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Implementing pertinent and sustainable clinical placement models for Gippsland CPN

Submitted by:

Latrobe Regional Hospital

In partnership with:

Education and Health Service Providers within the Gippsland CPN

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Contents

[Executive summary 5](#_Toc370475899)

[Key outcomes 5](#_Toc370475900)

[Conclusions 5](#_Toc370475901)

[Background and context 7](#_Toc370475902)

[Objectives 7](#_Toc370475903)

[Project activities and methodology 8](#_Toc370475904)

[Methodology 9](#_Toc370475905)

[Initiation: Steering group and project team established 9](#_Toc370475906)

[Ethics 9](#_Toc370475907)

[Establishing the baseline: Literature review 9](#_Toc370475908)

[Building supervisory capacity and capability 10](#_Toc370475909)

[Creating a vision 10](#_Toc370475910)

[Generating evidence 11](#_Toc370475911)

[New models of clinical placement and supervision piloted 12](#_Toc370475912)

[Project management 12](#_Toc370475913)

[Governance arrangements 12](#_Toc370475914)

[Stakeholder engagement 12](#_Toc370475915)

[Budget 13](#_Toc370475916)

[Timelines 13](#_Toc370475917)

[Outcomes and impacts 13](#_Toc370475918)

[Review of the literature 14](#_Toc370475919)

[Building supervisory capacity and capability 15](#_Toc370475920)

[Results 22](#_Toc370475921)

[Supported preceptorship model 22](#_Toc370475922)

[The clinical teacher plus preceptor model 29](#_Toc370475923)

[Opportunities to implement new models 43](#_Toc370475924)

[Pilot findings 43](#_Toc370475925)

[Limitations and management strategies 47](#_Toc370475926)

[Evaluation 48](#_Toc370475927)

[Future directions 50](#_Toc370475928)

[Conclusion 51](#_Toc370475929)

[References 53](#_Toc370475930)

Executive summary

This project sought to identify models of clinical placement and supervision that could promote Best Practice Clinical Learning Environments (BPCLEs) and support greater placement capacity across the Gippsland Clinical Placement Network (GiCPN). Other aims were to establish baseline supervisory capacity, expand the pool of trained clinical supervisors, engage with agencies that were under-utilised to explore opportunities for collaboration and involvement between health service providers, develop case studies that exemplify new and existing models and enlist the support of agencies to pilot selected models.

Partner organisations representing public and private sectors, aged care, mental health, Aboriginal health and community health services were identified and agreements to engage in project activities obtained. Three supervision workshops were provided in geographically strategic locations to extend supervisory capacity. As a basis for developing an integrated approach to placement policy and supervision in the GiCPN, a focused literature review was undertaken to identify existing models of supervision and placement that could be utilised to support an increase in placement capacity, case studies exemplifying established models of placement and supervision were evaluated and where possible, new models were developed and piloted.

Key outcomes

The sharing of information and resources regarding placement models generated ideas and opportunities for building placement capacity within the GiCPN through partner organisations collaborating to implement hub and spokes models that transcend traditional disciplinary and sectoral boundaries. Hub and spokes models of placement have the potential to expand opportunities for students to undertake a range of innovative clinical placements across Gippsland, expose students to the continuum of care and promote interprofessional learning opportunities (IPL).

Engaging education providers, placement providers and students in examining existing models and identifying/trialling new models of placement and supervision in the GiCPN has:

* Identified additional placement capacity that could be realised in under-utilised areas such as aged care, mental health, Aboriginal health, sub-acute care and the private sector, subject to further supports being implemented in these settings;
* Identified supported preceptorship and hub and spokes models as being well-suited to the rural context. These models could be meaningfully applied throughout the GiCPN and in other expanded settings to build placement capacity in pertinent and sustainable ways;
* Created additional capability of rural placement providers to effectively service and support students undertaking a range of innovative clinical placements in the GiCPN by increasing the skills and supervisory capabilities of 76 health professionals in 13 organisations; and

Increased capacity for quality student placements by facilitating progress towards the development of BPCLEs across the GiCPN.

Conclusions

This project established that there is capacity for smaller rural and other expanded settings to be utilised to build clinical placement capacity, however, it draws to attention that some models of placement and supervision are more pertinent and sustainable in the rural context than others. To achieve this potential, smaller rural health services need to adopt models that temper fluctuations in learning experiences, their limited staffing profile and lack of educational resources.

Supervisory capacity and capability has been increased, new clinicians and prospective placement providers have been engaged and inter-sectoral and interdisciplinary opportunities to network and collaborate to devise new models have been explored. Engaging education providers, placement providers and students in examining existing models and identifying and trialling new models of placement and supervision in the GiCPN has increased opportunities for a variety of placement choices and to accommodate students from more education providers. Additionally, it has informed a strategic and integrated approach to developing a BPCLE Framework in the GiCPN and sustaining models of placement and supervision relevant to the rural context. The achievements derived from this and two interrelated strategic projects will continue through five interlinked projects founded on the evidence generated. Collectively, these initiatives will continue to strengthen the clinical placement profile of the GiCPN in terms of placement capacity, supervisory capacity and capability, the quality of the clinical learning environment (CLE) and ultimately, student learning outcomes.

Opportunities to broker new models of placement and supervision suited to smaller rural health services and sustaining placement capacity in other expanded settings have been facilitated by the initiatives discussed or piloted during the course of this project, the infrastructure subsequently being implemented and the strategic appointments of a regional clinical support officer and expanded settings development officer.

To capitalise on the insights generated from this project it is imperative that further research be undertaken to identify the:

* Criteria pertinent to calculating clinical placement capacity in traditional and expanded settings;
* Features of models of placement and supervision that are pertinent and sustainable in the context of rural and other expanded settings and consistent with providing rich learning opportunities in a quality clinical learning environment;
* Attributes of a sustainable supported preceptorship model;
* Phenomenon of ‘burnout’ in the context of clinical supervision; and the

Role and merit of a dedicated clinical facilitator and what constitutes a reasonable student and preceptor load.

Background and context

A range of models, often developed to support the learning of groups of students in large urban and regional public health facilities, are utilised for clinical placements and supervision in the health professions without evidence that any one model is better than others (Kilminster and Jolly, 2001; Lekkas et al., 2007) or pertinent and sustainable in the rural context. Some heath sectors and smaller health services are under-utilised for placements because the models are unsuited to their environment, the potential learning opportunities available have been overlooked and/or devalued, or they lack the supports or resources required to promote student supervision in a culture of education and learning (Billett, 2004; Darcy Associates, 2009). There is an urgent need to target new or under-utilised areas in order to create increased placement capacity and promote greater flexibility in the style of clinical placement experiences that can be made available to students because the additional students required to meet projected workforce needs cannot be accommodated by large urban and regional public facilities (traditional placement providers).

Being educated in a rural environment and/or having quality rural clinical placement experiences has a significant influence on the career choices that graduates make. (Brazen et al., 2007; Dalton et al., 2008; Lea, et al., 2008; McGrail et al., 2011; Tate and Aoki, 2012). Increasing the number of rural clinical practice opportunities coupled with ensuring that health services staff are trained, supported and understand the needs of students are strategies likely to enhance the quality of clinical placements (Brazen et al., 2007; Killam and Carter, 2010; Lea, et al., 2008) and promote the recruitment of rural health professionals to areas of identified workforce need. (Department of Health, 2010).

This project investigated the evidence for current or alternative placement and supervision models that, a) provide a Best Practice Clinical Learning Environment, and b) work for specialist or smaller providers in specific sectors such as aged care, mental health, Aboriginal health services, smaller rural hospitals, community health services and the private sector including private practice settings.

Objectives

This project sought to identify models of clinical placement and supervision that could promote BPCLEs and support placements in a range of traditional and non-traditional settings across the GiCPN. Other aims were to establish baseline supervisory data, engage with agencies in expanded settings and under-utilised areas to explore opportunities for collaboration and involvement between health service providers, develop ‘case studies’ of existing models, build a critical mass of trained clinical supervisors to promote the placement capacity of health service providers and enlist the support of agencies to pilot ‘models’ that offered the potential for building and sustaining placement capacity in the GiCPN.

The objectives of the project were to:

* Identify models of clinical placement and supervision that:
* Promote BPCLEs
* Are pertinent to the circumstances of health service providers within the GiCPN
* Are sustainable in a range of settings.
* Audit supervisor capacity for potential placement providers in under-utilised areas.
* Engage with agencies not formerly providing clinical placement opportunities to utilise models that reflect a BPCLE they consider pertinent and sustainable.
* Explore opportunities for collaboration and involvement between health service providers (e.g., hospital, general practice and private practice) to facilitate student learning by selectively rotating them through pertinent sites or areas.
* Provide new and under-utilised clinical agencies with a clinical educator training workshop in advance of them taking students for placement.
* Utilise clinical agencies providing new and hybrid models of supervision or placement in the GiCPN as ‘models’ or ‘case studies’.

Report on models of placement and supervision currently utilised across the GiCPN and in other CPNs and explore their outcomes.

Project activities and methodology

This project incorporated six distinct activities conceptualised to produce an integrated insight to models of placement and supervision that could be pertinent to Gippsland health services and sustain growth in placement activity in the GiCPN (Figure 1). The project team and steering group were established and approval obtained from key GiCPN stakeholders for the project team to engage with staff, explore models of placement and supervision and enable staff to participate in supervisor training. The third and fourth elements involved a literature review and audit of baseline supervisory capacity. Basic and advanced supervisor training was delivered by external education consultants with expertise in clinical education, and the sixth activity was a workshop showcasing a range of placement and supervision models in use for medical, nursing and allied health students, an overview of the BPCLE framework and a progress report of a pilot BPCLE project being undertaken in Gippsland.

Figure 1: Project activities

Methodology

A mixed-methods approach was adopted as the style best suited to exploring opportunities to build clinical placement capacity, supervisory capacity and capability and strengthen the quality of clinical learning environments in the GiCPN in pertinent and sustainable ways.

Mixed-methods approaches can combine qualitative and quantitative elements to answer different research questions, elicit multiple perspectives, gain macro and micro perspectives or triangulate data, that is, to enhance the breadth and depth of understanding of the questions being asked and the answers found. The method is particularly useful for exploring different contexts, perspectives, processes and outcomes. The qualitative record provides understanding of the meaning of the concepts, while the quantitative analysis facilitates the understanding of patterns and underlying dimensions not always clear in the qualitative detail (Bazely, 2004). The approach adopted for this project was mindful that mixing methods remains somewhat contentious and that combining quantitative and qualitative methods is not always appropriate (Bazely, 2004; Denzin and Lincoln, 2005; Sarantakos, 2005). As the data was limited, the contexts varied and sample sizes were small, analysis was limited to simple descriptive statistics and thematic analysis. Collectively, the data sourced provided a broad insight to models of placement and supervision pertinent to the rural health service context and gave key stakeholders, including students, a legitimate voice.

Initiation: Steering group and project team established

A steering group was established from the GiCPN Committee to oversee the project, identify target organisations, ensure they included broad geographic and sectoral representation and to finalise the operational plan, project activities and evaluation criteria (Figure 1). Steering group members comprised an education provider, private sector health care, community health and community-based mental health. Initially the GiCPN committee’s Aboriginal Controlled Community Health Organisation (ACCHO) representative was nominated to join the steering group; however, despite encouragement, this member did not attend any meetings or engage with the group to provide input to project activities. The steering group provided ongoing input and feedback and received progress reports from the project team, the key content of which they were expected to disseminate to their respective sectors and professional groups. Overall, 11 steering group meetings were held to drive decision making and provide feedback. The project team, comprising a project manager, project officer and administrative assistant, organised, implemented and evaluated project activities. The project officer furnished a report to each steering group meeting and provided monthly summary reports to the GiCPN Committee.

Ethics

Approval for this project to be undertaken was granted from the Latrobe Regional Hospital Human Research Ethics Committee (LRH HREC). Latrobe Regional Hospital was the fund holder for this project and the LRH HREC, in addition to its own services, oversees ethics approvals for some smaller organisations in the region. Approval was also sought from administrators in participating education and clinical placement provider agencies. Explanatory statements were provided and consent was implied by participants choosing to complete the anonymous surveys. The surveys were designed by the project team to explore various elements of the project, including the student perspective of different models of clinical supervision and placement operating in Gippsland for nursing students.

Establishing the baseline: Literature review

An integrative literature review was undertaken to examine models of clinical placement and supervision utilised in traditional and non-traditional health settings by different disciplines that might be useful to building placement capacity and quality in the GiCPN. The search terms utilised were selected with reference to expert guidelines and international papers (Bithell, 2007; Dean et al, 2009; Threlkeld and Paschal, 2007; Skinner, 2007) and discussed with colleagues and librarians to ensure relevant terms were included. To ensure all relevant literature was identified, key words and phrases to describe the student, the education model, the educator and the settings of particular interest were applied to a range of electronic databases. The search results were supplemented by additional author searches and tracking the citations listed on the papers retrieved. Articles were included if they addressed a study of entry-level clinical education, evaluated characteristics that enhanced or detracted from student learning in the clinical setting and were published in English. All health disciplines were included, either singularly or in combination, however studies of interprofessional learning were not specifically sought.

Building supervisory capacity and capability

Supervisor training

The project provided an opportunity to train more clinicians as clinical supervisors, better prepare clinical facilitators/educators to support student supervision and to promote understanding of the BPCLE Framework. Three training workshops were undertaken to build supervisory capacity and capability in order to promote professional development and sustain relevant models suited for individual clinical learning environments. The Advancing Clinical Education (ACE) program, developed jointly by La Trobe, Monash and Deakin Universities was selected for this project because it was established to support clinical education and supervision by different disciplines in a variety of settings and therefore allowed for content to be tailored to the requirements of the GiCPN. The ACE program was adapted with the strategic intention to prepare all clinical supervisors in Gippsland, regardless of health profession, with the same baseline supervision training. The goal of adopting a standardised approach across disciplines and the region was to develop a sustainable pool of similarly trained supervisors and thereby maximise flexibility and transferability from one Gippsland organisation to another, create a community of supervisors, facilitate future opportunities for interprofessional learning and supervision and foster a peer support network.

Three supervisor training workshops were delivered at geographically tactical sites across the GiCPN to maximise the uptake and spread of a common program and to minimise the time and costs of travel for participants. The ACE Level One program delivered face-to-face in Gippsland was a two-day workshop, whilst the ACE Level Two program, held over three days, was an advanced program with an assessment component that built on Level One. The ACE Level One programs were delivered in East Gippsland and West Gippsland, whereas the ACE Level Two program was delivered centrally at Morwell. Two external education consultants involved with the ACE program were appointed to conduct the three ACE programs for a maximum of 30 participants in each workshop. Both consultants were contributors to a text on clinical education (Rose and Best, 2005) and one was also co-editor.

Key GiCPN stakeholder contacts were notified of the supervisor training workshops and invited to undertake the ACE program or invite others from their organisation to attend one of the programs being offered. To optimise this opportunity to build supervisory capacity a list of registrants was maintained to facilitate ongoing communication and in the event of cancellations or over subscription, to enable a waiting list to be established and for vacancies to be filled. To provide additional support to participants following completion of the training one copy of the clinical education textbook was provided to each participating organisation. Of the participants who undertook the ACE workshops, 73 completed a paper-based evaluation survey provided at the end of each program.

To inform the study, participants at the initial workshop were invited to participate in a focus group discussion on issues related to supervising students. Anonymity was assured, and participants were free to participate or withdraw at any stage without fear of reprisal.

Creating a vision

Workshop showcasing a range of models and features of a BPCLE

Having delivered the two ACE Level One programs and engaged with a number of providers, the project team identified a variety of models of placement and supervision utilised in Gippsland and elsewhere for undergraduate students from different health professions. Subsequently, key spokespersons associated with the models were invited to showcase their respective model/s to key education and placement provider stakeholders in the GiCPN with the intent of expanding their views of placement and supervision. The resulting workshop was attended by 25 members of the GiCPN including higher education (medicine, nursing and allied health), VET sector, community health, and regional, subregional and local public hospital placement providers. Six models of supervision were presented at this workshop, three utilised in nursing, one in medicine and two in allied health. Participants were also introduced to the features of a BPCLE and the progress of the Gippsland organisation involved in the state wide pilot BPCLE project. The models presented included:

* A chronic care model devised by one organisation to resolve a second year nursing placement issue
* A supported preceptorship nursing model
* An interprofessional allied health model
* A medical school model
* An allied health hub and spoke model from another region

Two existing collaborative nursing models.

Generating evidence

Exploring existing and potential models of placement and supervision

Representatives of placement provider and education provider organisations were either interviewed or surveyed about the model(s) of supervision practiced in their organisation or the potential for these to be modified to expand their capacity and capability to supervise students. Two interviews were undertaken to explore the different models operating in one local area that provide opportunities for medical and pharmacy students to be exposed to Indigenous health. Students undertaking particular placements in settings where different models of clinical supervision operated were surveyed about their clinical placement experience. Three interviews were undertaken with education and placement providers to explore ideas for developing models of placement suited to increasing nursing students’ understanding of commonly occurring chronic conditions and sub-acute care. Other interviews were undertaken to explore the potential to develop collaborative hub and spokes models of supervision and placement in aged care, general practice and mental health. Within the timeframe of the project three models of supervision were evaluated from a nursing student perspective and two models of clinical placement were piloted, one for nursing students and the other for allied health students. In all, seven models of clinical placement and supervision were examined, two pertinent to Indigenous health, four to nursing and one for allied health.

Case studies of established models of placement and supervision

Existing models of placement and supervision operating for nursing students in Gippsland were evaluated from a student perspective by means of a post-placement survey. The goals of the survey were to, a) elicit students’ perceptions about the model of clinical supervision utilised, b) evaluate students’ placement experience, and c) identify their perceptions of the advantages and disadvantages of undertaking a placement at a particular rural health care facility. The results reported under outcomes and impacts, are of a survey completed by 40 second-year nursing students that undertook a three-week placement under various models of supervision operating in four of the organisations that agreed to participate in the study. Explanatory statements were provided to students and consent was implied by students’ choosing to complete the survey.

For the second-year students who completed the survey, the placement represented their first acute clinical experience. To distinguish between groups and delineate the model of supervision being analysed, students were asked to indicate the ratio of students to supervisor they had experienced. The ratios nominated by students were consistent with the models of placement and supervision operating in the organisations in which they undertook placement.

To promote comparisons and consistency in reporting, the results of the survey were analysed descriptively and bracketed thematically under the following themes:

* how learning differed from students’ expectations
* perceptions of the advantages of undertaking the placement
* perceived disadvantages of undertaking the placement
* perceptions of the specifics of the clinical learning environment and placement model
* feedback regarding the frequency students found the CLE positive and constructive
* extent students perceived preceptors’ clinical workload affected their learning
* perceptions of who contributed most to students’ clinical learning
* factors that enabled students to achieve the most from the placement
* feedback regarding details about who and what enabled students’ learning
* perceptions regarding the role of debrief
* perceptions of the level of support provided

suggestions for improving the placement.

New models of clinical placement and supervision piloted

Within the timeframe of the project only two new models were able to be piloted: a chronic care model and a social work/mental health hub and spoke model.

Chronic care model

The chronic care model (CCM) was piloted with six nursing students at a medium-sized subregional hospital. The rationale underpinning the CCM was to build placement capacity without over-burdening sites/staff already being utilised. Key stakeholders in the organisation considered it appropriate to expose students to a broader range of health services and in particular, to sub-acute care because of the ageing of the population and proliferation of sub-acute care for people experiencing chronic conditions and multiple co-morbidities. This model involved students being placed in haemodialysis, district nursing, cardiac rehabilitation, respiratory rehabilitation and diabetes education. As part of the development the organisation worked with the education provider to ensure that all student competencies could be achieved whilst on the CCM placement. Feedback was provided by interviewing agency staff, clinical educators, the education provider and surveying students before and following placement.

Social work mental health placement

The placement was initiated as a result of a CPN project team visit to the mental health service to discuss current placement activity and capacity to increase it, particularly in areas where there was less student involvement. The potential additional opportunities identified by the mental health service were for social work and occupational therapy placements, as there were qualified and discipline-specific staff within the facility able to provide clinical supervision. One of the visiting team was aware of a social work program looking for placements in the mental health field and was able to pursue this potential placement opportunity. Following subsequent communication with the clinical facility and the education provider, placement arrangements were made that suited both services. The education provider and placement provider agreement, supervision and assessment arrangements were organised and the placements made available on a student preference listing. Students then made a positive choice to select the placement that offered the most suitable environment to facilitate their learning needs.

Project management

Governance arrangements

The steering group was formed as a sub-group of the GiCPN Committee on the basis of expressed interest in anticipated project outcomes. The steering group advised, reviewed documents, provided input to progress project activities such as the ACE supervision training workshops, and identified particular models of clinical supervision known to be operating in Gippsland and elsewhere. There were 11 face-to-face and/or teleconferenced meetings held over the project period.

Stakeholder engagement

Stakeholder engagement and consultation involved each local government area of Gippsland and incorporated a range of organisations and sectors that included placement providers, education providers and undergraduate health professional students. The 26 organisations engaged represented aged care, mental health, ACCHOs, the private sector, public hospitals, community health and mental health services. Representatives of these organisations were either interviewed or surveyed about the model(s) of supervision practiced in their organisation or the potential for these to be modified to expand the capacity and capability of the organisation to supervise students. The discipline most frequently engaged was nursing though medicine, pharmacy, radiography, occupational therapy, social work, midwifery and enrolled nursing were variously involved. Students undertaking placements in settings where different models of clinical supervision operated were surveyed about their clinical placement experience. Two interviews were undertaken to explore the different models operating in one local area that provide opportunities for medical and pharmacy students to be exposed to Indigenous health. Three interviews were undertaken with education and placement providers to explore ideas for developing models of placement suited to increasing nursing students’ understanding about chronic conditions and sub-acute care. Other interviews were undertaken to explore the potential to develop collaborative models of supervision and placement in aged care and mental health. Table 1 provides a synopsis of stakeholder engagement.

Table 1: Stakeholder engagement

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| ACE Supervisor training | Student feedback on four models of supervision/placement | Interviews to explore the potential for new models | Models workshop |
| 76 staff from 13 organisations(51 level 1 and 25 level 11) | 40 nursing, 1 social work student | 22 staff from 15 organisations | 25 participants from higher education, VET sector and placement provider organisations |

Budget

LRH was the project fund-holder. The project funding was utilised in accordance with the grant application to appoint a part-time project officer who worked with the overall project lead and a fractional administrative assistant. Other funding was expended on costs associated with supervision training, workshops and on related project expenses.

Timelines

The projected timelines were not all achieved as anticipated. The supervision training workshops were held as planned; however, other activities were dependent on timelines that were outside the control and jurisdiction of the project team. For example, there were limited opportunities to pilot new models and evaluate existing models in the timeframe of the project due to education providers tending to place students later in semester and over the semester break. The timing of placements delayed the surveying of students and subsequent analysis of the results regarding the placement and supervision experience. The *Final report* was delayed by the cumulative impact of these constraints.

Outcomes and impacts

This project achieved all but one of its objectives and in particular, identified supported preceptorship and hub and spokes models of placement and supervision as being effective and sustainable placement options that seem well suited to the particular environment of rural and non-traditional facilities. Sharing of information and resources regarding placement models generated ideas and opportunities for building placement capacity in the GiCPN through partner organisations collaborating to implement hub and spokes models that transcend traditional disciplinary and sectoral boundaries. Hub and spokes models of placement have the potential to expand opportunities for students to undertake a range of innovative clinical placements across Gippsland, expose students to the continuum of care and promote IPL. These models could be meaningfully applied throughout the GiCPN and in other expanded settings to build placement capacity in pertinent and sustainable ways.

Engaging education providers, placement providers and students in examining existing models and identifying and trialling new models of placement and supervision in the GiCPN has had a positive impact in that it has:

* Identified additional placement capacity that could be realised in under-utilised areas such as aged care, mental health, Aboriginal health, sub-acute care and the private sector, subject to further supports being implemented in these settings.
* Expanded the capability of rural placement providers to effectively service and support students undertaking a broader range of innovative clinical placements in the GiCPN by increasing the skills and supervisory capabilities of 76 health professionals in 13 organisations; and

Increased capacity for quality student placements by facilitating progress towards the development of Best Practice Clinical Learning Environments (BPCLEs) across the GiCPN.

The models trialled through these case studies have application throughout the GiCPN and elsewhere. Collaborative sharing of information and resources regarding placement models across the GiCPN and other CPNs will promote implementation of effective models and outcomes statewide. However, there are medium to long-term impacts of the project outcomes for participating supervisors, organisations, the GiCPN and regulatory authorities. The models of placement and supervision adopted need to be pertinent and sustainable in the rural context; that is, allow for the lean, part-time nature of the rural workforce, limited skill-mix of staff, fluctuations in learning experiences available and the benefits of bridging traditional organisational, professional and sectoral silos. The medium to long-term implications of building placement capacity requires planning to ensure sustainability. Strategies to provide peer support and mitigate burnout among supervisors by developing and maintaining a critical mass of trained supervisors and rotating staff on and off student supervision are crucial to sustaining placement load over time.

In order to capitalise on the latent placement capacity and learning opportunities available in rural and other expanded settings, it is also important that power brokers and regulatory authorities consider the models of supervision and placement that are pertinent and sustainable in these settings. It would be timely for placement and supervision requirements to be reviewed to ensure regulations align with changes to the health care system, that they can accommodate students undertaking placements in a broad range of practice settings, that issues around direct and indirect supervision and professional boundaries are addressed and that students are supervised appropriately in pertinent and sustainable ways. The pressure to utilise rural and other expanded settings for placements may justify lobbying regulatory authorities to amend placement and supervision requirements to facilitate broader clinical learning opportunities in these settings where traditional models may be neither pertinent nor sustainable. The following sections provide a more detailed discussion of project findings in terms of the activities undertaken.

Review of the literature

By profession, medical, nursing, occupational therapy, physiotherapy and speech therapy were the disciplines that featured most frequently in the literature on clinical or field placements and supervision but papers also included dietetics, medical radiation, chiropractic, clinical psychology and social work students undertaking field experience in health care settings. As the focus of this project was on increasing placements in areas that were under-utilised, the papers located were organised around the placement setting or area of practice.

The wide variation in papers gives an indication of the level of interest and variety of practice in the field of clinical placement and supervision. It also makes comparison difficult. Most research papers have a limited focus (one university, one profession) though some reach further but remain within state or country. Many studies identify issues and potential solutions relevant to their setting but are not necessarily applicable in other settings. Nonetheless there were some common factors to provide evidence that:

* students can gain meaningful learning experiences in different settings
* effective administration/organisation is an integral pre-requisite to supporting clinical placement
* there are educator attributes which facilitate student learning that can be supported and encouraged

some site factors such as space and resources promote or inhibit placement capacity and learning

Little evidence was found to support one model of supervision being superior to any other, although there is evidence that each model has strengths and limitations relative to other models.

Summary findings of the review of the literature

Reviewing the literature highlighted the parameters that delineate the clinical learning environment such as the setting, nature of placement – profession specific or interprofessional, the patient/client profile and caseload, staffing profile and skill-mix of staff, the organisational culture and students’ access to patients and learning resources. Models of clinical supervision are usually characterised by the ratio between students and supervisors (e.g., one-to-one, one to many, many to one or many to many), however, the nuances of supervision are often overlooked due to the considerable ambiguity and relatively little consensus around the nomenclature applied to clinical supervision (Lambert and Glacken, 2005; Mills et al., 2005).

Some models have different meanings in different disciplines or countries and others are used interchangeably (e.g., mentors and preceptors and clinical teachers, clinical supervisors and clinical facilitators). The model of supervision may be a hybrid, combining more than one model and though often discipline specific, it may involve supervision from other health professionals or a combination of direct and indirect supervision. Overall, reviewing the literature reaffirmed the findings of a number of studies that identified issues associated with supervising students in the rural context and the supports needed by staff and students to promote pertinent and sustainable models of clinical placement and supervision suited to providing quality rural placements.

Building supervisory capacity and capability

ACE supervisor training workshops

Two Level One ACE supervisor training programs were provided; one in East Gippsland and the other in West Gippsland. One Level Two ACE program was subsequently offered centrally at Morwell in early 2012. The first ACE workshop (Level One) at Paynesville was undertaken by 28 staff from eight health services. The second ACE (Level One) workshop was completed by 23 health professionals representing five health services. Collectively, participants included 25 registered nurses (RNs), five midwives, three physiotherapists, seven enrolled nurses (ENs), three radiographers, three welfare officers/counsellors, two occupational therapists, two speech pathologists and one interprofessional educator. Overall, a total of 51 Level One clinical supervisors and 25 Level Two clinical supervisors across 13 healthcare facilities and eight disciplinary groups were trained to support students undertaking clinical placements in the GiCPN. The results reported below relate to the combined feedback elicited from these participants via survey and a focus group discussion.

Profile of participants

The majority (75%) of participants had been in their role for less than five years and the years of experience they had in supervising students aligned fairly closely with the years in their role (24% <12 months; 47% 1 to <5 years; 24% 5 to <10 years; 6% ten years or more). In general, those who completed one workshop were more experienced than the other group though even then, approximately half had less than five years of experience.

Interestingly, the profile of participants that undertook ACE supervisor training defies the ageing workforce demographic (Figure 2). The tendency for less experienced staff to engage in supervisor training may reflect that more experienced clinicians have already undertaken such training; alternatively, it may reflect the inclination/disinclination of more experienced staff to engage in supervisor training and/or their interest in supervising students.

Figure 2: Profile of ACE participants by years of experience in role

Prior knowledge

There was a notable variation between participants in their level of training and prior knowledge of supervision. Before attending the ACE Level One training, half of the participants in workshop B had undertaken supervision training within the previous five years and a further two had undertaken such training five to ten years ago. In contrast, very few (three of 17 respondents) in workshop A, had undergone any supervision training prior to the ACE Level One training. Two of the three who had previously undertaken supervisor training had done so five to ten years ago. At each workshop there were only one or two participants who had undertaken a variety of clinical education/supervisor training programs over a number of years. These included: preceptor workshops, Certificate IV in Workplace Training and Assessment, working towards a Masters in professional education and a Clinical Teaching Certificate. Another participant was a coordinator and facilitator for an interprofessional supervisor training package.

Self-rated knowledge and skill as an educator

Before undertaking the two day ACE training program, almost two in three participants in workshop B rated their knowledge and skill as a clinical supervisor good or excellent and the remainder as average. In contrast, more than half of those undertaking workshop A rated their supervisory knowledge and skill as average.

Regardless of level of experience and perceptions of supervisory skill, having undertaken the workshop, all participants agreed that it improved their understanding of the knowledge and skills required for supervision. All but one person, who neither agreed nor disagreed, indicated there were aspects of their clinical supervision role that they would undertake differently as a result of attending the workshop. These results suggest that undertaking the ACE course was likely to improve supervision knowledge and skill for supervisors, irrespective of their prior knowledge and experience. Areas of supervision participants reported they were likely to change after undertaking the workshop were communication, providing feedback, planning, assessing students, their learning and teaching style and strategies to strengthen supervisor confidence and improve the learning environment (Table 2).

Table 2: Areas of supervision reported likely to change as a result of ACE supervisor training

|  |  |  |
| --- | --- | --- |
| Improving communication and feedback | Planning and goal setting  | Awareness of teaching and learning styles |
| * Ensuring students understand objectives
* Giving feedback in a timely manner, encourage preceptors to do the same with students
* Giving early feedback
* Give feedback more often
* Giving feedback and learning how to give it constructively
* Being more open to giving negative/constructive feedback
* Don’t presume I know, listen more, and talk less
 | * Think(ing) and planning to be done more thoroughly
* Looking at supervision from all perspectives and how goals are to be achieved
* Planning with students about their expectations and preferred learning styles
* Clarify goals at the beginning of each placement
* More interactions with students about needs and goals.
* Be better prepared for students and assess their level and knowledge
* Plan and prepare learning tasks, learning objectives and learning opportunities
 | * Different teaching styles and the importance of reflection in practice
* The workshop affirmed my ways of teaching and learning
* Awareness of different learning styles
* To be aware of my student’s learning styles along with my own teaching styles
 |
| Strengthen the learning environment | Evaluating student learning style | Explore student perspectives |
| * Importance of welcoming and socialisation for students
* Always being welcoming and supportive
* [Show] respect for individual needs
* Provide comprehensive orientation
* Get more staff involved
 | * More awareness of different learning techniques
* My approach to the learning styles and adapting the coaching styles for use
 | * [We need to] Try to understand better from student’s perspective the pressures/stress they face and their plans
* Find out students’ aims/goals and prior experience
* Closer attention to needs of students and ways to help them
 |
| Gaining confidence | Reflecting on practice, | Assessment |
| * Increased confidence in myself and my ability as a supervisor
 | * Going more over the overall process of what we do and how it works together
 | * [We] Need to begin implementing a clearer process for assessment of staff competency
 |

Organisational education systems

Prior to the ACE workshops, less than half the participants perceived their organisation had good clinical supervision systems in place, almost one third of all participants were non-committal and at one site, more than one in three participants perceived the organisation did not have good educational systems. After these workshops almost all participants agreed they could see ways to improve the clinical education systems in their organisation. The aspects of clinical education participants thought could be improved in their workplace rely on administrative processes being implemented to facilitate placement and adopting a leadership approach to promote the status of education in the organisation, motivating staff to see student supervision as an integral part of being professional and training of preceptors (Table 3).

Collegial support

Prior to undertaking the ACE training nearly two in three of the participants at one workshop considered they had the confidence, knowledge and skill as an educator to support their colleagues in their educational role, whereas at the other workshop approximately only one in three participants thought they did. Regardless of the level of experience or confidence participants professed coming into the training, after completing the two day ACE supervisor workshops, all participants reported that they felt more knowledgeable and confident about assisting colleagues with clinical supervision. Ways in which participants thought they could assist their colleagues become better educators focused on having strategies to help them work with students that are struggling. Assisting others in giving feedback, planning supervisory activities and sharing their knowledge about learning were also considered important ways they could assist colleagues become better supervisors.

Table 3: Participants’ suggestions to improve organisational education systems

|  |  |
| --- | --- |
| Implement administrative processes to facilitate placement | Adopt a leadership approach to promote education, motivation and training of preceptors |
| * Orientation manuals, resources, planning,
* Support from organisations
* A plan in place to increase training of all our preceptors on a train the trainer basis to increase sustainability.
* Plans put in place to give the student with a preceptor and a more structured process
* More access to a clinical facilitator – at present only available for clinical incidents
* More support for clinical educators, more time to reflect on their teaching skills
* Better support from management to support clinicians with students
* Strategies to strengthen the clinical learning environment and facilitate better continuity of student/mentor relationships
 | * Better support from management
* [Ensure] That the department heads are all on the same page when it comes to student education and overall outcomes
* [Inspire] Preceptors being passionate about students
* [Encouraging and supporting] More preceptors to attend these sessions, to facilitate more constructive feedback being given to students
* I think my organisation is already working on this, by sending so many staff by directive to the ACE course.
* Promoting the calibre and supervisory capability of staff regardless of the setting e.g., aged care
* Change the stigma/perceptions of aged care. More time and education by highly trained staff – not someone who hasn’t completed training for years and are very out-dated
* Grade 2 physios (not new grads!) should be supervising students!!
* I don’t think in the community it is well established. I feel I am in a position to change that
 |

The ACE workshops produced a broad range of data that could be utilised to guide expanded settings to prepare staff for clinical supervisory roles and inform administrative processes and supports that could enable staff to supervise effectively. Table 4 reports participants’ perceptions of the utility of the ACE program.

Endorsement of ACE training

Most participants (95% and 88% respectively) indicated they would recommend the ACE course to others that supervise students. The remainder were non-committal. Reasons given for recommending the course included how engaging, informative and supportive they found it (Figure 3). The majority, approximately three in every four of the participants that completed the ACE evaluation survey, agreed that clinical education training should become mandatory. However, almost one in four participants was non-committal.

Table 4: Selected outcomes of ACE supervisor training workshops

|  |  |  |
| --- | --- | --- |
| Areas of supervision likely to change after undertaking the ACE workshop | How could you help others improve student supervision? | Aspects of clinical supervision I would like addressed in my organisation |
| * Commitment to trying to understand better from students perspective the pressures/stress they face and their plans
* Understanding students’ goals
* Planning and preparing learning tasks to optimise learning
 | * Support and suggestions
* Share the notes from today
* Encourage them to give more feedback and include students in goal setting
 | * Better support from management
* More CNE support and availability
* More staff to be involved
* Formalised policies, roles and responsibilities
* More training support for preceptors
* To be fully informed in advance of students arriving to enable planning and having the time the student deserves
 |
| My approach to the learning styles and adapting the coaching styles for use | Greater awareness of different learning styles | Preceptors being passionate about students |
| * Planning, organisation, considering different learning, teaching methods and assessment
* Evaluating how students learn best
 | * Reinforce the need to keep the wires of communication open and that it doesn’t take a lot of time to make a big difference in a student’s life
 | * More preceptors attend these sessions
* More constructive feedback to students
 |
| Give feedback regularly, constructively and in a timely manner; encourage preceptors to do the same with students | Revamp preceptor workshop.Give preceptors feedback. Introduce a better feedback tool | That department heads are all on the same page when it comes to student education and overall outcomes |
| * Strengthen the clinical learning environment and preceptors’ teaching styles
 | * Share strategies for dealing with difficult situations
 | * Orientation manuals, resources, planning, support from organisations
 |

Figure 3: Participant comments endorsing ACE supervisor training

|  |
| --- |
| * Essential for all educators responsible for students
* Very informative, covered different training perspectives
* Supportive environment, diverse learning techniques, reinforced
* To gain a better understanding of the teaching process
* Covered a lot of areas, giving clear guidelines for teaching students
* Fun, engaging, well based theory lots of experimental learning – great model
* Increases/enhances clinical supervision skills
* Gives a greater understanding of the learning process and self as an educator. It helped me to greater understanding of myself. Also of the range of people we need to work with.
* Informative, confidence building
* It is appropriate to Rural-regional practice as all other participants are from the same area
* Changes attitudes which are central to making a lasting change
* Promotes effective communication skills
 |

Participants also made comments related to the quality of the presenters, course content, location, venues and catering. Suggestions for improvement included utilising a newer venue, providing a one rather than two-day version of the ACE course and providing access to the related textbook to individual departments rather than the organisation (Figure 4).

Figure 4: Feedback on ACE workshop facilities, facilitators and resources

|  |
| --- |
| * Great that we didn’t have to travel to Melbourne for fantastic training
* The resources were fantastic and relevant. Great balance of teaching and learning activities
* Thank you for a very enjoyable course – went quickly and very beneficial – taken away some very good advice
* Thank you – very good course
* Great 2 days. The two presenters worked beautifully to provide a balance of styles and experience.
* Would love to purchase the book ‘Clinical education, professional supervision and mentoring’
* The food was great. The presenters made it interesting.
* Maybe briefer format of one day
* Very good food, friendly atmosphere. Please can we have a copy of the book? ☺ I must have enjoyed it as I don’t usually write as much!
* Venue not great, bit old and dark
 |

The role of the supervisor is important in assisting students to develop and consolidate their learning within the clinical environment (Rose and Best, 2005). It is through the process of teaching and support during the clinical placement experience that the supervisor helps the student to accomplish a ‘safe passage’ (Bourbonnais and Kerr, 2007).

Table 5: Participants’ perceptions of the rewards related to clinical supervision

|  |  |
| --- | --- |
| Theme | Comments |
| Positive reactions | * Happy
* Positive feedback, staff, students, institutions, clinician
* Their appreciation/feeling valued
* Building trusting relationships
 |
| Contributing to professional growth of student | * Opportunity to change practice
* Learning new knowledge
* Contributing to profession
* Rewarding to see growth in student
* Employment opportunities
* Students taking pride in their profession and sharing enthusiasms for learning
* Students accepted as a team member
* Overcoming fears and challenges
 |
| Team learning opportunity | * Constructive feedback
* Instilling good standards
* Changing the stigma/know attitudes to different ones
 |
| Opportunity to nurture personal growth in self and others | * Consolidation of knowledge
* Achieve personal objectives
* Learn from self, amazing what you recall you know
* Social interaction/inclusion
 |
| Benefits to clients | * Clients/patients involved in education process
* Sharing knowledge
* Educating clients
 |
| Development of supervisor | * Good communicator
* Job satisfaction
* Acquiring skills and achieving levels of competency
* Refreshing your own practice
 |
| Extra hands to share workload | * High work productivity
 |
| Benefits for the organisation | * Contributes to team building and recruiting new staff
* Building the future/contributing to healthcare
 |

While students recognise that supervision is beneficial, the rewards for the supervisor are less obvious (Andrews and Wallis, 1999). Participants undertaking the ACE supervision workshops identified significant positive rewards and outcomes associated with their role in clinical education ranging from contributing to the professional growth of the student to benefits for patients/clients (Table 5).

Though the goal of supervision is to optimise learning outcomes (Burns et al., 2006), participants undertaking supervisor training highlighted a number of challenges and strains associated with juggling the multiple, often competing role demands of teacher and clinician within the busy CLE (Table 6).

Table 6: Participants’ perceptions of the challenges of clinical supervision

|  |  |
| --- | --- |
| Theme | Comments |
| Student attitude and behaviour | * Poor attitudes
* Shy
* Lack of student insight
* Poor retention of information
* Lack of interest
* Poor time management
* Can’t organise work load
* Difficult behaviour, argumentative, over confident, under confident
* Inappropriate communications styles condescending, rude, gen y’s different expectations
* Dealing with difficult behaviour
* Preconceived ideas
* Learning difficulties
* Lack of initiative
* Lack of motivation
* Don’t want to be there
* Outside influences
* Expectations different
* Engaging a student due to student mandated placement
* Lack of student insight
 |
| Variation in learning style | * Supervisors’ learning styles mismatch to students
* Different learning speeds/types
* Different learning styles
* Poor learner
 |
| Personality  | * Fear
* Lack of confidence
* Encountering difficult students
* Conflicting information from multiple educators
* Adjusting to differences in students
* Life experiences, confidence, response to positive and negative feedback
* People with disabilities
* Different personalities
* Students who think they know it all (over confidence)
 |
| Time constraints | * Administration costs/time
* Time consuming
* Exhausting on top of existing workload
* Less flexible (locked in placement times)
* Low work productivity
 |
| Discontinuity | * Low continuity/flow
* Poor/inadequate communication with universities
 |
| Burden of assessment | * ‘unnatural’ clinical situation
* Knowing how much and how to deliver feedback
* Assessments
* Adds another layer of accountability
* Difficult working in certain areas due to client sensitivities
 |
| Communication | * Lack of attention
* Number who don’t listen
* Communication/lack of/poor
 |

Summary comments of ACE workshop outcomes

The ACE supervisor training workshops have increased the capacity and capability of 76 staff in eight disciplines in 13 rural health services geographically dispersed across Gippsland to effectively supervise and support students undertaking clinical placements in their organisation. The evaluation of these workshops has been instrumental in realising the scope of outcomes deriving from them and garnering valuable data that can inform: future supervisor training programs; strategies to further develop and prepare expanded settings to accommodate students for placement; and decisions regarding the provision of ongoing infrastructure support. Furthermore, participants have identified a number of challenges and satisfactions associated with supervising students and numerous ways they can strengthen the clinical learning environment and support others supervising students. Another of the overarching outcomes and perceived benefits of the three ACE supervisor training programs has been the merit of preparing clinical supervisors with shared knowledge and understanding across sectors and disciplines. In the words of one participant who advocates others undertake ACE training, it brought together “a great variety of participants”.

The interprofessional nature of these workshops has enabled health professionals to learn together, with and from each other (Hammick et al., 2009) and therein realise a collective pool of shared understanding and experience of clinical supervision. This interprofessional learning (IPL) experience augers well for: promoting the potential to develop intersectoral and interprofessional collaborative placement relationships, including hub and spoke models of placement and supervision; developing innovative new models of placement and supervision; promoting IPL opportunities for students undertaking rural placements in the region; and developing an interprofessional peer support network of similarly trained clinical supervisors.

Case study exemplars of existing models of clinical placement and supervision utilised in Gippsland

Exposing nursing students to the realities of practice and giving them opportunities to learn from experts in the field who are able to assist them translate theory into practice is considered critical to preparing new graduates with the requisite knowledge, skills, attitudes, values and confidence to be ‘fit for practice’ and work ready (Billett, 2004; Field, 2004). There has been widespread professional concern however, about the diversity that characterises the quality of the CLE, how students experience their clinical placements and the variation in supervision and learning outcomes (Courtney-Pratt et al., 2011; Edwards et al., 2004). Besides confidence and competence, the variation in the quality of placements and supervision have important implications for recruitment because CLEs that are welcoming, positive, enabling and supportive are known to attract new graduates (Andrews et al., 2005; Courtney et al., 2002; Neill and Terry, 2002). As students’ clinical experience and learning outcomes are influenced by an organisation’s culture and attributes of the CLE as well as the model of clinical supervision (Andrews et al., 2005; Edwards et al., 2004), it is crucial students’ experiences are regularly evaluated and strategies are implemented to strengthen the CLE (Darcy Associates, 2009).

On the basis of a comprehensive review of the literature on supervision across disciplines, Kilminster and Jolly (2001) concluded there is no substantive evidence that any one model of supervision is better than another. Similarly, there is no empirical evidence that one model is better suited to supervising students from different health disciplines, different year levels within one discipline, or different practice settings.

The following section presents the findings of, a) a survey that explored students’ placement experiences under a range of models of clinical supervision utilised for health professional students undertaking placement in the GiCPN, and b) the outcomes of interviews with key placement stakeholders that identified opportunities for implementing innovative alternatives suited to a local situation. In the first three sections the findings were generated from a post-placement survey of 40 second-year nursing students following a three-week clinical placement at rural health services in Gippsland in June/July 2012. The goals of the survey were to, a) elicit students’ perceptions about the model of clinical supervision utilised, b) evaluate students’ placement experience, and c) identify their perceptions of the advantages and disadvantages of undertaking a placement at that health care facility.

Results

Supported preceptorship model

The ‘supported preceptorship model’ operating at one medium-sized subregional public hospital in Gippsland has been in place since 2007 as an outcome of a collaborative project between the hospital and three education providers. The approach taken to implement this model was action research which involved broad consultation with hospital staff, clinical educators and administrators. The model was trialed, tested and modified over a period of twelve months on the basis of feedback from students, supervisors, administrators and education provider partners (Barnett et al., 2007; 2008; 2010). The defining features of the supported preceptorship model as it functions in this organisation are:

* The principal role played by preceptors
* The dual administrative student/preceptor support role played by the overarching clinical facilitator who allocates students to preceptors and rosters staff on and off supervision to mitigate burnout
* The allocation and distinction between primary and secondary preceptors and buddies
* Staff access to preceptor training and professional development related to supervision

The fostering of a learning culture and sense of learning community.

The quality of the supported preceptorship placement was rated excellent by seven of the 10 students who completed the post-placement survey and above average by a further two. Only one student rated the experience average. For many survey items the results were very positive, however, some aspects of the placement and supervision were perceived more strongly or universally than others. Accordingly, the results identify opportunities to further strengthen the quality of the CLE and the effectiveness of the supported preceptorship (Supported Preceptor(s) [SP]+ Clinical facilitator [CF] =SPCF) model of supervision in this agency.

How learning differed from students’ expectations

Comments made by students about how their learning differed from their expectations indicate that for half of them the placement surpassed their expectations. Comments included:

* More confident than I thought I would of [sic] been at the end
* Learning IV technique was easier with continued supported practice
* Learned more about paeds [paediatrics]
* More IV and injectables

I learned a lot more about time management and patient assessment/shift management than I expected.

For three students there was no difference between what they expected to learn from the placement and what they did learn. One student explained: “… it did not differ – my expectations were high and these expectations were met by great staff.” There was only one student for whom the placement failed to meet their expectations: “Well I expected to be doing a lot more practice with my new skills. However I only got minimal practice on ECGs, IM, drainage tube, sutures and staples.” The findings suggest that though most students had realistic expectations about what they could expect to learn from one three-week placement, it is important to prepare students for the realities characterising different placement settings to mitigate the risk of unrealistic expectations.

Student perceptions of the advantages of this placement under the supported preceptorship (SPCF) model

The advantages most students associated with undertaking the placement at this particular organisation were captured in the words of one student: “experience and exposure, great support and extensive learning”. Students’ comments about the advantages of undertaking the placement were collapsed into three themes, ‘skill acquisition’, ‘opportunities to apply theory to practice’ and ‘staff support’. Perceived advantages included the staffing and patient profile, for example, “good ratios and varied patient ages,” “plenty of medications” and, “the preceptors were all experienced and very professional which made the learning process more valuable.” The rehabilitation ward, though not valued by one student as a suitable second-year placement, was identified by another student as providing a forum for “knowing your patients thoroughly” and enabling development of skills in “time management and medications.”

For one student, the advantage of undertaking a placement in this organisation related solely to its geographic locale and its relationship to their origin, proximity to family and intended career destination: “Close to family/home, in the facility I wish to work in”. For others, the location of this health service and its distance from their home and family was a disadvantage.

Perceived disadvantages of undertaking the placement

Some students identified the distance from home, travelling and the costs associated with these as disadvantages in undertaking a clinical placement in this organisation. Students’ comments reflecting concerns about the distance, travel and cost implications of undertaking a placement here included:

* Its’ to [sic] far away from home which costs a lot of money

Distance from home, extensive fatigue and having to manage living away from home

Students’ perceptions of distance, separation and costs being a disadvantage of the placement are salient in the context the organisation was some 140-150kms away from the education provider where they were studying. The issues of distance, isolation, loss of income and the costs of travel and accommodation associated with undertaking rural placements are known barriers to students’ choosing rural placements (Barnett et al., 2008; Schofield et al., 2009). The findings of this small study provide further evidence that students see location as a disadvantage and deterrent to rural placements and suggest it is unlikely that smaller and medium-sized rural health care facilities, located distant from students’ normal location will, despite their best efforts, attract optimal numbers of students to fill their potential placement capacity.

Another disadvantage of undertaking placement in this organisation identified by two students related to having a number of preceptors, “difficult when working with numerous amounts of preceptors” and “different preceptors, different ways of doing skills”. These references to multiple preceptors suggest a tension exists between how different staff deal with things and the student’s ability to accommodate variance. The comments also draw attention to the reality of rural placements in small to medium health care facilities. The lean, predominantly part-time staffing profile, number of nursing students placed, the regulatory mandate that all nursing students, (enrolled as well as registered) must be supervised by an RN and the availability of qualified RNs to supervise students necessitates that students are supervised by a number of preceptors. There is no information available about how many preceptors these students had, though a previous study in this organisation in 2007 (Barnett et al., 2008) found students were generally comfortable with up to three preceptors if one was nominated the primary preceptor.

One student identified concerns about the richness of the learning experience. For this student the disadvantage in undertaking placement in the organisation related to a perceived mismatch between the tasks and procedures he/she expected to be doing on placement and those he/she was able to practice. This student stated, “I was not in a [sic] acute care setting. Had minimal acute patients, minimal opportunities for sutures, staples, oxygen therapy, drainage tubes, ECGs etc.” Along similar lines, though not identifying this as a disadvantage, another student considered a three-week placement in a rehabilitation unit unsuitable for a second-year placement. These comments draw attention to what others have observed about nursing students’ tendency on clinical placement to be task and competency driven (Dalton, 2004; Grealish & Trevitt, 2005). The perception that rehabilitation, or any other non-acute clinical area for that matter, is not a suitable placement for second-year nursing students highlights the need for education providers and clinical agencies to liaise closely with each other to align learning opportunities with the objectives of placement. Such comments also draw attention to the ongoing need for education and placement providers to prepare students to be generalists and capitalise on the range of learning opportunities available in different settings and the breadth of the nursing role and skills required, not all of which are acute or procedural (Dalton, 2004).

Notably, three students perceived there were no disadvantages to undertaking a clinical placement in this organisation, one stating, “None – enjoyed everything”. Students’ perceptions of the specifics of the CLE and SPCF model of placement were prioritised into three clusters; those reflecting high student satisfaction, those flagging areas for further work and improvement and third, an area requiring prompt attention.

The most positive and universal findings were that students felt welcome and supported by the staff supervising them in clinical areas. The areas of least satisfaction and consensus were students’ perceptions of the limited opportunities they had to discuss and review their learning objectives with their preceptor(s) and how well they sensed staff were supported by the CF (Table 7).

Table 7: Student perceptions of the clinical learning environment and supported preceptorship model

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Statement | Strongly agreed | Agreed | Not sure | Disagreed | Strongly disagreed |
| Students knew who to contact if they had any difficulties | 8 | 1 | 1 |  |  |
| Students felt welcome | 7 | 3 |  |  |  |
| Students were briefed about what to expect from the placement |  |  |  |  |  |
| Students felt the hospital orientation assisted them to make the most of the placement | 5 | 4 | 1 |  |  |
| Students felt adequately prepared for the placement | 6 | 4 |  |  |  |
| Students considered the placement aligned well with what they were learning in the course | 5 | 5 |  |  |  |
| Students considered the learning opportunities available to them enabled them to achieve their personal learning objectives | 6 | 3 |  | 1 |  |
| Students considered this placement model provided a rich learning environment | 8 | 1 |  |  |  |
| Students considered they were supervised by experienced staff/experts in their field | 6 | 4 |  |  |  |
| Students had daily opportunities to observe skilled nurses deliver care | 6 | 4 |  |  |  |
| Students felt supported by the staff supervising them in the ward/unit | 7 | 3 |  |  |  |
| Students had opportunities daily to discuss and review their learning objectives with their preceptor | 2 | 5 | 1 | 1 |  |
| Students felt supported by the clinical facilitator | 5 | 4 | 1 |  |  |
| Students felt staff were supported by the clinical facilitator | 3 | 4 | 1 | 1 |  |
| Students felt clinical staff went out of their way to make the most of the clinical learning opportunities available | 6 | 3 | 1 |  |  |

The findings also suggest some reservation about, and hence opportunity to strengthen, the support provided to students’ by the CF. Given that responses about the CF were very positive, particularly regarding feedback, this suggests there may have been an issue with access, availability, students’ understanding of the distinctions between a CF and clinical teacher (CT), or competing priorities.

Students’ perceptions regarding the support provided by the CF highlights the importance of education and placement providers giving due consideration to the workload of the CF and to orientating students to the model of supervision operating in the setting where they will be undertaking placement. Arguably, the discrepancy between the support students felt they were provided by preceptors, other staff and the CF reflects the clinical focus of the supported preceptorship model of supervision and its reliance on preceptor(s) as the dominant clinical learning influence. Rather than clinical teaching, the role of the CF under this model was to liaise with the education provider, agency staff and students, administer student placements by rostering staff as preceptors, allocating students to preceptors, overseeing the placement, advising and supporting students and preceptors, troubleshooting challenges as they arose and facilitating additional learning opportunities in the context of the organisation more broadly.

Whilst nine of the ten students surveyed agreed the placement provided a rich learning environment, the results indicate the CLE could be further strengthened by ensuring students have regular, if not daily, opportunities to discuss and review their learning objectives with their preceptor, particularly in an environment where they have a primary and secondary preceptor and possibly a buddy. The quality of the CLE could also be strengthened by augmenting the clinical learning opportunities available in some settings by exposing them to additional learning opportunities available elsewhere in the organisation or enrichment and/or simulated learning activities aligned to students’ learning objectives. Table 8 presents more specific detail about students’ perceptions of the CLE.

Table 8: Frequency students found the clinical learning environment positive and constructive under supported preceptorship

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Frequency | Always | Usually | Sometimes | Rarely | Never |
| Students considered their preceptor approachable | 6 | 2 | 1 | 1 |  |
| Students found their clinical facilitator approachable | 6 | 4 |  |  |  |
| Preceptor had realistic expectations of students’ ability for their stage of training | 6 | 3 | 1 |  |  |
| Clinical facilitator had realistic expectations of students’ ability for their stage of training | 8 | 2 |  |  |  |
| Students report feedback from preceptors was helpful | 5 | 4 | 1 |  |  |
| Students found feedback from clinical facilitator helpful | 7 | 3 |  |  |  |
| Students report the unit atmosphere was pleasant to work in | 7 | 3 |  |  |  |

Student feedback about the CF’s contribution to their placement experience was generally very positive, as also, how positively they viewed the unit atmosphere. On the basis of these findings, almost every student found the CLE positive and constructive most of the time. The areas of the CLE subject to greatest variation were student perceptions of the helpfulness of the feedback provided by preceptors, the approachability of preceptors and how often they considered preceptors had realistic expectations for their stage of training.

Extent students perceived preceptors’ clinical workload affected their learning

Students’ perceptions about the extent to which their preceptors’ workload impacted their learning ranged from ‘moderate’ to ‘not at all’. For six students, preceptors’ workloads were considered to have had no effect on their learning; three others considered preceptors’ workloads had a moderate impact on their learning and another, that it affected their learning to some extent.

It is significant that six out of ten students reported the clinical load borne by their preceptors had no impact on their learning because there is an assumption that the clinical workload of preceptors limits their ability to optimise student learning (Burns et al., 2006; Croxon and Maginnis, 2009; Murray & Williamson, 2009).The variation in these findings highlights the need to recognise that clinicians are often busy and not always able to dedicate themselves to student learning.

Perceptions about who contributed most to students’ clinical learning

Students identified preceptors as those who contributed most to their learning (Table 9). The contribution made by preceptors reflects the strength of their role in the SPCF model. Under this model of supervision the preceptor plays the dominant clinical supervisory role. In contrast to the CT and preceptor (CT+P) model where the CT plays the dominant clinical teaching role, the CF plays an administrative, facilitative and supportive role involving staff as well as students. The powerful influence afforded by preceptors featured in students’ comments about what they considered enabled them to achieve the most from the clinical placement, for example, “Having wonderful preceptors to help facilitate the learning experience”.

Only one student perceived the contribution provided by the CF and another, that provided by other nurses to have been greater than that afforded by preceptors. Reflective of the supported preceptorship model and the role played by the CF and other nurses, it is perhaps not surprising that collectively, students valued equally their contribution to student learning. The role played by other nurses, including unit managers, corroborates the extent to which students found the unit atmosphere pleasant to work in and provides evidence that preceptors were supported in the clinical unit by nursing staff as well as the CF, acting together as a learning community; the goal (and a pre-requisite) of the supported preceptorship model. Comments such as: “Excellent staff”, “The staff that I worked with,” and “Having great preceptors and great NUM all of which provided support when required,” capture the contribution staff provided in supporting and enabling student learning.

To differentiate between how importantly students valued the contribution to learning afforded by each group, the results for each were scored from 1-4, with a score of 4 being allocated to the person/group a student rated as having contributed most significantly to their learning, and one, to the fourth person/group considered to have contributed most to their learning (Table 9).

The contribution students make to each other’s clinical learning is often overlooked though these findings reveal at least some of the students undertaking this placement felt their colleagues contributed importantly to their learning. This probably reflects students’ comfort in learning from peers. Roberts (2008, p. 35) suggests that though “peer learning in clinical practice is an informal and under-estimated aspect of clinical learning … it is valued by students.” She identifies three ways peers are used as a learning resource to contribute to each other’s learning on placement: learning with friends how to be a nurse, sharing survival skills and acquiring clinical skills.

Table 9: Students’ perceptions of who contributed most to their learning under supported preceptorship

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Group | 1 = 4 | 2 = 3 | 3 = 2 | 4 = 1 | Total score |
| Preceptors | 8 (32) | 2 (6) |  |  | 38 |
| Clinical facilitator  | 1 (4)  | 4 (12) | 3 (6) | 2 (2) | 24 |
| Other nurses |  1 (4) | 4 (12) | 3 (6) | 2 (2) | 24 |
| Other students |  |  | 2 (4) | 2 (2) | 6 |
| Clinical teacher |  |  | 2 (4) | 4 (4) | 8 |
| Doctors |  |  |  |  |  |
| Allied health team members |  |  |  |  |  |
| Total | 10 | 10 | 10 | 10 |  |

The results should be interpreted cautiously because six students included ‘clinical teacher’ among the four categories contributing most to their learning and the role did not apply to the organisation. One could surmise students were uncertain about the distinction between a CF and CT and included both in their desire to acknowledge the contribution afforded by the person fulfilling the overarching clinical educator role.

Students’ perceptions of the value of the supported preceptorship model

The majority of students (eight of the ten) who completed the survey reported that working with a preceptor enabled them to learn more from clinical placement than when placed with a clinical teacher alone (as occurred in first-year). One student disagreed and another was unsure whether having a preceptor enabled them to learn more than the CT model. Five students rated the combination of a preceptor and CF as very valuable and a further three, of some value. In contrast, four students rated the combination of a CT and preceptor very valuable and three, of some value.

Factors that enabled students’ to achieve the most from the supported preceptorship placement

From students’ comments it is clear the contribution and support provided collectively by preceptors, CF and other staff created a sense of a professional learning community and that all were conducive to making their placement experience positive and enabling. Students’ perceptions of the factors that enabled them to achieve the most from the placement reflect the value they placed on learning ‘hands-on’ from both preceptors and clinical educators and being surrounded by a community of health professionals that supported and valued student learning (Table 10).

Student perceptions regarding the role of debrief in the context of the supported preceptorship model

Follow-up discussions, often referred to as ‘debriefs,’ are generally assumed to play an important role in students’ clinical learning. Debrief allows them to identify, reflect on, and process the learning they have achieved in context in a safe learning environment. Salas et al., (2008) state that “the debriefing process allows individuals to discuss individual and team level performance, identify errors made and develop a plan to improve their next performance” (p. 518). Historically, the goal of the SPCF model was to ground the placement within the clinical setting and make the placement as realistic as possible for students; i.e., whole of shift onsite, students to be rostered to different shifts with their preceptor and to be included in handover. Debrief was to be structured insitu rather than abbreviate and fragment the time students spend in the unit unless the student and/or clinical preceptor or facilitator deemed time away from the ward/unit with other students more appropriate.

Table 10: Students’ comments regarding who and what enabled their learning

|  |  |  |
| --- | --- | --- |
| Preceptors | Clinical facilitator | Staff |
| Having the same preceptor for most of the shifts |  | The staff that I worked with |
| Having wonderful preceptors to help facilitate the learning experience |  | Excellent staff |
| Having great preceptors … which provided support when required |  | … and [having] a great NUM… which [sic] provided support when required |
| Support of preceptors  |  |  |
| My preceptor … and clinical facilitator | … and good staff |
| Personal initiative | Resources | Other |
| I had to be very initiative and naggy to get things done and skills ticked off [sic] | Availability of resources | … and other students |
| An open mind |  |  |

Only one student indicated they had an organised debrief daily with other students away from the clinical area and another, four times a week. Six students reported having debriefs with other students twice a week. The reason for such variation regarding the frequency of debrief is unclear. The variation may reflect attending debrief was optional and students chose to attend depending on what they were doing at the time of debrief.

Five students rated debriefs as very valuable to increasing their clinical learning and understanding and a further three considered it to be of some value. Only one student perceived debrief to be of little value. Seven students consider attending debrief with other students increases clinical learning more than if they stay on the ward/unit. Only one student did not believe attending debrief with other students outweighed the value of having more time in the clinical area.

Perceptions of the level of support provided under the supported preceptorship model

The survey included three items on support as a basis for validating data and cross-referencing and probing students’ satisfaction with the support provided. The findings were very comparable for the support provided in ward areas, by clinical staff and clinical teachers. Seven students perceived they were well supported whilst undertaking this supported preceptorship placement. Two students rated the support provided moderate and one, as slight. Delving into the findings more deeply for the student who felt only slightly supported, it appears they were somewhat disgruntled with the placement (rated the placement average, indicated other nurses contributed more to learning than preceptors, perceived preceptors were rarely approachable, and reported there were no debriefs).

Student suggestions for improving the placement

One student reported ‘nil’ and another offered no suggestions to improve the placement. Four students suggested the placement could be improved by strengthening communication, particularly between students and the clinical facilitator and having more organised debriefs with other students. Comments to this effect included:

* More communication
* Debrief once or twice a week would be good
* More debriefs with all students

Debrief, more communication between students and clinical facilitator.

Two students suggested the placement could be improved by exposing students to more clinical areas. One student suggested “A chance to experience a day or two in another ward” and another, “A day in ED [Emergency Department]”. Whilst it may be interesting to vary and enrich students’ exposure, particularly if placed in an area with limited opportunities to attain some learning objectives, the notion of ‘a day in ED’ belies the need for students to be specifically prepared and skilled for a placement in ED and that the ED is not appropriate for a student undertaking their first acute placement. Perhaps also reflecting one student’s concern with the limited learning opportunities available in one area, he/she suggested it was unsuitable to place students in Rehabilitation for a second-year placement; “Not a second-year placement for three weeks in Rehab.” Another student recommended that all staff should be involved and aware of students’ needs.

For one student, the placement could be strengthened by getting “more sleep”. It is unclear how the student thought this should or could be achieved or whether this related to travelling, doing ‘lates and earlies’ (afternoon and morning shifts) or the fatigue he/she associated with undertaking a three-week placement.

Summary comments on the supported preceptorship model

The supported preceptorship model of clinical placement and supervision is considered by one organisation to be pertinent and sustainable for providing nursing students at different levels of training with quality clinical learning opportunities in a supportive rural learning environment. The perspectives of ten second-year nursing students from one education provider that undertook one three-week placement under the SPCF model have been presented. All but one student valued their time and placement experience. The experience met or surpassed the expectations of eight students and they considered the organisation provided a rich, well-supported and welcoming clinical learning environment. Students appreciated the attitudes of preceptors, CF and staff towards them and their learning. Whilst not all preceptors were considered approachable, most students found the CF and other staff approachable and supportive and the unit atmosphere very enabling. The findings indicate that a model of clinical supervision that provides and facilitates hands-on learning by experienced RN preceptors who teach and facilitate student learning as they work is highly regarded by students provided the number of preceptors is limited.

Opportunities have been identified to further strengthen the quality of the CLE, students’ placement experience and the level of alignment between their theoretical preparation and learning objectives and the learning opportunities available. Students’ experiences of placement and their learning outcomes can be further strengthened by ensuring the strategy of allocating primary and secondary preceptors is maintained to control and minimise the number of preceptors a student has during the course of their placement. Allotting primary and secondary preceptors addresses the part time nature of the rural workforce and shares the supervisory load yet does not lose sight of the students’ need for continuity and stability. Such a model can buffer individual differences including the approachability or attitudes of some staff towards supervising students and giving feedback.

The findings related to the SPCF model also support the merit of a clinical model that can be flexible, responsive and able to promote efficacy and sustainability in the event clinical, staff or student contingencies arise. The preceptorship model supported by a dedicated CF, subject to the facilitator carrying a reasonable student and preceptor load, affords such flexibility and seems well-suited to enabling this subregional organisation to sustain its clinical placement capacity. It is likely that removing one of these levels, failing to limit the number of preceptors a student is supervised by or imposing additional load on the CF, would undermine students’ perceptions of the richness of the CLE, their learning outcomes, the level of satisfaction of students and staff (i.e., the broader learning community within the organisation) and ultimately, the sustainability of the placement capacity achieved.

It seems the sustainability of the SPCF model of placement and supervision espoused by this organisation is dependent on the organisation creating a culture of learning and a sense of learning community, other staff supporting and contributing to students’ learning and a CF overseeing the coordination, placement and rostering of preceptors and students. In particular, the results showcase the importance of a facilitator who can address the tension that exists with the lean part-time staffing profile of the organisation and the number of RNs available and needed to supervise students across a three-week block, the additional clinical learning opportunities that can be sourced in the context of those available from a broader organisational perspective to augment those available in some of the clinical areas utilised and the need for preceptors as well as students to be supported.

To establish a more substantive evidence base for the SPCF model of clinical supervision and its ability to sustain high levels of placement capacity and student learning activity over time, the organisation and education provider(s) need to take into account the perspectives of staff and the CF as well as students and more students need to be studied over more placement episodes. The frequency of organised debriefs with other students and the extent and conditions under which they contribute to student learning also warrant further investigation.

The clinical teacher plus preceptor model

The ratios nominated by students varied from 1:6 to 1:8 consistent with the difference between the second-year groups supervised by the clinical teacher plus preceptor model (CTP).The quality of the placement experience was rated excellent by 14 of the 20 students who completed the post-placement survey and above average by a further five. Only one student rated the experience average. For many survey items the results are very positive, however, there are some aspects of the placement and supervision which were perceived more strongly or universally than others. Accordingly, the results identified opportunities to further strengthen the quality of the CLE, students’ placement experience and the level of alignment between their theoretical preparation and learning objectives and the learning opportunities available.

How learning differed from students’ expectations

Most comments made by students about how their learning differed from their expectations reflect that it surpassed their expectations. Comments included:

* It was a great experience
* I learnt a lot more than I was expecting to

It was better than expected.

One of the differences between what students expected and what transpired related to how staff promoted student learning. For example, “The staff took the time to explain everything.” Some students found the learning to be easier than expected. In the words of one student, clinical placement was, “More simple than I thought it would be” and, “The technical skills were not as difficult as expected.” The adequacy of students’ preparation for placement and/or the level of learning support they were provided in the clinical setting may account for why they found learning and practising in the clinical setting to be easier than they expected.

Students’ responses identified some specific ways the experience differed from their expectations, for example, “Communication and assessment skills”, “Increasing observational skills” and “Strengthening and consolidating clinical and communication skills.” There were only two references that suggest students were disappointed with the learning opportunities available to them: “I expected that due to working in a specialised area I would be exposed to a wide variety of knowledge and skills… ” and… “There was (sic) a lot of elderly patients which I expected may have been a little more varied.” These differences indicate that some students have limited insight into the realities of health care, the implications of an ageing population and the dynamics and variation that characterise rural practice. To avoid misconceptions and prepare students for the realities characterising the setting in which they undertake placement, they need to be briefed about the organisation, the services it provides and patient profile, the types of learning experiences they can expect and the learning outcomes they should strive to achieve. Both education and placement providers need to consider how students can best be mentally as well as theoretically prepared for the realities they are likely to encounter in a particular practice environment.

Perceptions of the advantages of undertaking placement under the clinical teacher model

Students reported the advantages of the CTP model at this organisation included the placement being “Very in-depth” and staff being “More patient focused looking at every system of the body.” Their comments about the advantages of undertaking the placement were collapsed into four recurring themes, ‘confidence building’, ‘skill acquisition’, ‘opportunities to apply theory to practice’ and ‘staff support’.

Students’ comments that reflected these themes of advantage included:

* Gave me an opportunity to advance my clinical skills. Nurses were very helpful.
* Gained so much confidence in myself to use the skills I have learnt
* Confidence linking theory to practice

Familiarising oneself with the acute care setting and putting theory into practice

Two students referred to the organisation providing a broad range of learning opportunities, for example, “Having all different types of procedures” and going to “Different area, [you] see and do different things.” The richness of the CLE and value of the placement were also captured by students’ reference to: “Learnt a great deal” and “Knowledge gained.”

The organisational culture of the CLE as a collaborative team environment was also valued by students and identified to be an advantage of undertaking a placement in this organisation. Comments reflecting students’ valuing of the CLE were reflected in statements such as, “Teamwork and collaboration”, “Collaboration with multi-disciplinary teams” and “Being able to work well in a team environment”. “Demonstrating skills we have learnt” was also identified to be an advantage.

Given the distance between the organisation and the education provider, it is salient to note one student identified the potential to access accommodation as an advantage in undertaking placement in this organisation. “Staying (locally) gave me the advantage of not being so worn out”. The inference in this student’s statement is that the time students take to travel to placement potentially detracts from their placement experience and their ability to optimise the learning opportunities available in a more distant organisation.

Perceived disadvantages of undertaking the placement

Several students perceived there were no disadvantages to undertaking a clinical placement at this organisation. One stated, “none”, another, “Nil, I loved this placement, staff are so supportive,” and another qualified their satisfaction with, “…there’s not enough placement in general”.

Three students identified concerns about the richness of the learning experience in that one “… wasn’t able to complete all my objectives that I had competencies for…”, one “Didn’t have the opportunity to complete IVs and another considered placement in a specialist unit “may be a little too specialised of an area to help consolidate my nursing skills.” A fourth student considered “being teamed up with an EN a disadvantage. The latter suggests a tension exists between the staffing profile, number of RN students placed and the availability of qualified RNs to supervise students. It may also reflect the reality that the contemporary rural staffing profile is lean and also shifting – as the role of the EN has expanded and increasingly more ENs are medication and IV endorsed. It could also reflect that an education coordinator has deemed a particular EN more appropriate to supervise an RN student on their first acute placement than an RN who is possibly a recent graduate and/or the only RN on the ward on a particular shift.

Rather than representing limited learning opportunities available within the organisation, the issue of not being able to complete IVs on one particular three-week placement indicates an unrealistic student expectation. As much as possible, student expectations about clinical placements need to be addressed prior to clinical placement by the education provider, though given the vagaries of timetabling and student attendance, it is unreasonable to expect they will be able to reach all students to ensure their expectations are realistic. Only one student commented negatively on the quality of the learning environment in relation to staff, “Some staff [are] not as willing to help as others”.

Other disadvantages identified by students in undertaking a clinical placement in the organisation related to non-clinical aspects of placement, most of which are common to rural placements more generally. For example, six students cited financial considerations as a disadvantage of undertaking placement at this organisation, most of them related to loss of income. Comments reflecting students’ concerns about money included:

* Loss of money from not being able to work
* Working without pay
* Not being able to work my normal job so I wasn’t earning any money
* No income
* Not being paid is a large burden

No income sucks!!

It is often expected that students will not continue their paid work during placement. Regardless of an education provider or placement provider’s expectation students will not undertake paid work during their placement, if placement is at a site distant from a student’s term address the distance between the two sites will inevitably preclude them from continuing their work commitments during the period of the placement. Additionally, the time committed to placement and the hours associated with clinical placement prevent students from continuing paid work during placement. The inability of students to continue working during placement is something the placement provider organisation is unable to do anything about, though the issue of student income and costs to students of undertaking rural placements is known to be a problem faced by students undertaking rural placements away from their normal residence (Jones et al., 2003; Schofield et al., 2009). The implications of this perceived disadvantage are that providing a rich and supportive CLE or strengthening the quality of the CLE to attract more students is likely to have limited effectiveness when so many students are concerned about their ability to work and maintain an income. That placements at this particular organisation operate at ‘saturation level’ despite these perceived disadvantages bears testimony to the value students put on being able to undertake placements there.

Another non-clinical disadvantage identified by one student was the need to stay in local accommodation to avoid being over-burdened by the time and costs associated with traveling from University to the local area for placement. This finding highlights the benefit of rural placement providers having onsite or nearby accommodation available. However, providing accommodation does not address the parallel factor limiting the attractiveness of rural placements, i.e., “Staying away from home, not seeing my family”.

For one student the disadvantage in undertaking the placement related to the curriculum not having prepared them well for the particular setting in which they undertook their placement. The comment, “Needed more education through course about children” reflects the reality that sometimes curricula cannot adequately prepare students for a particular clinical area or there is incongruence between the timing of theory and placement. This inadequacy flags the need for students to be proactive, self-motivated and self-directed to address any learning deficits and to specifically prepare themselves for a particular placement in order to make the most of the learning opportunities available. Variations between curricula and the adequacy with which students are prepared for placements to capitalise on learning opportunities could be addressed by means of pre/post-placement consultation and collaboration between education providers and the placement agency, the clinical agency identifying some targeted clinical learning objectives relevant to particular areas, pre-clinical learning packages and/or online orientation activities.

Students’ perceptions of the specifics of the CLE and CTP model of placement were clustered into three areas: those reflecting high student satisfaction, those flagging areas for further work and improvement at some stage and third, areas that could be strengthened as a matter of priority (Table 11). The most positive and universal finding was that students knew who to contact in the event of any difficulties. The areas of least satisfaction and consensus were students’ perceptions of how well the learning opportunities available aligned with what they were learning and enabled them to achieve their learning objectives.

Table 11: Student perceptions of the specifics of the clinical learning environment and clinical teacher t model

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Statement | Strongly agreed | Agreed | Not sure | Disagreed | Strongly disagreed |
| Students knew who to contact if they had any difficulties | 19 | 1 |  |  |  |
| Students felt welcome | 14 | 6 |  |  |  |
| Students were briefed about what to expect from the placement | 14 | 6 |  |  |  |
| Students felt the hospital orientation assisted them to make the most of the placement | 17 | 3 |  |  |  |
| Students felt adequately prepared for the placement | 14 | 6 |  |  |  |
| Students considered the placement aligned well with what they were learning in the course | 10 | 8 | 2 |  |  |
| Students considered the learning opportunities available to them enabled them to achieve their personal learning objectives | 13 | 5 | 2 |  |  |
| Students considered this placement model provided a rich learning environment | 13 | 7 |  |  |  |
| Students considered they were supervised by experienced staff/experts in their field | 17 | 3 |  |  |  |
| Students had daily opportunities to observe skilled nurses deliver care | 17 | 3 |  |  |  |
| Students felt supported by the staff supervising them in the ward/unit | 16 | 4 |  |  |  |
| Students had opportunities daily to discuss and review their learning objectives with their preceptor | 17 | 3 |  |  |  |
| Students felt supported by the clinical teacher | 17 | 2 |  |  |  |
| Students felt staff were supported by the clinical teacher | 16 | 2 | 1 |  |  |
| Students felt clinical staff went out of their way to make the most of the clinical learning opportunities available | 14 | 5 | 1 |  |  |

Whilst all students agreed the CTP model provided a rich learning environment the results indicate the CLE could be further strengthened by augmenting the clinical learning opportunities available with enrichment activities pertinent to their learning objectives. Table 12 presents more specific detail about students’ perceptions of the CLE.

Table 12: Frequency students found the CLE positive and constructive under the clinical teacher model

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Frequency | Always | Usually | Sometimes | Rarely | Never |
| Students considered their preceptor approachable | 19 | 1 |  |  |  |
| Students found their clinical teacher approachable | 18 | 1 |  |  |  |
| Preceptor had realistic expectations of students’ ability for their stage of training | 15 | 4 |  |  |  |
| Clinical teacher had realistic expectations of students’ ability for their stage of training | 18 | 1 |  |  |  |
| Students report feedback from preceptors was helpful | 17 | 1 | 1 |  |  |
| Students found feedback from clinical teacher helpful | 18 | 1 |  |  |  |
| Students report the unit atmosphere was pleasant to work in | 11 | 8 |  |  |  |

Student feedback about the CT’s contribution to their placement experience was very positive, as was the approachability of preceptors. Whilst three quarters of the students considered preceptors had realistic expectations of their ability for their stage of training, this was one of the least consistent findings and therefore a weaker area of the CTP model. This finding suggests the CLE could be strengthened by making preceptors more aware of the curriculum and the extent of students’ clinical learning opportunities and experience. Almost every student found the CLE positive and constructive most of the time. Continuing effort to strengthen the unit atmosphere as a pleasant place for students to work and learn in would consolidate the quality of the CLE.

Extent students perceived preceptors’ clinical workload affected their learning

There is an assumption that the clinical workload borne by preceptors detracts from their ability to optimise student learning – especially as clinicians often perceive student supervision to be additional and peripheral to their core business of providing care. Students’ perceptions about the extent to which their preceptors’ workload impacted their learning ranged from ‘severe’ to ‘not at all’. Cumulatively, approximately one third (32%) of students reported that preceptors’ workloads impacted their learning to some extent. One student considered preceptors’ workloads had a severe impact on their learning, another that it had a moderate impact and four that it affected their learning to some extent. In contrast, 13 of the 20 students surveyed, considered preceptors’ workloads had no effect on their learning. The comment made by one student in identifying what enabled him/her to achieve the most from this placement, “Being with nurses who educated you as they worked and giving (sic) you opportunities to work on your skills,” may shed light on students’ understanding and tolerance that the dual workload borne by preceptors enabled as well as constrained their learning.

The variation in these findings highlights the need to recognise that clinicians are often busy and not always able to dedicate themselves to student learning. The results also highlight that a pertinent and sustainable model of clinical supervision in rural organisations where the practice setting is dynamic and staffing is known to be lean, needs to be flexible and responsive to account for fluctuations in supervisory capacity. A supervision model that augments the efficiencies of preceptorship with the expertise of a dedicated CT who is not constrained by clinical contingencies, provides an inbuilt safety net that buffers the risk of burnout and allows for flexibility, continuity and efficacy.

Perceptions about who contributed most to students’ clinical learning under the clinical teacher model

In identifying those who contributed most to their learning, students valued preceptors more than twice as frequently as CTs, other nurses, doctors, members of the allied health team or other students. However, it is striking that some students perceived the contribution provided by CTs or ‘other nurses’ to have been greater than that afforded by preceptors who were advantaged by proximity and having dedicated one-on-one learning time. Clinical teachers were the group second most likely to be valued by students as having contributed most to their learning. That students valued the learning afforded by their CT so highly is a significant finding given their presence cannot be guaranteed to be clinically timely; they are responsible for a number of students and may be physically dislocated from the clinical setting. Though ‘other nurses’ did not rate as frequently as preceptors and CTs as those most influential in promoting learning, they were acknowledged by students to have made an important contribution. The role played by other nurses reflects the organisation’s learning culture and evidence that preceptors were supported in the clinical unit by nursing staff as well as CTs, acting collectively as a learning community to facilitate student learning. The extent to which staff support student learning is captured in the words of one student who commented, “The staff took the time to explain everything.”

To differentiate how importantly students valued the contribution to their learning afforded by each group, the results were, as stated previously, scored from 1-4, with a score of 4 being allocated to the person/group a student rated as having contributed most significantly to their learning, 3 to the second, 2 to the third and one to the fourth person/group the student considered had contributed most to their learning (Table 13).

The findings presented here again suggest that some of the students undertaking this placement felt they learned more from their colleagues than some RNs. This could represent students’ comfort in learning from colleagues, or alternatively, it could flag, as one student states, “Some staff are not as willing to help as others.”

Table 13: Students’ perceptions of who contributed most to their learning under the clinical teacher model

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Group | 1 = 4 | 2 = 3 | 3 = 2 | 4 = 1 | Total score |
| Preceptors | 11 (44) | 4 (12) | 1 (2) | 1 (1) | 59 |
| Clinical teachers |  5 (20) | 5 (15) | 8 (16) | 2 (2) | 53 |
| Other nurses |  4 (16) | 8 (24) | 5 (10) | 2 (2) | 52 |
| Other students |  | 2 (6) | 3 (6) | 5 (5) | 17 |
| Clinical facilitator |  |  | 2 (4) | 4 (4) | 8 |
| Doctors |  |  |  | 3 (3) | 3 |
| Allied health team members |  |  |  |  | 0 |
| Total | 20 | 19 | 19 | 17 |  |

Factors that enabled students to achieve the most from the placement under the clinical teacher model

From students’ comments it is clear the contribution and support provided collectively by preceptors, CTs and other staff created a sense of a professionally comfortable learning community; and all were conducive to making their placement experience positive and enabling. Students’ perceptions of the factors that enabled them to achieve the most from the placement reflect the value they placed on learning hands-on from both preceptors and clinical teachers and being surrounded by a supportive community of health professionals that valued student learning (Table 14).

Table 14: Students’ comments regarding who and what enabled their learning under the clinical teacher model

|  |  |  |
| --- | --- | --- |
| Preceptors | Clinical teacher | Staff |
| Having a preceptor | Helpful teachers | Support from staff, feeling comfortable on the ward, |
| Being with nurses who educated you as they worked and giving you opportunities to work on your skills | Clinical teacher | Good nursing staff that were supportive |
|  |  Clinical Teacher’s guidance. | Nursing staff on the ward |
| Nurses willing for us to show our skills. |  | Support and teamwork. A great environment |
|  |  | Staff were great |
|  |  | Helpful staff |
|  |  | The staff and patients’ great attitude towards us |
|  |  | The staff |
| Opportunities to consolidate theoretical skills |
| Everything – learning hands on |

Though the majority of students (14 of 20) reported working with a preceptor enabled them to learn more from clinical placement than when placed with a CT alone – as occurred in first-year – the finding was not universal. Six students rated the combination of a CT and preceptor very valuable and one student rated it to be of some value. One student disagreed and four were unsure about whether having a preceptor enabled them to learn more than the CT model. One student perceived there to be little value in having a CT as well as a preceptor. It is unclear as to why the remaining students chose not to respond to this item but given the limited experience of the second year cohort it is possible they felt unsure about being asked to rate the merit of having a CT and preceptor. It would be useful to further explore students’ perceptions.

Reflecting the importance of being theoretically well prepared prior to placement, one student reported “Having a good understanding from uni” enabled him/her to achieve the most from the clinical placement. Another student identified the value of being able to make the most of the time available to optimise their learning: “Able to start working on objectives and competencies straight away.”

Student perceptions regarding the role of debrief in the context of the clinical teacher model

The variation in the frequency students reported having an organised debrief with other students outside the clinical area additional to debriefing with preceptor on-site in the clinical setting may reflect their interest and/or ability to get to those that were organised rather than the frequency debriefs were available. Only one student indicated they had a daily debrief. Ten students indicated they had four debriefs a week, another, three times a week and four, twice a week. For four students, there is no information available about how often they participated in organised debriefs with other students outside the ward/unit. Seven students rated debriefs as very valuable to increasing their clinical learning and understanding and a further nine as being of some value. Only one student perceived debrief to be of little value. In contrast to the limited value half the students saw in debrief, 14 believed that attending debrief with other students increases clinical learning more than if students stay on the ward/unit. Only one student did not believe attending debrief with other students outweighed the value of having more time in the clinical area. Three students indicated they had no opinion about the comparative merits of debriefing with other students or staying in the clinical unit. The disparity of student responses raises questions and requires further investigation.

Perceptions of the level of support provided under the clinical teacher model

The survey included three items on support as a basis for cross-referencing and probing students’ satisfaction with the support provided. The findings were very comparable for the support provided in ward areas, by clinical staff and CTs. Most students (18) perceived they were very supported whilst undertaking the placement in this organisation while two rated the support provided moderate.

Suggestions for improving the placement

One student reported he/she could suggest ‘Nothing’ to improve the placement. Some students left the item blank, notably those that responded positively to the advantages. Some of the ideas proposed by students were generic and pertinent to placements regardless of the organisation and setting and bore no relationship to the model being investigated.

* No late/earlies
* Being paid!

Paid placement

The only suggestions proposed of an organisationally or model specific nature related to the variable knowledge and understanding of some nurses/preceptors and one that reflected superior regard for learning from an ‘educator’, i.e., CT.

* Not all the nurses new [sic] what we required but most were great and very enabling.

More one-on-one from educator i.e., Allocate a whole day per student and then help whenever else educator can.

The notion that a CT could allocate a whole day per student and then help whenever else possible overlooks the logistics of such an arrangement that would necessarily advantage some students and disadvantage others and limit the ability of the CT to respond in a timely manner, when and where necessary. The comment suggests the learning and support provided by one or more preceptors may have been perceived to be inadequate. Alternatively, it may flag that the student was struggling and felt they required more intense support from a dedicated educator.

Summary comments on the clinical teacher and preceptor model

This study reflects the perspectives of nursing students from one education provider in one organisation. One group undertook a three-week placement under the CTP model. Students valued their time and placement experience in this organisation. For most students this rural placement surpassed their expectations and they considered the organisation provided a well-supported, welcoming and rich clinical learning environment.

Students were generally very appreciative of the attitudes of staff, CTs and patients towards them and their learning. Whilst not all staff were considered helpful, most students found the teamwork and support very enabling. The results indicate that students valued a model of clinical supervision that provided and facilitated hands-on learning by experienced RN preceptors who taught and facilitated student learning as they worked. They also draw attention to the need to incorporate a strategy that can buffer individual differences, the approachability or attitudes of some staff towards students and supervision and the variable knowledge preceptors have about what constitutes realistic expectations of students for a particular stage of their course. The findings also support the merit of a clinical model that can be flexible, responsive and able to promote efficacy and sustainability in the event clinical, staff or student contingencies arise. The preceptor model supported by dedicated CTs affords such flexibility and seems well-suited to enabling this subregional organisation to continue operating at ‘saturation’ clinical placement capacity. It is likely that removing one of these levels would undermine students’ perceptions of the richness of the CLE, the sustainability of the placement capacity achieved and/or the level of satisfaction of staff and students.

This study explored a model of clinical placement and supervision considered by one organisation to be pertinent and sustainable for providing nursing students with quality clinical learning opportunities in a supportive rural learning environment. It has identified opportunities to further strengthen the quality of the CLE, students’ placement experience and the level of alignment between their theoretical preparation and learning objectives and the learning opportunities available. To establish a more substantive evidence base for the CTP model of clinical supervision and its ability to sustain high levels of placement capacity and student learning activity over time, the study needs to be expanded to survey more students over more placement episodes, to elicit feedback from staff and clinical teachers as well as students. The issue of regular, organised debrief with other students and the extent and conditions under which this contributes to student learning also warrant further investigation in the context of the supervision model operating in an organisation.

Facilitated preceptorship model

The distinction between the facilitated preceptorship model as opposed to the supported preceptorship model reported previously, relates to the developmental underpinnings, investment in creating an organisational learning culture, level of structured support for staff supervising students and rotation of primary and secondary preceptors. Seven nursing students completed a survey in 2012 following a clinical placement at a subregional rural health service that utilised the facilitated preceptorship model (CFP). The ratio of students to CF that operated at the hospital was 1:16.

The quality of the placement was rated excellent by five of the seven students who completed the survey and above average by the other two. For many survey items the results were very positive, however some aspects of the placement and supervision were perceived more strongly or universally than others. Accordingly, the results identify opportunities to further strengthen the quality of the CLE and the effectiveness of the CFP model of supervision in this agency.

How learning differed from students’ expectations

Comments made by students about how their learning differed from their expectations reflect that for three of them the placement surpassed their expectations. Comments included:

* I have learned a lot compared to what I expected
* More involved in interesting things on the ward

I did not expect to experience nursing situations well advanced to my second year level. I am very happy to have had the chance to be around HDU for a first acute placement.

For another two students there was no difference between their expectations of the placement and what they actually learned. One student explained, “It was basically as I expected, although not a lot of contact with the clinical educator.”

Mindful of the small number, the findings suggest that most students had realistic expectations about what they could expect to learn from this three-week placement. However, one student claimed he/she “didn’t really know what to expect”. As noted previously, this exception draws attention to how important it is to prepare students for the realities that characterise different placement settings.

Perceptions of the advantages of undertaking placement under the facilitated preceptorship model

The advantages most students associated with undertaking the CFP placement at this organisation were gaining new insights into the role, for example, “Seeing how well the team of nurses in medical ward work so well together”…, and “Opens you up to a new perspective.” Other perceived advantages included the learning opportunities available to consolidate skills, for example, “Consolidation of medication administration, time management, pt load” and the support provided by preceptors and other clinical staff, including “New grads.” In the words of one student, “I felt like part of the team” and “I had a lot of opportunity to see everything.”

For another student, the advantage of undertaking a placement in this organisation related to the potential it may create for getting work there after graduating. “I might get a chance to do my grad year or work in the hospital.”

Perceived disadvantages of undertaking the placement

Though not identified as a disadvantage, one student suggested the placement could be improved by limiting the number of preceptors that supervise one student, e.g., “For myself I had 3 preceptors – 1-2 preceptors would be better but I understand why this cannot be achieved.” This reference to multiple preceptors suggests a tension exists between the part-time staffing profile in small to medium health care facilities and the requirement by education providers that students undertake placement on a full-time basis. Having multiple preceptors also draws attention to how differently some staff practice and students’ abilities to tolerate differences. Taken together, the lean, predominantly part-time staffing profile and therefore the availability of qualified RNs to supervise students, the number of nursing students placed and the regulatory mandate that all nursing students, (enrolled as well as registered) must be supervised by an RN necessitates that students are supervised by a number of preceptors.

Notably, three students perceived there were no disadvantages to undertaking a clinical placement in this organisation, one stating, “None – enjoyed everything”. Students’ perceptions of the specifics of the CLE and CFP model of placement were prioritised into three clusters; those reflecting high student satisfaction, those flagging areas for further work and improvement and third, an area that would benefit from prompt attention.

The most positive and universal findings were that students felt their preceptors were approachable, the unit atmosphere was pleasant, that preceptors and the clinical facilitator had reasonable expectations of them and they were supervised by experienced staff, expert in their field. The areas of least satisfaction and consensus were students’ reports about having been briefed about what to expect from the placement and their perception that staff were supported by the CF (Table 15).

The findings suggest students had some reservations about how adequately they were prepared for this placement, the level of alignment between curriculum and the learning opportunities available and the support provided by ward staff. Whilst four students agreed the placement provided a rich learning environment the results indicate the CLE could be further strengthened by ensuring students feel welcome, know who to contact if difficulties arise and have regular, if not daily, opportunities to discuss and review their learning objectives with their preceptor. When students are supervised by a number of preceptors, regular opportunities to review learning objectives become particularly important.

Students’ perceptions regarding the support provided by the CF reinforces the importance of education and placement providers giving due consideration to the CF workload and to orientating students to the model of supervision operating in the setting where they will be undertaking placement so that they align their expectations accordingly. As Lambert and Glacken (2005, p. 664) concluded from their literature review, there is “…considerable lack of role clarity” over “what constitutes clinical facilitation and the role of the clinical facilitator.” Arguably, the discrepancy between the support students felt they were provided by preceptors and the CF reflects the clinical focus of the facilitated preceptorship model of supervision and its reliance on preceptor(s) as the dominant clinical learning influence. Rather than clinical teaching, the role of the CF under this model was to liaise with the education provider, agency staff and students, administer student placements by allocating students to preceptors, overseeing the placement, advising and supporting students, and troubleshooting challenges as they arose.

Table 15: Student perceptions of the clinical learning environment and facilitated preceptorship model

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Statement | Strongly agreed | Agreed | Not sure | Disagreed | Strongly disagreed |
| Students knew who to contact if they had any difficulties | 3 | 4 |  |  |  |
| Students felt welcome | 3 | 4 |  |  |  |
| Students were briefed about what to expect from the placement | 3 | 2 | 1 | 1 |  |
| Students felt the hospital orientation assisted them to make the most of the placement | 4 | 3 |  |  |  |
| Students felt adequately prepared for the placement | 3 | 4 |  |  |  |
| Students considered the placement aligned well with what they were learning in the course | 3 | 3 | 1 |  |  |
| Students considered the learning opportunities available to them enabled them to achieve their personal learning objectives | 4 | 2 | 1 |  |  |
| Students considered this placement model provided a rich learning environment | 4 | 2 | 1 |  |  |
| Students considered they were supervised by experienced staff/experts in their field | 5 | 2 |  |  |  |
| Students had daily opportunities to observe skilled nurses deliver care | 4 | 3 |  |  |  |
| Students felt supported by the staff supervising them in the ward/unit | 4 | 2 |  | 1 |  |
| Students had opportunities daily to discuss and review their learning objectives with their preceptor | 4 | 2 | 1 |  |  |
| Students felt supported by the clinical facilitator | 4 | 3 |  |  |  |
| Students felt staff were supported by the clinical facilitator | 3 | 1 | 2 | 1 |  |
| Students felt clinical staff went out of their way to make the most of the clinical learning opportunities available | 5 | 1 | 1 |  |  |

The quality of the CLE could also be strengthened by augmenting the clinical learning opportunities available in some settings with enrichment activities aligned to students’ learning objectives or by exposing them to additional learning opportunities available elsewhere in the organisation.

Almost every student found the CLE positive and constructive most of the time. The only area of the CLE amenable to improvement relates to the role of the CF and how student feedback can be provided more helpfully. Table 16 presents more specific detail about how positively students’ perceived different aspects of the CLE.

Table 16: Frequency students found the CLE positive and constructive under the facilitated preceptorship model

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Frequency | Always | Usually | Sometimes | Rarely | Never |
| Students considered their preceptor approachable | 7 |  |  |  |  |
| Students found their clinical facilitator approachable | 6 | 1 |  |  |  |
| Preceptor had realistic expectations of students’ ability for their stage of training | 6 | 1 |  |  |  |
| Clinical facilitator had realistic expectations of students’ ability for their stage of training | 6 | 1 |  |  |  |
| Students report feedback from preceptors was helpful | 6 | 1 |  |  |  |
| Students found feedback from clinical facilitator helpful | 4 | 2 |  | 1 |  |
| Students report the unit atmosphere was pleasant to work in | 7 |  |  |  |  |

Extent students perceived preceptors’ clinical workload affected their learning

Students’ perceptions about the extent to which their preceptors’ workload impacted their learning ranged from ‘severe’ to ‘not at all’. For two students, preceptors’ workloads were considered to have had no effect on their learning; two others considered preceptors’ workloads had a moderate impact on their learning and another two, that it affected their learning to some extent.

It is significant that only two of seven students reported the clinical load borne by their preceptors had no impact on their learning because there is a widespread assumption that the clinical workload of preceptors limits their ability to optimise student learning. As stated previously, the variation in the findings reported here reinforces the need to recognise that clinicians are often busy and not always able to dedicate themselves to student learning. The results also highlight that a pertinent and sustainable model of clinical supervision for smaller and medium-sized rural organisations needs to be flexible and responsive to account for fluctuations in supervisory capacity, the dynamics of rural practice settings, their lean part-time staffing profile and limited access to clinical educator supports such as those that exist in larger regional and urban organisations.

Perceptions about who contributed most to students’ clinical learning under the facilitated preceptorship model

To differentiate between how importantly students valued the contribution to learning afforded by each group, the results for each were scored from 1-4, with a score of 4 being allocated to the person/group a student rated as having contributed most significantly to their learning, and one, to the fourth person/group considered to have contributed most to their learning (Table 17).

Table 17: Students’ perceptions of who contributed most to their learning under facilitated preceptorship

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Group | 1 = 4 | 2 = 3 | 3 = 2 | 4 = 1 | Total score |
| Preceptors | 6 (24) | 1 (3) |  |  | 27 |
| Other nurses |   | 6 (18) | 1 (2) |  | 20 |
| Clinical teacher | 1 (4) |  | 3 (6) | 2 (2) | 12 |
| Other students |  |  | 1 (2) | 1 (1) | 3 |
| Doctors |  |  |  | 3 (3) | 3 |
| Clinical facilitator |  |  | 1 (2) | 1 (1) | 3 |
| Allied health team members |  |  | 1 (2) |  | 2 |
| Total | 7 | 7 | 7 | 7 |  |

Students identified preceptors as those who contributed most to their learning. The contribution made by preceptors reflects the strength of their role in the CFP model. Under this model of supervision the preceptor plays the dominant clinical supervisory role. In contrast to the CTP model where the CT plays the dominant clinical teaching role, the CF plays an administrative, facilitative and supportive role involving staff as well as students (Lambert and Glacken, 2005). The powerful influence afforded by preceptors featured in students’ comments about what they considered enabled them to achieve the most from the clinical placement, for example, ‘my preceptors’.

Only one student perceived the contribution provided by the CT to have been greater than that afforded by preceptors. The results should be interpreted cautiously however, because six students included ‘CT’ among the four categories contributing most to their learning and the role did not apply to this organisation.

Notably, six of the seven students who completed the survey perceived other nurses contributed more to their learning than the clinical educator. The role played by other nurses corroborates the extent to which students found the unit atmosphere pleasant to work in and provides evidence that preceptors were supported in the clinical unit by nursing staff acting together as a learning community. The spread of key players such as doctors and members of the allied health team that contributed to students’ learning also reflects an organisational learning culture.

The contribution students make to each other’s clinical learning is often overlooked though the findings in Table 18, reveal two students undertaking this placement felt their colleagues contributed importantly to their learning. As noted earlier this probably reflects students’ comfort in learning from peers.

Table 18: Students’ comments regarding who and what enabled their learning under facilitated preceptorship

|  |  |  |
| --- | --- | --- |
| Preceptors | Clinical experience | Personal initiative |
| Being one on one with a preceptor every shift | The ability to be able to get all experience available at the time | By asking questions and being open to learn new skills and asking other nurses if they have the skills you want to achieve during placement |
| Working closely with preceptor, asking questions and advising preceptor what I want to achieve while on placement  |  | Willingness to learn |
| My preceptors  |   |  |

Factors that enabled students’ to achieve the most from the placement under facilitated preceptorship

From students’ comments it is clear the contribution and support provided collectively by preceptors, CF and other staff created a sense of a learning community and that all were conducive to making their placement experience positive and enabling. Students’ perceptions of the factors that enabled them to achieve the most from the placement reflect the value they placed on learning ‘hands-on’ from preceptors and being surrounded by a community of health professionals that supported and valued student learning.

Students’ perceptions of the value of the facilitated preceptorship model

All seven students that completed the survey reported that working with a preceptor enabled them to learn more from clinical placement than when placed with a CT as occurred in first-year. One student rated the combination of a preceptor and CF as very valuable, a further two considered the combination of some value and three, of little value. Similarly, one student rated the combination of a CT and preceptor very valuable, two, of some value and another two, of little value. It is clear is that these students valued the role of the preceptor very highly and considered the clinical educator’s contribution to their learning secondary.

Student perceptions regarding the role of debrief in the context of facilitated preceptorship

All seven students reported having an organised debrief with other students twice-weekly away from the clinical area. One student rated debrief as very valuable to increasing their clinical learning and understanding. A further five students considered debrief to be of some value to clinical learning. Only one student perceived debrief to be of little value. Five students considered attending debrief with other students more beneficial to clinical learning than staying on the ward/unit. One student reported having no opinion about the comparative merit of debriefing with other students or having more ward time and another did not believe attending debrief with other students outweighed the value of having more time in the clinical area. Such variations in student attitudes about debrief warrants further investigation and it is possible this aspect of the placement could be strengthened.

Student perceptions of the level of support provided under the facilitated preceptorship model

As a basis for validating data and cross-referencing and probing students’ satisfaction with the support provided the survey included three items on support. The findings were very comparable for the support provided though the results were more varied regarding the support provided to staff by the clinical facilitator. Six of the seven students that completed the survey perceived they were well supported whilst undertaking this placement.

Suggestions for improving the placement

One student reported “Nothing could make it more valuable” and along similar lines, another claimed “Everything was pretty good.” As noted previously, one student suggested the placement could be improved by limiting the number of preceptors that supervise any one student. The only other suggestion made related to assisting preceptors to manage their dual clinical and supervisory load; “Preceptors could be supported more by clinical educator with their workload while they are assisting students with their learning.”

Summary comments on the facilitated preceptorship model

The CFP model of clinical placement and supervision is considered by one medium-sized rural health service to be pertinent and sustainable for providing nursing students with quality rural clinical learning opportunities in a supportive environment. The experience met or surpassed the expectations of five of the seven students who completed the post-placement survey and they considered the organisation provided a well-supported clinical learning environment. Five students rated their placement experience as excellent and the other two, as above average. Students appreciated the experience, expertise and attitudes of preceptors and other staff towards them and their learning. Preceptors were considered by all students to be approachable, most students found the CF and other staff approachable and supportive, their expectations realistic and the unit atmosphere very enabling. The findings again indicate that students value a model of clinical supervision that provides and facilitates students’ learning hands-on from experienced RN preceptors who teach and concurrently facilitate student learning as they work. The results also furnish evidence that there is a fragile tension between preceptors being able to optimise student learning outcomes in situations where their clinical workload impacts on their preceptoring role, when students are unaware about what to expect of a particular placement and when students’ theoretical preparation may be sub-optimal.

Opportunities have been identified to further strengthen the quality of the CLE by clarifying the role of the CF and the ways they provide feedback to students and by promoting a welcoming environment. Students’ experiences of placement and their learning outcomes can be further strengthened by incorporating a strategy that can buffer the need for multiple preceptors and differences in how individual clinicians practice. The preceptorship model supported by a dedicated CF subject to the facilitator carrying a manageable workload and being accessible when needed affords flexibility and seems well-suited to enabling this subregional organisation to sustain placement capacity.

The sustainability of the facilitated preceptorship model of placement and supervision espoused by this organisation could be strengthened by the organisation creating a culture of learning and a sense of learning community, other staff supporting and contributing to students’ learning and a clinical facilitator overseeing the coordination, placement and rostering of preceptors and students. In particular, the results showcase the importance of a facilitator who can address the tension that exists with the lean part-time staffing profile of the organisation and the number of RNs available and needed to supervise students across a three-week block. There is also a need for preceptors as well as students to be supported.

To establish a more substantive evidence base for the CFP model of clinical supervision and its ability to sustain high levels of placement capacity and student learning activity over time, the organisation and education provider(s) need to take into account the perspectives of staff and the clinical facilitator as well as students, and again, more students need to be studied over more placement episodes. There is a need to carefully delineate the CF role and establish what constitutes a reasonable and manageable CF workload. The frequency of organised debriefs with other students and the extent and conditions under which they contribute to student learning also warrant further investigation.

Comparing student feedback on different models of supervision and placement experiences

The results of the survey reinforce that regardless of the model of placement or supervision, exposing nursing students to the realities of practice and giving them opportunities to learn directly from experts in the field who can assist them translate theory into practice was considered by students to be critical to preparing them for their professional role. Regardless of the model, for most of the nursing students surveyed, preceptors were perceived to be central to their clinical learning. Following preceptors, students valued highly the role played by a clinical educator regardless of whether this was a clinical teacher or facilitator. However, the contribution students perceive the clinical educator makes to their learning appears to have been limited by the ratio of students to clinical facilitator. The greater the ratio, the less highly students rated the educator’s contribution to their learning and the more value they attributed to other nurses. The category ‘other nurses’ were considered by students at two organisations, (one operating a supported preceptorship model and the other, a clinical teacher plus preceptor model) to have made an almost equal contribution to their learning as had the clinical educator. It is noteworthy that the organisations where students considered other nurses had made such a contribution reported an organisational culture of learning and commitment to supporting student learning.

The contribution afforded by other students should not be overlooked, particularly in the context of the clinical teacher/preceptor model. Notably, these models do not appear to have facilitated IPL, i.e., nursing students learning from other members of the health team. Students rated the contribution to their learning provided by doctors and members of the allied health team to be less than other staff or students.

The findings of the post-placement survey dispel to some extent, professional concerns about the diversity that characterises the quality of the rural CLE, and how students experience rural clinical placements. However, the feedback provided by these nursing students reinforces the need to regularly evaluate students’ placement experience and suggest there is a fragile balance between the model of placement and supervision in operation, the quality of the broader CLE, the learning opportunities available, the nature of the organisational culture and preparedness of other nurses to support student learning and the ready access students have to a clinical educator.

The results also highlight that a pertinent and sustainable model of clinical supervision for smaller and medium‑sized rural organisations needs to be flexible to account for fluctuations in supervisory capacity, the flux of rural practice settings, their lean part-time staffing profile and limited access to clinical educator supports. A model of that augments the benefits associated with preceptorship with the educational expertise of a dedicated clinical educator who is not constrained by clinical contingencies, provides an inbuilt safety net that allows for flexibility, continuity and efficacy. Subject to maintaining a manageable ratio of students to clinical educator, such a safety net is especially relevant in medium and smaller rural health services that do not have the additional clinical supervisory infrastructure backup that exists in larger centres.

Opportunities to implement new models

Chronic care placement model

The chronic care model was a new composite model that involved students rotating through a series of under-utilised areas that collectively expose them to a range of learning opportunities and nursing expertise around the area of chronic care. It was devised as a solution, a) to placing second year students in the Emergency Department, a highly specialised acute care area for which it was identified they were not ready, and b) to avoid undue stress on students, the staff supervising them and any possible risk to the public. The model was proposed by the health service in response to an identified need and in recognition of the need for the agency to optimise its potential placement capacity. In consultation with administration, managers in under-utilised areas and the principal education provider, clinical educators mapped clinical learning objectives to the learning opportunities available through rotating students through specific areas. As the placement was the first acute care placement undertaken by students it was felt there were significant learning opportunities and benefits to be gained from enabling them to work alongside experienced and expert nurses and to be exposed to the continuum of post-acute care and to clients living and coping with commonly occurring chronic health conditions.

It is important to note that although the CFP model operated at this hospital for other nursing students undertaking placement, the varied nature of this model and its requirement that students were necessarily engaged in non-acute areas of the hospital and sometimes in the community, meant they rarely had easy face‑to‑face access to the CF or were available to attend organised debriefs with other students. However, the facilitator was available to support the CCM students and staff involved, ensure students knew when and where they were expected to be and to address any issues that may have arisen.

For this component of the project, the piloting of the chronic care module, clinical educators, clinicians involved in supervising students, the students that undertook the three-week placement and the clinical course coordinator had the pilot explained, were given an explanatory statement and told they were able to withdraw from the project component of the placement at any stage. Students were given a pre-placement survey to examine how adequately prepared they felt for the placement. Following the placement students, clinical educators and student supervisors were interviewed and/or completed a survey to explore how well the placement aligned with their expectations, students and supervisor preparedness, clinical learning objectives and to gain insight to the placement experience for administrators, students, education provider and supervisors.

Pilot findings

The results reported here are of pre/post-placement surveys completed by four of the six second-year nursing students that participated in the piloting of the CCM model. Two focus group discussions were also undertaken following the placement with the students, education provider, clinical educators and supervisors.

To reveal students’ level of understanding about the CCM placement they were asked to provide information about the areas they expected to be going to. All but one student expected the placement would include district nursing and haemodialysis, though they were less unanimous about cardiac, respiratory rehabilitation and diabetes education which one student collapsed under the umbrella of ‘chronic care’. Only one student indicated they were “Not sure what to expect.”

Variety was one of the factors that attracted students to the model. As one student stated, it provided “The option of being able to work with a variety of people in a variety of fields.” Another “Wanted a variety of experiences in different fields.” Most students had little idea about what they could expect to learn from this placement. Prior to the placement two were stressed about its apparent fragmentation and their comparative isolation from other students. This draws to attention how important it is to: prepare students for the realities characterising different placement settings; to brief them about the learning opportunities available; to give students some ability to select where they will do placements; and to selectively counsel students about their choices, their learning objectives and their expectations.

The quality of the placement was rated excellent by five of the six students who completed the CCM placement. The first group was more positive about the variation, the time spent with ‘experts’ and broader learning achieved than would be expected on a ward. The primary concern for students in undertaking this chronic or sub-acute care placement was about their ability to meet unit objectives and have technical skills assessed as competent. The advantages and limitations of the CCM are captured in the words of one student:

*“I thoroughly enjoyed the Chronic Care placement that you put together. I believe this placement offers students the benefit of seeing nursing from a different perspective. It allows us to see what is outside the ward. It offers us a look at job prospects outside the hospital as well as the importance of programs such as HARP, Cardiac rehabilitation, and Dialysis as well as District Nursing. The only negative aspect of this placement is the ability to accomplish our competencies (I was lucky to pass 3 of the 5), but I feel in some ways they could be incorporated. Chronic diseases will play an important part in our nursing careers and learning more about them and how we can keep these people in their homes is an important part of nursing. Thanks for putting this together, and I hope many more students enjoy it as much as I did.”*

There were some aspects of the placement and supervision which could be adapted to further strengthen the quality of the CCM as a viable and student-attractive alternative to an acute care placement; for example, the level of alignment between the learning opportunities available under the CCM and students’ theoretical preparation and learning objectives. Students worked very closely, 1:1 with very experienced nurses, sometimes for quite brief periods of time. The preceptorship model characterising the CCM was supported by the dedicated organisational CF; a lynchpin to the model’s stability and sustainability because the position provides the flexibility needed to work around the workloads of specialist solo-practitioner nurses and/or unplanned leave. It is likely that removing this flexibility would destabilise the model, put tension on other partners, jeopardise students’ learning outcomes and compromise the level of satisfaction of students and staff.

The sustainability of the CCM preceptorship model of placement and supervision devised by this organisation is dependent on the organisation creating a culture of learning and a sense of learning community, other staff supporting and contributing to students’ learning in the areas where they are placed and the CF overseeing and monitoring the placement and re-deploying students as needed. To establish a more substantive evidence base for the CCM preceptorship model of clinical placement and its ability to sustain student placement activity over time, the organisation and education provider(s) need to take into account the perspectives of staff and the CF as well as students and more students need to be studied over more placement episodes. The opportunities for students undertaking the CCM to participate in organised debriefs with other students, the frequency of these and the extent and conditions under which they contribute to student learning also warrant further investigation.

Hub and spokes models of placement and supervision

In response to changes in the health system and policy and the need to build placement capacity, there is a need for higher education and regulatory authorities to develop new and innovative models of placement that reflect and address these changes. Hub and spoke models of placement (founded on the notion of a bicycle wheel which has a strong central hub and a series of connecting spokes), have been found to increase placement capacity and expose students to the breadth of contemporary practice (Cameron et al., 2011; Roxburgh et al., 2012). In the context of practice learning, the hub and spoke model features a composite of contrasting but complementary learning experiences in different agencies and/or sectors which are conceptually connected by ‘screws’ that denote the placement category or label (Roxburgh et al., (2011). The settings utilised reflect a coherent combination and include a primary hub agency or setting and one or more secondary or spoke placement(s) in health, social and/or community-based settings (Roxburgh et al., 2012). Collectively, under the hub and spoke model, students are exposed to a broader range of learning experiences than possible in either one hub or spoke agency alone. Typically the hub and spoke model reflects shared clientele, referral pathways and/or shared service provision and thus exposes students to the care pathway of service users and broadens their horizon and insight to the continuum of care. In the process, the model raises their awareness of non-acute service providers, the role and expertise of other members of the health care team and potential career options beyond acute care (Roxburgh et al., 2012).

Hub and spoke model 1: Social Work Mental Health Placement

A new placement setting for social work students in a community mental health setting was facilitated by the project team. The placement model is currently in use in other locales; however, the particular setting has not been used for social work clinical placement in the past and is therefore a new model for the particular placement provider. The rationale for adopting this arrangement was to provide social work students with exposure to mental health and promote capacity building with the hope that the experience might fill an area of urgent workforce need by increasing the likelihood students might return to a mental health service as graduates. A pre-placement survey was undertaken to establish social work students’ interest and preparedness to undertake a mental health placement in their undergraduate study. For one student the motivation was:

*“I have always been interested in mental health and psychology. There were not many other options dealing with mental health and I wanted a placement in mental health so much I was prepared to go anywhere this was available.”*

The two students who chose this 14-week social work mental health placement attended a pre-placement meeting with the clinical facility supervisors to identify and negotiate a suitable workload (number and type of clients). At this meeting the students and staff discussed the model and identified the student’s strengths and learning objectives for the placement. This dialogue assisted the development of a suitable plan to facilitate students to achieve their objectives. As a result of this meeting the students were also aware of opportunities and resources that would assist them to prepare for the placement. The merit of the pre-placement meeting is captured in the words of one student:

*“In our course we cover a lot about ethics, confidentiality, interviewing, psyche, and indirect support via family. We don’t cover mental diseases. From this pre-placement meeting I can see that it would be worthwhile reading up about the Mental Health Act and DSM4 before I start next week.”*

A pre-placement survey indicated that the students expected the mental health placement would provide a rich learning environment, enable objectives to be achieved and they anticipated being supervised by experienced staff expert in their field. The only area one student identified to feel unsure about was how adequately theoretically prepared they were to undertake this placement. There was slightly less conviction the mental health placement would fit with course learning or that in developing personal learning objectives they would match the learning opportunities likely to be available. The aspects of the placement that most appealed were:

* Keen to experience a bit of everything; am not focused on one area
* Seeing mental health/psychology in practice: being exposed to the physical part
* of what I’ve learned theoretically

To get a feel for the role of social work in mental health

The reasons given for choosing the placement included:

* I want to get a sense of how social work fits with mental health.
* I want to explore what’s involved in social work in mental health and see how this relates in practice

I am doing a double degree in health and social work because I am interested in health, social work and mental health. This brings these interests together.

During this placement there were also opportunities to work with/engage with medical and nursing students and another social work student from a different university. The local regional hospital has a Chair in allied health jointly appointed by the hospital and Monash University who was able to facilitate opportunities for students to meet and engage with a psychiatrist, a broad range of social workers and other key staff in a range of related services/programs such as schools, police, Department of Justice, hospital and Aboriginal child care.

Two placements, of a 14-week duration, were undertaken and the feedback from students and staff was so positive there are plans to continue and expand this model in the future.

Hub and spoke model 2: Public hospital service and general practice

In one Gippsland health service a collaborative hub and spoke model of placement enabled registered nursing students to undertake a shared placement between the public hospital and a nearby General Practice (GP) Clinic. The placement time was divided between the two services: one week at the hospital and one week at the GP clinic. The students had specific learning objectives to be achieved which could be met in either setting. This placement arrangement allowed students to develop a better understanding of healthcare services outside the acute hospital setting, the needs of the patient when discharged back to the community and exposed them to primary care issues and potential employment opportunities. There was a *Memorandum of understanding* between the two organisations with the public hospital (the hub agency) having overall responsibility for the students’ placement. Whilst on the GP phase of the placement the clinical educator/facilitator from the hospital serviced any issues that may have arisen and was responsible for the overall assessment of the student. Due to the success of this established hub and spoke arrangement, other GP practices and the hospital propose extending the model.

Hub and spoke model 3: Aboriginal community placement

Gippsland is uniquely situated to provide health professional students with opportunities to engage with Aboriginal Community Controlled Health Organisations (ACCHOs) that provide a range of health services. Exposing students to ACCHOs will increase their awareness of the local community-based resources and services available to support Indigenous people to achieve optimal health outcomes and thereby, promote a more collaborative and integrated approach to health service delivery; a model amenable to ‘closing the gap’. In some areas there is local engagement with ACCHOs and capacity for placement to be facilitated within a range of disciplines. However, whilst these opportunities are potentially available, developing the relationship and placing students relies on personal contact, local knowledge, initiative and vision.

Two disciplines have initiated opportunities for students to gain insight to the services provided through one ACCHO; an opportunistic observational model of placement for pharmacy students and slightly more structured model for medical students. The initiative by local pharmacies assisted students to develop an awareness of cultural issues for the Indigenous community and added value to the clinical placement. However, this model was available on an ad hoc basis and subject to the student having a placement in one of the pharmacies that had an arrangement with the ACCHO. Whilst the placement provided an ideal opportunity for cultural immersion and raised students’ awareness of Indigenous health and services available through the ACCHO, the experience was limited by the lack of specific or structured learning objectives, preparation and limited discussion and feedback provided. This placement was observational and had no assessment component.

A more structured approach to exposing students to an ACCHO service was adopted by one rural medical clinical school. The students who were placed locally were rostered to attend an ACCHO one or two days per week for several weeks. This model again provided the opportunity for cultural immersion and facilitated the development of cultural safety. Because of the proximity of the settings and medical school relationship with the ACCHO, this experience was scheduled as a routine part of clinical activity. However, as with the pharmacy arrangement, this was an ad hoc opportunity that relied on placement with the particular school. It is not clear if the students had specific or structured learning objectives around Indigenous health issues or whether there was any assessment or debrief associated with the placement.

Additional composite models

In principle, the agreement was also achieved to implement the following composite models, although they were not able to be piloted within the project timeframe:

Hub and spoke model 4: Public hospital service, community health service and aged care

A collaborative three-site hub and spoke model of placement involving a public hospital as the hub and community health and aged care services as spokes has been devised for a shared three-week second-year registered nursing student placement. The model was developed to increase placement capacity, allow students to develop a better understanding of a range of healthcare services and to implement an indirect supervision model from the hub agency (public hospital) via video-link because the spoke agencies have limited capacity to provide direct supervision. A *Memorandum of understanding* has been developed between the three organisations with the public hospital having overall responsibility for the students’ placement. Whilst on the spoke phases (community and aged care) of the placement the clinical educator/facilitator from the hospital will be responsible for servicing any issues that might arise and for the overall assessment of the student. The placement time is to be divided equally between the three services with the requisite learning objectives able to be achieved within and between these settings. Though the model was unable to be piloted within the timeframe of this project, it is to be piloted in 2013. The organisation has indicated this model may be suitable for allied health students as well as nursing students.

Hub and spoke model 5: Public hospital service and general practice

As previously discussed, one subregional hospital had already established a collaborative arrangement for nursing students with a medical practice and on the basis of its success, proposed extending the model to another practice.

Composite expanded care model

The horizon or expanded care model proposed by one hospital for nursing students reflects a broader, more contemporary health care perspective and is expected to incorporate pre-admission, Hospital Admission Risk Program (HARP), chemotherapy, radiology, haemodialysis and out-patients.

Summary comments on opportunities for new models of placement and supervision

Harnessing local knowledge to broker a broader placement experience, as utilised in the models outlined above, seems a logical way to build placement capacity however it is dependent on reconceptualising placement and supervision, resolving regulatory constraints and all stakeholders demonstrating commitment and collaborative goodwill. A hub agency needs to attend to the administrative arrangements necessary to set up the placement and the formalities of communication, supervision and assessment. The hub and spoke model of placement seems in-principle, to be particularly well suited for expanding rural placement capacity; however, further study of the model is needed to examine its impact on student learning. Students that participated in the composite models piloted (CCM and social work mental health hub and spoke models) were able to experience a broader range of learning opportunities than traditionally available through one agency and overall, were able to achieve personally negotiated and prescribed learning objectives. Under a composite model, the student moves from one setting to another and works with different clinical supervisors so they necessarily need to feel well-supported and assume an active role in pursuing the learning opportunities available. A Scottish study using mixed-methods and a multiple case study approach to evaluate the effectiveness of three-hub and spoke models adopted for nursing students (Roxburgh et al., 2011; 2012) found it important that spoke areas were clear about the role they played in student learning, the hub agency attended to the formalities and ensured regular and consistent communication between hub and spoke supervisors and students and that students were encouraged to proactively seek and capitalise on the learning opportunities available.

Limitations and management strategies

Inevitably, as with any project there were some delays and issues which limited the progress and potential to achieve optimal outcomes. For example, access to students was delayed by the university calendar and the scheduling of clinical placements. To facilitate timely access to students the principal education provider was approached to discuss the clinical calendar and most appropriate time to access students. Communication was maintained with the education provider and clinical educators in the lead up to each targeted placement period and in the case of the new chronic care model being piloted, immediately following placement.

Seven of those who registered to undertake the ACE Level One program at one venue did not attend – some due to health concerns for children and animals or overwhelming workload and inability to be released. Others did not provide a reason or notify the organisers of their withdrawal. Their failure to advise the project team of their intentions undermined this opportunity to provide affordable, quality supervisor training locally within the region because it mitigated any chance to re-allocate funded places. To optimise the uptake of the ACE programs and allow for emergent issues that may arise, a strategy was adopted to maintain a list of clinicians waiting to undertake this training so that any vacancies could be filled. The success of such a strategy was dependent on people notifying the project team of their inability to participate.

Not all participants registered to complete the ACE Level Two program were able to complete the final day and present their applied project. To manage this situation and encourage them to complete the program at a later date, their contact details and record of participation have been kept and they are aware that they can do so.

To promote engagement with Indigenous health providers the initial composition of the steering group included an ACCHO representative. However, despite numerous attempts to find a solution, this member did not participate in project activities. Every effort to engage this person and later, to find a replacement ACCHO representative were thwarted, primarily due to their internal issues with time, distance and staffing.

Evaluation

Evaluation has been embedded in each activity throughout the project (Table 19). The ACE supervisor training and models workshops were evaluated by post workshop survey. The two models of placement and supervision that were piloted were evaluated by means of interviews with key stakeholders and pre/post-placement student survey. Generating data about the models of placement and supervision currently operating across the GiCPN included evaluating them by means of a post placement student survey. The reach of the project and level of participation and engagement geographically and by individuals, professional group and organisation were evaluated by tracking attendance records, registration, withdrawal and non-participation.

The audit of supervisory capacity was intended to provide a benchmark as a basis for reporting increased placement capacity; however this was beyond the jurisdiction of the project team and meant the quantitative targets established at the commencement of the project were unable to be calculated. Notwithstanding this inability to quantify the increase in capacity achieved through project activities, the evaluation strategies adopted demonstrate unequivocally that the project has made a significant contribution to building the capacity and capability of a number of new and existing placement providers to effectively supervise students in the GiCPN.

The tools developed as part of this project, namely the supervisor training workshop evaluation survey and the pre/post-placement surveys, have been tested and generated valuable learnings that could inform similar training workshops elsewhere and further exploration of alternative models of clinical supervision with other student groups and in other jurisdictions.

The key project outcomes were:

* Created additional capability of placement providers to effectively service and support students undertaking clinical placements in a range of settings across Gippsland by identifying a range of placement models that enable facilities to provide pertinent and sustainable placements for their particular environment.
* Increased capacity for quality student placements by increasing the skills and supervisory capabilities of 76 health professional staff in the GiCPN.
* Identified additional placement capacity in under-utilised areas such as aged care, mental health, Aboriginal health and the private sector, however, this increase cannot be realised until further supports have been implemented in these settings.
* Facilitated 13 organisations across Gippsland to progress their development towards establishing and promoting BPCLEs.
* Identified existing and innovative models of placement and supervision that have broad application throughout the GiCPN and elsewhere to build placement capacity in pertinent and sustainable ways.

Generated ideas and opportunities for stakeholders to collaborate and implement innovative new composite and hub and spoke models through sharing of information and resources regarding placement models.

Table 19: Evaluation of outcomes/achievements against/objectives and activities

|  |  |
| --- | --- |
| Objectives  | Outcomes/achievements |
| To identify models of clinical placement and supervision that:* provide best practice clinical learning environments
* are pertinent to the circumstances of health service providers within the Gippsland CPN
* are sustainable in a range of settings
 | Interest and support to implement hub and spoke models:* Extended model, hub (subregional health service) + spokes (community health service + private local aged care)
* Subregional health service + GP clinics
* Regional community health service/regional mental health service
* Clinical teacher + preceptor model: Operates in a subregional hospital where there is a self-identifying organisational culture of learning – wherein the position description (PD) of every staff member incorporates responsibility for supporting student learning.
* Supported preceptorship. The model operates in a subregional hospital within an organisational culture of learning/learning community
* Clinical facilitator + preceptors. The model operates in regional and subregional hospitals. Tensions exist with what constitutes a reasonable student load and allows students timely access to the CF.

Innovative sub-acute models: * Chronic care model: Specialist nurses supervise students 1:1 supported by the CF. Students rotate through non-traditional areas reflecting chronicity and sub-acute care (diabetes education, cardiac and respiratory rehabilitation, haemodialysis and district nursing).
* Horizon model: Specialist nurses supervise students 1:1 supported by the organisational CF. Students rotate through non-traditional areas reflecting a broader horizon of care pre-admission, Hospital Admission Risk Program (HARP), chemotherapy, radiology, haemodialysis and out-patients.
* Indigenous model: Local public hospital/ACCHO hub and spoke model for medicine and pharmacy students offers real potential and has implications for other disciplines but requires formalising and refinement.
* Interprofessional placement model: Two integrated community health services offer an interprofessional preceptored placement opportunity for students from different disciplinary backgrounds.
 |
| Audit supervisor capacity for potential placement providers in under-utilised areas  | The response rate to the audit was very low and precludes quantifying the latent supervisor capacity within the GiCPN. However, the data generated on some organisations provides a rich and meaningful insight to the manifest and latent placement opportunities available and highlights the value of periodically seeking such data. |
| Engage with agencies not formerly providing clinical placement opportunities to utilise the identified models | Agencies and clinical areas previously under-utilised or not utilised for clinical placements were engaged. As a result, clinicians and/or administrators indicated preparedness to work collaboratively with partner organisations to devise new models of placement and supervision, provide student rotations to their areas and give them access to the learning opportunities available in their setting. |
| Explore opportunities for collaboration and involvement between health service providers (e.g., hospital, general practice and private practice) to facilitate student rotation between these areas |
| Provide agencies with a clinical educator training workshop to allow preparation and support in advance of placements | All health service providers were seen as potential placement providers. Accordingly, clinicians from a broad range of health professional backgrounds, organisations and sectors were invited to participate in the ACE supervisor training workshops held in the region as a basis for preparing them as supervisors and to facilitate opportunities for them to meet and network with other supervisors in the region. |
| Utilise these agencies as ‘models’ or ‘case studies’ in the GCPN | Within the timeframe of the project only two models were able to be piloted, however the interest generated and goodwill shown suggests both education and placement providers are ‘ready’ to bridge traditional professional and sectoral silos to explore innovative opportunities to expand their placement activity. |
| Report on the models utilised and outcomes across the GiCPN and with other CPNs statewide | The models workshop showcased six distinctive models of placement and supervision operating in Gippsland and in another CPN for nursing, medicine and allied health and generated new and innovative ideas. |

Future directions

This project has identified a range of placement and supervision models that are pertinent for the Gippsland region. In order to maximise potential to increase and sustain placement capacity, rural and regional health services and education providers that place students in Gippsland need to continue exploring opportunities to collaborate with other providers and across professional disciplinary boundaries, to devise new and innovative placement and supervision models that are pertinent and sustainable in the local context. Future directions and activities include:

* The continuing need to consolidate the gains achieved through this project, to continue to progress an integrated GiCPN policy regarding clinical education and supervision and to establish a career path in clinical supervision. These needs are currently being addressed in another project through the additional CSSP funding granted by HWA.
* Ongoing mapping and tracking of supervisor capacity and capability in expanded settings
* Investing in supports to increase supervisory capacity and capability and develop a BPCLE to effectively utilise the latent placement capacity available in aged care. The potential for aged care to contribute more to placement activity informed the submission for the appointment of the Gippsland Expanded Settings Development Officer (GESDO) and will be progressed through that role.
* Further research be undertaken to examine:
* Criteria pertinent to calculating clinical placement capacity in traditional and expanded settings;
* The characteristics of models of placement and supervision that are pertinent and sustainable in the context of rural and other expanded settings and consistent with providing rich learning opportunities in a quality clinical learning environment;
* The attributes of a sustainable supported preceptorship model;
* The role and merit of a dedicated clinical facilitator and what constitutes a reasonable student and preceptor load; and
* The phenomenon of burnout in the context of clinical supervision.

Project activities have informed a number of initiatives which will consolidate the gains achieved and progress the capacity and capability of the GiCPN into the future:

* Identified strategies and resources needed to increase the capacity and capability of rural organisations to effectively supervise students and provide students with positive clinical experiences.
* Informed three strategic submissions for further infrastructure funding to support supervision training in organisations within the Gippsland CPN to sustainably develop their clinical placement capacity, capability and quality into the future.
* One submission provided funding to appoint a Gippsland-wide Clinical Supervision Support project officer to coordinate an integrated approach to increasing the number of clinicians in Gippsland qualified with Level One supervisor training.
* To further increase the supervisory capacity in Gippsland this grant provided a career structure to prepare some staff at more advanced levels, created a locally sustainable program (Gippsland Regional ACE (GRACE) program (modelled around the ACE program to harness synergies and promote a cohesive approach to supervisor training) to be able to continue to train supervisors into the future and provided funding to train the trainer and create a pool of experienced supervisors in the region who could collaborate to share the training load and continue the program.
* The second submission informed by the results of this project provided a developmental support officer to assist smaller non-traditional placement providers in the region to become more actively engaged in placement activity.
* The third submission targeted effective communication and collaboration by providing connectivity between different health sectors, education and placement providers and in so doing, sought to provide a forum for peer support between experienced and less experienced supervisors and staff in traditional and non-traditional settings and education providers.

Promoted sustainability of any gains in placement capacity achieved in the medium to longer-term by accessing further funding to put infrastructure supports in place to prepare organisations and clinicians for an increase in student placement activity.

Conclusion

This project demonstrates there is capacity for smaller rural and other expanded settings to be utilised for clinical placement and, from the perspective of most of the 42 students surveyed, to provide rich and satisfying placement experiences. By engaging education providers, placement providers and students, providing supervisor training, examining existing models and identifying and trialling new models of placement and supervision in the GiCPN this project has:

* Increased supervisor capacity and capability
* Engaged new clinicians and prospective placement providers
* Increased inter-sectoral and interdisciplinary opportunities to network and collaborate to offer innovative new models
* Increased opportunities for a variety of placement choices and to accommodate students from a variety of education providers
* Informed a strategic and integrated approach to developing a BPCLE Framework in the GiCPN and sustaining models of placement and supervision relevant to the rural context.

The achievements derived from this project will continue – and be further supported through five interlinked projects.

Maintaining placement load is contingent on models of placement and supervision being pertinent and sustainable. To be pertinent models need to fit:

* Students’ learning objectives, i.e., expose them to adequate and suitable learning opportunities that reflect best practice and enable them to achieve prescribed learning objectives;
* The agencies’ staffing profile, skill-mix and supervisory capacity and capability; and

Fit education provider needs and expectations, i.e., expose students to a suitable range of experiences, in a positive, supportive learning environment; enable them to demonstrate competence; and meet regulatory requirements, e.g., students are appropriately supervised, assessed and can meet specified targets, e.g., for midwifery, adequate number of birthing deliveries and follow-throughs.

To be sustainable, models need to:

* Be flexible, responsive and able to promote efficacy and continuity in the event clinical, staff or student contingencies arise.

Provide staff with supportive back-up from clinical colleagues and educators.

On the basis of the clinical placement literature, consultation with placement providers and examining four models of placement and supervision from a student perspective, there appears to be no single model of placement or supervision that suits or is sustainable in the varied and unpredictable clinical milieu that typifies rural practice. The preceptorship model supported by a dedicated clinical facilitator or teacher, subject to the facilitator carrying a reasonable student and preceptor load, affords the flexibility needed in expanded settings and seems well-suited to enabling organisations to sustain clinical placement activity. It is likely that removing one of these levels, failing to limit the number of preceptors a student is supervised by or imposing additional load on the CF, would undermine students’ perceptions of the richness of the CLE, their learning outcomes, the level of satisfaction of students and staff and ultimately, the sustainability of the placement capacity achieved.

Supervisors in disciplines that do not have access to back-up support such as allied health may not be able to sustain placement load and maybe more vulnerable to burnout and resistance. Regulatory requirements around clinical placement and supervision are not designed to facilitate flexibility, innovation or collaboration. However, these could be achieved to some degree if mandated requirements distinguished between direct and indirect supervision and allowed for students to undertake interprofessional learning under the supervision of other health professionals.

Whilst the preceptorship plus dedicated clinical facilitator model affords the flexibility needed in expanded settings and seems well-suited to enabling organisations to sustain clinical placement activity, the nature and staffing profiles of some expanded settings mitigate their ability to appoint a dedicated CF. A hub and spoke model wherein a CF is appointed by the hub organisation to provide outreach support to preceptors and students in spoke agencies would overcome this impost and promote quality and capacity of clinical placement in expanded settings. To increase placement capacity health services such as those engaged in the activities of this project will need to continue to explore opportunities to collaborate and devise innovative models such as a hub and spoke and other composite models that reflect contemporary healthcare. There is potential for aged care to contribute more to placement activity, however, to effectively utilise the latent placement capacity available in this area, supports need to be invested to increase supervisory capacity and capability and strengthen the quality of the CLE.

The potential for burnout and turnover makes it imperative that mapping and tracking of supervisor capacity and capability is ongoing. There is an ongoing need to consolidate the gains achieved through this project, to establish a career path in clinical supervision and dedicate resources to further research related to placement capacity, clinical placement in expanded settings and the attributes of models of placement and supervision that are pertinent and sustainable in these contexts.

The capacity of the GiCPN to continue to attract students for placement will be contingent on regional commitment by education and placement providers to forge rich and meaningful inter-sectoral and interprofessional partnerships; education provider and student respect for the unique learning opportunities available in smaller rural health services in the GiCPN; dedicated education and learning resources being allocated to strengthen the CLE of smaller health services that do not have recourse to the education infrastructure available in larger organisations; and the support of regulatory authorities and education providers for models of placement and supervision that are pertinent, flexible and sustainable in the rural context.

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