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INNOVATION IN CLINICAL PRACTICE: PROVIDING UNDERGRADUATE NURSING STUDENTS WITH A BEST PRACTICE CLINICAL LEARNING ENVIRONMENT

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The aim of this study was to explore how an innovative clinical model could meet the requirements of Best Practice Clinical Learning Environment (BPCLE) framework. What emerged from the data was evidence that the innovative flexible clinical model met the key elements that are considered essential underpinnings for quality clinical learning environments. This model provided a new framework to understand the ways that students identify as nurses in clinical placements and show engagement in the workplace through practices of participation as well as non-participation. From the results it was noted that students were able to actively build on their knowledge and skills through interplay of existing expertise with new experiences. It was clear that this model established a partnership between key stakeholders developing communities of practice.

Keywords: Building partnerships, Enhancing learning, Belonging, Promoting value and respect.

Introduction

This study explored the qualities of a partnership between faculty, students and nursing staff and investigated students' attitudes and learning during the implementation of a Flexible Clinical Education Model (hereon known as the flexi model). The interest in conducting such a study came about from the researcher's experience as an academic observing the frustration and often distresses that clinical placement caused students and staff both academic and clinical.

The overarching aim of the flexi model was to provide students with a positive clinical learning environment that maximised the achievement of learning outcomes and capitalised on the expertise of both clinicians and faculty. Previous researchers (Edgecombe, Wotton, Gonda, & Mason, 1999 and Ranse & Grealish, 2007) purport that Dedicate Education Units (DEU's) provide students with a positive clinical learning environment that enhances student learning. The DEU model of clinical education fosters a collaborative partnership, allowing nursing education to inform nursing practice and patient care delivery.

The flexi model has been designed around the DEU, forming a partnership between faculty and nursing staff on the unit that provided a synergistic environment to best educate the next generation of nurses. Also the flexi model enabled students to work alongside clinicians as team members while at the same time offering opportunities to expose students to the experiences of weekends and after hours.

Literature Review

The flexi model was informed by Wenger's (1998) social theory of learning known as Communities of Practice theory. Engagement and participation in the clinical workplace are essential for nursing students and the Communities of Practice theory provided a framework to understand the ways that students learn and identify as nurses in clinical placements. Strategies to support learning in the workplace can be shared between students and clinicians as nursing students engage in the workplace through practices of participation and non-participation.

The flexi model enabled nursing students to have extended exposure to learning in the clinical environment. The flexi model was established to provide undergraduate nursing students the opportunity to work all 3 shifts across the 7 day week. This meant students could work weekends and night duty. Theoretically, using the premise of social learning, students in the flexi model were exposed to a culture of learning by observing and working under the guidance of experienced nurses. The flexi model allowed nursing students to be active constructors of their own learning, a central view of learning in the Communities of Practice framework. The entire ward was responsible for student learning, offering students a strong interprofessional learning experience.

Among the many challenges of facilitating adult learners is diversity among learners. A study by Papalia (2009) recognises that psychologists have made significant progress in understanding the psychological processes involved in how people vary their approach and preferences to learning styles. In the adult education literature, Leonard (2009) suggests that Communities of Practice generally belong to the learning theory of 'constructivism', where learning occurs in groups and members can learn from and with each other, constructing knowledge in a personal and meaningful way.

Myers (2008) claims that there are three broad perspectives relating to three theories of learning: behaviourism, cognitive theories and constructivism. Behaviourism focuses only on the objectively observable aspects of learning. Cognitive theories look beyond behaviour, to explain brain-based learning. Constructivism views learning as a process in which the learner actively constructs or builds new ideas or concepts. Hill (2002) elaborates that behaviourism and cognitive theories support the practice of analysing a task and breaking it down into smaller pieces; in contrast, constructivism encourages a more open learning experience, where the methods and results of learning are not easily measured and may vary from learner to learner (Chowdhury, 2006).

Early literature was inconclusive about the relative advantages of any one clinical education model. However, Edgecombe et al. (1999) claim quality clinical learning exists where academics and clinicians are well prepared to meet the objectives of student placements, and where patients are provided optimal care and treatment. This is further supported by Kruger, Davies, Eckersley, Newell and Cherednichenko (2009), who maintain models clearly provide quality learning environments where they involve genuine partnerships between clinical agencies and the university and where student learning is central and valued.

Over the last decade, the field of research into clinical learning in the workplace and community for nursing undergraduate students has received extensive attention. Several studies have described student perceptions of clinical placement (Dunn & Hansford, 1997; Edwards, Smith, Courtney, Finlayson & Chapman, 2004; Henderson, Heel, Twentyman & Lloyd, 2006). Others have evaluated programs to improve the clinical placement experience (Chan, 2003; McKenna & Wellard, 2004: Lloyd & Bristol, 2006). Emerging research, however, has explored the partnership between faculty and nursing staff on the unit, and how it can provide a synergistic environment to better educate the next generation of nurses (Ranse & Grealish, 2007).

Niederhauser Macintyre, Garner, Teel & Murray (2010) suggest developing a more structured and cohesive partnership between registered nurses and students. They argue that although the nursing care environment has changed significantly over the past 30 years little has changed in the educational methods used to prepare new nurses. Students are still attending clinical venues in short-block models. This disruptive arrangement can compromise the cohesiveness of the nursing team and limit opportunities for building professional relationships between students, registered nurses and other members of the health care team. Consequently, Niederhauser et al. (2010) claim collaborative partnerships between nursing faculties and health service providers are the cornerstone of successful clinical experience for nursing students – collaborative partnerships, in this sense, have the potential to rejuvenate clinical education in nursing.

Beal (2012) undertook an extensive review of the literature on academic-service partnerships in the profession of nursing, with over 300 articles being accessed. Beal supports the notion that the challenge of providing an optimal learning environment is enormous, given the current environment in health. It has become apparent to many leaders in organisations who attempt to address the clinical learning environment that they must develop partnerships with others in the education-care continuum. Beal (2012) claims that as this realisation comes to consciousness, these leaders are becoming more aware of the need for partnerships as the foundation of a different type of strategic response. In taking early steps towards a partnership, leaders are becoming sensitive to the different demands that a true partnership places on them and their colleagues.

In May 2008, the Victorian Department of Human Services (now the Department of Health) commissioned the *Best Practice Clinical Learning Environments* (BPCLE) project, to examine the nature of successful clinical placements and develop a model of best practice. The project was part of a comprehensive strategy developed by the department, aimed at enhancing the capacity and quality of clinical placements in medicine, nursing and allied health in Victoria (Darcy Associates, 2012).

The Best Practice Clinical Learning Environments BPCLE framework provides a guide for health services and training providers to coordinate and deliver high-quality clinical placements for health students. From the report, Darcy Associates (2009, pp. 75-78) identifies six key characteristics of high-performing clinical learning environments identified in the Best Practice Clinical Learning Environments framework: an organisational culture that values learning; best practice clinical practice; a positive learning environment; an effective health service-training provider relationship; effective communication processes and appropriate resources and facilities.

Methodology

An ethnographic approach was used for this research, as this method requires the researcher to be immersed in a group for an extended period, observing behaviour, listening to what is said in conversations, and asking questions (O'Reilly, 2008). Ethnography is an appropriate methodology because the learning theory informing the flexi model is a social learning theory. Ethnographic fieldwork is especially well suited to study interactions among members of a defined community, such as the relations between clinician and student in a ward environment.

Data from this study were collected using four collection methods: individual interviews, focus group interviews, and participant observation and field notes. According to O'Donoghue & Punch (2003), data triangulation occurs when a piece of data, a finding, or a generalisation is able to be verified using several different research methods. In this research, data from each collection method were analysed individually, then compared against each

other for similarities. This added to the credibility of the research, ensuring reliability in the findings.

The field notes, focus group and individual interview transcripts were examined closely. Information and responses were coded and categorised into themes. The themes were then compared to the literature and the differences, relationships and similarities were determined. Experts (Holloway & Wheeler, 1996; Polit & Beck, 2004) recommend that researchers transcribe interview data themselves, because it is an effective way to become immersed in the data. This method provides more time to listen, analyse and note details about issues such as voice tone All interviews were transcribed verbatim and read a number of times, allowing the researcher to become familiar with the content.

This study's focus was on the clinical experience of undergraduate nursing students in a medical and surgical environment. The study was conducted in four wards at a large public hospital in Victoria, Australia. Two were surgical wards and two were medical wards. A classroom was booked in the education department of the hospital, where the focus groups were conducted. Academic staff were interviewed at Victoria University.

Three types of participants were recruited for this study: undergraduate nursing students (n=15), clinical ward staff (n=7) and academic staff (n=4). Undergraduate nursing students were participating in the flexi model at Western Hospital completing their final semester of the Bachelor of Nursing at Victoria University. Clinical ward staff comprised preceptors (registered nurses) Clinical Facilitators (CF) and Nursing Unit Managers (NUM), across the four wards designated as the flexi model workplace. Academic staff came from the School of Nursing and Midwifery at Victoria University. A summary of participants can be seen in table 1.

Table 1. Participant summary.

	Ward A	Ward B	Ward C	Ward D
Clinical Facilitator x 2 Individual interview and observation	CF1	CF1	CF2	CF2
Nursing Unit Manager x 2 Individual Interview	NUM1		NUM2	
Preceptor x 3 Observation	P1, P2	P3,		
Undergraduate nursing student x 15 Focus Group Interview	S1, S2, S4, S5, S9,	S6, S8, S15	S3, S11, S12, S13, S14	S7, S10,
Academic x 4 Individual Interview	A1, A2, A3, A4 (Academics not assigned to wards)			

Discussion

The six elements of the Best Practice Clinical Learning Environment are the essential underpinnings for a quality clinical learning environment with many of the elements overlapping or interrelated. However, if clinical learning environments are to represent best practice, more than the minimum standards are required. The following is a discussion on how the findings from this study demonstrate how the flexi model aims to meet the criteria of the six elements.

An organisational culture that values learning

In the context of a health service, an organisational culture that values learning ensures education, educators and students are valued. Victoria University first recognised the merits of the flexi model when early findings achieved the objective of reducing the cost of clinical educators. It was also acknowledged by Victoria University and industry (Western Hospital)

that the model showed potential for improving student learning. Both organisations were encouraged with student focused outcomes and supported the further development of this model.

It was evident from the interviews and focus groups that this model provides an organisational commitment to teaching. In the interviews, preceptors remarked they began to recognise undergraduate students as potential colleagues and commented they accepted them more willingly on the ward. This was in stark contrast to the traditional supervision model where staff in the interviews commented that students were a 'hindrance' and 'slowed them down'. In this model students completed a full 8.5 hour shift and preceptors and students attribute the extended ward time presence as a positive move towards acceptance. Preceptors on the wards encouraged students to attend professional development seminars offered to Western Hospital employees further supporting the notion of organisational culture that values learning.

Victoria University supported the model by offering a preceptor education program to all clinical staff and the hospital established a dedicated teaching position (Clinical Facilitator) to provide an additional education career pathway. The Clinical Facilitator position was established with involvement from both university and industry into a position description. Academic staff and preceptors voiced their approval of this position as it provided a central point of communication regarding student queries or issues.

Both organisations expected clinical staff to take on undergraduate students and the arrival of future students was anticipated and planned for. The orientation day played an integral part in welcoming students and the importance of attending this day was emphasised by students, academic staff and clinical educators. Students commented that on arrival to the hospital, they felt they were treated as part of the team, respected for what they brought (new ideas, critical appraisal, and future workforce) and given opportunities to learn.

Best practice clinical practice

Best clinical practice is a "reflection of the skill, knowledge and competency of staff, but also of the adoption of best evidence into practice, which is both an individual and an organisational responsibility" (Darcy, 2009, p. 75). Recruitment of highly skilled staff was a key factor in this model and as mentioned previously a dedicated Clinical Facilitator was appointed by the hospital in consultation with the Clinical Coordinator at Victoria University.

This role was pivotal to ensuring an organisational culture was established that promoted skill development amongst its clinical staff. The position description outlined the Clinical Facilitator was responsible for ensuring guidelines were provided for all activities undertaken, including clinical services, administration and education. Policies and procedures are the basis for delivering consistent standards of service across the organisation and provide an important resource to assist in the enculturation of learners. As such, Victoria University provided Western Hospital with student clinical procedures, which also included learning objectives for each clinical placement. In addition to having highly qualified staff, the data findings highlight the need to ensure that regular reviews of clinical practice of preceptors are conducted to maintaining high standards. The Clinical Facilitator was the linchpin between the university's clinical education department and clinical staff at Western Hospital. In the individual interviews with clinical staff and in student led focus groups it was stated that the Clinical Facilitator was well respected by all parties because of their ability to liaise effectively among all staff.

The position description outlined the Clinical Facilitator was to ensure both Western Hospital and Victoria University policies and procedures were accessible to learners with language that was clear and non-technical, with limited jargon. The documents were easily identified in a white folder with the blue Victoria University logo. They were located in each

ward. The documents were 'user friendly' and could be easily understood by someone unfamiliar with the document. One such document that was particularly relevant for keeping contemporaneous records on student learning was the preceptor's daily notes. This document was developed by the Clinical Facilitator for the flexi model to provide preceptors with a template to provide daily feedback on individual students. This document ensured contemporary notes regarding student performance were captured. A positive outcome of such note taking was that detailed account of student progress was accessible to clinical facilitator which assisted in accurate formative assessment and summative evaluations to be recorded for each student. Recruitment of expert staff and innovative documentation confirms that findings from data support the view that the flexi model provides best practice in clinical practice.

A positive learning environment

The positive learning environment concept is complex to define, in part because it is a subjective concept. That is, the elements that might make a learning environment positive from a clinical educator's perspective might not be the same elements that make it positive from a student's perspective (Darcy, 2009).

Students in the flexi model frequently commented that a welcoming environment was achieved where students received an appropriate orientation/induction. Students commented they were made to feel wanted and valued (not a burden or hindrance) when staff took the time to remember their names. The student participants in this study also asserted that involvement in staff activities such as professional development helped them to feel like part of the nursing team. In the individual interviews, preceptors commented that they identified their students as "potential" colleagues and wanted to promote the good aspects of working at Western Hospital. One preceptor even admitted to openly encouraging some student to apply to her ward at Western Hospital.

According to the data analysed, another aspect relating to the construction of positive learning environments in the flexi model was linked to the presence of appropriate learning opportunities that encouraged collaboration and team work between students, teachers and patients in the same space. Noteworthy was the impact of inter-professional learning opportunities on increasing staff and student morale. In addition the benefit of engaging in staff administrative duties provided learning opportunities for students that help them to become practice-ready. Comments from students when they reflected on their daily practice when they worked alongside other health professionals, their responses included 'understanding what a physio does' (focus group 1) and 'it was good to join in the doctors round' (focus group 2).

A supportive health service-training provider relationship

Working together fostered a close, collaborative, committed relationship with clinical partners. Findings from this study have shown the flexi model to be an innovative collaborative model that bridges education and practice and where student learning as central to the model's modus of operandi.

Maintaining a sustainable and productive partnership was one of the major challenges of the university and It was seen that effective communication nurtures trust, which is a key component in enhancing relationships. Students in focus groups noticed this and commented that once preceptors "got to know them" they were able to take on more of a nurse's role and less of the student role. Rapport building is therefore an essential element for reciprocal

development of preceptors' as well as stimulating students' learning and the development of the profession.

A supportive relationship developed between Victoria University and Western Hospital with both preceptors and academics stating the recognition and importance and value of the other. One element of this relationship was an understanding by all stakeholders of the institutional and systemic drivers and limitations that impact on the design and/or delivery of clinical education activities. Timing of the flexi model was negotiated between both partners, with Western Hospital knowing the semester dates and agreeing to an orientation program commencing during week 2 of each semester. This supportive relationship was fostered through open communication between the partners and strengthened through joint committees and regular meetings between educators and coordinators.

Effective communication processes

Effective communication processes foster interaction and exchange of ideas and provide clarity about when to communicate, who to communicate with and how best to achieve the communication (Darcy 2009). In this study Students commented they felt ill prepared by academics although it was acknowledged that information was available to students electronically. Academics commented they felt frustrated when students commented "we weren't given information" as academics knew the information was available to students. It became clear that while academics believed students had been provided with adequate preparation for clinical placement this was not in fact the case.

Students commented that they did not routinely access webct prior clinical placement, to seek information and highlighted that the pathway of communication was not always connected.

When all members were present, effective communication was noted. This was seen on orientation day when academics, preceptors and students all commented that communication at orientation was purposeful and effective.

Darcy (2009) indicates that an important aspect of communication is feedback and needs to be specific, timely, balanced, constructive and two-way. Students identified the importance of feedback and commented that this was something they looked for in a preceptor.

Timing of feedback was a key issue for students with most commenting the preferred to be provided with feedback immediately following an event or procedure. Students commented that feedback was less effective when provided at the end of the shift or worse on the interim appraisal half way through their placement. The daily preceptor notes was a positive example of how effective communication can be achieved.

Appropriate resources and facilities

The resources and facilities that are required to enhance or facilitate clinical learning will vary between health professions, health services and levels of learners however it is suggested the general principle is that learners should have access to the facilities and materials needed to optimise their clinical learning experience. Lack of space and resources is often considered an issue in clinical practice as rooms are limited or requires booking by a permanent staff member. These limitations were addressed in the flexi model by integrating students as part of the nursing team from orientation day. Students were provided with a car park pass and relevant key codes to access staff toilets and patient pathology results. Students acknowledged having access to these resources was appreciated as it made them feel part of the team and also minimised wastage of time trying to locate a permanent staff member to do things for them.

The nature of the flexi model ensures students had adequate time between shifts to access further information required to assist their learning. Time away from clinical practice provided students opportunity to access appropriate resources to enhance their learning experience. Students were encouraged to book into the nursing skills laboratories at university to practice a skill or time in the library to review a medical condition or unfamiliar medication. Students in focus groups stated they were grateful of the time between shifts so they could familiarise them self with unfamiliar skills or terminology.

The notion of students having access to appropriate resources in addition with time between shifts to access information provides an ideal learning environment. This encouraged good learning practices (such as reflection) that students can carry with them throughout the remainder of their education and into the practice as registered nurses.

It was evident in this study that a Community of Practice was in place, as described by Wenger (2006) as "groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly" (no pg.). A Community of Practice theory underpins the principles of the flexi model ensuring students learning is central where all members learn from each other, and have an opportunity to develop themselves personally and professionally.

In the flexi model the whole multidisciplinary team (including health and allied staff) are engaged in teaching the students, which enhanced their capacity to learn. Social theories of learning suggest that learning occurs in the "lived experience of participation in the world"

Students are social beings and place importance on acceptance by inclusion in the group. It is because of this that the Communities of Practice theory has been proposed as a good fit with evidence emerging from local and international studies of nurses as learners

The flexi model was developed using the principles of Communities of Practice that promote clinical staff to become involved as educators with a central concept around the belief that the clinical nurses' educational role is vital to the development of students' professional skills and knowledge. The data has shown that the flexi model has the potential to allow clinical practitioners and academics to collaborate to challenge and change current practice.

As an approach to community engagement, this way of working has the potential to create a vibrant work and learning environment for both staff and students. The findings from this study demonstrate that a supportive health service-training provider relationship existed between Victoria University and Western Hospital through the flexi model.

Summary

The establishment of a Community of Practice emerged and facilitated the integration of scholarship and professional practice. Evidence that for a student learning environment to be enhanced through the flexi model collaboration with university based academics and researchers must occur and effective communication must exist.

The Flexible Clinical Education Model balances university prescribed student learning outcomes with key industry partner needs for work-ready graduates, while adhering to policy mandated by external professional bodies. A collaborative approach provided an optimal environment for faculty and clinical nursing staff to maximise the benefits of clinical placements for students. The model can be adapted to suit individual organisations by ensuring students are career-ready and community minded The overarching aim of the model was to create a more supportive clinical learning environment, thereby maximising the opportunities for students to achieve learning outcomes, and at the same time, enhancing closer collaborations between clinical staff and academics. A flexi model exists when a community of practice occurs and students, academic and clinical staff are well prepared.

Figure 6.1 demonstrations how principles from the best practice in clinical learning environment (Darcy 2009) are met with a Flexible Clinical Education Model.

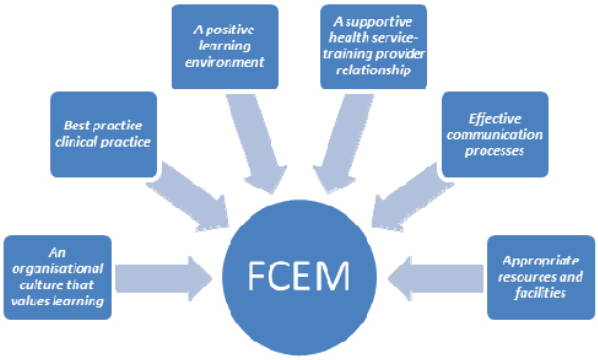

Figure 6.1. Flexi model meets BPCLE.

Conclusion

Overall, the findings of this study show that the Flexible Clinical Education Model enhanced the practical learning experience for undergraduate nursing students. The results also indicated that staff, both clinical and academic, valued the flexi model as a favourable model of clinical learning. Key features found to be important in facilitating these outcomes included the collaborative nature of the flexi model and a sense of ownership by staff and students alike. These factors showed a Communities of Practice was in place that enabled the development of positive learning environments in the wards where students were allocated clinical experience.

Equally important was ensuring that supervision of students in the clinical environment was undertaken by facilitators with preceptorship education and experience. Further, continued support from the university before, during and after each clinical placement was shown to be important, if not essential. These factors, acting in combination, promoted enhanced access to learning opportunities and improved learning outcomes for students and staff.

Clinical education is a vital component of undergraduate nursing courses. This study has demonstrated the positive impact of an innovative model of clinical education in the learning experience of students. The study also identified a range of factors that played a pivotal role in achieving best practice in the clinical learning environment for students and nursing staff. The findings propose that positive outcomes are more likely to be achieved when a Communities of Practice exists and is underpinned by a partnership between key stakeholders. The factors that were identified in this study as influencing the outcomes for students and nursing staff advance the understanding of what constitutes an exemplary model of clinical education for undergraduate nursing students. It is therefore proposed the Flexible Clinical Education Model promotes enhanced learning opportunities for students and findings have unequivocally confirmed that this study has demonstrated how the flexi model meets the criteria established by the best practice clinical learning environment framework.

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