and meet "trustworthiness" standards. Secondly, the inclusion of excerpts of the transcripts in the context of the researcher's analysis and attributed themes are included in the findings and discussion chapters of this thesis, allowing for the evaluation of data analysis by peers and examiners.

This chapter has presented the methodological framework chosen to conduct this study and justified its use. It outlined ethical and potential conflict of interest concerns and how this was address. Study design, participant recruitment and data collection were also explained. The chapter also clarified the two phase data analysis process used to examination the data and discusses the process adopted to optimise the trustworthiness and demonstrates how this study demonstrates rigour. The next chapter will report the findings of the study. This involves very briefly reporting the data extracted from the demographic questionnaire, and then, presenting the findings of the three focus groups.

CHAPTER 4: FINDINGS

Introduction

This chapter reports the supplementary data collected by the demographic survey, and presents the findings of the three focus groups. The data from the demographic online questionnaire, whilst not the primary focus of this study, will provide understanding of the diverse nature of the students who enrol in RE/RF programs. The primary focus of the findings chapter is the outcomes of the three phase thematic analysis of the three focus groups.

After the reporting of the demographic data, the findings from the focus groups will be reported in order of occurrence. Results from focus group one will be described first, and reflect what RE/RF students expected from their clinical facilitator during their placement. Focus group two will be reported in the context of the pre-placement expectations and the actual placement experiences of study participants. Findings from focus group three will be reported with the results of focus group two as they too relate to actual placement experiences. Examples of participants' responses included in the text of this chapter will be referenced using the prefix FG representing "focus group" followed by the focus group number (1, 2, or 3) and page (p) of the focus group transcript where the comment was made. For example FG1p3 would denote a comment was taken from focus group 1, page 3. This inclusion of excerpts from the focus groups' transcripts will enhance the "trustworthiness" of the findings, and therefore the rigour of the research.

Reporting of the results of focus group analysis is not simply the process of recording and presenting the findings. Firstly, it is the final stage of the cyclic process of qualitative analysis which leads to the concluding research findings and the challenges of presenting the information in a clear and organised manner (Hennink 2013). Secondly, it provides an opportunity to present the researcher's interpretation of the data and, relate it back to the focus of the research, which is, an understanding of the clinical facilitation needs of RE/RF students.

Upon conclusion of reporting the primary results from the three focus groups, a further interpretation of the data will be reported. This secondary analysis was performed with the aim of identifying factors which may possibly influence

participant's expectations of the clinical facilitator and their role. This enabled theorising about the clinical facilitator role and the reasoning behind people's expectations and experiences.

Demographic Questionnaire Data

As reported in the methodology chapter six RE/RF students participated in the first focus group. Demographic data was collected anonymously from the six student participants via the secure learning management system used by the primary hospital for delivering the RE/RF program enhancing the user friendliness of this survey for the study participants. Results are presented below in table four. For the questionnaire see Appendix 10.

In summary, the student participants (n=6) were all female and varied in age. Four students were aged between 41-50 years of age , one student was aged between 20-30 years, and one between the age of 51 - 60 years or older. The earliest nursing qualification gained was in 1970 with the most recent nursing entry qualification awarded in 2008. Two study participants had gained their initial nursing qualifications in hospitals, with the remaining four completing their undergraduate nursing education in a university. One of the six study participants had gained their initial qualification oversea, with the remaining five holding qualifications obtained across three different states of Australia.

Initially the researcher planned to use this questionnaire to ask the study participants about their clinical facilitation experiences. The decision not to pursue this data was made due to the lack of agreed meanings and variability in interpretation of clinical facilitation models and terminology.

Table 4: Demographic Questionnaire Results (N=6)

Question		Results	Number
1.	What is your age?	20-30 years	1
		31-40 years	0
		41-50 years	4
		51+ years	1
2.	Gender	Male	0
		Female	6
3.	When did you obtain your original nursing qualification?	1978	1
		1992	3
		2007	1
		2008	1
4	Was your original RN qualification…?	Certificate	1
		Diploma	2
		Bachelor Degree	3
5	5.1 Where did you obtain your initial registration qualification?	Hospital	2
		University	4
	5.2 Please provide geographical location and setting.	University of South Australia	1
		Flinders University of South Australia	1
		Royal Alexandra Alberta, Canada	1
		Cairns Based Hospital	1
		Queensland University of Technology	1
		Curtin University of Technology	1

Whilst the demographic data was not expected to provide a significant source of data to this study, it does illustrate the diversity of the RE/RF student undertaking the clinical placement.

Expectations of Clinical Facilitation: Findings of focus group one

Focus group one data was reviewed and analysed first to inform the conduct of focus group two. The analysis of this data produced multiple common codes related to the participants' expectation of the clinical facilitator. These codes were then grouped into categories and themes. Four themes became apparent as analysis of focus group one progressed. These were termed:

1. Guide leaning
2. Facilitate clinical assimilation
3. Advocacy.
4. Support.

The heading assigned to each theme is intuitive to the codes and categories within it. Theme one titled "guide learning" linked ideas relating to the teaching, assessment and learning activities that may be expected of the clinical facilitator supporting RE/RF students. The second theme "facilitate clinical assimilation", clustered together activities performed by the clinical facilitator which supported the integration and acceptance of the RE/RF student into the clinical environment and, aided their transition from RE/RF student to RN. The ideas raised in this theme related to fostering relationships, and providing clinical and professional guidance. The third theme "advocacy" encapsulated ideas raised that represented tasks, actions or processes which protected the student and their rights as learners during clinical placement. The fourth and final theme entitled "support" captured activities and practices related to the provision of practical, emotional, or professional support or counselling. The categories of each theme and their related codes and categories will be identified in the following sections, and an overview of the dominate ideas that arose in each category will be provided.

Theme 1: Guide Learning

The RE/RF students participating in focus group one identified many different ways in which they expect the clinical facilitators may guide their learning while undertaking clinical placement. From this data, 19 different ways (codes) a facilitator may guide a student's learning during clinical placement were identified. These 19 codes were clustered to form the theme of "guide learning". These codes relate both to tasks such as clinical or academic teaching and,

more abstract concepts, including facilitating reflective practice and goal setting. After the development of codes and, in preparation for reporting the results, it became apparent that a middle layer of categorising was necessary to enable results to be reported in a clear and organised manner. For this reason the 19 codes were organised into three sub-themes, or, categories. These categories were labelled “teaching”, “assessing”, and “learning”. The theme “guide learning”, and the associated categories and codes are shown in Table 4. The category level will be used to report the findings of the “guide learning” theme.

Table 5: Theme One: Guide learning and associated categories and codes

Theme 1	Categories	Codes
Guide Learning	1.1 Teaching	Clinical teaching Providing in-service Provide supplementary teaching Teaching Academic teaching/support
	1.2. Assessing	Monitoring progress Identifying knowledge/skill deficits Assessing performance Providing feedback
	1.3 Learning	Scaffold learning Patient allocation/selection Facilitate learning Facilitate reflective practice/sessions Assist with goal setting Provide individual support Act as a resource person Problem solving Provide clarification Providing/guiding remediation

Category 1.1: Teaching

During focus group one some study participants indicated they expected the clinical facilitator role would involve direct teaching for the RE/RF students during their clinical placements. The type and amount of teaching they anticipated varied amongst the participants in the group. Whilst group participants indicated this teaching was primarily clinical in nature, they perceived it may also include

the provision of in-service sessions and supplementary or academic teaching, depending on individual student needs.

In this context, clinical teaching was understood to refer to the teaching, and or, support of a RE/RF student in the development of practical skills and knowledge. This teaching may be undertaken in either the clinical setting at the bedside or away from the bedside, such as in a clinical skills lab. Whilst clinical teaching was identified by some of the RE/RF students participating in the study as an important element of the role, there were divided thoughts on its importance, with not all participants giving it the same level of priority. One participant expressed that clinical teaching provided by the clinical facilitator would be helpful; they explained:

> *"they [the ward staff] would show me the same skill ten different ways I don't even know how to do the skill. So how am I going to work out which is the best way to do [it] if I didn't know? So the facilitator could come in and you could say 'can you go through this with me again?'" (FG1p13).*

*O*ther participants suggested the teaching by the clinical facilitator needed to be flexible and directly in response to the teaching provided, or not provided, by ward staff, and matched to individual student needs. The RE/RF students' expected the clinical facilitator's teaching role to be relative to clinical staff's ability to provide effective clinical teaching. One participant stated *"If I felt lost and was fumbling on the ward, didn't attach myself to anyone per se, then I would be needing my facilitator" (FG1p21).* The participants described the need for the clinical teaching from a clinical facilitator to be paired to an individual's need, as highlighted by the following discussion:

> *Moderator: "Am I right in saying that the clinical facilitator does not support you in the clinical area? Is that how you perceive their role or not their role?"*
>
> *Participant: "In my experience they support the people that need the support, so if there are wards that don't have the time and they are having trouble with something, that's when the facilitator steps in to help."*
>
> *Moderator: "Would you expect that from your clinical facilitator?"*
>
> *Participant: "Yes." (FG1p24)*

And also

> *Participant: "If I want to stay back and if the pump is still there, I can have a look at it, in a kind of space that is away from the patient's bedside and I am sure that if I need to come back up here, I would like to think that someone*

> *[clinical facilitator] would take the time with.me…if I needed a bit more time. (FG1p16)*

Following on from this discussion point, it was recognised by some participants that having a location of clinical placement off site from the primary hospital may impact on the ability for the clinical facilitator to support them through clinical teaching. One participant responded to the expectation the clinical facilitator could just step in to the clinical setting when having trouble with something, by saying:

> *"Yes because the facilitators are here, our facilitators are all over the place…. and can't always come and show you" (FG1p24-25).*

This inequity in accessibility to a clinical facilitator, resulting from the use of three different facilitator models in this RE/RF program, is a recurrent topic through this and other themes arising from the data.

Category 1.2: Assessment

The second group of codes clustered within the theme of "guide learning" reflected activities best described as contributing to processes of assessment of RE/RF students clinical performance. This group was clustered together to form the "assessing" category. The activities coded within this category were associated with monitoring students' progress, identifying knowledge and/or skill deficits, assessment of performance, and providing feedback (see Table 4). Participants felt that the clinical facilitator from the RE/RF program was in a good position to effectively monitor and assess their progress, as they had a pre-established relationship and was able to identify knowledge or skill deficits during the pre-clinical study days and clinical workshops. One participant explained:

> *"The facilitator from the theory base often knows you through discussion and through watching you do stuff, and where you're at. And so can guide you down the right path a little bit whereas the nurse on the ward often don't even know these gaps and you have to try and explain to them" (FG1p5).*

This suggested that the process of assessment by the RE/RF clinical facilitator commenced earlier than when the students commenced their clinical placement, and placed them in a crucial position for monitoring progress, assessing performance and providing feedback.

Assigning the provision of "feedback" to a category in the "guide leaning" theme was challenging. The questions raised during this process were: Where does feedback fit? Is it teaching, assessment or learning? The decision to allocate it to the assessment category was made as it could be argued that teaching and learning can occur in the absence of feedback, but, it was felt this was not the case with assessing a student's performance within a program. The following comment, based on their past facilitation experience, supports this view:

> *"Because they [the clinical facilitator] were the constant – they could see how you were progressing and at set times – I think it was every two weeks because it was a late placement. We would then look at our goals for the placement on the ANMC competencies and she would tell you, you're not going to meet your goals by the end of the placement, you can go do this or this. So you had one constant who knew, where every other different nurse on the ward had a different perception how good you were at meeting that criteria" (FG1p12).*

Whilst this participant demonstrates the value of the established relationship between students and clinical facilitator in assessing the students' performance, it does not consider the benefits or limitations of these activities within the RE/RF program structure and three clinical facilitation models used. Nevertheless it highlights the participant expectation of the clinical facilitator having an active role in assessing student learning and the value of one constant person performing formative and summative assessments and, providing feedback.

Category 1.3: Learning

The third and final category of the "guide learning" theme included aspects of the clinical facilitator role that focused on assisting a student's learning. Essentially, participants expected their clinical facilitator to support their learning on an individual level. For example, one study participant suggested "*the facilitator who can adapt to the style of a person is probably the most beneficial...so it is about how each different person is – where they were at" (FG1p7).* It was felt student learning could be enabled by the clinical facilitator in a variety of ways, as demonstrated in the codes of this category as shown in Table 4. It may occur for example, through practical problem solving support strategies or, by acting as a resource person providing *"direction"* when students are "*looking for certain information……[the clinical facilitator] can direct us to where to find the information as well" (FG1p27).*

Some RE/RF students in the study indicated that clinical facilitators who actively supported their learning through a scaffolding of learning approach were highly valued. Scaffolding an individual's learning is an educational approach which allows a person in the role of educator, teacher or peer, support the learner to achieve mastery of skills and knowledge incrementally (informED 2014), whilst gradually decreasing the structural support framework (van de Pol, Volman & Beishuizen 2010). Whilst the participants did not use the term scaffolding learning, they did describe activities the facilitator could do which are known to scaffold learning. Such activities include planned teaching strategies, the provision of resources, or exposure and opportunity to practice and develop skills. Participants expected the clinical facilitator would guide their learning through monitoring and managing patient allocation, to facilitate their achievement of the identified learning needs. One participant stated *"your facilitator is going to go in there and have a look at the patient mix and pick out what sort of patient is going to suit best for your learning needs" (FG1p4).*

Participants indicated that they expected the clinical facilitator may assist their learning by promoting and participating in reflective practice. One participant supported this view by contributing, *"I sort of see the facilitator role more reflective…If you still need to balance on things, with a patient…talk about it with the facilitator in a reflective way" (FG1p26).* This reflective practice would facilitate the student's learning, assist with goal setting and remediation if required.

In summary, analysis of the first focus group suggests that the RE/RF student may expect a clinical facilitator to provide individualised support for their learning, using a wide range of educational approaches in response to individual student needs, in conjunction with the clinical support provided by the ward staff with whom they are working. This concept of individualised support to guide learning was deemed dependent on the quality of the relationship between the student and the clinical staff hosting the clinical placement, which underpins the following theme of facilitating clinical assimilation.

Theme Two: Facilitate Clinical Assimilation

The second theme from focus group one was allocated the heading "facilitate clinical assimilation", linking together activities which assist the student to

integrate into the ward and its culture, and transition from student to RN. The 13 codes identified represented activities and processes which assist students to integrate into the clinical environment and transition from student to competent professional nurse were organised into two categories. Category one linked concepts connected to the role of the clinical facilitator in fostering relationships between stakeholders, and, category two incorporated activities related to providing clinical or professional guidance. These categories and their associated codes are shown in Table 5 and will be used to report the findings of the "facilitate clinical assimilation" theme.

Table 6: Theme Two: Facilitate Clinical Assimilation and associated categories and codes

Theme 2	Categories	Codes
Facilitate Clinical Assimilation	2.1 Fostering Relationships	Prepare students Prepare ward Liaise with ward staff Liaise with student Conflict prevention and resolution Promote learning culture / environment Provide conduit between clinical and education sectors
	2.2 Clinical and Professional Guidance	Promote role transition Provide guidance on professional issues Guidance on clinical issues Provide objectivity Administration Complement ward staff in teaching

Category 2.1: Fostering Relationships

Study participants indicated that they expected the clinical facilitator to assist their integration to the clinical setting through the fostering of relationships. This includes preparing both students and clinical staff for the upcoming clinical placement, ongoing liaising with students and staff, managing any conflict that

may arise, promoting an environment that is conducive to learning, and fostering effective communication between the education and health services.

It was evident from the participant group that effective preparation of both students and clinical staff by the clinical facilitator was considered very important. This was particularly evident in respect to preparation of the ward staff. One participant suggested that "*the best facilitators did [spent time preparing the ward staff before students arrived], so the staff knew you were coming, because the facilitator had been there" (FG1p8).* This was supported by another participant, who said *"it was all about preparation by the facilitator" (FG1p8).*

However, a caveat was placed on the preparation role of the clinical facilitator and their relationship with ward staff. One participant felt that whilst preparation promoted acceptance of the student by ward staff in many cases, it was equally important that the clinical facilitator recognise that for some environments, their presence may act as a barrier to the assimilation of some students into the clinical team. This related to continued presence following preparation on the wards. They suggested that:

> *"if the facilitator was there, you get treated differently by the staff. So it is better for them not to be there and you're more as a group, and you're in with them [ward staff]….instead of being segregated by your facilitator" (FG1p8).*

Therefore, the role of the clinical facilitator was to know when to, and how long to remain present in the clinical environment to foster relationships between the ward staff and student, and not to hinder their development. The diversity of the student RE/RF population, and the variability of support provided on wards by clinicians, suggests that this need for the foster of relationships will vary amongst students. For the clinical facilitator, this may mean gaining an awareness of the student's experience, level of confidence, personal preference for support, and the learning culture, or student friendliness of the ward receiving the student prior to the placement to ensure their presence promotes, rather than inhibits, clinical assimilation.

Conflict resolution was another aspect of the clinical facilitator's role that study participants suggested should be approached on a flexible and individual basis to promote clinical assimilation of the RE/RF student. The participants spoke of self-expectation to manage any issue creating conflict on their own behalf initially, but

anticipated the clinical facilitator would assist if needed. One student expected "*the facilitator will need to work out some work conflict" (FG1p19)* should a satisfactory resolution to any problems not be achieved on her own. The following comment was typical of this view point of the group.

> *"Hopefully I'll find a way in to discuss that with them...but if not I will expect [the clinical facilitator] to sort of help with that" (FG1p22).*

Drawing on past negative experiences participants anticipated that the role of the clinical facilitator was "*not just preventing conflict, but resolving conflict that we have to revisit, not just the ward" (FG1p19).* This view suggests that effective preparation and communication between clinical facilitator, student and ward staff would minimise conflict, but that each individual student may also be dealing with their own negative past. It also highlighted the need for the clinical facilitator to identify early any experiences which may influence a student's expectation in relation to the management of conflict, to reduce any barriers to the fostering of clinical assimilation and development of positive relationships during their clinical placement.

In order to foster positive relationships, it was also felt that the clinical facilitator was in a position to mediate as conduit between the education service and the clinical health service. Participants felt the clinical facilitator should be familiar with the ward and staff to achieve this, as illustrated by the following two comments;

> *Moderator: "find a healthy solution?"*
> *Participant: "Yes just because you know them and I don't" (FG1p22)*

> *Participant: "Just the connection between the education and the actual clinical area" (FG1p27)*

But overwhelmingly it was emphasised that the clinical facilitator's role in facilitating clinical assimilation needed to be individualised and controlled to a greater extent by the individual student, and the acceptance and ability of the ward staff to effectively support the student, as demonstrated by the following responses:

> *"helpful when needed…not there when I didn't need anything" (FG1p8)*

> *"so if there are wards that don't have time… that when the facilitator steps in to help them" (FG1p24)*

Therefore the participants expected the clinical facilitator to assist their assimilation to the workplace through fostering of effective relationship, and this required the clinical facilitator to have flexibility, initiative and self-awareness of when their presence was helpful and when not. This expectation affords individualised support, which was also evident in supporting clinical assimilation through clinical and professional guidance.

Category 2.2: Clinical and Professional Guidance

The second category in the clinical assimilation theme "clinical and professional guidance", linked concepts where the clinical facilitator's role was to promote firstly, the integration of the RE/RF student into the clinical team, and secondly, the successful transition from student to competent professional. Whilst this transition requires successful mastery of the elements of the "guided learning" theme, it similarly relies on the progression from student to professional nurse within the context of a professional team. Study participants indicated that they expected the clinical facilitator to contribute to this process. This may be achieved through a scaffold learning approach where the *"aim was to build you up…to be an independent practitioner"* (FG1p7), supporting individuals as they gradually accept increased professional responsibilities and accountabilities.

For some RE/RF students this may simply be a process of assisting them develop strategies for managing professionally challenging situations which arise during clinical placement. For example, one participant asked *"How can your facilitator deal with that without it falling back on your shoulders…I don't know how to deal with this problem? And like I said this is one of my concerns now" (FG1p2).* Alternatively the student may need to adjust their own personal expectations, or manage situations arising as a result of the expectations of others, as illustrated by the thoughts of this participant:

> *"Is it the expectation you think they are going to have on you, because you have already done this and you know this" (FG1p19).*

Other participants "*found that there was also a benefit to having someone removed from the environment that you could relate to and talk to" (FG1p13),* emphasising the importance of having someone separate from the clinical team from whom they could gain professional objectivity. This is supported by the following participants' comments:

> *"So a reality checks from your facilitator, you expect them to also be objective" (FG1p24).*
>
> *"You stand as a neutral person as a facilitator I think. You don't get caught up in some of the situations...that objective view of something." (FG1p26).*

In summary, concepts clustered together to form the "facilitate clinical assimilation" theme suggests RE/RF students' assimilation to their clinical area, and ultimate transition from student to competent practitioner, relies upon the support of ward staff, and a neutral, objective clinical facilitator. The investment in the student by ward staff and the resulting integration into the clinical environment is enhanced by the fostering of relationships between the education and ward staff. Discussions emanating from the focus group suggest RE/RF students consider this active development of relationships, before during and after a students' clinical placement, an important aspect of the clinical facilitator's role.

Theme Three: Advocacy

Study participants indicated that it was also the role of the clinical facilitator to provide advocacy, both for them, and their role as a learner and the ward staff. Activities, such as advocating for the rights of individuals, and for the RE/RF role as supernumerary students, were clustered together to create the third theme of "advocacy". Previous experiences for some participants had led them to believe that it was also the role of the clinical facilitator to advocate for the ward staff if the need arose. For this reason the theme of "advocacy" was separated into the two categories, one for advocate for student, and the other, advocate for ward staff. These categories and their related codes are shown in Table 6 and will be used to report the findings for the "advocacy" theme.

Table 7: Theme Three: Advocacy and associated categories and codes

Theme 3	Categories	Codes
Advocacy	3.1 For Student	Advocate for student Advocate for student role Protect supernumerary student status
	3.2 For Ward Staff	Advocate for ward staff

Category 3.1: The Student

It was evident from the group discussion that the participants considered the clinical facilitator was expected to advocate for individuals on both practical and professional matters. Practical matters which might need the advocacy of the clinical facilitator related to rostering and patient allocation, while professional matters included ensuring the RE/RF student is afforded supernumerary learner status. The RE/RF participants undertaking the program are often required to manage many competing demands. This may include, to greater or lesser degree, part-time employment, other study demands and family commitments. The need for flexibility in their rosters was seen as key to managing these commitments and enabling successful completion of the program for their future employment. Traditionally, the rosters are negotiated by the student with the ward Clinical Nurse Consultant. Pressures upon wards to facilitate large numbers of students at any one time can reduce roster flexibility resulting in difficulties for the RE/RF students. Participants suggested that should they encounter such difficulties in arranging suitable rosters that they would expect their clinical facilitator to advocate on their behalf. One participant emphasised the importance of advocacy in just such a situation:

> *Participant: "Well what are you going to do if they can't work around you with the shifts?"*
>
> *Participant: "Well I'd come back to… (Clinical Facilitator)"*
>
> *Moderator: "so a facilitator is also an advocate?"*
>
> *Participants (multiple): "Yeah" (FG1p22-23)*

Practical matters were not the only element of their clinical placement that study participants expected the clinical facilitator may need to advocate on their behalf. Participants felt the clinical facilitator role includes protecting their rights as supernumerary students, and their primary role as learners. This was considered particularly pertinent in the case of the RE/RF student who may have extensive experience, or currently be practicing as a nurse in another role. One participant stated *"I don't want to get out here and people say oh well, she's still working in aged care, but she still knows how to do this, we're really down in numbers today, can you go and do that" (FG 1p2).* The following comment from another participant suggests that the clinical facilitator will support them as learners through advocacy.

> *"Just the connection between the education and the actual clinical area and advocate…and keep you where you need to be" (FG1p27).*

Alternatively, participants viewed the clinical facilitator advocacy role may also involve supporting a student's professional behaviour where their competency and skill threatens one of the nurses. An example of such a situation was provided by one participant who had advanced clinical skills due to their qualification as a paramedic. In this previous learning situation as a nursing student undertaking clinical placement, they found themselves in an emergency situation where they had more advanced skills than the supervising RN. In this situation the student found themselves responding to the emergency doing *"what they would normally do"* (FG1p19) to ensure the patient was managed safely. The resulting conflict between the student and ward staff was an example of where this study participant would expect the clinical facilitator to advocate on their behalf. Whilst it was acknowledged there would be complexities regarding acting within their scope of practice, this scenario highlights the challenges which may face some RE/RF students during clinical placement given some have status as registered nurses, and may possess a broad range of knowledge and clinical skills which they bring with them to the student role.

Participants anticipated the clinical facilitator would advocate on their behalf in both overt and covert ways. The previous example identifies an overt instance where study participants indicated they would expect their clinical facilitator to advocate on their behalf. The influence of the clinical facilitator's presence as a covert means of protecting the students' role as a supernumerary learner was also raised. Just the sheer presence of the clinical facilitator, whether real or perceived, was seen as a valuable advocacy tool by participants.

> *Moderator: [with having the facilitator around] "Do you feel more protected? Isolated from the complex relationships…"*
>
> *Participant: Yes I think so… I can think, like you rarely had that situation, because you had your work facilitator close at hand, not that they were there all the time" (FG1p5)*

As demonstrated by these comment, some study participants saw advocacy as important and integral component of the clinical facilitator role. Some also perceived, as a result of previous experience, that the advocacy role may also extend to the staffs that are supporting the student during their placement.

Category 3.2: Ward Staff

Whilst not a dominant idea in the discussion, previous experience had meant that participants anticipated that the clinical facilitator role as advocator should extend to advocating for ward staff. One participant contributed the following comment to the group discussion:

> *"They would come past, [and ask the staff] 'everything ok, yes, everything is ok'. I think they spent a lot of time talking with the people in charge of the ward who told them 'get rid of' or 'keep her here', or 'make sure she comes here again'" (FG1p8).*

The clinical facilitator was anticipated to advocate for ward staff, ensuring they have an appropriate patient allocation when working with the students, as well as ensuring they felt supported in their preceptor role.

In summary, there is no doubt from the analysis of this data, that the RE/RF participants expect the clinical facilitator to act as advocate on both their, and others behalf if and when required in a variety of situations. Given the variety of both professional and personal experiences of the RE/RF cohort, it is reasonable to anticipate that the situations or circumstances which may require them to act as advocate may be broader and more complex than for undergraduate nursing students.

Theme Four: Support

The fourth and final theme "support" clustered the six identified activities a clinical facilitator may undertake to provide support to a RE/RF student during their clinical placement. The six activities were arranged into two categories of "counsel" and "practical". The first category of "counsel" covered the activities of debriefing, motivating, nurturing, assisting the RE/RF student with unrealistic expectation of self and others, and providing emotionally support. The second subcategory "practical" grouped mechanisms that offered concrete support to students together. This included facilitating meetings or providing practical support as required by the RE/RF student. These categories and related codes are shown in Table 7 and will be used to report the findings of the "support" theme.

Table 8: Theme Four: Support and associated categories and codes

Theme 4	Categories	Codes
Support	4.1 Counsel	Debrief Assist with expectations Provide emotional support Motivate Nurture
	4.2 Practical	Facilitate meetings

Category 4.1: Counsel

Study participants believed an important responsibility of the clinical facilitator was to offer support through debriefing and provision of emotional support, and assisting with theirs and others expectations of performance. This cluster of codes was labelled "counsel".

The opportunity to *"just debrief"* (FG1p12) with the clinical facilitator in a timely manner was considered important by many of the study participants. Two study participants provided the following comments which highlight the importance placed on the opportunity to debrief with the clinical facilitator:

> *"I think a good facilitator for me is someone I can go to and say this is what is bothering me" (FG1p28).*
>
> *"Having a facilitator right there to go through it, so that you don't have to suppress your emotions" (FG1p4).*

The latter response was qualified even further by the participant explaining that this type support would enable to *"keep me in there"* (FG1p4), suggesting that effective support motivated students such as herself to continue under difficult circumstances. Another participant emphasised that if they knew it was going *"to be a bad day"* they could "*adjust…as long as I had my facilitator to come back and debrief*" (FG1p12). The term *"nurture"* was also used by one participant, to describe the way they felt when well supported by a clinical facilitator, especially in the early stages of a clinical placement (FG1p5). Whilst the primary focus of support was categorised as counselling, some participants anticipated practical support may be required from the clinical placement.

Category 4.2: Practical

The practical support that study participants felt they may need during from the clinical facilitator during clinical placement was principally taking responsibility for ensuring opportunities for them to meet. Previous experience of one participant indicated they valued the clinical facilitator actively taking responsibility to organising meetings with students (FG1p12). The participants spoke of the role of the facilitator to be proactive in this type of practical support.

In summary analysis of the data indicates RE/RF students expect a range of counselling and practical support activities to be provided by the clinical facilitator. Counselling support they perceived may be required included debriefing, assisting them maintain their motivation and, nurturing whilst practical support included initiating the arrangement of meetings.

Summary of focus group one findings

In this section the findings of focus group one has been described. This pre-clinical placement focus group explored the expectations of RE/RF students of the clinical facilitator supporting them during their clinical placement. It was evident from the data that whilst expectations of the role of the clinical facilitator varied between individuals participating in the study, the activities expected of the clinical facilitator could be clustered into four main themes. These themes related to the role of the clinical facilitator in guiding students' learning, facilitating their assimilation into the ward and assisting their transition to competence as an RN, acting as an advocate and providing counselling and practical support. Data analysis also indicated study participants expected the support provided by the clinical facilitator would be according to individual student needs and, in consideration of the clinical environment accommodating the clinical placement. With these expectations in mind, the findings from the post clinical placement focus groups - two and three will now be reported.

From expectations to outcomes – Findings of focus group two and three

The following section presents the findings of focus groups two and three. Focus group one asked participants to explore their expectations of the role of their clinical facilitator prior to undertaking their clinical placement. This data was analysed and used to guide focus groups two and three. Focus group two, which

was conducted after clinical placements had been completed, asked the same participant group to reflect on how their experience matched their expectations. In focus group three the clinical facilitators were also asked to reflect on questions drawn from the findings of focus group one (Appendix 12). The findings from focus group two will be reported under the themes identified in focus group one, and will incorporate relevant points made by the clinical facilitators from focus group three.

Focus group two was introduced with a brief overview of the themes that had been identified following the analysis of focus group one. This included the role of the clinical facilitator in *guiding student learning*, developing and maintaining *relationships*, *advocating* for students and their learning and, *supporting* both individuals and organisations before and during students' clinical placement. After the overview, the group was asked how the clinical facilitation provided during their program had lived up to their expectations as presented in focus group one. The moderator also took the time to qualify that the discussion was intended to consider the role of the clinical facilitator, and not the preceptors (being the nurses they worked with on a day to day basis).

Summary of recurrent themes through Focus group one two and three

Theme 1: Guide learning

In the first focus group participants indicated that the clinical facilitator could be expected to undertake a variety of activities to support and guide their learning during clinical placement (see Table 4). They also expected the activities, clustered into categories of teaching, assessing or, learning, to be contextualised by the clinical facilitator to meet the needs of individual, and complement the support provided by the clinical staff, rather than be defined by routine or prescription. Analysis of the second focus group suggested that the majority of the RE/RF students relied less on the clinical facilitator for activities associated with guiding their learning than expected. This was in contrast the RE/RF clinical facilitators who considered guiding a student's learning an important part of their role. These findings will be reported under headings of the three categories teaching, assessing and learning.

Category one incorporated activities which related to teaching the RE/RF student in the clinical setting. Broadly speaking, apart from academic support (FG2p5), study participants experienced very little teaching from the clinical facilitator during their clinical placement. In general, the RE/RF students felt they were *"Self-directed" (FG2p34-35).*

This may have been related to the priority given by some participants to establishing relationships with ward staff early in their clinical placement as indicated by the following response;

> *"there was a point early on in the program [clinical placement]…[I tried to] find someone on the ward that you resonate with…that is willing to spend time more time with you, or that has an understanding [of a] student relationship" (FG2p34-35).*

This however was not the case in all student experience. The one occurrence where this did not occur was in the case of the RE/RF student who undertook their clinical placement offsite and this will be considered in more detail at the end of this section.

The RE/RF clinical facilitators participating in focus group three viewed teaching as part of their role. The clinical facilitators recognise the diversity of student needs and believed they adjusted their teaching accordingly, as demonstrated by the following comment when discussing teaching the use of pumps:

> *"It depends on what sort of students [there are]…You've got some that just pick up straight away and others, and others that haven't seen [them] in ten years "(FG3p29)*

They indicated this *"flexible"* (FG3p1) and individualised approach was applied to all components of their role relating to guiding a RE/RF students learning. This may include teaching both clinical and non-clinical tasks in the clinical setting. They also viewed their pre-clinical placement teaching role as important in the skill development of the RE/RF student as indicated by the following response:

> *"with this particular group I found they really wanted to know a lot of clinical skills...and I just found the afternoon was not enough…it would have been great to have more [time] because that's what they were really interested in" (FG3p26-27)*

The second category of guiding learning covers aspects related to assessing the RE/RF student's performance. Assessing their performance and competency has many components and includes both academic and clinical assessments. Within

the clinical placement environment students are required to complete a number of clinical skills audits. Generally performed under the supervision of the clinical staff, the clinical facilitator may undertake this activity if staff are either unwilling, or unable to assess the student. All other assessments are completed by the program coordinator. In focus group one the students expressed an expectation that the clinical facilitator would have an active role in assessing their performance, monitoring their progress, identifying knowledge and or skill deficits and providing feedback. Focus group two data indicated that this was not the case, but rather, the program design enabled independence for the students with assessment activities (FG2p37) and self-direction in addressing their own learning needed to overcome any performance deficits. One participant explained:

> *"and because the information was so achievable [accessible] on a disc…your clinical facilitator doesn't have a focus in that because your independent, your made independent with your learning information." (FG2p37)*

This was not disputed by the data provided from focus group three, but was qualified. The clinical facilitators spoke of *"assessing them [the RE/RF students] constantly"* (FG3p50) suggesting their assessment role has both formal and informal assessment aspects. The clinical facilitators in the study indicated they may assist with formal assessments when students experience difficulty getting ward staff to perform an assessment given their view that assessment of students' progress is "constant" it may be speculated that their informal assessments occur during any interactions with students such as debriefing.

As part of the "assessing" category, study participants in focus group one identified the provision of feedback as one of the roles of the clinical facilitator. For most of the study participants the need for, or receiving of feedback from the clinical facilitator was of primary concern. Despite this, focus group two data indicated that most participants were self-directed in seeking feedback on their clinical performance from the ward staff. For some RE/RF students however, they may be less self-directed in seeking feedback from either clinical staff or the clinical facilitator. One individual reported they had not been provided with feedback from staff in their clinical area stating:

> *"It wasn't explained [to me until] the end of the course that if you have no feedback then that is a good thing" (FG2p14).*

The same participant later added to this by indicating they felt that the clinical facilitator would have been the "*best person to [get] feedback off"* highlighting the need for the clinical facilitator to adjust their role to address shortcomings in teaching, assessing, or learning activities not provided by clinical staff. Surprisingly, the clinical facilitator's role in providing feedback to RE/RF students did not emerge as a theme in the analysis of focus group three data.

The third category of this theme, "learning" recognised the clinical facilitator's role in supporting the RE/RF student's learning. In the first focus group participants indicated they would expect the clinical facilitator would support their learning according to individual need in a variety of ways. Analysis of focus group two suggests that participants were generally self-directed, taking responsibility for their own learning with one participant indicating that even if they were working with an RN who was not skilled in supporting their learning they *"would take control of [their] own learning and own [responsibility for] patient safety"* (FG2p17).

Analysis also indicated there was no evidence the clinical facilitator played a role in remediation or, development of learning plans to scaffold the learning for any of the RE/RF students. This may be indicative of a cohort without re-mediation needs. Alternatively it may demonstrate the shortcomings of the model of clinical facilitation this program uses to support students at satellite hospitals, given one participant had negative learning experiences which is discussed at the end of this section.

What data analysis did indicate was RE/RF students found it reassuring to have the clinical facilitator available as a resource person. One participant stated:

> *"you…do like having someone just to ask a question…because you don't want to ask them [ward staff] a very simple thing…like urinalysis…it is a very different dipstick to what I used…so there's some questions like that… you don't want to go to your charge….the facilitators there you can ask that question" (FG2p41)*

This view point illustrates the advantage of having a clinical placement at the primary hospital site providing opportunistic access to a resource person and *"problem solver"* (FG2p40). Participants also recognised their time spent with the

clinical facilitator offered an opportunity to engage in reflective practice, with one participant indicating that interactions can be

> *"a cork sort of popping experience because you never know what is underneath the light chitchat" (FG2p29).*

Interestingly another participant saw the clinical facilitator as an opportunity to escape the learner role, suggesting that

> "*it's nice to see their bright little familiar face… to stop for a moment and be a person as opposed to a learner…It's like you can sort of breathe" (FG2p23).*

This was further supported by the view that the time with the clinical facilitator was a *"not learning thing"* (FG2p25). This *"not learning thing"* does not appear however, to mean that the clinical facilitator does not influence, or play a role in facilitating the learning of a RE/RF student. It appears it may be more related to enabling ward staff to support effective learning and teaching of the RE/RF student. This is particularly relevant for satellite and remote hospitals where the clinical facilitator role may be focused on setting up networks of supports so local staff are able to provide education and assistance with learning as indicated by this clinical facilitator's response:

> *"it was just nice to set something up so that she [hospital staff member] could go and introduce [themselves] and say if [you've] got an education problem were [you] want to learn something [they] are available for them [RE/RF student]" (FG3p8).*

The role of the clinical facilitator as an "enabler" of learning rather than the primary teacher was supported further by focus group three data which suggests clinical facilitators support the students' learning in response to individual needs, and ward staff ability to meet the student's learning needs. The guiding of student learning undertaken by the clinical facilitator is not prescriptive, but rather in responses to gaps in what a student needs, but not provided by the clinical staff. The clinical facilitators identified this support ranges from providing simple problem solving strategies (FG3p4) to manipulating patient allocation to ensure appropriate supervision and learning opportunities (FG3p32). They also recognised the difficulty of providing high level support to students with significant leaning needs when the student is attending clinical placement at either a satellite or remote hospital. One study participant identified one specific situation where they felt this directly impacted on one student's experience:

> *Moderator: "It was very evident [from FG1 & 2 data] that the level of support that was given [was] completely different across….the different organisations".*
>
> *Clinical facilitator: I suspect that would have been a very, very different experience for [student] at the clinical level…..simply because the facilitator would have been face to face frequently and [would have] reduced the anxiety." (FG3p46)*

The RE/RF students undertaking clinical placements off site at a satellite hospital are supported by the program clinical facilitator (PCF). In the PCF-SS model the PCF is expected to visit students at satellite hospitals once weekly, unless otherwise indicated. This model allows for extra visits and support if initiated by either the student or clinical facilitator, or, if it is apparent that the student has learning needs which are not being addressed by the ward staff. Phone clinical facilitation is also available for students in the PCF-SS and can be requested by the student, or instigated by the Clinical Facilitator if they believe it is warranted. The RE/RF students attending clinical placement at remote hospitals are supported by a local facilitator (LF), but can access support via phone or email if required. The LF is also able to access clinical facilitation support from the PCF if required. Effectively supporting the learning of students by either of these clinical facilitation models can be challenging.

This challenge was evident for one study participant who undertook their clinical placement at a satellite hospital. While most participants felt the clinical facilitator role adequately supported their learning, one participant's experience demonstrated the potential risk for students' learning when attending clinical placement at either a satellite or remote hospital. In the first focus group it was highlighted that the clinical facilitator's role in supporting the RE/RF in their learning should be aimed at scaffolding their learning and be responsive to the individual needs of students. This student, located at a satellite hospital, and supported by the PCF was visited, as per curriculum requirements, once a week for one hour. Whilst this level of support is designed to be flexible, this relies upon effective communication between the student staff and clinical facilitator, which in this student's situation did not occur. The student explained:

> *"I know I needed something completely different from the facilitator… than what you girls needed…..it's a whole different experience for me. I didn't have that culture in nursing…. I didn't have the context….I had all these skills and knowledge… I really*

> *struggled to put them into that context for the first few weeks" (FG2p26).*

While this was the only evidence of a participant not receiving the clinical support needed in the early stage of their clinical placement, other participants identified another risk to their learning opportunities. This risk was the result of confusion around the RE/RF student role and what they were allowed to do.

Focus group two indicated the confusion surrounding the role of the RE/RF student may result in limiting their learning opportunities and experiences. Study participants indicated that despite the program literature being provided in to clinical areas prior to their area receiving RE/RF students, many ward staff were unclear as to the limitations on their practice. This resulted in them being excluded from performing some activities that were within their scope of practice as a RE/RF student, resulting in students feeling *"responsible for taking charge of their own learning"* (FG2p17). It was felt by some, that clearer guidelines explaining what activities they can undertake as a student would take the pressure off staff, and enable students *"to work within the proper role*" (FG2p20).

Whilst it may be argued that this activity of the clinical facilitators role falls within the "facilitating assimilation theme" as initially coded in focus group one, the apparent detrimental impact this lack of clarity, may have on the learning opportunities of the RE/RF student, suggests it may be more appropriately allocated to the "guide learning" theme (FG2p17). This view is supported by one RE/RF student participating in the study who stated:

> *"I think there was still confusion between whether you were a refresher or re-entry and…what [you] can and can't do, some people would say well, you just can't do that.., or you should be doing that". (FG2p17)*

Given the limited clinical placement time provided for RE/RF students, and the recognised importance of workplace learning in the literature (reference) maximising learning during this time should be a priority of the clinical facilitator role.

In summary, the results from focus groups two and three indicate that contrary to initial expectations, the clinical facilitator played a less significant role in guiding the RE/RF student's through teaching, assessment and learning activities than anticipated. These activities were mainly undertaken by ward staff. Primarily, the

support clinical facilitators provided was either academic or simple problem solving. RE/RF students were generally self-directed and took responsibility for their own learning rather than relying on their clinical facilitator. In general the participant clinical facilitators agreed with the views of the RE/RF students, but emphasised the importance of the clinical teaching that they provide prior to the students commencing clinical placement. They also indicated they play a role in both assessing the students' progress both informally or formally when needed, and establishing support networks other than themselves for students in the clinical setting.

Theme 2: Facilitate Clinical Assimilation

In focus group one study participants indicated they expected the clinical facilitator would assist their integration into the clinical environment and, their transition from student to competent nurse. It was expected this would be through fostering relationships or, by providing clinical or professional guidance to the RE/RF students and ward staff (see Table 5). Fostering relationship included student and ward staff preparation followed by regular liaisons with both students and clinical staff. Clinical and professional guidance included activities where the clinical facilitator promoted the transition from student to RN. This was expected to be achieved by providing guidance on clinical and professional issues. The results from focus group two and three will be considered under these two categories.

Integration into the clinical team for the RE/RF student is important, and study participants indicated this could be enhanced by the clinical facilitator through fostering relationships between students and ward staff. Such a role would require the clinical facilitator to engage with students and ward staff and, education and health service staff. It was anticipated that this would occur both prior to, and during the student's clinical placement. This included preparation of both students and clinical staff prior to clinical placement; maintenance of ongoing relationships with students, staff, education and health service staff; management of conflict and; promotion of learning environment. Analysis of the data from focus group two and three indicates that whilst most study participants' expectations were met in the majority of cases, this was not the case for all. This was particularly evident in the case of the study participant attending clinical

placement offsite at the satellite hospital and supported by the PCP-OS model of facilitation.

Study participants indicated in focus group one they expected the clinical facilitator to foster relationships between the RE/RF student and clinical staff through effective pre-clinical placement preparation. Data from focus group two indicated that generally, study participants felt *"they were well prepared"* (FG2p38). One participant viewed the preparation by the clinical facilitator as the most *"essential part"* explaining:

> *"I thought the best benefit [of] the facilitator [was] the foundations at the beginning…the foundations of what was expected...the relationships and how you were going to…pre-empt the stress, pre-empt the change" (FG2p38).*

Clinical facilitators participating in focus group three supported the need to prepare students for their clinical placement however, their focus was on the initial settling in to the ward period as indicated by the following remark:

> *"I always show them the allocation book…where to find your [student's] name…and go through all those things and get them comfortable with the computers…just to get them feeling they belong in the area" (FG3p37).*

The expectation that ward staff would also be adequately prepared to support the students was an area where the clinical facilitation model did not met the expectations of all the study participants. In a positive experience one student indicated that the ward was well prepared:

> "[that even though] *there were a lots of students on board... [and] your…one of them…but on my ward…they were very much aware…for me….the best benefit…for me to be my own boss." (FG2p22).*

In contrast, another participant undertaking their clinical placement at the satellite hospital and supported by the PCF-SS model explained:

> "*this woman [nurse] …seems to have no idea…what I am here for or what I am trying to achieve" (FG2p9).*

Focus group three analysis indicated that the clinical facilitators acknowledge the importance of preparing the ward staff and their role in undertaking this responsibility. One stated:

> *"it makes a big difference if they [ward staff] are well prepared and expecting them [the students] and greeted them positively as a result of the*

> *work of the clinical facilitator…at the end of the day it made a big difference" (FG3p40)*

It is evident from focus group one analysis that study participants expected this engagement with RE/RF students and ward staff would continue throughout the clinical placement. It was expected the clinical facilitator would continue to foster relationships through regular liaising with both students and staff and, provide a conduit between education and health care services. Analysis of focus group two data initiated that the clinical facilitation model did not fulfil the expectations of all the study participants in all clinical environments in this regard.

The participant who undertook clinical placement at the satellite hospital felt there was an active avoidance of the clinical facilitator by the ward staff. They stated it was like they were *"two separate entities with no crossover with either of them"* (FG2p9). This participant also felt that when ward staff needed to communicate with the clinical facilitator staff were reluctant to do so as highlighted by this response:

> *"[the nurses] almost…did not want to know her...they wanted to deal with me as a separate entity to the facilitator" (FG2p9).*

This was no the experience for all RE/RF students. As part of their engagement with ward staff clinical facilitators use their established relationships with staff to identify clinicians who they believe will be a valuable and trustworthy resource person for students:

> *"I…try and foster relationships with other staff members on the ward … because I got to know quite a few people in the hospital…its really helpful if you go down to the ward…and…say…if you want to know anything [nurse]…is fantastic…she's been on the ward forever she'd like [help] you wouldn't you [nurse]? So you actually sort of boost their ego a bit as a staff member on the ward and letting [the student know who to go to]" (FG3p38).*

They also describe approaching clinicians, encouraging them to keep an eye on the students on their behalf. One clinical facilitator indicated:

> *"if you can get two or three of those [nurses] per ward looking out for your student it can work quite well" (FG3p38).*

Given one facilitator in the study expressed limitations in the ability to develop rapport with staff at satellite hospitals in the PCF-SS model, it could be assumed that there may be a reduction in the ability for the clinical facilitator's ability to

establish these informal support networks with ward staff. This clinical facilitator stated:

> *"I probably don't develop a rapport with the…staff at [satellite hospital]…there are a few at [hospital] that have [done]…the program…so I know them" (FG3p7).*

Whilst this problem may be more evident for students at satellite and remote hospitals who are supported through the PCF-SS model, there were some aspects of relationship development which did affect a broader group of study participants irrespective of model of support used. In particular there appears confusion and lack of clarity regarding RE/RF student's scope of practice and, the RNs' roles and responsibilities in providing supervision for this nursing student cohort. This ambiguity was not just noted by students supported by the PCF-SS model. It appeared problematic for some study participants supported by the PCF-SS model as indicated by the results reported in the "guide learning" theme which may be directly related to ineffective relationship with clinical staff.

Such evidence would suggest other aspects of the clinical facilitator's role requiring a collaborative relationship between ward staff and the clinical facilitator may be compromised on occasions. This may include complementing the ward staff in meeting the learning and support needs of the student during their clinical placement or preventing or managing conflict.

This suspicion can be further supported by the experience of the same student who experienced difficulty gaining advocacy from the clinical facilitator when the staff in the clinical area were using them as part of the staffing numbers. This created some conflict between the staff and student, which despite the student's efforts to resolve, required intervention by the clinical facilitator. This intervention occurred sometime after the event due to the use of the PCF-SS model to support this student resulting in unwarranted distress. The student explained:

> *"They're not there every day…it is like once a week…and if you're having a busy shift the opportunity wasn't there to catch up…the problem happened you're trying to deal with it…and then you go home…and then you come back the next day…but the problem escalates over a period of days…before they come down next" FG2p13).*

The analysis of focus group three did not yield significant thoughts from the clinical facilitator's participating in the study in respect of conflict resolution but

they did acknowledge that facilitating students off site had it challenges, and these may present barriers to meeting the expectations of the RE/RF student. One study participant explained:

> *"You have to be organised…[I] try to see them [all] on the one day…if ones not on… then there is no point going down there really" (FG3p6).*

And another:

> *"You develop a rapport with the CSCs…because I stick my nose in [their office]… probably don't develop a rapport with the other staff [at the satellite hospital]" (FG3p7)*

Given this absence of rapport between clinical facilitator and ward staff, it is hard to imagine that the clinical facilitator will be able to contribute to the promotion of a learning culture or, that they will be able to complement the ward staff in their support of students' assimilation and transition processes as expected by the study participants.

Analysis of focus group two and three within the context of the theme of "facilitate clinical assimilation" highlighted one other concept of fostering relationships that was not obvious in focus group one. This was the role program design plays in fostering the relationship between the clinical facilitator and the RE/RF student. Students participating in the study indicated that they believed the opportunity to establish a relationship with the clinical facilitator before they begin their clinical placement was valuable and allowed the clinical facilitator to gain insight into their individual needs as illustrated by the following remark:

> "*and the facilitators…because we have done the theory side of it [with them], in that time [you've] gotten to know why each of us is doing the course…and the individual things we wanted to get out of it."(FG2p7)*

The clinical facilitators participating in the study also found the tendency to develop strong relationships with their students indicating a desire to protect students and a feeling of ownership with study participants indicating they consider students *"one of yours [theirs]"* (FG3p24). This relationship assists the clinical facilitator to meet RE/RF student expectations in the second category of this theme.

The second category “clinical and professional guidance”, linked concepts where the clinical facilitator’s role promotes both the integration of the RE/RF student into the clinical team, and successful transition from student to competent professional. In focus group one, participants expected the clinical facilitator would support their integration into the clinical area and their progression to independent practitioner. They anticipated this would be through providing objective guidance on professional clinical matters, and administrative tasks. Data analysis of focus group two and three indicates study participants felt some of these expectations were met more effectively than others. Administrative tasks were not identified in any of the data in either a negative or positive way. The ability for clinical facilitation to meet the expectations in respect of other elements of this category were also less clear.

The expectation the clinical facilitator would promote role transition was not overtly confirmed or dismissed during analysis of focus group two and three. In focus group one it was suggested that clinical facilitator support should “build you up…to be an independent practitioner” (FG1p7). This requires them to accept gradual increases in accountability and responsibility for their practice in the clinical care of their patients. Given this it is reasonable to assert that the concerns raised in the theme “guide learning” relating to a lack of clarity surrounding the scope of the RE/RF student’s practice may impact on the opportunity for RE/RF students to progress their practice from student to practitioner.

As more than one study participant felt that there was a need for greater clarity on the scope of practice of the RE/RF student, it is suggestive of the need for this aspect of the facilitator role to be developed further. The following comment by one participant supports this view:

> *“maybe more knowledge for them…it takes all that pressure off them [nurses supervising] and the student so that your able to work within the proper role.” (FG2p20)*

Study participants in focus group one also expected their role transition would be supported by the clinical facilitator though guidance on clinical and professional matters. Study participants felt they would need assistance with managing workplace clinical and professional issues. Analysis of the data from focus group

two and three did not highlight any significant evidence that any participant needed this guidance, apart from the one undertaking their clinical placement at the satellite hospital.

This participant experienced problems with adjusting to the both the culture and clinical workings of the ward environment. They remarked:

> *"This ward does not work like the surgical ward or the ED…Each ward is so very different." (FG2p21)*

The data did not suggest that the clinical facilitation of this student assisted them with either the professional or clinical issues raised, again highlighting the difficulty for clinical facilitators to meet the expectations of some students within the PCF-SS model. Clinical facilitators in focus group three also indicated they expected to provide guidance on professional and clinical matters. One participant stated:

> *"I have a rapport with a lot of them…they want to ask your advice because they are unsure on whether they are doing the right thing" (FG3p16).*

This comment not only confirms the role of the clinical facilitator in supporting the clinical and professional development of the RE/RF student but also highlights the importance of relationships in promoting dialogue.

Focus group one data also indicated the clinical facilitator was expected to maintain objectivity. Whilst analysis of focus group two data did not indicate this need was either meet or needed, clinical facilitators in focus group three indicated they believed they were expected to bring objectivity to situations. One clinical facilitator in focus group three indicated that despite their desire to "want to protect them" (FG3p24).

> *"you try and not be judgmental…about what's going on…you've got to try and get that bigger picture" (FG3p24).*

This concept of objectivity was linked with another concept, the notion that the clinical facilitator would provide the RE/RF student with a constant, neutral person, external to the ward staff who could provide clinical and professional guidance. From analysis of focus group two and three it would appear that the clinical facilitation model met this expectation in the majority of participant's experiences.

One participant highlighted in the discussion that "everything is new" (FG2p25), but due to the established and, ongoing relationship, the clinical facilitator is one constant element in a dynamic environment. Again, the participant who felt clinical facilitation did not meet their expectations was the student attending clinical placement at the satellite hospital. This study participant responded to the other participant's comments with:

> *"Yes so I did not have what you had. I didn't have…a constant contact" FG2p13).*

The importance of this neutral person was not lost on the clinical facilitators who indicated the lack of affiliation with the ward potentially lead to more authentic dialogue. One participant comment:

> *""we don't have an affiliation… with the ward…so they probably feel they could say…blah-blah-blah" (FG3p17)*

In summary, results from analysis of all focus groups suggests whilst the RE/RF student may expect the clinical facilitator to promote their clinical assimilation through fostering relationships and clinical and professional guidance, however under current models this may not always occur. Some aspects of the clinical facilitators role that promote this assimilation such as fostering of relationships through preparation of students and ward staff was effective in the majority of cases – but not for all. This is also the case where clinical and professional guidance may be required by students. Of particular note is that students attending clinical placement at either a satellite or remote hospital may be at greater risk of these expectations not being met.

Theme 3: Advocacy

In focus group one, study participants indicated there was an expectation that the clinical facilitator would advocate, both for them as individuals, and for their role as a learner, and for the ward staff. Therefore, aspects of this theme were divided into the categories of, advocacy for the student and, advocacy for the ward staff (see Table 6). This data also indicated some students' previous experiences where the clinical facilitator was remote to the clinical placement venue were less satisfactory than those where the clinical facilitator was on site.

While focus groups two and three indicated some study participants experienced advocacy on their behalf, there was no evidence the clinical facilitator acted as advocate for ward staff during this study. Results from focus group two and three do however, highlight two main points and identify a new aspect of the role of the clinical facilitator in advocating for the RE/RF student. One main point evident is the importance of the clinical facilitator advocating for the role of the RE/RF student as a supernumerary learner and, the second, is the potential risk of limited advocacy for students attending clinical placement at a satellite or remote hospital. The new concept to emerge was the role of the clinical facilitator in enabling self-advocacy in the RE/RF students. Given there was no evidence of advocacy for the ward staff the results from focus group two and three will be considered in the context of advocacy for the student and their role as a learner, the impact of attending clinical placement at an alternative site to the primary hospital, and the role of the clinical facilitator in promoting self-advocacy.

Study participants in focus group one expected they may need advocacy for both personal and professional matters during their clinical placement. The personal matter of main concern was the possible need for advocacy if rosters were not negotiated to meet RE/RF student's personal commitments. Neither focus group two or three provided any evidence the clinical facilitator acted as advocate on any matters related to rostering or, any other personal matters for RE/RF students during their clinical placement.

What was evident however, from both focus group two and three data analysis, was the importance of the clinical facilitator in advocating for their professional role as supernumerary learner. RE/RF students participating in the study anticipated there was a risk they would be *"suck[ed] up"* into the numbers and coerced *"to do what they [ward staff] want you to do"* (FG1p4) and that they expected the clinical facilitator to advocate on the behalf if this occurred.

Only the study participant who attended clinical placement at the satellite hospital indicated their student status was not respected and they were used as part of the staff numbers. Interestingly, other study participants indicated they felt the presence of the clinical facilitator provided legitimacy to their status as students, as one participant put it:

> *"reaffirming…[the students'] professional presence…[giving it] validity, not in a dramatic way, just in a passive way" (FG2p9).*

This act of "passive" advocacy suggests for some, the arrival of the clinical facilitator in the clinical area may legitimize their RE/RF role as a supernumerary student, smoothing the way for them to leave the ward to debrief, and as one participant explained:

> "*introduce[ing] this is my facilitator. I'm going off with this person …and you knew that the work had to …carry on while you [the student] weren't there…I am not just sort of bludging" (FG2p6-7).*

Analysis of focus group two data indicated that the only situation where active advocacy was required was for the study participant who attended clinical placement at the satellite hospital and supported under the PCF-SS model. In contrast to others' experiences, this participant identified an incident where they were used to cover staff sick leave.

Despite the student's protest they were used to fill the staffing gap and accept a patient load without supervision. On reflection in the focus group this student stated

> *"Again the facilitator needs to be able to sort it right there and then not let it get through [the] shift and think at the end of the day I'm not coming back."* (FG2p15)

Whilst the clinical facilitator was available by phone this student indicated that they did not ring them as they were too busy and under too much pressure *"and it was very difficult because you re then expected to go back and front the ward" (FG2p16)* raising concerns regarding the risk of limited access to timely support for RE/RF students at satellite or remote hospitals. This student's experience resonated their previous experiences with clinical facilitation expressed during focus group one. They explained:

> "*unless I got on the phone and rang [the clinical facilitator] and you often didn't have time to do that, or [the clinical facilitator] wasn't available, the facilitation was very much a waste of time and you had to rely very much on the ward staff" (FG1p3)*

The problem of providing active advocacy was supported in focus group three by the clinical facilitators who recognised the need for, and had in the past, advocated for RE/RF students to protect their role as supernumerary learners as illustrated by the following comment:

> *"The refresher brought the problem up that she felt she was being counted in the numbers and there wasn't someone facilitating or supporting her…I contacted the CSC and said what's going on here?" (FG3p9).*

The facilitators also felt they needed to advocate for the right to have effective quality supervision by experienced staff as demonstrated by this response:

> *"I've had to intervene before with allocations…for example you've got an experienced RN or two on the ward working together and then you put a transition nurse with a reliever with an enrolled nurse" (FG3p32).*

Whilst analysing focus group two data against the categories of "advocacy" theme a new concept emerged that was not evident in focus group one. This was the concept of "enabling self-advocacy". Results from focus group two indicate the clinical facilitator can enable "self-advocacy" in the student as a result of their interactions. One participant expressed it as a result of the "reality check" which occurred at a meeting with the clinical facilitator which enabled them to

> *"face the culture that you're so familiar with, that you have to become re-familiar with...because you have taken a step back and thought no, I am not going to be a dog's body or a mouse or a lion…I am going to be more assertive or more of an advocate, or whatever it is you want to improve" (FG2p24).*

Whilst it may be a little simplistic to suggest that the clinical facilitator empowers the RE/RF student to achieve an effective level of self-advocacy given the complex nature of the clinical setting and the RE/RF student, this aspect of the clinical facilitator's role may be more relevant to this cohort than other more traditional clinical facilitator roles.

In summary, results from analysis of all focus groups suggests whilst the RE/RF student may expect the clinical facilitator to advocate for both the student and the ward staff, their main advocacy role is for the student. This advocacy may occur in active or passive ways. Students participating in focus group one and two expected that the clinical facilitator may need to advocate on practical or professional matters, but, given the cohorts previous experience in nursing, their primary advocacy need may be protecting and legitimising their role as supernumerary learner. They also indicated that clinical facilitators are able to promote self-advocacy in students. RE/RF students undertaking clinical placement at sites other than the primary hospital may be at greater risk of being used as a pair of hands 'in the numbers' rather than afforded the appropriate

supernumerary student status given the limited presence of the clinical facilitator at the clinical placement site.

Theme 4: Support

In focus group one, study participants indicated there was an expectation that RE/RF students may require the clinical facilitator to provide them with support in the form of counselling or practical support (see Table 7). Analysis of post clinical placement focus groups confirmed the RE/RF students' expectations they would need both counselling and practical support from the clinical facilitator during their clinical placement. Review of these focus groups also brought to light new concepts in both categories. In their counselling role clinical facilitators could be expected to provide reassurance, validation and humanize the clinical experience. In the area of practical support the RE/RF student may also expect individualised career guidance and assistance with practical strategies for managing the clinical placement environment. The results will be reported within the context of the two categories counsel and practical support.

Focus group one indicated study participants expected the clinical facilitator to provide counselling through nurturing and providing emotional support, assisting the students maintain motivation and realistic expectations and, providing opportunities for debriefing. Analysis of the two post clinical placement focus groups indicated that the clinical facilitator provided these services as expected.

The expectation that the clinical facilitator would nurture the RE/RF student was voiced by both students and clinical facilitators in their respective focus groups. One student participant felt that the time spent with the clinical facilitator *"just lets you be a person"* which they felt was *"really important"* (FG2p25). The clinical facilitators also saw this as part of their role suggesting they wanted to *"protect"* the student FG3p24) and, at times they took on a *"mother role"* (FG3p1).

The role of the clinical facilitator in motivating RE/RF students, identified in focus group one, was also affirmed in focus group two and three with both students and clinical facilitators recognising it as an expectation of the role. One student expressed what the clinical facilitator did to motivate them was to *"just cajole us along our path" (*FGp24), whilst the clinical facilitators were more direct in their comments, indicating

> *"There are a few jittery nerves starting the program….I guess I see it's my role to try to encourage them to stay with the program it as their role to "encourage them to stay with the program "(FG3p4).*

This may have been achieved by assisting the RE/RF student maintain realistic personal and professional expectations, both of themselves and others. One participant said they were

> *"grateful to have a facilitator…who would say I can see why you are struggling" (FG2p27)* and then later *"it all came together…that was predominantly the chats...this is how I am going" (FG2p31).*

This view was supported by another participant who indicated spending time with the clinical facilitator offered them a *"reality check"* (FG2p24). The view that the clinical facilitator has a role to play in assisting RE/RF students was also supported by the analysis of focus group three. The clinical facilitators indicated that this particular student cohort needed guidance to ensure they were realistic with their expectations of themselves. One clinical facilitator stated:

> *"it's trying to support them…[telling them]…do one thing at a time…rather than looking too far ahead…rather than worry[ing] about what you are supposed to be doing in five month's time…they have high expectations of themselves" (FG3p3).*

Much of this support was provided during debriefing sessions which was also identified as a key area of support expected of the clinical facilitator.

The belief that RE/RF students would value the opportunity to debrief with the clinical facilitator during clinical placement was raised in focus group one and supported with evidence after their clinical placement in focus group two. One participant described the process of debriefing as a *"real benefit"* (FG2p26) and highlighted the trust in the relationship. They explained;

> *"Probably the nice thing…you could debrief with your facilitator and not feel...you weren't being judged" (FG2p45).*

Interestingly, one participant who was at a satellite hospital commented that the debriefing was not of value in the earlier weeks of their clinical placement as they were in need of more practical support. However, once this early practical support had been provided the debriefing was appreciated. (FG2p31). In response to other study participant's feelings that debriefing was a *"real benefit"* this participant stated:

> *"I know I needed some[thing] completely different from the facilitator than what you girls needed…to not come from that nursing background...it was a whole different experience for me" (FG2p26).*

The importance of debriefing was also identified by the clinical facilitators in focus group three. They recognised the value of debriefing to the students and, emphasised that the program design allows them to develop a rapport with students right from the beginning of the clinical placement as illustrated by the following two comments:

> *"sometimes they don't actually even want you to solve their problems…they just want to spew out what has happened or [talk about] somebody giving them a hard time...then once they've done that they're quite happy to move on…..they just wanted to tell you about it…I think as clinical facilitators we tend to devalue that, we don't see the importance for them. We feel it is just chatting" (FG3p39).*

And:

> *"I feel like I have a rapport with a lot of them and they've already started telling you [clinical facilitator] quite a bit, even just after meeting them really for the study days and a couple of observation days and having that contact through the [online] forum or on the phone" (FG3p16).*

Analysis of both focus groups also highlighted the importance of debriefing in a neutral environment, removed from the clinical setting. One student explaining:

> *"it was important to go off the ward...not just [for] the confidentiality but also because it takes you away from the environment " (FG2p5).*

A clinical facilitator supported the practice of leaving the clinical area for debriefing suggesting *'that if there are issues we [clinical facilitator] could take them [student] away from the ward [to] discuss it"* (FG3p9).

During analysis of the post clinical placement focus group three new ideas arose which fit the theme of "support" and its category "counsel". This included the clinical facilitator providing reassurance, validation and, humanising the clinical placement experience for the RE/RF student. The need to provide validation and/or reassurance was raised by the clinical facilitators who felt, at times, debriefing was used by the RE/RF student to *"validate"* (FG3p39) their actions or thoughts. This seems particularly pertinent in the case of the RE/RF student who may have a wealth of knowledge and experience that is not congruent with their clinical placement experiences. The student study participants did not raise the

need for validation, however they indicated they looked for reassurance from the clinical facilitator in respect to their progress with one student stating their was an implied sense they took from the program staff as a result of the established relationship that the clinical facilitator would:

> *"umbrella you [the student] where ever you are, you just be where you are [in terms of progress] "(FG2p24).*

They also felt that the clinical facilitator was the human element of the learning process. For example one participant felt

> *"That person comes along [clinical facilitator]…it's like you can sort of breath… you become a whole person. It is just a really humanising experience" (FG2p23).*

This was supported by another participant who commented *"it [clinical facilitation] could be whatever it needed to be for you [the student]"* (FG2p26). This view was reinforced by the clinical facilitators in focus group three, who considered the role of the clinical staff as primarily task focused whereas, they felt they *"worked for them [the students]"* (FG3p31). This concept of student focused support was also identified in the practical support expected by the student participants who emphasised the importance of individualised support – even when the support was practical rather than in the form of counselling.

In focus group one study participants indicated they expected the clinical facilitator would provide practical support as well as counselling support. The expectation was that they would need the clinical facilitator to organise meetings. While it is not clear that this did not happen, it was not a focus of discussion in any of the post clinical placement focus groups. What did emerge was the clinical facilitator provided practical support by providing career counselling and practical advice on managing sensitive situations that was tailored to the individual needs.

Study participants expected practical support be individualised to suit the RE/RF student. One stated they felt *"vulnerable"* (FG2p43) during the program and the clinical facilitator's role *"changes to each individual"* (FG2p43), commenting further they found they initially experienced difficulty trying to

> *"build up…that knowledge… of who I was and where I am coming from and what my concerns in this place were because that then allowed both*

[clinical facilitators] to help me…through my own individual issues" (FG2p39).

Individualising the support for RE/RF students appears vital given the broad range of professional experience skills and knowledge and, the diversity of clinical areas used for clinical placements. Focus group three findings support these views with the clinical facilitators indicating they needed to offer "*flexible support"* (FG3p1) which may be *"strategic problem solving"* in nature (GFG3p16), *"social"* (FG3p1) or *"career counselling"* (FG3p11-12).

In summary, the results from focus groups two and three suggest the expectations of RE/RF students would need both counselling and practical support from their clinical facilitator was accurate. Findings also identified new areas of support that might be expected of a clinical facilitator supporting RE/RF students. Counselling support was expected and received by the study participants in the form of nurturing, motivation, debriefing and assistance with their expectations of themselves. Unexpected support in the form of reassurance, validation and humanisation of their clinical experience by their clinical facilitator was also provided. The practical support required by the RE/RF students was not what had been expected and was primarily in the form of individualised assistance with strategies for managing clinical environment issues and, career guidance.

Possible influences on participants expectations

Given the aim of this study was to explore whether the clinical support model of clinical facilitation met the expectations of the RE/RF student, it is important to acknowledge the uniqueness of an individual's expectation and the role this plays in any examination of the ability for any support model to meet a groups' individual expectations. For this reason, and in an endeavour to acknowledge the diversity of expectations anticipated in a student cohort such as the RE/RF group, a second round of data interpretation was performed after the initial thematic analysis. This secondary analysis was undertaken with the aim of identifying factors which may possibly influence a RE/RF student's expectations of the clinical facilitator. This examination provided an opportunity to reflect on the clinical facilitator role and the reasoning behind people's expectations and experiences, and the reality of the expectations being met. From this final analysis thirteen elements of interest where identified. These elements were

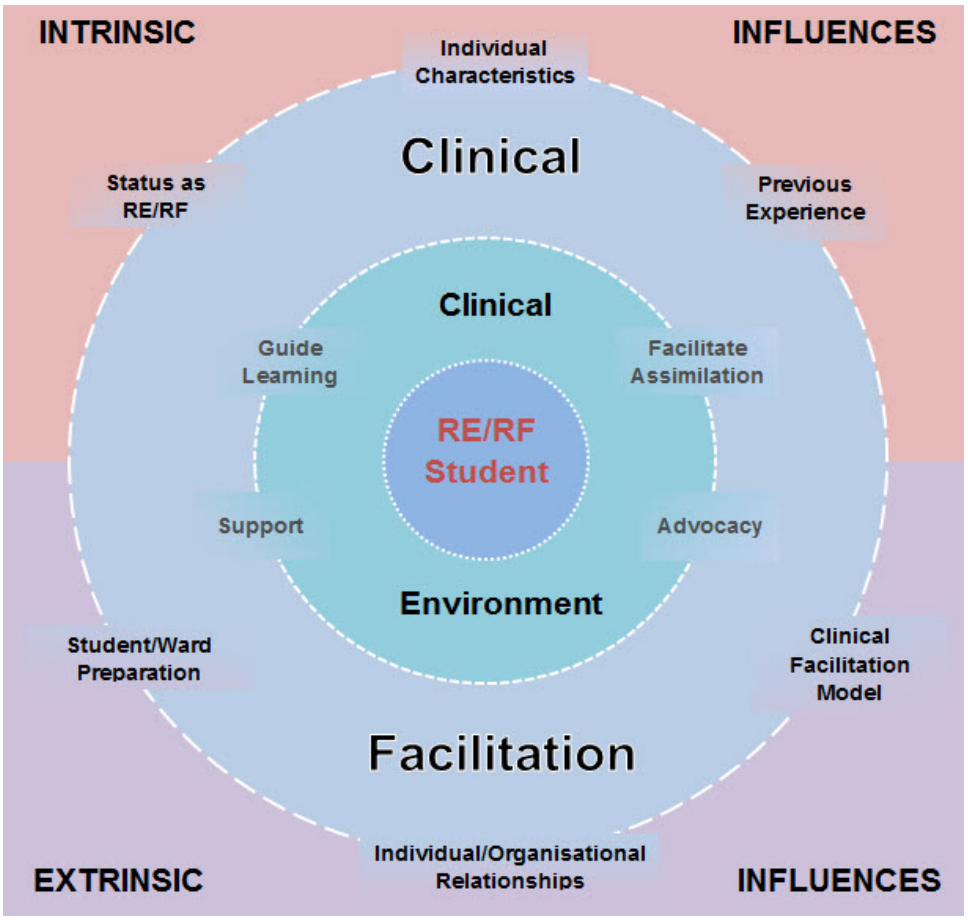
clustered into six categories, and then grouped into two themes. The themes and accompanying categories and elements can be seen in Table 9.

Table 9: Possible Influences of RE/RF Students' expectation of Clinical Facilitation

Theme	Categories	Elements
1. Intrinsic Influences	1.1 Status as RE/RF Student	Not a graduate Not an undergraduate
	1.2 Individual Characteristics	Self-agency Personality traits
	1.3 Previous Experiences	Previous work experience as an RN Previous clinical placements experiences
2. Extrinsic Influences	2.1 Student/Ward Preparation	Explanation of role Setting of expectations
	2.2 Individual/ Organisational Relationships	Clinical facilitator Program staff Ward staff
	2.3 Clinical Facilitation Model	Primary Hospital (PCF-PH) model Satellite Site (PCF-SS) model

When reflecting on the elements, categories, and themes, presented in Table 9 a concept diagram began to develop. This diagram (see diagram 1) demonstrates my thoughts on how the possible influences, drawn from the focus group data, might affect the expectations RE/RF students have of the clinical facilitator supporting them during clinical placement. It also demonstrates the complexity of meeting the expectations of the RE/RF students clinical placement support needs.

Diagram 1 Clinical Facilitation of RE/RF Students



The two themes, intrinsic and extrinsic influences, have been used to form the foundation of the diagram. The intrinsic factors are elements which represent the unique perspective each RE/RF student brings to the expectations of the clinical facilitator and their experience of being supported through the clinical facilitation model. Elements sharing common characteristics have been clustered into three categories related to either their status as a re-entry or refresher student, their individual personal characteristics and, and their previous personal and professional experiences. Professional experiences included both their experiences as a registered nurse, and their experiences of clinical support in the clinical environment. Examples of student perspectives which may be interpreted as intrinsic elements are presented below in Table 10 under each of the elements.

Table 10: Theme One: Intrinsic factors categories and associated codes

Category		Responses
1.1 Status as an RE/RF student	Not a graduate	*"It's different being older and post graduate…we are expected to be a bit more autonomous..." (FG1p5)*
	Not an Undergraduate	*"we're obviously going back to a very different scenario" (FG1p6)* *"It was exactly like going to the undergraduate placement "(FG2p28)*
1.2 Individual Characteristics	Self-agency	*"I think we have to be centred and focused ourselves…it is from within, isn't it not from without" (FG230)* *"For me I needed a lot more support…for me the placement was completely overwhelming" (FG2p39)*
	Personality traits	*"I don't expect anything, because you can't expect anything, because then your disappointed"(FG1p7)* *"there is a whole world of pain there if you want to take things personally" (FG2p29)* *"You always get the person that you'll go and see them every day, yes I'm fine and then…then you find out afterwards that they didn't have such a great time…but they won't open up to you" (FG3p10)*
1.3 Previous Experiences	Previous work experience as an RN	*"you've already done this so your just putting your skates on and doing it again" (FG2p38)* *"I had not come from a nursing background…and to not come from that background…it was a whole different thing for me" (FG2p26)*
	Previous clinical placements experiences	*"My clinical facilitation wasn't very good…I suppose that is what I am worried about even with this course" (FG1p2)* *" My facilitator[was]…my most valuable person" (FG1p12)*

The second theme, extrinsic influences, represents variables of the clinical facilitation experience that are external to the student. Elements identifies under this theme were organised into three categories which were termed student and ward preparation, individual and organisational relationships, and the facilitation model used. Examples of possible extrinsic factors which may be interpreted from the data may which may influence a RE/RF student's expectation of the clinical facilitator or clinical facilitation, are presented below in Table 11 under each of the elements.

Table 11: Theme Two: Extrinsic factors categories and associated codes

Category	Element	Responses
2.1 Student/Ward Preparation	Explanation of role	*"so you have to fight the fact that they [staff] don't know who you are and what you can…and can't do" (FG1p6-7)* "*we were well prepared" (FG2 p38)*
	Setting of expectations	*"its been pressed upon us…you have to adhere to your [learning] needs (FG1p7)* *"most essential part [knowing]…what was expected" (FG2p38)*
2.2 Individual and organisational relationships	Clinical facilitator Program staff Ward staff	*"I found if the facilitator was there you'd get treated differently by the staff…better for them not to be there…[so] your in with them" (FG1p8]* *"If someone said something the follow up was there…so the trust is built up and maintained." (FG2p46)*
2.3 Clinical Facilitation Model	Primary Hospital (PCF-PH) model	*"the thing is just the knowledge that that person was there and could be called upon is oceans…not that you want to…it's just that you can." (FG2p43)*
	Satellite Site (PCF-SS) model	*The clinical facilitator… was remote…so unless I got on the phone and rang her…the facilitation was very much a waste of time (FG1p3)* *"the placements…[in] different hospitals…you just utilise the people on your ward…that's the network to get what you need" (FG1p26)*

Within the diagrammatic framework of the intrinsic and extrinsic themes, the themes which emerged for the primary research analysis were considered (see Diagram 1). Firstly, and most importantly, as in any adult learning approach, the student was placed in the middle of the diagram to indicate it is a student centred approach to clinical learning. The two surrounding circles represent the two components of the student's learning support team which may either promote, or inhibit a RE/RF student's learning – that is - the clinical staff and clinical environment; and the clinical facilitator and associated model. The lines surrounding each component of the learning support team is broken to represent the ideal of a flexible symbiotic (Prideaux, Worley & Bligh 2007) relationship between all parties. The four major themes identified in this study are purposefully placed between the learning support teams, with graded colouring to demonstrate the flexibility in accepting responsibility for meeting these expectations of the student, and the inter-relationship between the clinical facilitator and the clinical staff.

Summary

This chapter has presented the results of the demographic questionnaire and reported the meaning attributed to the data taken from the three focus groups using a three phase thematic analysis approach. The demographic data collected highlights the diversity of the student cohort in respect of age, educational qualification, and previous nursing experience and life experiences. These variations may go some way to explain the diverse expectations of the student upon the clinical facilitator as demonstrated by the analysis of the three focus groups. The findings of the three focus groups demonstrated the RE/RF students expect varied, individual, and flexible assistance from the clinical facilitator. This may come in the form of guiding their learning, facilitating their assimilation into the clinical and professional environment, advocacy and support. The level to which the clinical facilitator provides this assistance may be related to the interaction of multiple extrinsic and intrinsic factors, the student, and their clinical placement environment.

The study findings highlights what the literature alludes to – that finding one size fits all model of clinical support for undergraduate students is no easy task, and meeting the support needs of RE/RF students may be of equal challenge. The following discussion chapter will consider these findings in the context of

available literature examined in the literature review, and draw on literature to support my critical analysis of the research. It will also consider the impact of this research on the current approach to clinical support of RE/RF students and what it might mean for future programs.

CHAPTER 5: DISCUSSION

Introduction

In this chapter the important ideas to arise from this study's findings of the RE/RF students' expectation and experience of clinical facilitation will be discussed. The first section of the chapter will report the limitations of the study. The second section of the chapter will discuss the key findings from the analysis of the data, and will consider the results in the context of existing research and understandings. The final section of the chapter will discuss further research related to the findings.

Study limitations

Stewart and Shamdasani (1990) (cited in Jamieson & Williams 2003 p 273) argue that whilst a focus group moderator who is "immersed in the culture of the group enhances the communication and interaction of the group it has possible negative implications for the results that the focus group data ultimately produces". Therefore the closeness of the moderator to the research subject and study participants risks introducing bias. For this present study, this risk was identified prior to conducting the focus groups. To minimise the risk of moderator bias affecting the data, a series of questions to be used during the focus groups were formulated in consultation with the primary supervisor. Whilst it was recognised that an alternative data collection approach may have further reduced the possibility of bias, it was decided to use focus groups for two reasons. Firstly, the purpose of this study was investigative, and as little research has been undertaken in respect of this student cohort, any side issues raised during the focus groups discussions may have been valuable. Secondly, it was anticipated that bias affecting either the data collection or analysis would be addressed by the trustworthiness strategies discussed earlier.

A second concern in relation to possible bias brought to the study by the dual role of focus group moderator and RE/RF program coordinator which may have compromised the information contributed by the study participants is one of power imbalance. Whilst recruitment to the study was voluntary, there was a prior relationship between the researcher, and the study participants as a result of the RE/RF program. It is not possible to be certain that my role of program coordinator and focus group moderator did not influence the contribution of study

participants in either of the focus groups. Having recognised this potential bias, in future research I will be more critical of the influence of roles and relationships between researcher and participants.

The second key study limitations are the sample size used for the study and the composition of the study group. Whilst it is recognized that qualitative data collection is about the richness of the data collected and not about numbers of study participants, this study may have been enhanced by data collected from a larger number and broader range of RE/RF students and clinical facilitators. This could have been achieved by collecting data across multiple RE/RF program cohorts delivered by the primary hospital in this study, or engaging its partner provider. Using multiple sites may have added to the trustworthiness of the results generated by the study. It would also have provided a safety net for any attrition, as happened in focus group two. Taking a broader approach would also have increased the chance of the study capturing data from students being supported by all three models. Whilst a small study such as this may not be sufficient to add great weight to a body of research it has raised new understandings which demonstrate a number of important concepts worthy of further consideration and research.

Key findings and what they may mean

The aim of this study was to explore whether the clinical support model commonly referred to as “Clinical Facilitation” met the expectations of the RE/RF student. The program at the centre of this research uses three variations of the clinical facilitation models to support RE/RF. The Program Clinical Facilitator (PCF) is an RN employed by the health service delivering the RE/RF Programs. In model one, PCF-PH the PCF facilitated the clinical placement of students undertaking clinical placement in the primary hospital. In model two, PCF-SS, the PCF provided facilitation for students who attended clinical placement at hospitals affiliated with the primary hospital but not at the same site. The third and final model, Local Facilitator (LF), provided facilitation for students who were undertaking clinical placement at a remote hospital. The LF was affiliated with the hospital hosting the student, but has not relationship to the primary hospital, or program staff. Whilst anecdotally it is recognised that all of these models have strengths and weaknesses, this study highlighted a number of important points and raises questions about the models in relation to RE/RF students and their

learning and support needs during clinical placement. This discussion will explore the appropriateness of the clinical facilitator role in the key findings of facilitating students': 1) learning, 2) assimilation back into the clinical environment, 3) advocacy and lastly 4) personal support.

Firstly and possibly foremost, this study's findings reinforce that the RE/RN student is unique in their learning and support needs as described in Chapter Two. In particular, this suggests they are a very different nursing student to that of the undergraduate nursing student and therefore have unique learning needs. This validates the need for a study such as this, which firstly, explores the appropriateness of using a model adapted from one designed for undergraduate nursing students, to support RE/RF students during their clinical placement, and secondly, begins to consider what support this student cohort requires during clinical placement. For example, research by Lambert and Glacken (2004) has indicated that the primary roles of personnel who are engaged in supporting nursing students in the clinical learning environment, regardless of title or role description, is to assist the student make the connection of theory to practice, with the result that the student develops the skills, knowledge and attitudes required to perform their role competently. While Lambert and Glacken's (2004) research suggests this may be the case for undergraduate nursing students, the finding from this study would highlight that this may not be the case for the RE/RF student. The findings from this study corroborates previous work by Curtis and Schneibenbach (1991) and Hammer and Craig (2008) who describe RE/RF students as motivated learners, with the majority of this study's participants demonstrating a willingness and ability to take responsibility for ensuring their own learning needs are met, regardless of the clinical teaching support provided.

Findings from this study suggest that whilst RE/RF students expected the clinical facilitator may be required to guide their learning in a range of ways during clinical placement, in practice the clinical facilitator may have played a much smaller role in supporting learning than anticipated by either the student, or program staff. That said, it does need to be recognised that whilst this was generally the case, the diversity of the RE/RF cohort in level of post registration experience, and length of time away from practice may influence the amount of support required. Given the RE/RF students have previous experience as nurses, and they are motivated to take responsibility for their own learning it is

reasonable to question the type of assistance they need to achieve their learning outcomes, and who is best placed to assist them with this. Perhaps further exploration of this cohort may suggest a well-structured and supported mentoring or preceptorship arrangement would satisfy the need to guide learning of RE/RF students equally as well.

The learning support the clinical facilitator did provide that was perceived as valuable by the RE/RF participants in this study was the educational support prior to clinical placement. This learning support was provided in preparation for the clinical placement rather than during clinical placement. It included didactic sessions updating their clinical skills, and practical clinical skills sessions which was a shared responsibility of the program coordinator and the clinical facilitator. Once in the clinical environment RE/RF students, generally, sought clinical learning support from the clinical staff. This is suggestive that the relationship between the ward staff directly influences the learning assistance the RE/RF student will expect from the clinical facilitator. The relationship between the RE/RF student and the clinical staff may therefore be a critical factor in the level of reliance on the clinical facilitator, both for their learning, and for the second point to be discussed in this chapter, that of their assimilation into the clinical unit or ward. Further understanding of the RE/RF students' assimilation into the clinical setting may be achieved by evaluating the perceptions of this integration thought the eyes of the clinical staff who support RE/RF students during clinical placement.

The second key theme that the study's results demonstrated was that RE/RF students expected they may need assistance from the clinical facilitator to assimilate into the clinical unit. However, it was shown that the majority of participants were able to achieve this with minimal support. Research by Courtney-Pratt et al. (2012 p 1386) reports that the relationship between undergraduate nursing students and the RNs who provide them with direct supervision are an importance influence on the quality of their clinical placement experience for the student. A similar view was presented by Cope et al (2000 p 851-852), who stated that strength of the clinical learning environment is that it provides an opportunity where "experts can guide novices through the complexities of practice". However, we know the clinical placement experience is much more than just a teaching environment for technical skill and theoretical

knowledge. As Henderson points out (2011 p 4), clinical placement experience provides the student with an valuable opportunity to experience and learn about the culture of the work place, and observe the professional behaviour as it is modelled by the clinicians.

For undergraduate nursing students this assimilation to the workplace is an important part of their learning which may be influenced by the quality of the teaching provided by clinicians in the clinical setting, or as Henderson and Eaton (2013 p 197) describe them, the "learning guides". As this teaching is often seen as a "secondary activity " (Henderson & Eaton 2013 p 198) it may be influenced by factors such as the busyness or learning culture of the clinical environment, or the skill of the nurse undertaking the activity. This is where a supernumerary role, such as the clinical facilitator can make up shortfalls. What this study showed is that this may be less important for the RE/RF student, who, due to prior experience, understands their professional role, and are familiar with the culture of the clinical environment and, may have developed strategies for managing these challenges. It needs to be said however, that as the RE/RF is a group of students with a diverse range of clinical experience, and it should not be taken for granted that all students have past clinical experiences as an RN, or strategies to overcome these potential barriers, and that careful evaluation of this by the program coordinator could identify potential problems and resolutions.

Another consideration in the relationship between the student and both the clinical staff and the staff who support learning in the clinical setting is the issue of power imbalance. Brown (1993 p 113) highlights the traditional hierarchical nature of the nursing profession in his article which reports on the perception of power in the nurse teacher and student relationship, emphasising the belief that the power lies with the educator. It could be argued that this could be rationally taken to a logical conclusion that this imbalance is also reflected in the nurse-student relationship in the clinical setting, again reinforcing the need for a clinical facilitator supporting the education of undergraduate nursing students. Whilst this study's findings do not show whether that the RE/RF students encountered a power imbalance, it suggests that given the experience and knowledge the RE/RF student brings to the clinical placement, the power inequity may have less impact on their ability to be agentic learners. Richards, Sweet and Billett (2013 p 262) explain that agentic learners are individuals who intentionally engage with

the processes in the clinical environment and this engagement is central for effective learning to occur. This study's results suggest that the RE/RF student is motivated to engage with the clinical staff to optimise their learning, thereby putting into question the role of the clinical facilitator in this process, other than to ensure the clinical staff and students are well prepared for their roles. Undertaking further research to explore if this is typical of the RE/RF student would assist program developers and convenors to adopt a model of support more reflective of a self-development and supporting the agentic learner.

This self-agency may also explain why the RE/RF students did not require the clinical facilitator to advocate for them to the extent they had expected. Initially, the RE/RF students had expected they would need the assistance of the clinical facilitator to advocate on their behalf. This advocacy included protecting their role as a student and their learning needs, and practical issues related to rostering. However findings suggest that the RE/RF students took responsibility for being their own advocate, rather than relying on anyone else. Whilst the study did reveal one student needed the clinical facilitator to advocate on their behalf, the incident requiring this intervention may have been the result of miscommunication and ineffective ward staff preparation. Addressing these ambiguities prior to clinical placement in future programs may avoid the need for this advocacy in the future. This could be achieved by further understanding the clinical staff's perceptions of their role in supervising the RE/RF student, and their understanding of the RE/RF student's role.

Whilst this study supports that the RE/RF students are self-directed learners, motivated to assimilate into the clinical workplace, and able to advocate for their own learning, they valued the clinical facilitator as a neutral, constant person, who provided them with personal psychosocial support. Unlike some of the undergraduate models of clinical facilitation, this RE/RF program's design allows for the RE/RF students to establish a relationship prior to commencing clinical placement.

Whilst the RE/RF students recognised that the clinical facilitator was someone who could offer them the definitive answer to practical clinical questions, it was the activities clustered into the counselling category of this theme that appeared most important to study participants. This suggests that whilst the RE/RF student

are able to seek opportunities to get their learning needs met through alternative sources to the clinical facilitator, the importance of the trusted relationship of a ward outsider, be it the clinical facilitator or program coordinator should not be underestimated.

Andre and Hall (1999 p 239) suggest the RE/RF student could be described as a "special needs" student. This study demonstrated that whilst they may experience anxiety and fears, appropriate support for the clinical facilitator assisted them to, either overcome, or manage their fears and concerns effectively. This may be related to the program design. The program format enabled students to discuss their feelings and concerns with the clinical facilitator and program coordinator prior to clinical placement, but at the completion of six weeks of workshop and contact time. It may be that this opportunity to develop rapport fostered a relationship of trust promoting valuable and productive debriefing sessions that took place during clinical placement. This raises the question of whether this debriefing could equally be undertaken by the program coordinator, or incorporated as group debriefing sessions into the program at regular intervals. Anecdotally the debriefing sessions undertaken jointly by the clinical facilitator and the program coordinator during the RE/RF program have been well attended and students appear to engage with their peers, seemingly benefiting from the opportunity to relate to their fellow students. Further research into the value of these peer debriefing sessions may reveal whether they provide equally beneficial personal and psychosocial support to the support offered by the clinical facilitator. This may enhance the support provided to RE/RF students by increasing the network of support open to them.

Summary

In this chapter I have presented the important ideas that arose from this study's findings on RE/RF students' expectation and experience of clinical facilitation along with the study limitations. The following and final chapter will summarise my research topic, the key findings and discussion points, and make some recommendations for program developers and researchers.

CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

This qualitative exploratory study set out to investigate the RE/RF student's expectations of clinical support provided by a clinical facilitator. This aim has been achieved. This small study contributes new knowledge to what is known about the RE/RF student, and what they might expect from staff who provide support to them during their clinical placement. It also offers new information which can assist program coordinators develop RE/RF programs with appropriate support models for students undertaking clinical placement.

The literature review in this study demonstrated that to date, there has been little research which has contributed to an understanding of what support the RE/RF students expect during their clinical placement and who is best placed to provide it. It also demonstrated that little is known about the learning needs of the RE/RF student, and regulatory agencies review current RE/RF program requirements, new knowledge generated about the learning needs or preferred model of support is valuable.

The key findings and following discussion explored what the RE/RF student expected from their clinical facilitator. Firstly, the study results suggest that the RE/RF students, whilst expecting the clinical facilitator would assist them meet their clinical learning needs they were self-directed learners who developed strategies for ensuring their learning needs were met. Secondly, despite their expectations to the contrary, the study also suggests RE/RF students, given their previous experience as registered nurses are motivated to, and able to promote their own assimilate back into the clinical workplace. Thirdly, that RE/RF students are able to be self-advocates, and that ward and student preparation may reduce the need for program staff intervention. And lastly, but possibly most importantly, that RE/RF students value the relationship they establish with program staff prior to commencing clinical placement as it offers them the opportunity to debrief and be supported with a constant, neutral and trusted person.

What this study reveals has implications for both future research and program design and delivery. Firstly, results from this study indicate that the RE/RF student have different learning and support needs to undergraduate nursing students, and therefore further exploration of these needs should be undertaken

to ensure program designs and models of support reflect these needs. Secondly, given the clear indication that the RE/RF student seek clinical support from the clinicians in the clinical area, and personal and professional support from the clinical facilitator program designers should consider, firstly strengthening relationships between clinical staff and program staff to develop consistency in the quality of the clinical teaching for RE/RF students in the clinical setting, and secondly reviewing the way personal and professional support is provided to RE/RF students during the clinical placement. Considerations could be given to placing greater emphasis on peer support though regular group debriefing sessions with the program coordinator and the use of online forums, particularly in view of students not placed at the primary hospital.

In conclusion this small study highlights the importance of understanding the learning and support needs for this student cohort, contributes a greater awareness of the RE/RF student, their learning needs, and the appropriateness of clinical facilitation as a model of support. It also presented some suggestions for alternative support approaches which may be more suitable to this particular student group and makes some recommendations for areas which warrant further research and exploration.

In conclusion, this small study has demonstrated that the RE/RF student has unique learning and support needs. These appear quite different to those of the undergraduate student, therefore, the adaptation and use of a support model designed as a result of research not unique to this cohort may not be offering them the appropriate support to meet their needs.

CHAPTER 7: APPENDICES

Appendix 1: Local Facilitator/Clinical Nurse Support Role Description

Registered Nurse Re-entry/Refresher Program

LOCAL FACILITATOR/CLINICAL NURSE SUPPORT ROLE DESCRIPTION

INTRODUCTION

Registered Nurse (RN) Re-entry and Refresher Programs, funded by SA Health, have been provided at Flinders Medical Centre since 2001. The curriculum was updated and implemented as a Flexible Delivery Program in 2004. The current curriculum is approved by the Nursing and Midwifery Board of Australia (NMBA) until 2013.

The program provides a pathway for previously registered nurses to re-register (Re-entry) and a clinical update for currently registered nurses who have not worked in a clinical unit for a number of years (Refresher). The program is a valuable initiative to recruit more registered nurses to the nursing workforce.

This is achieved through a balance of clinical learning experiences and knowledge and theory acquisition. The Local Facilitator assists the RN Re-entry/Refresher in the development of clinical competence and the acquisition of the ANMC National Competency Standards for the Registered Nurse.

The Local Facilitator functions within the framework of the Memorandum of Understanding between Flinders Medical Centre, Centre for Nursing & Midwifery Education and Research, and the South Australian Health Facility providing clinical placements.

POSITION SUMMARY

The Local Facilitator is a senior experienced registered nurse accountable to the RN Re-entry/Refresher Program Coordinator for coordinating and implementing learning experiences that will facilitate the RN Re-entry/Refresher's clinical and professional development.

The Local Facilitator's role includes the following duties related to RN Re-entry and Refresher:

- socialisation back into the workforce/acute care environment
- facilitating a supportive clinical learning environment
- clinical teaching and assessment
- performance development
- leadership, liaison with, and support of unit nursing staff

POSITION CHARACTERISTICS

Socialisation back into the workforce

The Local Facilitator ensures orientation of the RN Re-entry/Refresher to the clinical placement unit. This includes:

- facilitating the orientation of the nurse to unit staff, practices and routine, unit policies and procedures
- orientating the nurse to the physical layout of the clinical unit
- identifying methods of communication within the hospital
- locating available resources useful for care of patients

Facilitating a supportive clinical learning environment

The Local Facilitator coordinates and implements learning experiences that will facilitate the RN Re-entry/Refresher's clinical and professional development throughout their clinical placement. Clinical competence of the RN Re-entry/Refresher is dependent upon the clinical support and continuing skill development provided during the RN Re-entry/Refresher Program. The Local Facilitator can promote clinical support by:

- ensuring appropriate patient assignment to develop competence in patient care coordination and management
- incorporating practical demonstration or supervised practice to enhance the learning of new skills/ equipment
- ensuring there is adequate resources to support learning
- providing learning opportunities to achieve competencies eg. supervised medication rounds
- providing feedback on documentation and performance

Clinical teaching and assessment

70% of the program assessment focuses on collaborative performance assessment by the participant, Local Facilitator and clinical unit staff. The Personal Practice Journal (PPJ) recorded evidence of learning achievements contributes to the overall assessment of competence. The Local Facilitator is responsible for:

- providing appropriate information to clinical support staff about assessment requirements and procedures to enable them to effectively assist with the clinical teaching and assessment of the nurse
- incorporating clinical teaching that relates to reflective and best practice which helps embed contemporary nursing practice
- feedback on PPJ recorded activities, assessment and documentation of competency achievement

Performance development

Goal setting is used as the lynchpin for performance development. The Local Facilitator is responsible for:

- assisting the RN Re-entry/Refresher to establish specific learning objectives/goals, resources and strategies for accomplishing the goals
- monitoring progress and providing informal and formal feedback to the RN Re-entry/Refresher on his/her performance
- obtaining feedback from the clinical support staff regarding the RN Re-entry/Refresher 's performance and progress
- reviewing regularly; providing feedback and documenting comments on activities recorded in the RN Re-entry/Refresher's PPJ

Leadership, liaison with and support of unit staff

The Local Facilitator collaborates with the Program Coordinator and clinical support staff to facilitate the learning of the RN Re-entry/Refresher by:

- communicating regularly with the Program Coordinator regarding the progress and achievements of the RN Re-entry/Refresher
- identifying issues regarding the clinical development of the RN Re-entry/Refresher and liaising with the clinical support staff to implement appropriate action
- collaborating with the CSC, or other experienced unit staff to foster valid assessment of the RN Re-entry/Refresher's overall performance/ability to meet ANMC National Competency Standards for the Registered Nurse
- monitoring the nurse's progress towards completion of learning activities recorded in the PPJ and successful achievement of ANMC competencies

Appendix 2: Ethics Approval

Flinders University and Southern Area Health Service

SOCIAL AND BEHAVIOURAL RESEARCH ETHICS COMMITTEE

Research Services Office, Union Building, Flinders University
GPO Box 2100, ADELAIDE SA 5001
Phone: (08) 8201 3116
Email: human.researchethics@flinders.edu.au

FINAL APPROVAL NOTICE

Principal Researcher:	Ms Helen Hughes
Email:	helen.hughes3@health.sa.gov.au
Address:	Centre for Nursing & Midwifery & Education
Project Title:	Clinical Facilitation of Refresher and Re-entry Nurses - Does it meet expectations?

Project No.:	Final Approval Date:	Approval Expiry Date:
5194	8 June 2011	**31 December 2012**

The above proposed project has been **approved** on the basis of the information contained in the application, its attachments and the information subsequently provided.

If you have any outstanding permission letters (item D8), that may have been previously requested, please ensure that they are forwarded to the Committee as soon as possible. Additionally, for projects where approval has also been sought from another Human Research Ethics Committee (item G1), please be reminded that a copy of the ethics approval notice will need to be sent to the Committee on receipt.

In accordance with the undertaking you provided in your application for ethics approval for the project, please inform the Social and Behavioural Research Ethics Committee, giving reasons, if the research project is discontinued before the expected date of completion.

You are also required to report anything which might warrant review of ethical approval of the protocol. Such matters include:

- serious or unexpected adverse effects on participants;
- proposed changes in the protocol (modifications);
- any changes to the research team; and
- unforeseen events that might affect continued ethical acceptability of the project.

To modify/amend a previously approved project please either mail or email a completed copy of the Modification Request Form to the Executive Officer, which is available for download from http://www.flinders.edu.au/research/info-for-researchers/ethics/committees/social-and-behavioural-research-ethics-committee/notification-of-committee-decision.cfm. Please ensure that any new or amended participant documents are attached to the modification request.

In order to comply with monitoring requirements of the *National Statement on Ethical Conduct in Human Research (March 2007)* an annual progress and/or final report must be submitted. A copy of the pro forma is available from http://www.flinders.edu.au/research/info-for-researchers/ethics/committees/social-behavioural.cfm.

Your first report is due on **8 June 2012** or on completion of the project, whichever is the earliest. *Please retain this notice for reference when completing annual progress or final reports.* If an extension of time is required, please email a request for an extension of time, to a date you specify, to human.researchethics@flinders.edu.au before the expiry date.

Andrea Mather
Executive Officer
Social and Behavioural Research Ethics Committee
8 June 2011

c.c Dr Linda Sweet, linda.sweet@flinders.edu.au
Prof Esther May, esther.may@unisa.edu.au

Appendix 3: Supporting letter from Executive Director of Nursing and Chief Executive Officer of the Health Service delivering the program

Government of South Australia
SA Health

The Chair
Social and Behavioural Research Ethics Committee
Flinders University and Southern Area Health Service
Research Services Office
Union Building
Flinders University
GPO Box 2100
ADELAIDE SA 5001

Office of the Director of Nursing

Flinders Medical Centre
Level 2, Executive Office
Flinders Drive
Bedford Park SA 5042

Tel: (08) 8204 4066
Fax: (08) 8204 5605

Dear Sir / Madam

This is to formally acknowledge that I give my full support to Helen Hughes in her undertaking of the proposed research project, which will be in the form of focus groups, utilising volunteer Participants and Clinical Facilitators from the July 2011 RN Refresher and Re-entry Program held at Flinders Medical Centre.

The details of the Proposed Research Project are as follows:

- Project Number 5194
- Proposed Project "Clinical Facilitation of Refresher and Re-entry Nurses – Does it meet expectations?"
- Researcher: Helen Hughes (Principle Researcher), Program Coordinator RN Re-entry and Refresher Program, Flinders Medical Centre, Masters of Clinical Education Student, School of Medicine

No further permissions are required from Flinders Medical Centre.

Yours sincerely

Appendix 4: Letter of Introduction – RE/RF Student

Rural Clinical School
School of Medicine
GPO Box 2100
Adelaide SA 5001
Australia
Tel: 61 8 8204 5017
Fax: 61 8 8204 5800
linda.sweet@flinders.edu.au

Dear Sir/Madam

This letter is to introduce Helen Hughes who is a Masters of Clinical Education student in the School of Medicine at Flinders University. Helen also holds the position of Program Coordinator of the RN Refresher and Re-entry Program at Flinders Medical Centre.

Ms Hughes is undertaking research leading to the production of a thesis and other publications on whether the Flinders Medical Centre model of Clinical Facilitation for Refresher & Re-entry Nurses meet their expectations or not.

She would be most grateful if you would volunteer to assist in this project, by completing a brief demographic questionnaire and participating in 1 or 2 focus group discussions. The survey can be completed through the link she will provide electronically through the FMC Moodle site. There will be a pre and post clinical placement focus group for student participants and a single post placement focus group for the clinical facilitators. It is anticipated that these focus groups will take approximately 60-90 minutes each.

Be assured that any information provided will be treated in the strictest confidence and none of the participants will be individually identifiable in the resulting thesis, report or other publications. You are, of course, entirely free to discontinue your participation at any time or to decline to answer particular questions.

If you have any queries regarding this project please contact Dr Linda Sweet on the above address or by telephone on (08) 8204 5017, by fax on (08) 8204 5800 or by email: linda.sweet@flinders.edu.au

Thank you for your consideration of this activity.
Yours sincerely

Dr Linda Sweet
Senior Lecturer, Masters of Clinical Education
This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project Number 5194). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email *human.researchethics@flinders.edu.au*

Appendix 5: Information Sheet – Focus Groups for RE/RF Students

Project title: Clinical Facilitation of Refresher & Re-entry Nurses - Does it meet expectations?

Investigators: Ms Helen Hughes, Dr Linda Sweet and Professor Esther May

What is the Research Project about?

Nursing students undertaking clinical placements require educational support, clinical supervision and assessment from clinicians employed by the health care venue (Registered Nurses (RN) employed as a clinician in the clinical setting by the health care provider), and, educational facilitation and support from staff from the education provider. The Clinical experience is unique for each individual, as is the support required to maximise experiential learning.

Research investigating clinical support of undergraduate nursing students highlights the importance of quality support in ensuring quality learning outcomes, student satisfaction, and, retention within the profession (Henderson et. al 2006). The model of clinical support used by the Refresher Re-entry Program at Flinders Medical Centre is commonly referred to as "Clinical Facilitation."

This project aims to explore, and compare, the expectations and experiences of participants in the RN Refresher and Re-entry Program relating to Clinical Facilitation, as used at Flinders Medical Centre, during their clinical placement. It also seeks to gain insight into the experience of the staff who are Clinical Facilitators for the program participants

Why am I being asked to be in this research project?

The researchers are seeking RN Refresher and Re-entry participants to contribute to this project. As a successful applicant for the July 2011 Refresher and Re-entry Program at Flinders Medical Centre, you would be eligible to participate in this project.

What do I need to do to be in this research project?

This project seeks to gain an understanding of participants' expectations, and, actual experiences of their clinical placement experience. During the July 2011 Refresher and Re-entry Program I will be conducting two focus groups – one prior to clinical placement (date to be confirmed), and, one at the completion of the program (November – date to be confirmed). It is anticipated that each focus group will last approximately 60 minutes. A Focus group is a small groups of individuals from the program (8-10) who, through discussion, explore thoughts and ideas about a particular theme or concept in greater detail and depth. With group consent, the focus group discussions would be audio taped and transcribed for the purpose of analysis and thesis preparation.

Associated with the first focus group would be a short questionnaire to gain preliminary information such as your age, gender, nursing education and nursing history. This questionnaire should take up to 10 minutes to complete.

Clinical Facilitators involved in this program would also be recruited to a post program focus group to explore their experiences of the Clinical Facilitation experience (end of November 2011 – date to be confirmed) and a short questionnaire to gain preliminary information such as participants' age, gender, nursing education and nursing and facilitation history would be completed at this time.

No names, addresses or other identifying information will be recorded. Participation is confidential and voluntary and you may withdraw from the project at any time. If you participate, you may choose not answer any or all of the questions and discussions in the focus groups, or, on the preliminary questionnaire. You may choose to have any information that you have contributed removed from the content of the project. You will not incur any personal costs.

Along with this information sheet, you will have received an introductory letter and a consent form. It is important that read these documents carefully. If you have any additional questions please contact Helen to discuss the project further. Once you have the opportunity to read these documents and discuss the project with another person like a friend or family members, you may consider participation. If you choose to participate, then you will need to sign the consent form and return it to Helen during the Introductory Workshop. Once you have confirmed your willingness to participate, Helen will provide you with further details relating to the time and date and venue for the focus groups.

What are the alternatives to participating in this project?

You may decide not to participate in this project. Participation is completely voluntary and choosing not to participate will have no effect on your educational program or entitlements you may receive. This study has been reviewed and ethical approval granted through Flinders University's Social & Behavioural Ethics Committee.

Is there likely to be a benefit to me?

It is likely that being part of this project will not be of any direct benefit to you, apart from the potential of reflecting on your clinical experience.

Clinical Facilitators may gain useful insight into how other Clinical Facilitators work with students.

What are the possible risks and/or side-effects?

It is likely that being part of this project will result in a time burden for you. It is not intended to have a negative consequence for students or Clinical Facilitators. Focus groups will be conducted at the conclusion of study days to avoid additional travel or inconvenience to you.

Is this research funded?

No

How will the results be distributed once the project is complete?

The results of this study will provide useful data which will assist in the evaluation of clinical support methods currently utilised as part of the RN Refresher and Re-entry Program at Flinders Medical Centre. For this purpose a written evaluation report will be provided to the Director: Centre for Nursing & Midwifery Research and Education - Flinders Medical Centre.

As a Masters research project the results will be written up in the form of a thesis and submitted to Flinders University. The research will also be considered for publishing in peer review journals and presented at higher education and nursing education conferences. Any report or publication from this study will not identify or contain your name.

Thank you for considering participation in this study. If you are willing to participate in this study please contact me on any of the below methods. A completed consent form will be

required for participation and can be returned to me at the commencement of the program on the 25th July 2011.

Investigator: Helen Hughes

Program Coordinator - RN Refresher & Re-entry Program, Flinders Medical Centre

Masters Student – Masters of Clinical Education – School of Medicine, Flinders University of South Australia

Centre for Nursing & Midwifery Education and Research
Room 7E142, Level 7
Flinders Medical Centre
Telephone 08 8204 4368
Email: Helen.hughes3@health.sa.gov.au

If you have any queries regarding the ethical conduct of the research project you may contact the Human Ethics Sub-Committee. Project Number: 5194 Flinders University Social and Behavioural Research Ethics Committee.
Telephone: (08) 8201 3116, Fax: (08) 8201 2035
Email: human.researchethics@flinders.edu.au

REFERENCES

Long J., West S., (200). "Returning to nursing after a career break: elements of successful re-entry" Australian Nursing Of Advanced Nursing 200 Vol 25, No1, pp 49-55.

Henderson A., Twentyman M., Heel A, Lloyd B., (2006). "Students' Perception of the Psycho-
Social Clinical Learning Environment: An Evaluation of Placement Models". Nurse Education Today 2006 Vol 26 No7 pp 564–571

Appendix 6: Consent Form for Participation in Research by Focus Group

I ….....

being over the age of 18 years hereby consent to participate as requested in the 'Letter of Introduction' and 'Information Sheet' for the research project on "Clinical Facilitation of Refresher & Re-entry Nurses - Does it meet expectations?".

1. I have read the information provided.
2. Details of procedures and any risks have been explained to my satisfaction.
3. I agree to audio recording of my information and participation.
4. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.
5. I understand that:
    - I may not directly benefit from taking part in this research.
    - I am free to withdraw from the project at any time and am free to decline to answer particular questions.
    - While the information gained in this study will be published as explained, I will not be identified, and individual information will remain confidential.
    - Whether I participate or not, or withdraw after participating, will have no effect on my progress in my course of study, or results gained.
    - I may ask that the recording be stopped at any time, and that I may withdraw at any time from the session or the research without disadvantage.

6. I agree/do not agree* to the tape/transcript* being made available to other researchers who are not members of this research team, but who are judged by the research team to be doing related research, on condition that my identity is not revealed.
** delete as appropriate*

7. I have had the opportunity to discuss taking part in this research with a family member or friend.

Participant's signature……Date……..

I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

Researcher's name…….....

Researcher's signature……..Date…….

Appendix 7: Letter of Introduction – Clinical Facilitators

Rural Clinical School
School of Medicine
GPO Box 2100
Adelaide SA 5001
Australia
Tel: 61 8 8204 5017
Fax: 61 8 8204 5800
linda.sweet@flinders.edu.au

Dear Sir/Madam

This letter is to introduce Helen Hughes who is a Masters of Clinical Education student in the School of Medicine at Flinders University. Helen also holds the position of Program Coordinator of the RN Refresher and Re-entry Program at Flinders Medical Centre. Ms Hughes is undertaking research leading to the production of a thesis and other publications on whether the Flinders Medical Centre model of Clinical Facilitation for Refresher & Re-entry Nurses meet their expectations or not. She would be most grateful if you would volunteer to assist in this project, by participating in one focus group discussion. It is anticipated that this focus group will take approximately 60-90 minutes. It will be held onsite at Flinders Medical Centre, however to ensure equity and enable participation of remote facilitators a teleconference call will be available. Be assured that any information provided will be treated in the strictest confidence and none of the participants will be individually identifiable in the resulting thesis, report or other publications. You are, of course, entirely free to discontinue your participation at any time or to decline to answer particular questions. If you have any queries regarding this project please contact Dr Linda Sweet on the above address or by telephone on (08) 8204 5017, by fax on (08) 8204 5800 or by email: linda.sweet@flinders.edu.au Thank you for your consideration of this activity. Yours sincerely

Dr Linda Sweet

Senior Lecturer, Masters of Clinical Education

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project Number 5194). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au.

Appendix 8: Information Sheet – Focus Group for Clinical Facilitator

Project title: Clinical Facilitation of Refresher & Re-entry Nurses - Does it meet expectations?

Investigators: Ms Helen Hughes, Dr Linda Sweet and Professor Esther May.

What is the Research Project about?

Nursing students undertaking clinical placements require educational support, clinical supervision and assessment from clinicians employed by the health care venue (Registered Nurses (RN)) employed as a clinician in the clinical setting by the health care provider), and, educational facilitation and support from staff from the education provider. The Clinical experience is unique for each individual, as is the support required to maximise experiential learning.

Research investigating clinical support of undergraduate nursing students highlights the importance of quality support in ensuring quality learning outcomes, student satisfaction, and, retention within the profession (Henderson et. al 2006). The model of clinical support used by the Refresher Re-entry Program at Flinders Medical Centre is commonly referred to as "Clinical Facilitation."

This project aims to explore, and compare, the expectations and experiences of participants in the RN Refresher and Re-entry Program relating to Clinical Facilitation, as used at Flinders Medical Centre, during their clinical placement. It also seeks to gain insight into the experience of the staff who are Clinical Facilitators for the program participants

The researchers will be asking RN Refresher and Re-entry participants to contribute to two focus group interviews, one to be held in July prior to commencement of clinical Placement, and, one in November upon completion of the program.

Why am I being asked to be in this research project?

As a Clinical Facilitator for participants in the July RN Refresher & Re-entry Program your contributions relating to your experiences of the Clinical Facilitation Model from a Facilitator perspective are valuable.

This project seeks to gain an understanding of participants' expectations, and, actual experiences of their clinical placement experience. During the July 2011 Refresher and Re-entry Program I will be conducting two focus groups with participants in the program – one prior to clinical placement (27th July - during the Clinical Skills Workshop), and, one at the completion of the program (November – date to be confirmed).

What do I need to do to be in this research project?

As a Clinical Facilitator you are invited to participate in a post program focus group.

Firstly, you would be asked to complete a short questionnaire so as to gain preliminary information such as your age, gender, nursing education, nursing history and clinical facilitation experience. This questionnaire should take up to 10 minutes to complete and is available online.

Upon completion of the questionnaire, you would be asked to contribute to the focus group. It is anticipated that the focus group will last approximately 60 minutes. A focus group is a small group of individuals (5-8) who, through discussion, explore thoughts and ideas about a

particular theme or concept in greater detail and depth. With group consent, the focus group discussions would be audio taped and transcribed for the purpose of analysis and thesis preparation.

The focus group, to be held toward the end of November (date to be inserted) and would be held in the meeting room at the Centre for Nursing and Midwifery Education and Research at Flinders Medical Centre (Level 7). As some participants in the program may be located at regional hospitals, and, have Clinical Facilitators associated with the regional hospital, the option of joining the focus group via teleconference could be negotiated to ensure country Facilitators wishing to join the project, but unable to participate due to travelling commitments, would not be disadvantaged.

No names, addresses or other identifying information will be recorded. Participation is confidential and voluntary and you may withdraw from the project at any time. If you participate, you may choose not answer any or all of the questions and discussions in the focus groups, or, on the preliminary questionnaire. You may choose to have any information that you have contributed removed from the content of the project. You will not incur any personal costs.

Along with this information sheet, you will have received an introductory letter and a consent form. It is important that read these documents carefully. If you have any additional questions please contact Helen to discuss the project further. Once you have the opportunity to read these documents and discuss the project with another person like a friend or family members, you may consider participation. If you choose to participate, then you will need to sign the consent form and return it to Helen during the Introductory Workshop. Once you have confirmed your willingness to participate, Helen will provide you with further details relating to the time and date and venue for the focus groups.

What are the alternatives to participating in this project?

You may decide not to participate in this project. Participation is completely voluntary and choosing not to participate will have no effect on your educational program or entitlements you may receive. This study has been reviewed and ethical approval granted through Flinders University's Social & Behavioural Ethics Committee.

Is there likely to be a benefit to me?

Clinical Facilitators may gain useful insight into how other Clinical Facilitators work with students.

What are the possible risks and/or side-effects?

It is likely that being part of this project will result in a time burden for you. It is not intended to have a negative consequence for Clinical Facilitators. Focus groups will be conducted at the conclusion of the program additional travel or inconvenience to you, and teleconferencing may be negotiated to reduce this inconvenience for regional Facilitators.

Is this research funded?

No

How will the results be distributed once the project is complete?

The results of this study will provide useful data which will assist in the evaluation of clinical support methods currently utilised as part of the RN Refresher and Re-entry Program at

Flinders Medical Centre. For this purpose a written evaluation report will be provided to the Director: Centre for Nursing & Midwifery Research and Education - Flinders Medical Centre.

As a Masters research project the results will be written up in the form of a thesis and submitted to Flinders University. The research will also be considered for publishing in peer review journals and presented at higher education and nursing education conferences. Any report or publication from this study will not identify or contain your name.

Thank you for considering participation in this study. If you are willing to participate in this study please contact me on any of the below methods. A completed consent form will be required for participation and can be returned to me at the commencement of the program on the 25th July 2011.

Investigator: Helen Hughes
Program Coordinator - RN Refresher & Re-entry Program, Flinders Medical Centre
Masters Student – Masters of Clinical Education – School of Medicine, Flinders University of South Australia
Centre for Nursing & Midwifery Education and Research
Room 7E142, Level 7
Flinders Medical Centre
Telephone 08 8204 4368
Email: Helen.hughes3@health.sa.gov.au

If you have any queries regarding the ethical conduct of the research project you may contact the Human Ethics Sub-Committee.
Project Number: 5194
Flinders University Social and Behavioural Research Ethics Committee.
Telephone: (08) 8201 3116, Fax: (08) 8201 2035
Email: human.researchethics@flinders.edu.au

REFERENCES

Long J., West S., (2007). “Returning to nursing after a career break: elements of successful re-entry” Australian Nursing Of Advanced Nursing 200 Vol 25, No1, pp 49-55.

Henderson A., Twentyman M., Heel A, Lloyd B., (2006). “Students’ Perception of the Psycho-
Social Clinical Learning Environment: An Evaluation of Placement Models”. Nurse Education Today 2006 Vol 26 No7 pp 564–571

Appendix 9: Consent Form for Participation in Research by Focus Group

I ….....

being over the age of 18 years hereby consent to participate as requested in the 'Letter of Introduction' and 'Information Sheet' for the research project on "Clinical Facilitation of Refresher & Re-entry Nurses - Does it meet expectations?".

6. I have read the information provided.
7. Details of procedures and any risks have been explained to my satisfaction.
8. I agree to audio recording of my information and participation.
9. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.
10. I understand that:
    - I may not directly benefit from taking part in this research.
    - I am free to withdraw from the project at any time and am free to decline to answer particular questions.
    - While the information gained in this study will be published as explained, I will not be identified, and individual information will remain confidential.
    - Whether I participate or not, or withdraw after participating, will have no effect on my progress in my course of study, or results gained.
    - I may ask that the recording be stopped at any time, and that I may withdraw at any time from the session or the research without disadvantage.

6. I agree/do not agree* to the tape/transcript* being made available to other researchers who are not members of this research team, but who are judged by the research team to be doing related research, on condition that my identity is not revealed.
** delete as appropriate*

7. I have had the opportunity to discuss taking part in this research with a family member or friend.

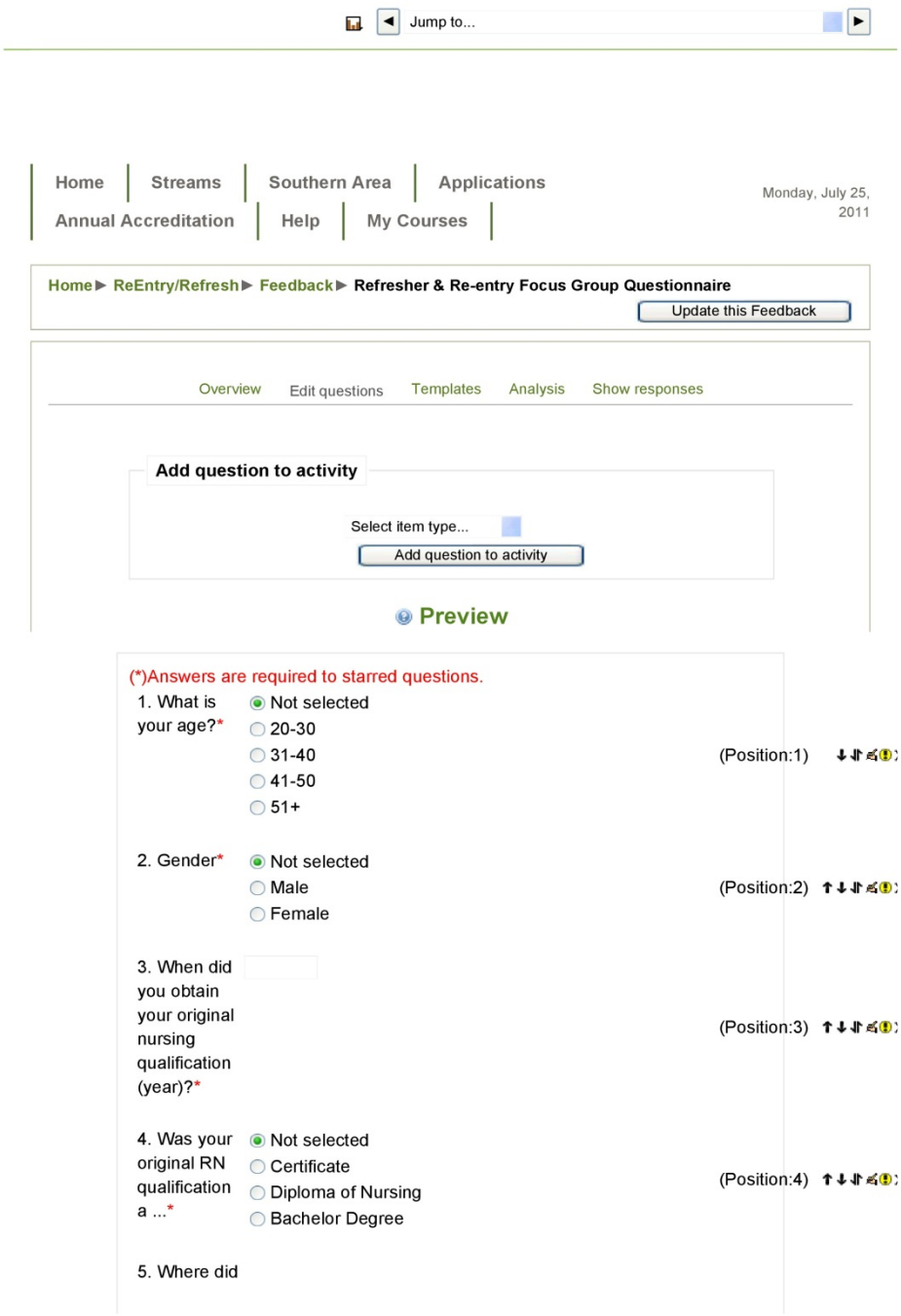
Participant's signature……Date……..

I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

Researcher's name…….....

Researcher's signature……..Date…….

Appendix 10: Demographic Survey



you obtain your initial nursing qualification? Please provide geographical location and setting.* (Position:5)

6. Have you had a clinical placement with a clinical facilitator before?* (Position:6)
- Not selected
- Yes
- No

If yes please (Position:7)

i) Describe the experience in relation to your learning (Position:8)

ii) What where your expectations, and, were they met? (Position:9)

Thank you (Position:10)

Appendix 11: Focus Group One Questions

Planned questions and actual questions asked in focus group one
1. Have you had a clinical placement in the past that has used this model for clinical supervision and if so, can you reflect on your experiences? (10 minutes)
Have you had a clinical placement in the past where you have used this model before as your clinical supervision? If so, reflect back on that experience. (16:37)
2. What other models of support have you experienced during clinical placements and, were they positive? (10 minutes)
Have you experienced any other models of clinical support? (2:16)
3. What kind of clinical support do you believe will be of most value to you during your clinical placement? (10 minutes)
Back to the point of the Refresher re-entry, do you think, what are your feelings about what your going to need as a clinical support? What are the things that are going to be most important to you while you're at clinical placement as a refresher re-entry nurse?(13)
4. What aspects of your clinical placement are worrying you most? (10 minutes)
What's worrying you most all about your clinical placements? What's causing you anxiety? What are the things that worry you?
5. What kind of support do you believe will be of most value to you during your placement, and from who do you expect that support? (10 minutes)
This question was asked in several ways over the discussion
So who do you expect to get the most support from to overcome those areas, you perceive either rightly or wrongly, areas you are going to struggle with?
So where do you seek your primary support from?
6. When considering both your clinical placement, and learning needs, what does the "Clinical Facilitation" mean to you? (10 minutes)
So when considering your clinical placement and learning needs, what does the term Clinical Facilitator mean to you.?
7. How are you feeling about your upcoming clinical placement and what is your expectation of your clinical facilitator? (10 minutes)
Would you day it is a secondary role, the facilitator to your clinical placement, is that how you see it?

Appendix 12: Focus Group Three Questions

1	What do you see as the role of the clinical facilitator?
2	How so you see the difference between your role as clinical facilitator and the people who work with these students in the ward?
3	How clear are you on your roles and responsibility? Do you feel that this particular role is clearly outlined in what's expected as opposed to how it just evolves?
4	What are the positive aspects of your role? What things do you really enjoy?
5	Are there any negatives about the role?
6	Have you ever felt the support you are able to offer is limited by the scope of the role?
7	Do you feel our role is structured with enough support?
8	Do you get the same satisfaction in your role of supporting students on other sites?
9	So if there was anything that could be done to improve the role of the facilitator for re-entries, refreshers at the moment what would that be?
10	The focus groups run with the students raised concepts related to the role of the clinical facilitator. These included advocacy for students' learning, empowering/self-agency, debriefing, performance monitoring and feedback, planning their learning how does this fit with how you see your role?

Appendix 13: Final thematic analysis results from focus group one: Role of the Clinical Facilitator.

Themes	Codes
Guide Learning	Clinical teaching Problem solving Patient allocation/selection Monitoring progress Providing in-service Facilitate learning Assessing performance Identifying knowledge/skill deficits Provide individual support Scaffold learning Providing feedback Facilitate reflective practice/sessions Provided clarification Provide supplementary teaching Act as a resource person Assist with goal setting Teaching Academic teaching
Facilitate Clinical Assimilation	Liaise with ward staff Administration Student preparation Complement ward staff in teaching Promote learning culture/environment Provide conduit between clinical and education service Conflict prevention Conflict resolution Promote/support role transition to independence Guidance on professional issues Guidance on clinical issues Liaise with student Provide objectivity
Advocacy	Advocate for student Protect student status Act as buffer Advocate for ward staff Self-agency/empowering self Conflict resolution direction Humanness versus task focus
Support	Debrief Assist with expectations Provide emotional support Motivate Nurture Organise meetings Complement ward Staff Validate student role

Appendix 14: Comparative Table of appearance of themes across focus group one, two and three

Theme One: Guide learning and associated categories and codes			
Categories	Codes identifying expectations of clinical facilitator from Focus Group One	Subsequent appearance of codes and frequency	
		Focus Group Two	Focus Group Three
1.1 Teaching			
1.1a	Clinical teaching	5	6
1.1b	Providing in-service	0	0
1.1c	Provide supplementary teaching		
	Teaching	1	0
1.1d	Academic teaching/support	2	1
1.1e		2	0
1.2 Assessing			
1.2a	Monitoring progress	1	0
1.2b	Identifying knowledge/skill deficits		
	Assessing performance	0	0
1.2c	Providing feedback	0	1
1.2d		2	0
1.3 Learning			
1.3a	Scaffold learning	2	0
1.3b	Patient allocation/selection	0	1
1.3c	Facilitate learning	2	1
1.3d	Facilitate reflective		
	practice/sessions	1	0
1.3e	Assist with goal setting	2	0
1.3f	Provide individual support	7	2
1.3g	Act as a resource person	1	1
1.3h	Problem solving	4	1
1.3i	Provide clarification	0	0
1.3j	Providing/guiding remediation		
		0	0

** Not noted in Focus Group 1 but identified in Focus Group 2

*** Not noted in Focus Group 1 but identified in Focus Group 3

Theme two: Facilitate Clinical Assimilation and associated categories and codes			
Categories	Codes identifying expectations of clinical facilitator from Focus Group One	Subsequent appearance of codes and frequency	
		Focus Group Two	Focus Group Three
2.1 Fostering Relationships			
2.1a	Prepare students	3	1
2.1b	Prepare ward	6	5
2.1c	Liaise with ward staff	4	5
2.1d	Liaise with student	0	1
2.1e	Conflict prevention and resolution		
2.1f	Promote learning culture /environment	0	0
2.1g	Provide conduit between clinical and education	1	2
2.1h	Complement ward staff in teaching/assessing	2	1
2.1i***	Set up informal support staff	3	2
2.1j***	Develop relationship before clinical placement	0	2
2.1k***	Conduit between PC & CF	2	1
		0	1
2.2 Clinical & Professional Guidance			
2.2a	Promote role transition	2	2
2.2b	Provide guidance on professional issues	2	1
2.2c	Provide guidance on clinical issues	1	0
2.2d	Provide objectivity	0	1
2.2e	Administration	0	0
2.2.f**	Constant/External/neutral guidance	5	0

** Not noted in Focus Group 1 but identified in Focus Group 2

*** Not noted in Focus Group 1 but identified in Focus Group 3

Theme Three: Advocacy and associated categories and codes			
Categories	Codes identifying expectations of clinical facilitator from Focus Group 1	Subsequent appearance of codes and frequency	
		Focus Group 2	Focus Group 3
3.1 For Student			
3.1a			
3.1b	Advocate for student	5	3
3.1c	Advocate for student role	3	1
3.1d**	Protect and legitimise supernumerary student status	3	0
	Enable student self-advocacy	7	0
3.2 For Ward Staff			
3.2a	Advocate for ward staff	0	0

** Not noted in Focus Group 1 but identified in Focus Group 2

** Not noted in Focus Group 1 but identified in Focus Group 2

Theme Four: Support and associated categories and codes			
Categories	Codes identifying expectations of clinical facilitator from Focus Group 1	Subsequent appearance of codes and frequency	
		Focus Group 2	Focus Group 3
4.1Counsel 4.1a			
4.1b	Debrief	5	3
4.1c	Assist with expectations	4	4
4.1d	Provide emotional support/counsel	0	4
4.1e	Motivate	1	3
4.1f**	Nurture	2	2
4.1g***	Provide reassurance	1	5
4.1h**	Validate	0	1
	Humanise	2	1
4.2Practical			
4.2a	Facilitate meetings	1	0
4.2b**	Individualise	1	5
4.2c***	Provide strategies	2	1
4.2d***	Career Counsellor	0	2

*** Not noted in Focus Group 1 but identified in Focus Group 3

Possible influences on expectations associated categories and codes			
Categories	Codes identifying expectations of clinical facilitator from Focus Group 1	Subsequent appearance of codes and frequency	
		Focus Group 2	Focus Group 3
5a	Previous Experiences	3	1
5b	Preparation by program staff	1	0
5c	Status as Re/Rf students	3	3
5d	Relationships	2	0
5e	Clinical placement location	4	0
5f	Individuality	1	1

Reference List

Alden, KR & Carrozza, MA 1997, 'The North Carolina AHEC Self-Paced RN Refresher Program: An Evaluation of the First Two Years', *The Journal of Continuing Education in Nursing*, vol. 28, no. 1, pp. 14-19.

Andre, CA & Hall, C 1999, 'Nurses re-entering the workforce: a special needs group', *Contemp Nurse*, vol. 8, no. 1, pp. 238-44.

Andrews, CE & Ford, K 2013, 'Clinical facilitator learning and development needs: Exploring the why, what and how', *Nurse Education in Practice*, vol. 13, no. 5, pp. 413-17.

Anonymous 1952, 'Refresher Courses', *AJN, American Journal of Nursing*, vol. 52, no. 6, p. 702.

Asselin, M, Osterman, P & Cullen, HA 2006, 'In their own words: the experience of returning to acute care practice', *Journal for nurses in staff development : JNSD : official journal of the National Nursing Staff Development Organization*, vol. 22, no. 3, p. 104.

Australian College of Nursing 2014, *Overseas, re-entry and refresher pathway program*, viewed 22/09/2014, <http://www.acn.edu.au/overseas_pathway_refresher>.

Accreditation Standards for Re-entry to the Register – Registered Nurse 2014, by Australian Nursing and Midwifery Accreditation Council, Published by the Australian Nursing and Midwifery Accreditation Council 2013.

Banning, M 2005, 'Approaches to teaching: Current opinions and related research', *Nurse Education Today*, vol. 25, no. 7, pp. 502-8.

SA Health 2010, *Registered Nurse Re-entry Curriculum (2010)*, by Bassett, S & Nissen, J, 4th edn, SA Health,.

Beckett, C & Wall, M 1985, 'Role of the clinical facilitator', *Nurse Education Today*, vol. 5, no. 6, pp. 259-62.

Bellack, JPPRNF 1995, 'Characteristics and Outcomes of a Statewide Nurse Refresher Project', *The Journal of Continuing Education in Nursing*, vol. 26, no. 2, pp. 60-66.

Belock, S 1983, 'Preparing a Reentry Program for Inactive RNs', *JNE. Journal of Nursing Education*, vol. 22, no. 4, pp. 165-70.

Bernardo, LM 2011, 'Ready, set, go! How to return to the nursing workforce', *American Nurse Today*, vol. Vol. 6, no. No. 8, <http://www.americannursetoday.com/ready-set-go-how-to-return-to-the-nursing-workforce/>.

Blankenship, JS, Winslow, SA & Smith, AU 2003, 'Refresher course for inactive RNs facilitates workforce reentry', *Journal for nurses in staff development : JNSD : official journal of the National Nursing Staff Development Organization*, vol. 19, no. 6, pp. 288-91.

Bonds Shapiro, A 2012, 'Being Wary of Our Expectations. Do our expectations know the territory?', *Psycology Today*, viewed 19-4-2014, <http://www.psychologytoday.com/blog/healing-possibility/201210/being-wary-our-expectations>.

Borgfeld, JK 2014, 'A registered nurse refresher course: serving the community', *J Contin Educ Nurs*, vol. 45, no. 2, pp. 77-82.

Bourgeois, S, Drayton, N & Brown, A-M 2011, 'An innovative model of supportive clinical teaching and learning for undergraduate nursing students: The cluster model', *Nurse Education in Practice*, vol. 11, no. 2, pp. 114-118.

Brown, GD 1993, 'Accounting for power: nurse teachers' and students' perceptions of power in their relationship', *Nurse Education Today*, vol. 13, no. 2, pp. 111-120.

Brown, L & Waddell, G 1988, 'Professional Outcomes of Participants in a Nursing Refresher Course: A Five-Year Followup', *The Journal of Continuing Education in Nursing*, vol. 19, no. 3, pp. 134-136.

Budgen, C & Gamroth, L 2008, 'An overview of practice education models', *Nurse Education Today*, vol. 28, no. 3, pp. 273-283.

Burns, I & Paterson, IM 2005, 'Clinical practice and placement support: supporting learning in practice', *Nurse Education in Practice*, vol. 5, no. 1, pp. 3-9.

Burns, K, Sakraida, TJ, Englert, NC, Hoffmann, RL, Tuite, P & Foley, SM 2006, 'Returning Nurses to the Workforce: Developing a Fast Track Back Program', *Nursing Forum*, vol. 41, no. 3, pp. 125-132.

Burrows, DE 1997, 'Facilitation: a concept analysis', *J Adv Nurs*, vol. 25, no. 2, pp. 396-404.

Callaghan, D, Watts, WE, McCullough, DL, Moreau, JT, Little, MA, Gamroth, LM & Durnford, KL 2009, 'The experience of two practice education models: Collaborative learning unit and preceptorship', *Nurse Education in Practice*, vol. 9, no. 4, pp. 244-252.
Carpenter-Connell, SD 1984, 'An RN refresher course that works', *Nursing management*, vol. 15, no. 4, p. 13.
Centre For Nursing and Midwifery Education and Research Flinders Medical Centre 2013a, *Registered Nurse Re-Entry/Refresher Program : RN Re-entry Participant Portfolio*, by SA Health.
Centre for Nursing and Midwifery Education and Research Flinders Medical Centre 2013b, *Registered Nurse Re-Entry/Refresher Program : RN Refresher Participant Portfolio*, by 2014, *Flinders Medical Centre RN Refresher Program*.
Cope, P, Cuthbertson, P & Stoddart, B 2000, 'Situated learning in the practice placement', *J Adv Nurs*, vol. 31, no. 4, pp. 850-856.
Courtney-Pratt, H, FitzGerald, M, Ford, K, Marsden, K & Marlow, A 2012, 'Quality clinical placements for undergraduate nursing students: a cross-sectional survey of undergraduates and supervising nurses', *J Adv Nurs*, vol. 68, no. 6, pp. 1380-90.
Cross, KD 1996, 'An analysis of the concept facilitation', *Nurse Education Today*, vol. 16, no. 5, pp. 350-355.
Croxon, L & Maginnis, C 2009, 'Evaluation of clinical teaching models for nursing practice', *Nurse Education in Practice*, vol. 9, no. 4, pp. 236-243.
Cundall, RRNBSNMSN, Emert, BRNBSNMS, Gowens, DRNBSN, Hedrick, CRNBSN, Phillips, MRNBSNMSN, Schulze, BRNBSNMSN & Sredl, DRNMSNP 2004, 'Designing a Nurse Refresher Course Curriculum', *The Journal of Continuing Education in Nursing*, vol. 35, no. 4, pp. 164-75.
Curran, CL & Lengacher, CA 1982, 'RN Re-Entry Programs: Programmatic and Personal Considerations', *Nurse Educator May/June*, vol. 7, no. 3, pp. 29-30.
Curtis, P & Schneidenbach, L 1991, 'Brief: Successful Strategies for a Reentry Program-One Example', *The Journal of Continuing Education in Nursing*, vol. 22, no. 1, pp. 36-38.
Davidhizar, RERNDNSAF & Bartlett, DRNMS 2006, 'Re-Entry Into the Registered Nursing Work Force: We Did It!', *The Journal of Continuing Education in Nursing*, vol. 37, no. 4, pp. 185-190.
Deakin University 2013, *Return To Practice and Initial Registration (Overseas Nurses) Courses*, viewed 04-09-2014, <http://www.deakin.edu.au/health/pdu/forms/FINALISED%20Nursing-Brochure-Apr-2013.pdf>.
Dickson, C, Walker, J & Bourgeois, S 2006, 'Facilitating undergraduate nurses clinical practicum: The lived experience of clinical facilitators', *Nurse Education Today*, vol. 26, no. 5, pp. 416-422.
Durand, MA & Randhawa, G 2002, 'Nurses' views about returning to practice after a career break', *British Journal of Nursing*, vol. 11, no. 7, p. 477.
Ellis, R & Hogard, E 2003, 'Two deficits and a solutiion? Explicating and evaluating clinical facilitation using consultative methods and mulitple stakeholder perspectives.', *learning in Health and Social Care*, vol. 2, no. 1, pp. 18-27.
Elwin, C 2007, 'Returning to nursing practice: A learning journey', *Contemporary Nurse : a Journal for the Australian Nursing Profession*, vol. 24, no. 2, pp. 203-11.
Ferris, L & Brown, L 1992, 'A 10-Year Follow-Up Study: Nurse Refresher Program', *The Journal of Continuing Education in Nursing*, vol. 23, no. 5, pp. 220-3.
Flinders University 2014a, *Bachelor of Nursing (Re-Entry)*, viewed 22/09/2014, <http://www.flinders.edu.au/courses/undergrad/bngp/>.
2014b, *Findit@Flinders Patron guide: how to navigate through Findit@Flinders*, viewed 3 septmber 2014, <http://flinders.libguides.com/findit>.
Ford, K, Courtney-Pratt, H & Fitzgerald, M 2013, 'The development and evaluation of a preceptorship program using a practice development approach.(Research Paper)(Report)', *Australian Journal of Advanced Nursing*, vol. 30, no. 3, p. 5.
Franklin, N 2013, 'Clinical supervision in undergraduate nursing students: A review of the literature', *The E - Journal of Business Education & Scholarship of Teaching*, vol. 7, no. 1, pp. 34-42.
Gabb, R & Keating, S 2005, 'Worked-based learning curricula in nursing', *postcompulsory learning curricula in nursing*.

Grudens-Schuck N, Lundy Allen B, Larson K, and, DoAE & Sociology, Sa 2004, *Focus Group fundamentals Methodology Brief*, viewed 12 September 2014, <https://store.extension.iastate.edu/Product/Focus-Group-Fundamentals-Methodology-Brief>.

Hall, C & Andre, CA 1999, 'Nurses re-entering the workforce: a special needs group [corrected] [published erratum appears in CONTEMP NURSE 1999 Jun; 8(2): 13]', *Contemporary Nurse: A Journal for the Australian Nursing Profession*, vol. 8, no. 1, pp. 238-44.

Hammer, VREMNRN & Craig, GPEMSNRN 2008, 'The Experiences of Inactive Nurses Returned to Nursing After Completing a Refresher Course', *The Journal of Continuing Education in Nursing*, vol. 39, no. 8, pp. 358-67.

Hawley, JMMSNRN & Foley, BJPRNF 2004, 'Being Refreshed: Evaluation of a Nurse Refresher Course', *The Journal of Continuing Education in Nursing*, vol. 35, no. 2, pp. 84-8.

Health Workforce Australia 2010, *Health Workforce Australia 2010: Clinical Supervisor Support Program – Discussion Paper,*.

Henderson, A 2011, 'Leadership in clinical education — Embedding learning in everyday practice', *Nurse Education Today*, vol. 31, no. 1, pp. 4-5.

Henderson, A & Eaton, E 2013, 'Assisting nurses to facilitate student and new graduate learning in practice settings: What 'support' do nurses at the bedside need?', *Nurse Education in Practice*, vol. 13, no. 3, pp. 197-201.

Henderson, A, Heel, A & Twentyman, M 2007, 'Enabling student placement through strategic partnerships between a health-care organization and tertiary institutions', *Journal of Nursing Management*, vol. 15, no. 1, pp. 91-6.

Henderson, A & Tyler, S 2011, 'Facilitating learning in clinical practice: Evaluation of a trial of a supervisor of clinical education role', *Nurse Education in Practice*, vol. 11, no. 5, pp. 288-92.

Hennink, MM 2013, 'Writing focus group results', in *Focus group discussions*, 1 edn, Oxford University Press, USA, pp. 127-70.

Huggins, MFMAMSN 2005, 'Registered Nurse Refresher Course as an Adjunct in Nurse Recruitment', *The Journal of Continuing Education in Nursing*, vol. 36, no. 5, pp. 213-7.

informED 2014, *Instructional Scaffolding: A definative guide.*, <http://www.opencolleges.edu.au/informed/teacher-resources/scaffolding-in-education-a-definitive-guide/.>.

Kalnins, I, Phelps, S & Glauber, W 1994, 'Outcomes of Nurse (RN) Refresher Courses in a Midwestern City', *The Journal of Continuing Education in Nursing*, vol. 25, no. 6, pp. 268-71.

Kelly, PD 1980, 'A refresher program for RNs', *Supervisor nurse*, vol. 11, no. 7, p. 23.

Kitzinger, J 1995, *Qualitative Research: Introducing focus groups*, vol. 311.

Lambert, V & Glacken, M 2004, 'Clinical support roles: a review of the literature', *Nurse Education in Practice*, vol. 4, no. 3, pp. 177-83.

Lambert, V & Glacken, M 2004, 2005, 'Clinical education facilitators: a literature review', *Journal of Clinical Nursing*, vol. 14, no. 6, pp. 664-73.

Lee, EJERN 1988, 'Analysis of Coping Methods Reported by Returning RNs', *Journal of Nursing Education*, vol. 27, no. 7, pp. 309-13.

Liamputtong, P 2009, *Qualitative Research*, Oxford University Press, Melbourne.

Long, J & West, S 2007, 'Returning to Nursing after a Career Break: Elements of Successful Re-entry', *Australian Journal of Advanced Nursing, The*, vol. 25, no. 1, pp. 49-55.

Luhanga, FL, Billay, D, Grundy, Q, Myrick, F & Yonge, O 2010, 'The one-to-one relationship: is it really key to an effective preceptorship experience? A review of the literature', *Int J Nurs Educ Scholarsh*, vol. 7, p. Article21.

Macdonald, K & Freise , W 1989, 'Home Study Refresher Courses for RNs and LPNs', *The Journal of Continuing Education in Nursing*, vol. 20, no. 6, pp. 272-6.

Mackay, MT, Brown, RA, Joyce-McCoach, JT & Smith, KM 2014, 'The development of a model of education for casual academic staff who support nursing students in practice', *Nurse Education in Practice*, vol. 14, no. 3, pp. 281-5.

Mallik, M & Aylott, E 2005, 'Facilitating practice learning in pre-registration nursing programmes – a comparative review of the Bournemouth Collaborative Model and Australian models', *Nurse Education in Practice*, vol. 5, no. 3, pp. 152-60.

Mannix, J, Faga, P, Beale, B & Jackson, D 2006, 'Towards sustainable models for clinical education in nursing: An on-going conversation', *Nurse Education in Practice*, vol. 6, no. 1, pp. 3-11.
Mannix, J, Wilkes, L & Luck, L 2009, 'Key stakeholders in clinical learning and teaching in Bachelor of Nursing programs: A discussion paper', *Contemporary Nurse : a Journal for the Australian Nursing Profession*, vol. 32, no. 1/2, pp. 59-68.
Marczak, M & Sewell, M 2014, *Using focus groups for evaluation*, viewed 14/10/2014, <http://ag.arizona.edu/sfcs/cyfernet/cyfar/focus.htm >.
Mather, C & Marlow, A 2012, 'Audio teleconferencing: Creative use of a forgotten innovation', *Contemporary Nurse : a Journal for the Australian Nursing Profession*, vol. 41, no. 2, pp. 177-83.
McLafferty, I 2004, 'Focus group interviews as a data collecting strategy', *J Adv Nurs*, vol. 48, no. 2, pp. 187-94.
McMurtrie, LJ, Cameron, M, Oluanaigh, DP & Osborne, DYT 2014, 'Keeping our nursing and midwifery workforce: Factors that support non-practising clinicians to return to practice', *Nurse Education Today*, vol. 34, no. 5, pp. 761-5.
Monterosso, L & Zilembo, M 2008, 'Nursing students' perceptions of desirable leadership qualities in nurse preceptors: a descriptive survey', *Contemporary Nurse: A Journal for the Australian Nursing Profession*, vol. 27, no. 2, pp. 194 -206.
Moscato, SRERN, Nishioka, VMP & Coe, MTP 2013, 'Dedicated Education Unit: Implementing an Innovation in Replication Sites', *Journal of Nursing Education*, vol. 52, no. 5, pp. 259-67.
National Nursing and Nursing Education Taskforce 2005, *Re-entry Programs for Nurses and Midwives*, The Department of Human Services Victoria,.
Nursing and Midwifery Board of Australia 2006, *National Competency Standards for the Registered Nurse*, <http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx>.
2010, *Recency of Practice Standard*, by ——.
Nursing and Midwifery Board of Australia 2014, *Draft re-entry to pratice policy*, by , Nursing and Midwifery Board of Australia.
Nursing and Midwifery Board of Australia 2012, *Re-entry to practice policy.* <*http://*www.nursingmidwiferyboard.gov.au/documents/default.aspx?record=WD12%2F7698&dbid=AP&chksum=4MTWJHf296
Office of the Chief Health Professions Officer & Department of Health Perth 2008, *Evaluation of the need for re-entry programs*, <http://www.ochpo.health.wa.gov.au/docs/Evaluation_of_the_need_for_re-entry_programs.pdf>.
Oxford Dictionaries 2014, *Oxforddictionaries.com*, Oxford Universtiy Press2014, < http://www.oxforddictionaries.com/definition/english/expectation
Oxford Dictionaries 2014, *Oxforddictionaries.com*, Oxford Universtiy Press2014, <http://www.oxforddictionaries.com/definition/english/individual>.
Pearce, M 1962, 'Something really refreshing: Back in nursing and happy about it is a nurse whi returned via a refresher course.', *AJN, American Journal of Nursing*, vol. 62, no. 2, pp. 98-9.
Phelps, SL & Morice, SV 1992, 'Feeling refreshed: helping RNs return to the work force', *Journal of nursing staff development : JNSD*, vol. 8, no. 2, p. 51.
Pollard, C, Ellis, L, Stringer, E & Cockayne, D 2007, 'Clinical education: A review of the literature', *Nurse Education in Practice*, vol. 7, no. 5, pp. 315-22.
Prideaux, D, Worley, P & Bligh, J 2007, 'Symbiosis: a new model for clinical education', *The Clinical Teacher*, vol. 4, no. 4, pp. 209-12.
Råholm, M-B, Thorkildsen, K & Löfmark, A 2010, 'Translation of the Nursing Clinical Facilitators Questionnaire (NCFQ) to Norwegian language', *Nurse Education in Practice*, vol. 10, no. 4, pp. 196-200.
Richards, J, Sweet, L & Billett, S 2013, 'Preparing medical students as agentic learners through enhancing student engagement in clinical education', *Asia-Pacific Journal of Cooperative Education*, vol. 14, no. 4, pp. 251-63.
Rowan, P & Barber, P 2000, 'Clinical facilitators: A new way of working', *Nursing Standard*, vol. 14, no. 52, pp. 35-8.
Ruona, WEA 2005, 'Analyzing Qualitative Data', in E Holton, F., Swanson, R, A. (ed.), *Research In Organizations: foundations and Methofs of Inquiry*, EBESCO Publishing: e-book collection.

Sanderson, H & Lea, J 2012, 'Implementation of the Clinical Facilitation model within an Australian rural setting: The role of the Clinical Facilitator', *Nurse Education in Practice*, vol. 12, no. 6, pp. 333-9.
Schneider, Z, Whitehead, D & Elliott, D 2007, *Nursing & midwifery research : methods and appraisal for evidence-based practice*, 3rd edition edn, Marrickville, N.S.W. : Mosby/Elsevier Australia, Marrickville, N.S.W.
Sharp, JQ & Frederick, BJ 1990, 'Nursing refresher programs. Back for the future', *Journal of nursing staff development : JNSD*, vol. 6, no. 3, p. 118.
Silverman, D 2010, *Doing Qualitative Research*, 3rd Edition edn, SAGE Publications Ltd, London.
Smedley, ARNBME, Morey, PBDME & Race, PRNBAMHAP 2010, 'Enhancing the Knowledge, Attitudes, and Skills of Preceptors: An Australian Perspective', *The Journal of Continuing Education in Nursing*, vol. 41, no. 10, pp. 451-61.
Struksnes, S, Engelien, RI, Bogsti, WB, Moen, ÖL, Nordhagen, SS, Solvik, E & Arvidsson, B 2012, 'Nurses' conceptions of how an alternative supervision model influences their competence in assessment of nursing students in clinical practice', *Nurse Education in Practice*, vol. 12, no. 2, pp. 83-8.
Tobin, GA & Begley, CM 2004, 'Methodological Rigour within a Qualitative Framework', *J Adv Nurs*, vol. 48, no. 4, pp. 388-96.
Twentyman, M, Eaton, E & Henderson, A 2006, 'Enhancing support for nursing students in the clinical setting', *Nurs Times*, vol. 102, no. 14, pp. 35-7.
van de Pol, J, Volman, M & Beishuizen, J 2010, 'Scaffolding in Teacher–Student Interaction: A Decade of Research', *Educational Psycholigy Review*, vol. 22, pp. 271–96.
Varjavand, N, Novack, DH & Schindler, BA 2012, 'Returning physicians to the workforce: History, progress, and challenges', *Journal of Continuing Education in the Health Professions*, vol. 32, no. 2, pp. 142-7.
Waldock, J 2010, 'Facilitating student learning in clinical practice: many clinical nurses believes they are ill prepared and poorly supported to supervise students. Heavy workloads also prevent effective teaching and learning taking place', *Kai Tiaki: Nursing New Zealand*, vol. 16, no. 1, 2010/02//, p. 14+.
Walker, S, Dwyer, T, Moxham, L, Broadbent, M & Sander, T 2013, 'Facilitator versus preceptor: Which offers the best support to undergraduate nursing students?', *Nurse Education Today*, vol. 33, no. 5, pp. 530-5.
Walsh, P & Jones, K 2005, 'An exploration of tripartite collaboration in developing a strategic approach to the facilitation of practice learning', *Nurse Education in Practice*, vol. 5, no. 1, pp. 49-57.
Williamson, GR, Callaghan, L, Whittlesea, E & Heath, V 2011, 'Improving student support using Placement Development Teams: staff and student perceptions', *Journal of Clinical Nursing*, vol. 20, no. 5-6, pp. 828-36.
Workforce Development & Leadership Branch NSW Health 2007, 'Allied Health ReConnect Project Literature Review', Workforce Development & Leadership Branch NSW Health.