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Registered Nurses' Perceptions of the Recognition of, Preparation and Support for Teaching and Supervision of Undergraduate Nursing Students.

Report

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May 2019

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Acknowledgements

Nurses at the Lyell McEwin and Modbury Hospitals of the Northern Adelaide Local Health Network who took the time to participate in this study, and the support from the participating Nurse Unit Managers.

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Abbreviations

Clinical Facilitator	CF
Clinical placement management system	CPMS
Lyell McEwin Hospital	LMH
Modbury Hospital	MH
Nursing Students	NS
National Competency Assessment Schedule	NCAS
Nurse Unit Manager	NUM
Registered Nurse	RN
Teaching and Supervising/Supervision	T&S
Transition to Professional Practice Program	TPPP
Vocational Education and Training	VET

Executive Summary

Background

The requirement for teaching and supervision (T&S) of nursing students (NSs) is a continual high volume, high impact essential requirement of nursing staff with the number of NSs undertaking clinical placement increasing each year. Registered nurses (RNs) play an integral role in facilitating the learning of NSs in the practice environment to deliver quality safe care.

Nursing clinical placements within SA Health are coordinated via a centralised unit called Better Placed. The Better Placed team coordinate nursing clinical placements in conjunction with the various University and vocational education and training sector Education Providers and Health Site venues within SA Health jurisdiction.

Methods

This study used a sequential mixed methods approach integrating both survey and focus group findings to answer the question: How well recognised, prepared, and supported do RNs perceive they are to T&S undergraduate NSs in the practice environment? This study additionally aimed to identify any potential barriers for RNs to achieve their responsibilities for T&S NSs as well as recommendations.

Findings

Recognised:

- RNs recognised T&S of NSs is a requirement of their professional role and is important in preparing the future workforce.

Not Recognised:

- High workloads along with the complexity and relentless pressure of the responsibility to T&S NSs was perceived, by RNs, not to be well recognised within the health and education system.
- Lack of time allocated to RNs within current workloads to T&S NSs.
- Lack of time not only impacted RNs' management of allocated patient workload, but also impacted the NSs' learning experience.
- In addition to NSs, a number of other student practitioners, including medical and physiotherapy students undertake their placement on hospital wards. This factor is not often recognised in terms of its impact on the T&S workload of RNs.
- Information from the different universities was not always readily available, and NSs often did not know what their particular learning needs were for the placement. The academic year of the NS could not be assumed as a guide to the NS's level of competence, because some Year Two/Three NSs were undertaking their very first acute care clinical placement.
- Without direction of NS's learning and assessment requirements, more time was required by RNs to make a preliminary risk assessment of the NSs' current level of knowledge and skill.

- When NSs were assessed as 'not safe', because they did not demonstrate the basic knowledge and skills or who were just not coping, RNs reported that this group of students required additional time. One group that RNs mentioned across all of the focus groups that were more time consuming and complex were those students whose primary language was not English.
- It was not always possible to allocate NSs to an experienced RN due to staffing levels and patient acuity.

More Preparation:

- There was an assumption that all RNs had teaching skills. RNs reported a lack of formal education in these skills, and that more preparation would be welcomed. In particular, skills in addressing NSs' poor performance were reported to be an area of in which RNs would like more preparation.

Supported:

- NSs who had a positive attitude towards taking every opportunity to learn were valued by RNs.

More Support:

- RNs perceived that there was a discordance between the responsibility and expectation by university staff that RNs will T&S NSs, yet NSs reported that they cannot undertake a clinical procedure, when an opportunity arises, if the NS had not undertaken the topic or skill at the university first. This approach was reported as potentially reducing learning activities for NSs. Though it was recognised that more discussion with clinical facilitators (CF) could address this.
- RN participants perceived that CF access was key to supporting their T&S role. In particular communicating regularly and directly with the RNs about the NSs' learning needs and expectations was of significant importance to RNs.
- CFs to have a greater role on the ward/unit with those NSs who were not coping.
- Timing of CFs in accessing NSs was problematic at handover time for RNs.
- Some NSs on clinical placement were not organised. Examples given were: Not turning up on time and/or not completing the shift; not being proactive with their assessments and not finalising reports before the end of the final shift with the expectation that RNs would complete their report on the last day.

Conclusion

RNs do recognise their role in T&S and believe that they have an investment in the future of the profession. However, they do not believe that the impact on them of the continuous and increasing number and varied preparedness of NSs was recognised by all components of a disconnected clinical placement system. In particular continually having to balance the care and safety of patients with trying to provide the best learning experiences for increasing numbers of NSs.

CFs are an important link to the education providers, but their regular presence and support was missed on the wards.

For the clinical placement system to improve, the different components must reconnect and work together to consider the impact on patient care and the RN. The increasing number of NSs without the capacity of the workplace to meet this growth, has potential consequences for the quality of the NSs' learning experience, patient safety and the well-being and work satisfaction of the RNs.

Summary of Barriers and Recommendations

Issues	Current Barriers	Recommendations
Not sufficiently recognised for the impact of NSs on workload	So many variations on the types of courses that are being run by schools of nursing.	NSs should be able to articulate to the supervising RN their current scope of practice and course assessment requirements.
	Different versions of the National Competency Assessment Schedule (NCAS) assessment forms provided by the schools of nursing for the assessment of the NSs.	Schools of nursing coordinate to have one NCAS assessment form. Training/information by education providers for RNs on the types of assessments required for the different cohorts of NSs.
	Limited protected time on a shift for NS training and supervision.	More allocated and protected time. Patient care hours to include T&S.
	NSs allocated to health services that require extensive/difficult access to transport, which impacts on the shift time on the ward/units	Clinical placement teams to be more mindful of NSs' travel requirements and how this may impact on NSs' ability to be on placement for a full shift.
More support of RNs to reduce the impact on workload is required.	CFs cannot have direct contact with patients because they are not employed in the CF role by the Health Service, they are employed by the education provider.	Review model of clinical facilitation. CF's title to be reviewed based on model (University or Institutional facilitated) CFs to be more accessible and to have a regular presence on the wards/units.
	NSs who are not ready for a clinical placement or do not attend the whole shift.	Assessment of the NSs' readiness and preparation to take responsibility for their learning and assessments before they actually go on clinical placement.

	RNs do not have time to provide extra support and supervision for NSs who are not coping with the experience of a clinical placement	CFs manage more closely underperforming NSs, which includes more frequent and regular supervision by CFs, sharing of information about progress, assistance with providing constructive feedback to the NS, writing their report and removal of the NS quickly if necessary.
	NS are often pulled away from the ward/area at 'handover time'.	Improved timing of NSs' meetings with CFs so that it did not cross-over shift 'hand-over time'.
	NSs being the conduit for communication between the CF and supervising RN.	More direct communication between the supervising RN, CF and the NS.
More preparation of RNs would be useful to T&S NSs.	Some RNs lacked confidence in undertaking T&S of NSs	Information/training on how to write informative, constructive and yet honest assessment reports as well as how to give negative feedback to under-performing NSs. Modularise current Hospital preceptor course to enable more staff to attend in Professional Development time i.e as a refresher course.

Other Recommendations

- Employers and education providers to acknowledge and monitor the increasing number of NSs undertaking clinical placement and the resultant impact on the RN's workload.
- Support RNs to teach NSs new skills even if not undertaken as part of their current course. This would need to occur through liaison with the relevant CF to ensure appropriateness of the learning experience.

Registered Nurses' Perceptions of the Recognition of, Preparation and Support for Teaching and Supervision

Introduction

The requirement for teaching and supervision (T&S) of Nursing Students (NS) is a continual high volume, high impact essential requirement on nursing staff with the number of NSs undertaking clinical placement increasing each year. A recent Australian study (Rebeiro, Evans, Edward & Chapman, 2017) identified a significant negative impact on the quality of the practice environment through the pressure on registered nurses (RNs) and unstructured clinical T&S of NSs, highlighting the consequences this has on the quality and safety of patient care, the wellbeing of RNs, and retention of NSs into the nursing workforce. The study also highlighted the need for further research on the impact of NSs on RNs in the clinical setting.

This study takes up the challenge presented by Rebeiro et al (2017) to build on the previous findings. Specifically, this study is designed to improve understandings of how prepared and supported RNs are in NALHN to deliver quality T&S to NSs. A quality component of the practice environment is good supervision of NSs by RNs skilled and supported in clinical teaching.

Expected benefits:

- Identify RN's perception of the current level of recognition, preparedness and support in their role to T&S NSs
- Identify and explore enablers and barriers to T&S NSs.
- Identify and explore any strategies to improve the employer's systems/education for T&S by RNs and University preparation of NSs.
- Findings will contribute significantly to maintaining the quality of the practice environment that focuses on patient's safety within the health service.

Background

RNs play an integral role in facilitating the learning of NSs in the practice environment (Casey & Clarke, 2011). The Nursing and Midwifery Board of Australia Code of Conduct (2018) outlines how RNs are required to "commit to teaching, supervising and assessing students and other nurses in order to develop the nursing workforce across all contexts of practice". A study by Rebeiro et al (2017) identified stress and tension in RNs resulting from the ambiguity and unstructured nature of their T&S role, and identified the need for further research.

The issues raised by the study (Rebeiro *et al* 2017) resonated with the Nurse Educators at the Lyell McEwin and the Modbury Hospitals, who wanted to gain a better understanding of the RNs' perception of their T&S role in this health service practice environment.

Considering the dynamic changing landscape of health services, it is important for nurse educators to maintain current understandings of how workplace factors impact on RNs' T&S roles. To our knowledge however, no studies have investigated Australian RNs' perceptions of the specific factors of support, recognition and preparedness for this role. As such, we

argue that there is insufficient evidence to inform the education sector and health services about how these factors affect RN's ability to fulfil their professional responsibilities with regards to T&S of NSs.

Nursing clinical placements within SA Health are coordinated via a centralised unit called Better Placed. The Better Placed team coordinate nursing clinical placements in conjunction with the various University and vocational education and training sector Education Providers and Health Site venues within SA Health jurisdictions. The clinical placement management system (CPMS) utilised for this process is called Placeright™. The journey commences with annual capacity planning (Health sites), curriculum and block review (Education Provider) and expected NS placements required.

The Education providers will request placements in direct correlation to the NSs' year level and theoretical focus of their current studies. The clinical placement coordinator role within the health site(s) receives clinical placement requests from the various Education providers via Placeright™ which are either accepted or declined dependant on capacity, appropriateness and availability of placements.

NS names are then allocated to the offered and accepted placement opportunity with relevance to their year level and scope of practice. The NSs will then present to their allocated health site with information provided (orientation/induction) as per the specific health site.

Literature review

The databases of CINAHL complete, OVID and Medline complete were searched using the key terms of – buddy nurse OR preceptor OR clinical educator OR mentor AND registered nurse AND student nurse.

The role of RNs in teaching and supervision of NSs

The following section will provide a brief summary of the role of RNs in T&S NSs. We then move on to summarise the literature concerned with issues of recognition of, support for, and the preparation of RNs in taking on T&S roles.

Historically NSs undertook their training through an apprenticeship style of education, in which they occupied a paid role in the healthcare workforce (D'Cruz & Bortoff, 1986). More recently however, the education of NSs takes place largely within the tertiary education system (Rebeiro, Edward, Chapman & Evans, 2015). Despite this shift in approach, a significant proportion of nursing education will still occur in the clinical setting in the form of clinical placements (Rebeiro et al, 2015). In order to meet requirements of undergraduate nursing curriculums for registration to practice, Australian NSs must undertake a minimum of 800 hours of supervised practice (Australian Nursing and Midwifery Accreditation Standards, 2012). RNs play a central role in the T&S of undergraduate NSs undertaking their clinical experience. NSs rely on RNs to help them to refine their clinical skills and to become competent, safe practitioners (Anderson, Broadbent & Moxham, 2016).

A number of clinical education models exist worldwide for NSs on clinical placement (Rebeiro et al, 2015). The clinical facilitation model is described by Health Workforce Australia (HWA, 2008) as one where an RN is funded by an education provider to supervise a group of NSs. In contrast, the term preceptorship is largely used to describe the allocation

of new graduate nurses to a senior RN employed at a health care facility (Myrick, Yong, Billay & Lahunga, 2011). The preceptor then can be defined as an RN that holds a dual role, consisting of carrying out clinical duties while also providing one on one supervision, and guidance to the newly graduated nurse (Usher, Nolan, Reser, Owens & Tollefson, 1999). Investigating the RNs' role in T&S both undergraduate NS and new graduate nurses is however beyond the scope of this report. As such, this study will focus on RNs experience with T&S undergraduate NSs.

In some jurisdictions of Australia the 'buddy nurse' model is used in the provision of clinical education for NSs. The buddy nurse model has been argued to represent a hybrid of the preceptorship and clinical facilitation model (from Rebeiro et al, 2015; Rebeiro et al, 2017) wherein RNs are allocated one or more NSs, to whom they are to provide informal supervision, guidance and orientation. Similar to the preceptor model, allocations of NSs to RNs represent added responsibilities in addition to RN's existing clinical workload.

Despite the ostensibly informal nature of the 'buddy nurse' role, a number of responsibilities have been identified as being associated with taking on a NS. These responsibilities include but are not limited to assessing students (Broadbent, Moxham, Sander, Walker & Dwyer, 2014), liaising with universities regarding student progress, particularly regarding failing students (Casey & Clark, 2011) and maintaining an awareness of competency standards and student's scope of practice (Anderson et al, 2016). A number of studies have concluded that these wide ranging responsibilities of RNs taking on a buddy role, result in a very complex T&S role that does not appear to be fully recognised.

Importantly, not all RNs have had training for their informal role of facilitating the learning of NSs in clinical settings. Still, it is expected by the nursing profession that RNs take on these informal nurse buddy roles, as part of their scope of practice (Nursing and Midwifery Board (NMBA), 2018). The findings of Rebeiro et al's 2017 systematic review additionally suggest that Australian RNs frequently report that the T&S role lacks clarity, structure and sufficient support. As far as we are aware however, there exists minimal evidence regarding the specific contributions of support, recognition and preparedness to RNs of their T&S role.

This project aims to investigate how well recognised, prepared, and supported RNs perceive they are to T&S NSs in the practice environment. Also of interest is how RNs perceive any potential barriers and enablers to achieving their T&S responsibilities. An improved understanding of these issues is important due to the significant role RNs play in supporting undergraduate NSs. A positive clinical experience of T&S by RNs will contribute significantly to keeping NSs in the workforce as well as improving RN's job satisfaction. This project will also contribute more broadly to a growing body of literature concerned with RN's role in T&S of NSs.

Aim

The aim of this project is to assess how recognised, prepared and supported RNs' feel in their T&S of undergraduate NSs.

Methodology

Participant site

The project commenced in July 2018 at two sites: Lyell McEwin Hospital and the Modbury Hospital.

Participants

Participants included RNs located at two metropolitan hospitals: the Lyell McEwin (LMH) and Modbury Hospital (MH). RNs were recruited for this study from a number of different wards at the LMH (n=7) and the MH (n=5).

This mixed method study consists of three sequential phases: Phase 1: a paper based survey of RNs in selected wards. Phase 2: focus groups with RNs to explore the findings from the survey in more depth. Phase 3: feedback sessions and development of recommendations.

Recruitment:

Phase 1: Following negotiation with the Nurse Educators or Nurse Manager, RNs were invited to participate in the pilot of the survey form on one of the medical wards at the LMH (n=10). The survey contained additional questions asking how easy the form was to complete and the time taken to complete the form and an open question asking for any suggestions for change (Appendix G).

For the finalised survey (Appendices A, B & C) RNs were invited to participate in the survey through information provided via a flyer at staff meetings and notice boards (Appendix D).

Phase 2: After determining what themes have evolved from the questionnaires, focus groups were arranged with RNs to explore those themes in more depth (Appendix J).

Phase 3: Project Feedback sessions. Discussion of findings and development of recommendations with participating ward/unit staff. Additional discussions with the broader nursing community through Nursing and Midwifery Grand Round sessions and senior nurse's forums was also conducted.

Data Collection

This mixed method study consists of three sequential phases:

Phase 1a: A pilot paper based survey of RNs in selected wards. A questionnaire was developed for pilot with a small number of RNs (n=10) who would not participate in final survey.

Phase 1b: RNs were invited to complete a paper survey that examined the following points:

- How recognised RNs feel for their role in T&S of NSs
- How prepared RNs feel for their role in the T&S of NSs
- How supported RNs feel in their T&S of NSs

Data was collected over a period of 2 weeks using a paper based survey (n=59). Staff survey data was entered into SPSS. Quantitative data was analysed using descriptive statistics. Survey data was used to inform focus group questions

Phase 2: focus groups with RNs to explore the findings from the survey in more depth.

Phase 3: feedback sessions and development of recommendations.

Ethics

This project received ethics approval from the Central Adelaide Local Health Network Human Research Ethics Committee (HREC), *HREC/18/CALHN/211* *SSA/18/NALHN/52* and the University of Adelaide HREC

Findings

Phase 1: Quantitative data analysis

Questions on this survey could be grouped into three domains; perceived recognition, preparedness and support. These respective domains contained items relating to how recognized, prepared and supported RNs felt in their T&S of NSs. The survey additionally contained demographic questions pertaining to age, gender and supervising experience. The survey also asked participants if any prior training to prepare for supervision of NSs had been completed. Data was analysed using IBM SPSS 24.

1. Descriptive statistics

Table 1. Demographic data

Variable	Levels	N
Age	Aged younger than 25 years	6
	Aged between 25-45 years	29
	Aged older than 45 years	24
Gender	Male	5
	Female	54
Prior experience supervising	Yes	50
	No	7
Formal training for supervising	Yes	25
	No	34
Total sample		59

Respondents to this survey (n=59) were grouped into a number of demographic variables of age, gender, prior supervising experience and prior supervisory training. The majority of respondents fell into the age group 25-45 years (n=29) and older than 45 years (n=24). A small number of respondents (n=6) were aged less than 25 years. The vast majority of respondents were female (n=54), while a small number identified as male (n=5). The majority of respondents had previous experience supervising NSs (n=50) while a relatively small number did not (n=7). The number of those who had previously received formal training to prepare for their supervising of NSs (n=25) was slightly lower than the number of those who had not received formal training (n=34).

1.2 Recognition, preparedness and support domains

Table 1.2. Overall scores on recognition, preparedness and support domains

Domain	Minimum score	Maximum score	Mean score	Standard Deviation
Recognition	12	35	27.0	5.3
Preparedness	4	20	15.7	3.5
Support	4	20	12.4	3.8

Note: Domain of preparedness contained seven questions, while the recognition and support domains each contained four questions. All items within these domains were scored on a five point likert scale (where 1= strongly disagree, and 5= strongly agree)

Scores on the recognition domain had a minimum of 12, and a maximum of 35. The mean cumulative score on this domain was 27.0(3.8). Preparedness had a minimum possible score of 4, with a maximum score of 20. The mean cumulative score on the preparedness domain was 15.7(3.5). The support domain also had a minimum score of 4, with a maximum score of 20. The mean score on the support domain was 12.4(5.3) which is lower than scores on the recognition domain which had the same number of items.

Table 1.2.1. Recognition domain break down

	Question	Mean score	Standard deviation
Lowest scoring question on this domain	I feel that CFs recognise my role in the T&S of NSs	3.49	1.1
Highest scoring question on this domain	I believe that the T&S of NSs is a part of my role as an RN	4.27	1.0

Note: The domain of preparedness contained seven items. A full list of these questions, along with their mean scores, and standard deviations can be found in the appendices.

The lowest scoring item on the recognition domain (I feel that CFs recognise my role in the T&S of NSs) had a mean score of 3.49(1.1) out of a possible 5. The highest scoring item on this domain (I believe that the T&S of NSs is a part of my role as a RN) had a mean score of 4.27(1.0) out of a possible 5.

Table 1.2.2. Preparedness domain break down

	Question	Mean score	Standard deviation
Lowest scoring question on this domain	I think that I am equipped to balance any risk to patients against the need for independent learning by NSs	3.81	1.1
Highest scoring question on this domain	I feel confident in my ability to make objective, unbiased assessment decisions regarding the progress of NSs	4.07	0.9

Note: The domain of preparedness contained four questions. A full list of these questions, along with their mean scores, and standard deviations can be found in the appendices.

The lowest scoring item on the recognition domain (“I think that I am equipped to balance any risk to patients against the need for independent learning by NSs”) had a mean score of 3.81(1.1) out of a possible 5. The highest scoring item on this domain (“I feel confident in my ability to make objective, unbiased assessment decisions regarding the progress of NSs”) had a mean score of 4.07(0.9) out of a possible 5.

Table 1.2.3 Support domain break down

	Question	Mean score	Standard deviation
Lowest scoring question on this domain	I feel I have enough time to engage in T&S of NSs within practice environments	2.61	1.0
Highest scoring question on this domain	I feel supported by line management in my T&S of NSs	3.75	1.2

Note: The domain of preparedness contained four questions. A full list of these questions, along with their mean scores, and standard deviations can be found in the appendices.

The lowest scoring item on the recognition domain (“I feel I have enough time to engage in T&S of NSs within practice environments”) had a mean score of 2.61(1.0) out of a possible 5. The highest scoring item on this domain (“I feel confident in my ability to make objective, unbiased assessment decisions regarding the progress of NSs”) had a mean score of 3.75(1.2) out of a possible 5.

2. Comparison of group means by demographic variables

Table 1. Comparison of mean scores on recognition, preparedness, support and overall domain scores

		n	Domain 1- Recognition			Domain 2- Preparedness			Domain 3- Support			Overall		
			Mean	SD	P	Mean	SD	P	Mean	SD	P	Mean	SD	P
Sex	Male	5	28.2	4.6	0.576	16.6	3.6	0.716	13.6	2.7	0.321	58.4	10	0.635
	Female	54	26.9	5.4		15.6	3.5		12.3	3.9		54.8	12	
Age	Less than 25 y/o	6	24.5	7.2	0.349	12.7	5.4	0.040*	11.7	4.4	0.832	48.8	17	0.263
	25-45 y/o	29	26.7	5.5		15.5	3.3		12.4	4.0		54.6	11	
	Older than 45 y/o	24	27.9	4.5		16.6	2.9		12.7	3.5		57.2	9.9	
Prior experience supervising	Yes	50	27.7	4.7	0.109	16.3	2.8	0.248	13.0	3.5	0.405	57.0	9.6	0.072
	No	7	24.6	7.0		13.1	4.8		10.4	4.3		48.1	15	
Prior supervising training	Yes	25	27.2	5.4	0.755	15.9	3.3	0.478	12.6	3.6	0.515	55.7	11	0.847
	No	34	26.8	5.3		15.5	3.7		12.4	4.0		54.6	12	

A one-way analysis of variance was conducted to explore the impact of age on levels of perceived recognition, preparedness and support. Participants were divided into three groups according to their age; (group 1: <25; group 2: 25-45; group 3: >45). There was a statistical difference at the $p < .05$ level in preparedness scores for the three age groups: $F(2, 56) = 3.412$, $p = 0.04$. In addition to reaching statistical significance, the actual differences in mean score was medium-large. The effect size, calculated using eta squared was 0.11. Post hoc comparisons using Tukey HSD test indicated that the mean score for Group 1 ($M = 12.7$, $SD = 5.35$) differed significantly from group 3 ($M = 16.6$, $SD = 2.87$). Group 2 ($M = 15.5$, $SD = 3.26$) did not differ significantly either from group 1, or group 3.

Independent sample t-tests were conducted to compare the mean recognition, preparedness and support scores for gender, those with and without prior supervising experience, and those with and without formal supervising training. There were no significant differences on any of the three domains, amongst any of these groupings.

2.1 Gender

An independent sample t-test was conducted to compare the mean recognition, preparedness and support scores for males and females. There was no significant difference in scores on the recognition measure for males ($M = 28.2, SD = 4.60$) and females ($M = 26.8, SD = 5.39$). There was no significant difference between scores on the measure of preparedness between males ($M = 16.6, SD = 3.38$) and females ($M = 15.6, SD = 3.51$). There were also no statistically significant difference on measures of perceived support between males ($M = 13.6, SD = 2.70$) and females ($M = 13.6, SD = 3.87$).

2.2 Prior Experience Supervising

An independent sample t-test was conducted to compare the mean domain scores for participants with prior experience supervising to those without prior experience. There was no significant difference in scores for scores on the recognition measure for those with prior experience ($M = 27.7, SD = 4.68$) and for those without ($M = 24.7, SD = 7.04$). There was also no statistically significant difference on measures of perceived support between those with prior experience ($M = 13.0, SD = 3.47$) and those without prior experience ($M = 10.4, SD = 4.31$).

There was a statistically significant difference between scores on a measure of preparedness for those with prior supervising experience ($M = 16.3, SD = 2.77$) and those without prior experience ($M = 13.1, SD = 4.81$); $t(55) = 2.58, p = .013$.

2.3 Formal supervising training

An independent sample t-test was carried out to compare the mean recognition, preparedness and support scores for those with prior supervising training, and for those without supervising training. There was no significant difference in scores for scores on the recognition measure for those with prior supervising training ($M = 27.2, SD = 5.41$) and without supervising training ($M = 26.7, SD = 5.30$). There was also no significant difference on measures of perceived preparedness between those with training ($M = 15.9, SD = 3.27$) and those without training ($M = 15.5, SD = 3.68$). There was also no significant difference on measures of perceived support between those with training ($M = 12.6, SD = 3.60$) and those without training ($M = 12.4, SD = 3.95$).

2.4 Overall scores on three domains

The cumulative mean scores of the three domains (recognition, preparedness and support) were calculated, to find the overall mean. Independent sample t-tests were conducted to compare the overall scores between males and females, those with and without prior supervising experience, and those with and without formal supervising training. There were no significant differences on any of those variables.

A one-way analysis of variance was conducted to compare the overall mean scores of the three age groups (group 1: <25, group 2: 25-45, group 3: >45). There were no significant differences between the three age groups on their overall mean scores.

Phase 2: Qualitative data analysis

This study aimed to understand how well recognised, prepared, and supported RNs perceive they are to T&S undergraduate NSs in the practice environment, including any potential barriers and enablers to achieve their responsibilities for T&S.

The first phase of the study a survey, asked very general questions about the RNs' perception of being recognised, prepared, and supported to T&S undergraduate NSs in the practice environment. The response to the surveys informed the development of the questions for the focus groups to gain a deeper understanding of the RNs' views on being recognised, prepared, and supported to T&S undergraduate NSs.

This second Phase of the study consisted of 6 focus groups (n=45) across NALHN, at the Lyell McEwin and Modbury Hospitals. At each focus group a brief overview of the study was provided and consent forms were completed (Appendix I and J). The focus groups lasted between 45 - 60 minutes.

A thematic analysis was conducted using Ritchie and Spencer, qualitative analysis for applied policy research (1994) to guide the process. The research team members reviewed the transcripts separately for the familiarisation stage and then met to discuss and gain consensus on the emerging themes. To guide this process a thematic framework was chosen using the focus of the research question: sufficiently recognised, prepared and supported to T&S undergraduate NSs. The framework assisted to sift and sort the data, followed by abstraction and conceptualisation to identify recurrent themes. Four major themes emerged with themes and sub themes as outlined in Table 1.

Table 1. Thematic analysis to answer the question: Are RNs sufficiently recognised, prepared and supported to T&S undergraduate NSs in the practice environment?

Major Themes	Themes	Sub Themes
1 The role of T&S NSs is recognised by the RNs.	1.1 It is our responsibility	
2 The role is not recognised at a system level.	2.1 There is no time 2.2 Its very complex	2.1.1 Impact on RNs' workload 2.1.2 Impact on NSs' learning 2.2.1 Additional complexity involved in T&S. 2.2.2 Complexity of NS allocation.
3 Not as prepared for clinical T&S as we would like	3.1 More preparation through training would be useful	3.1.1 The current preceptor course 3.1.2 Teaching strategies and report writing assistance 3.1.3 Having difficult conversations with NSs
4 There is not enough support for RNs in their clinical T&S role by the education	4.1 More support from health service management	

<p>providers and health care system</p>	<p>4.2 More support from University Schools of Nursing</p> <p>4.3 More support from CF</p> <p>4.4 More support from some NSs</p>	<p>4.2.1 Improved communication on the expectations of the NSs level of learning</p> <p>4.3.1 More communication and feedback required</p> <p>4.3.2 Having a regular presence</p> <p>4.3.3 Timing of NS interactions</p> <p>4.4.1 Not organised for the experience</p> <p>4.4.2 NSs must be willing participants.</p>
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1. The role of teaching and supervising nursing students is recognised by the registered nurses.

This first major theme explored **RNs' perception of the level of recognition** they have for the role of T&S undergraduate NSs in the practice environment: Though they accepted that they have a responsibility to teach, the RNs indicated that the system does not provide them with the necessary recognition of their high workloads as well as their role to support NSs, enable their learning and manage the additional complexity of the varied clinical placement demands required by universities and individual NSs.

1.1 It is our responsibility

There was a very strong view expressed by the majority of RNs in the focus groups that they do have an important responsibility to T&S undergraduate NSs:

... we've got a responsibility to teach them and guide them, they're the upcoming profession basically so it's what you put in is what you get out (FG1pg1).

We try to nurture and educate the next wave of the nurses but it is hard (FG2pg2)

We definitely have a responsibility because of the university education system, making sure that we're then educating people in the practical side is vital (FG3pg1)

You have a responsibility to educate (FG4pg1).

This is one of the basic responsibilities of a registered nurse to look after the students and give guidance and support, a kind of mentorship (FG6pg1).

The RNs recognised that T&S of NSs is a requirement of their professional role and that it is important to prepare the future workforce. However, the high workload along with the complexity

and relentless pressure of the responsibility to T&S NSs was perceived not to be recognised within the health and education system.

2. The role is not recognised at a system level.

2.1 There is no time

The RNs when asked the direct question “How recognised is this responsibility within the health service? The RNs expressed an overall perception that the system does not recognise the commitment they are required to give to this role:

I don't feel like, to me personally, it's recognised (FG1pg2)

No. Don't think so (FG5pg5)

No, not at all. [recognised] (FG6pg2)

In particular the lack of **time** allocated to RNs within their current workload to T&S NSs:

I think it's recognised that we're a tertiary hospital and we're here to teach but there's not a recognition to allocate time to fulfil that role, that's the challenging part (FG1pg2)

That it actually takes a lot of time (FG2pg2)

We have eight students on our ward and it's pretty well all through the year and RNs, ENs, it's pretty well eight or nine constantly and they're not all smooth running, you have to put time into the fact (FG1pg2).

[time required]when ... there's clinical challenges (FG1 pg2).

It basically comes down to time (FG2 pg5)

So no, there's not a lot of support on the ground for taking out additional time (FG3pg8)

2.1.1 Impact on nurses' workload

The lack of recognition for additional time required for T&S impacted on the RN's experience of completing their own workload and finishing the shift on time:

well it's part of the scope of practice to teach, but I suppose a lot of nurses would feel the same that it would be nice to be recognised ... because it is a lot of extra workload on top of looking after your patients (FG1pg2)

Likely it's quite challenging on yourself because they are slower, they are learning and things don't quite go to plan and then you'll have to pick things up so we've got to pick the speed up and you will get out late (FG1pg3)

Sometimes it's really nice to have a student to give you a hand with things but other times when you have to explain everything it just really impedes on your work (Fg2pg2).

... time is an essence, things are just so quick, this is happening, you've got to get this patient in, get this one out, you've got other things you're doing and then you've got this person [student] you've got to think .. [about] (FG2pg2)

Just say, Here you go, here's the medication key, I'm right here, let's do the medications. Obviously XX patients, could have six pages, so it could be for me a three-minute job but if I allow that student to do it we could be there for forty-five minutes so it creates a bit of a snowball effect, and that's a challenging part I think of the supervision (FG1pg3)

[Would like] a couple of hours a week to sit with them and write reports. I used to do them all at home (FG3pg8).

... it's hard to balance your workload and have a student come on and having to teach them.. (FG4pg6)

2.1.2 Impact on student learning

The RNs perceived that the lack of time not only impacted on their management of the allocated patient workload, but they expressed a concern that the lack of time also impacted on the NSs' learning experience:

I would love to see someone allocated supernumerary to actually spend time with them [students] on that first day and actually orientate them properly especially for the long placement, like that eight week placement (FG1pg6)

I love teaching so I don't want to stop doing that but, it's the time, the time factor is huge for me and I've orientated many a student and spent a lot of time with them but I hear it over and over down there that they don't have the time which I think is a shame because I think sometimes that could jeopardise their learning experience (FG1pg7).

I just find that sometimes I feel embarrassed that I don't have as much time as I could with a student because our unit is so fast paced (FG5pg12)

And as I said, you come onto a ward and the pace could be quite fast and they're not going to be able to carry you [the student] hand in hand all day so be prepared for that. Ease them into the fact that there's going to be times when your nurse is a bit all over the place, she won't know where she is because she's off doing stuff and they're there stuck; what am I meant to be doing ?(FG2pg13)

... that it's just, Oh there's four more students coming, they're yours, that's gone on for quite some time. And yeah there's no support for that, you're not given extra time to actually sit with a student, What are your objectives?, What do you want to achieve from this?, and then once a week sitting with them and saying, How do you feel you're going?, Are there obstacles to your learning?, and this sort of thing, we just don't have the time to sit with them and before you know it they're at the end of their placement and you're writing a report, but you need to get feedback from other people because we all work a lot of different shifts, ... they work with a lot of people which isn't a bad thing either because they learn from a lot of different people's experiences (FG3pg3).

More time for orientating NSs to the placement environment was seen as essential to support the NSs and prepare them for the clinical placement:

Some more time to orientate the students (FG4pg12)

RNs mentioned the importance of having time during the shift to be able to discuss with the NSs their learning objectives, assessment requirements and how best this could be achieved within the allocated shift:

Possibly having the time just to spend with a student and do that assessment and see where they're at and what their goals are and what they're hoping to achieve (FG3pg13)

Time at the beginning of your shift maybe and tell all your staff to go off with your student, have a few five or ten minute chats and then at the end of the shift again you can give them feedback on how they've achieved the shift (FG2pg13)

2.2 Its very complex

The RNs mentioned the lack of recognition of the additional time required to respond to the complexities of ensuring patients' safety, under the care of the student, as well as a good learning experience for the student. This required the RNs to assess the NS's current capabilities before the student was allowed to provide any care to a patient. Determining the different levels of skill and knowledge of NSs was identified as a challenge for RNs, because the information from the different universities was not always readily available to them, and the NSs often did not know what their particular leaning needs were for the placement. The academic year of the NSs could not be assumed as a guide to the student's level of competence, because some Year Two/Three NSs were undertaking their very first clinical placement.

Each university had a different learning pathway:

[Students Scope of practice]... Yeah we do get sheets on that but we've run into problems with that before because we have students so regularly, you could have an RN Year 3 and then they're there for eight weeks and then you get eight new ones which might be XX and it's their first placement..... but it's very hard for the staff on the floor to keep track of where all the levels are at (FG1pg2)

Which is hard ... because there's so many universities, a lot of them are coming through as English as a second language as well and they're doing a different course entirely, and different year levels and different unis have different like some can't do IVs, some can (FG2 pg 2)

I just get them to watch me until I can clarify with their preceptor or their facilitator. But I've had a few that they don't know what they can do and there's so many different courses and year levels and stuff (FG2pg4)

2.2.1 Assessing different learning requirements

The RNs mentioned the complexity of assessing not only the different academic levels (knowledge and skills) but also the different levels of confidence of each NS allocated to them for the shift:

...more a direct supervision especially in their first week or so and medication is always done with supervision anyway ... and also we need to know where they're at with their studies, what they can do, what they can't do (FG2 pg1)

What level they are, if they're first, second, that's important as well (FG2pg1)

So having something available to jog our memories of what we are actually marking them on, all those myriad of skills we have to, it would be good to make sure that that is clear from the get-go (FG3pg5)

... they can give us paperwork, they can tell us, generally this is what I've been told to tell you, but it's very much a he said, she said, you hope they're telling you everything they need to tell you. Very rarely, I mean we can harp onto our students twenty times, At the start of every shift, please go to your nurse and tell them your objectives for the day before you even go to handover, ... (FG3pg3)

sometimes knowing different unis allow students to do different things, like the first year students, the second year students, and then also NALHN have different requirements for what students are and aren't allowed to do ...So if a student doesn't know what they're allowed to do, because yeah a catheter needed to go in, so those sorts of things, having that from the facilitator for the students when they come, even if each time they come they say, These are the four students, this is what they are able to do in this placement. To know that I think would help. (FG3pg4).

I don't mean to be disrespectful, but ... second year grads come into education, so they come onto the ward as a second year student with no practical experience so you need to ask them. ... don't assume anything, ask them (FG4pg1).

You have to gage their knowledge and their background because some of them are enrolled nurses that are doing their registered nursing and so sometimes they know mostly everything ... so I chat with them first before we start, What's your year, what do you know about nursing, what are you confident with, I tell them the basics, You have to be safe, you have to tell me what you know and what you don't know, you have to be honest, tell me if you feel like you don't know what you're going to do, and you have to know the basics of hand hygiene and the precautions and everything ... (FG4pg2)

Having written documentation was perceived to be useful:

Documented plans are great, for us to tick off along the way and say okay we've achieved that, what's the next step, not relying on memory, we've got something written that across the ward people can check (FG3pg4)

Without a clear indication or direction of the NS's learning and assessment requirements, more time was required by the RNs to make a preliminary assessment of the NS's current level of knowledge and skill. This required the nurses to undertake their own assessment of the NS's risk to provide safe patient care, the level of supervision and then the appropriate tasks to delegate to the NS for that shift. RNs had different ways of making this student risk assessment:

What year are you in and where have your other placements been (FG2pg12)

I tend to not trust my students until I've worked with them a bit or I've heard some feedback, and once I've developed an understanding of who that student is, their level of productivity, their level of understanding and demonstrated skill, based on that I'll start to engage them more with the leading role (FG3pg2)

Probably I'm doing more of the work and just testing them a bit more to see how they go, but then still throughout the shift those changes, so if I see from the start of the shift that they

actually know their stuff then I'll take that step back even if it's the first time working with them. (FG3pg2)

Their ability to communicate with the patients, like do they go in and have a chat to the patients or are they a stone faced wall as they walk into the room, their time management skills, their thinking out loud, I always encourage students to just tell me what they want to do and that way I can see, right well they've got a whole shift to plan for, they can go for it. (FG3pg2)

It's part of a risk assessment, what's safe and what's not, what's safe for them to do. You have to know their scope of practice as well, I think there needs to be education on the scope of practice of each year of students that come through (FG4pg1).

we've had a lot of students that have come from different areas, we had a student that had a degree in X, so at XXX they skipped the whole first year which is pretty much the foundation of anatomy and physiology and they're straight into a second year and if you go into an area like ours it is quite intense, for someone who hasn't had any health background [degrees]..... (FG4pg1)

Added to the level of complexity for the RNs in supporting the NSs were those NSs who were assessed as 'not safe' because they did not demonstrate the basic knowledge and skills or who were just not coping in the bustling, stressful ward environment. The RNs reported that this group of NSs required additional time, which the RNs perceived as not recognised. One group that RNs mentioned across all of the focus groups that were particularly time consuming and complex were those NSs whose primary language was not English.

The thing is to be more vigilant then because of the lot of the time yeah, they [international students] require more assistance than first year students (FG2pg1)

They [international students] don't even understand, they don't understand what we're trying to tell them sometimes, it takes longer to explain but sometimes you're better off just showing. But I don't think that RNs are prepared either, I think it would be nice if they went to the ward and then these students had an education on basic things like even show them how to use the pump, even though they're not meant to but it's a good idea to show them so they know what they're doing straight away. Like again, the charts, the observation charts, what to do. I think it would be nice if they had a background (FG4pg5)

Some are beautiful students, don't get me wrong, they are willing, you could really tell that they really wanted to do but their language, it does set them up to fail, put added pressure on our staff. We know we've got a responsibility to teach but you can't teach a language. (FG4pg10).

Also if they've come from another country and English is not their first language, people find that sometimes quite difficult because they tend to not understand the language very well so then we have to explain things in more minute detail over and over again and it can become very time consuming (FG6pg3).

2.2.2 Complexity of allocating students.

As well as the overall complexities, challenges and additional time required to consider each NS's learning needs, balanced with ensuring patient safety, there were a number of considerations

related to the allocation of NSs to RNs that were not perceived as recognised. The challenges of allocation impacted once more on the RN's workload and the time they had to ensure that appropriate care was given to their assigned patients. The allocation of NSs to RNs within wards/units had many variables that need to be considered including who will orientate NSs to the clinical environment, number of RNs available per shift, skill mix of staff, how their own staff are coping and the value of NSs on night duty in that particular ward/unit environment.

In some areas there are two (2) distinct roles related to student allocation. One role oversees the orientation of the NSs to the ward as well as writing-up the overall assessment of each of the NS's performance. This requires the RN to contact each of the RNs who worked with the NS to gauge the NS's level of competence. The other role is the direct clinical T&S of NSs by the RN who was assigned a NS for the shift. Each role had its own additional issues as indicated by this participant:

There's two kinds of allocations, like this nurse is going to write your report and then there's the shift by shift you're going to work with this person ... I didn't have enough time to do anything, I did it all at night when I got home and it was very frustrating to sit at home after a day's work and do a ... report (FG3pg7)

RNs identified that it was not always possible to allocate a NS to an RN due to staffing levels, patient mix and the different requirements of nursing skill mix for the different wards/units.

I think it depends on the person doing the allocation, they have to consider that, the patient load, the experience of the registered nurse (FG2pg10)

Continuity of the same RN and NS combination cannot be guaranteed.

Sometimes it's good to get different nurses because everyone is different, no offence some nurses are really good at clinical education compared to someone else (FG2pg11)

RNs also identified that it is not always possible to allocate NSs to the most experienced RNs or even to an RN:

That's why they are given to the seniors because having a student is actually harder because it slows them down, if you're a novice on the ward you're already trying to work out your workload yourself so having an additional responsibility of having to teach you're not, I mean teaching is good because it cements your knowledge but if your knowledge is still, if you're still working on it and it's still base it's a bit unfair to the student (FG4pg5)

[Allocation] ... there's eight of them (students), we have six nurses on the floor Those six nurses on the floor could vary from agency, casual staff that perhaps some of those staff may have never worked on our floor, they could be T PPPs, we often have two T PPPs out of that six (FG1pg5)

We only have two staff the majority of the time, so that would be a T PPP (FG5pg8)

And there are RN skills that would need to be supervised by an RN for that RN student but I mean ADLs, observations, that's not an RN only skill. Assessments, wound care, that's not an RN only skill, ENs do this all the time (FG3pg11)

And we don't have enough RNs to buddy the students up with RNs. I mean ENs can only have them around (FG5pg6)

Like the other day, ... everyone was relieving and we had numerous ENs that day and so I had to allocate a second year student to the EN, we had no choice (FG5pg6)

When we're in xxx we've only got three nurses on the floor so quite often, there were two students a few weeks back, one EN, two RNs so I had to have one and everyone sort of shares the load a little bit (FG6pg10)

You want them with RNs preferably over ENs because that's the role they're following. We're definitely 40% ENs on our floor so it means there's three staff really to pick from (FG6pg10)

Yes they [Casual and Agency staff] do sometimes because if you've got four students and you've got.. (FG4pg6)

You know for us having a casual come in to our ward who is not a regular on our ward and then hand them a student as well (FG5pg6)

And there was a phone call to say, this is what you've said you can take, do you have potential to take more, well no. I mean realistically we're a xx-bed ward, that's four on an early, three on an arvo, we can't take any more than four students (FG5pg5)

A few RNs mentioned that occasionally RNs were allocated more than one NS per shift:

Because we had like three staff and four students (FG5pg6)

Someone was also having two students with them (FG5pg6)

RNs discussed the importance of looking after each other when NSs were being allocated for a shift. This occurred when there were exceptionally heavy patient workloads or if an RN was feeling too stressed that day: This consideration was to benefit both the RN and the NS:

So yeah we try and be fair to the nurses because obviously if it's going to be a tough day for them we don't want to throw a student into the mix who's still just learning the ropes (FG3pg8)

I've had nurses say that to me, like I've allocated, not so the student would hear it of course, but they say, I just can't do it today (FG2pg10)

And you want the student to have a good experience, you don't give them a nurse that's already in a grumpy mood or having too much happen and they're just not in the right frame to have a student (FG2pg11)

Especially at the start, you're quite new to the practice and having a student it can be quite hectic and stressful (FG6pg2)

2.2.3 Nursing students allocated to night shifts

There was discussion across all focus groups about the value of NSs being allocated to night duty. RNs indicated that some universities expected that this would happen while others did not. The relevance of the type of ward/unit was highlighted, as this affected the number and skill mix of staff on night duty. All of these issues needed to be considered in the allocation of NSs onto nights, as these RNs explained:

I think it depends on the person doing the allocation, they have to consider that, the patient load, the experience of the registered nurse (FG2pg10)

We do late shifts, we do early and lates but not night shift, we don't have students on night shift (FG3pg8)

Some of the RNs identified that there were benefits for NSs to be allocated to night shifts:

(Night shift) we encourage them to do some nights because again it's a good chance to see the routine and I think get over the phobia about night shift because some students finish up and they've never done them (FG1pg7)

Just getting back to the night shift you probably have more time as well to spend with your student. There's a few more MET calls than what you realise during the night and that's a really good learning opportunity for a student and it's not as if there's a ton of people, it's a small group of people and they probably get to see a lot more. There are lot of benefits for a student doing night shift I reckon (FG6pg11)

There were however a few RNs who shared their concerns about the busyness of night duty and the lack of potential learning opportunities.

... I think it's an unfair responsibility on the staff ... because nights are hectic, they're busy, there is no lull anymore, it's go, go, go (FG4pg7)

... it would benefit us, we'd love to have a student on a 10-hour night duty because it would be great, it's at extra set of hands, but in terms of would it benefit them, they wouldn't learn (FG5pg7)

There was consensus in the discussion that if NSs were to do night duty then only third years should be allocated. This was because they were more experienced, would not need as much supervision and it was a good experience for them to understand the full picture of nursing in acute care before they registered:

You wouldn't put first and second years on nights (FG4pg7)

Third years are different, they're almost finished I agree but not seconds (FG4pg7)

3. Not as prepared as we would like.

This theme explored how prepared RN's perceived they were to T&S NSs.

3.1 More preparation through training would be useful

3.1.1 The current preceptor course

A few of the RNs had undertaken a preceptor course in the past, which they found very useful:

I know that most of us have done preceptorship courses and I found that very helpful (FG4pg2)

I think some of [Preceptor Course] it is very good but there are parts that I don't quite understand what they're trying to achieve with it (FG6pg2)

I think the preceptor courses are good. I think I did that coming straight out of my TPPP and that was good, and now you sort of think about their learning, but I'd really like to do that, more like a refresher that's just like three hours every sort of two years because you get this big one day or two days and that's great (FG2pg6)

3.1.2 Teaching strategies and report writing assistance

RNs recognised that some RNs were perhaps not as prepared for T&S NSs as they would like to have been, given a much more complex education system:

... experience in their placements, it can make or break them basically. And I do think a lot of people that are precepting the students aren't equipped or aren't taught, too much is expected of some of them with regard to looking after students (FG3pg1)

But I do think even a half a day a year or full every two years, a day every two years or something just to update, to have a chat, see what's working for other preceptors, getting an idea of what works for them and how they handle difficult students or things like that, you can learn from each other in just a bit of a workshop type environment (FG3pg11)

But I think it would be good to touch base again and get an update on that sort of thing (FG3pg10)

I feel like yes it could be drilled into more people that you do have a responsibility to educate because as we said it depends on the personality, we're not all born teachers (FG3pg10)

A regular update may assist in building RNs' confidence with T&S NSs as these RNs indicated:

Some just don't have the confidence, they might have the skills but they absolutely can lack the confidence to deal with students and don't really want to take that active education role just because maybe they don't trust themselves, their knowledge to pass on or other reasons (FG3pg1)

And depends on you as well how confident you are to actually educate, give information and not just information but correct information (FG2pg4)

Many of the RNs were very experienced but had not had any formal training on teaching strategies:

How to actively engage and create meaningful learning opportunities as well. There's different arms to being an effective teacher (FG2pg5)

Guidance in writing student assessment reports was identified as a useful topic to include in any training:

And maybe just more education I think on how to write their reports (FG2pg15)

And I think also too when it comes to writing constructive criticism, sometimes even if you just had little... (FG2pg6)

3.1.3 Having difficult conversations with NSs

Participants suggested that some RNs may not be prepared to have critical conversations with NSs about the NS's performance and competence, because it was a hard and uncomfortable activity to do:

I think they need to provide us some education on how we can provide constructive feedback (FG2pg3)

And it's really hard to find that balance of what positive feedback is as opposed to negative feedback (FG2pg3)

But then you do feel uncomfortable giving them [students] negative feedback (FG2pg3)

(prepared) Yeah I've probably had too much of it [difficult conversation or feedback], but there are other staff that feel very uncomfortable about that and they then will come to the more senior staff to deal with that (FG1pg2)

There are important consequences for the future of patient safety if an RN does not feel prepared to address a NS' poor performance, as highlighted by these RNs:

... We have seen students come through at year three ... and we think they're unsafe, how did they get this far, and that's scary because other nurses haven't cared enough through the rest of their placements, they've just thrown their hands in the air ... (FG3pg5)

you're going?, Are there obstacles to your learning?, and this sort of thing, we just don't have the time to sit with them and before you know it they're at the end of their placement and you're writing a report, but you need to get feedback from other people because we all work a lot of different shifts, it's just not lates and earlies in our area, we've got like seven or eight different shifts so we can't always give the student to people or one person to work with, they work with a lot of people which isn't a bad thing either because they learn from a lot of different people's experiences. But getting feedback from other people is sometimes difficult as well, you say, How do you find so and so is going? and their answer is, Oh yeah, they're alright. So getting that feedback from your fellow peers is often difficult as well (FG3pg3)

And that's where they need to up the initiative to go and find someone, ... I'm going to pick three people and say to them, I want you three to do my form at the end. It's much easier for us to do it between us than it is as one person to go, I've met you twice. But for me you can be completely fine but for somebody else they could've seen issues that hopefully would've been addressed FG6pg5)

And sometimes it's really hard like we've had some great students but we've had some pretty crappy ones as well .. and they don't speak English very well and you get to the placement and you know that they've paid so much money for the course and you think how can I sign off on you being a safe practitioner and we don't have the training to say whether that's okay in where she is in her education, like is she going to go for another three more placements, so we don't have that sort of training or insight (FG6pg5)

Overall the view by the RNs was that there is an assumption that all RNs had teaching skills and could clinically supervise NSs. This assumption was perceived as incorrect for all RNs and that more preparation would be welcomed.

4. There is not enough support for RNs in their role of teaching and supervision by the health and education system.

This major theme presents the perceptions of the RNs related to how unsupported they feel in undertaking the T&S of NSs. Though there was support from Nurse Unit Managers, the RNs perceived there was very little support from the health system, education provider, and in particular some CFs, and at times from the NSs themselves.

4.1 More support from the health service management

The main areas the RNs highlighted where they perceived there was the lack of support from within the health service was related to having sufficient time locked into their patient allocation to teach, provide feedback and write the reports for the NSs:

To sit with that student and go through things which as I said you don't have it [time] sometimes and if the system had given you an extra member, staff member, you'd have time to go off and do that (FG2pg5)

Like the medical staff that you just have one hour a week that is protected time between an RN and a student or something like that. (FG2pg5)

and the dissemination of timely information about NSs.

But it doesn't sometimes tend to filter down but I did have a suggestion ... to actually put them [information] on the intranet into university and semester and year and update them every year. ... because everyone can actually access the intranet, doesn't matter early, late, night duty, and you don't have to rely on your NUM to be around to filter that information through. ... I rock on Monday morning with six students in toe and not surprising you'll go, I didn't know I was getting any students because the information hasn't been passed on for whatever reason (FG6pg7).

4.2 More support from the Universities Schools of Nursing

The RNs perceived that university academic staff did not appreciate the additional stress that was placed on RNs, due to different university expectations for reporting on the assessment of NSs:

... more streamlined, more consistency across the universities (FG2pg15)

And reports, some streamlining (FG3pg8)

Once upon a time the students did everything sort of the same. Now each facility does it different so they need to incorporate that when they're teaching the facilitation course so that we actually understand what their paperwork and objective is. We've had the students that like to try and pull the wool over your eyes about their paperwork and what is actually required, they almost want to dictate what they want you to say, that sort of thing. But if we actually knew the information better ... (FG6pg6).

It [information] needs to be uniform across the units; this is what needs to be filled out, this is what we expect from the RN who is assessing you. (FG6pg7)

4.2.1 Improved communication on the expectations of the NS's level of learning and requirements

The RNs wanted to receive more clear information about the expectations of a NS when they were on clinical placement:

And even like what they're [students] trying to achieve, like what their clinical goals are meant to be by the universities and we don't know that unless they tell us that (FG2pg4)

I suppose what our expectations are of them before they come out, what most RNs would expect our student to be when they're on placement (FG2pg14)

Maybe a folder would be good like we're saying, like universities, their scope for each year, maybe some ideas and tips on how to fill out the paperwork or each thing that they're asking for like some examples because sometimes you read this and you think I don't even know what that means myself (FG2pg15)

... there's no standard for us to practise by to make sure that we're giving a good educational experience (FG3pg1)

Sometimes it can vary because we get the issue with students not being able to give injections. I think if we get XX students they can but everyone else can't until they've done it in uni which seems a bit pointless, you know they're coming to learn about the everyday role of an RN and they can't give injections which you know we can give 10, 15 a day some days so really that needs addressing that they should do that before they come up to the ward to be trained to give insulin or any sort of injection (FG5pg1)

Just the basics, we're not asking for every single thing under the sun, a good basis of what we can expect them to come out with on that first day on the floor. We don't expect them to put an IV cannula in or take blood on the first day, we expect them to be competent at doing basic assessment skills. So it would be better than nothing (FG6pg8)

University staff provided different messages to the NSs about shift requirements for the clinical placement, which the RNs may not necessarily agree with, such as undertaking a full shift:

Where discrepancies lie is that some people say that it is alright whereas others are like, if you're here you're here for the full shift, you have to be from 7 [am] to 3:30 [pm], you see the shift from the start and see it all the way through (FG6pg13)

There were a number of suggestions to improve communication between the health facility and the university:

What might be nice is the scope of practice attached to their NCAS form and they discuss that with you when they came out and that was there so you could actually look at that when you're discussing objectives (FG6pg8)

Something documented by the universities with what level they're at and their scope of what they can and can't do (FG3pg4)

Even a folder in our unit that's got all the different universities, Year 1, Year 2, Year 3, then we can just refer back to it. (FG3pg4)

... from the get-go is, we can start out, have a four week placement ahead of us and we have got no idea how exactly we're marking them and therefore we as nurses don't know to push students to meet those goals, but it's not just that it's just that written form, that feedback

form, we don't get given that until a couple of weeks into placement and we're giving no instruction most of the time of how to actually fill it out (FG3pg4)

They come to the ward and I say, do you know what sort of ward this is? No, so they're not given any information of where they're going (FG4pg5)

the uni to give a print out and keep that on the noticeboard what their aim is for the first year students, what we're supposed to do and what they can do. For the level 2, year 2s as well and the year 3s whoever is doing their roster they normally print out and put on the noticeboard so we can help with them (FG5pg1)

Just the information involved of how they set up their facilitation (FG6pg7)

Importantly the RNs perceived that there appeared to be a discordance between the responsibility and expectation by the university staff that they will T&S NS, yet NS reported that they cannot undertake a clinical procedure, when an opportunity arises, if they had not done the topic or skill at the university first. This approach was reported as potentially undermining the RNs' teaching role and reduced some learning activities for NSs as this RN states:

Because of the changes in placements like the timings of them they can actually be having a placement before they've learnt the clinical skills of their second year. So for instance, IV antibiotics preparation, I would normally jump in with students and say, Here, this is how we draw it up, but in some cases we're told by students, We haven't done that in clinical, are we allowed to, like in uni, are we allowed to actually on the floor do it, I don't think we are. And that's confusing to me because it's like well why aren't we trying to engage you, it's like saying, well we're not equipped to teach you the practical skills because you haven't done it at uni first to learn the basics then what's our point of being here if there's no trust between the uni and the hospital to say that we as registered nurses aren't equipped to teach a student how to put together an IV antibiotic infusion, that's tricky to overcome because again we've got these, sometimes, these lists saying second years can do these skills but then on the ground of that placement they say, No, we're actually not because we haven't learnt it in uni yet. So that's a bit confusing (FG3pg4)

4.3 More support from CF

The role of the CF was perceived by RNs as key to supporting them in their T&S role. In particular, communicating regularly and directly with the RNs about the NSs' learning needs and expectations was of significant importance to the RNs as evidenced from the number of comments made.

4.3.1 More communication and feedback required

Our nurses just think they [clinical facilitators] should be checking in asking the nurses how they're [students] going, how they're progressing, if there are problems what are the problems, how can they help support that ..(FG1pg4).

... it would be good if the student goes to the facilitator and says, this is not happening, it would be good if they come back to you and you could discuss it because you could say, no this is happening, , so they've got the two-way conversation, it's not just all, she's not doing this, she's not doing that (FG2pg8).

Or we could have like a three-way communication, like a meeting with a facilitator, the nurse and the student and then we can all talk and the student might feel more comfortable talking if they've got the facilitator there(FG2pg8)

We never see them [clinical facilitators], they only come and say is this such and such student here and then they take them off but they don't really communicate with us or come back to give us any feedback (FG2pg7).

A bit of communication about the progress of the students and whether they're actually sort of living up to their expectations and coping (FG2pg8)

it depends on your skill set what you're teaching them that shift, then if you don't have any guide to say we like our students to have a three patient load by the end of this week, we like to make sure they're at least aware of how to fully prepare for this procedure, how to look at the patient post this procedure, without that kind of, like there's no baseline and trend monitoring, there's no way of saying well no they can't met that so technically our placement objective for you were to fail. Basically having a standard for what we want our students to achieve (FG3pg9)

Communicating directly with us is one thing, I get sick of communicating to them through the students and vice versa, I would rather have that one on one chat of, These are our expectations for our students, we need you help them meet these in these following ways (FG3pg4)

with uni facilitators that have been quite defensive as well when we've approached them about issues with students that we feel are valid and they seem to think aren't, with regard to we think they should be more on the floor dealing with patients and we've had some facilitators that have said to us, No it's okay for them to sit on the computer and to look stuff up during the work hours, so that sort of has defeated the practical or clinical placement, and then they're quite strong, the facilitator, with that, No, I've told them they are allowed to do that, and we're saying to the student, Well I think it's more important at this stage for you to be out there reacting or interacting with the patients and learning some practical clinical skills, the computer you can do at home, but the facilitator will say, No, they can do that in their work placement. So we had a bit of contradicting things from different facilitators from different unis (FG3pg3)

There was one time where one of the students actually came with a list of scope of practice, he brought it with him ... But that would help because their facilitators come and introduce them but the facilitators don't actually give you any background of what those students have done prior to coming. I only glean that when I do the orientation day with them and then I asked them, Where have you worked, what experience have you got prior to this, but until that point we don't know (FG4pg2)

You don't get any information from the facilitators about what education they give the students and all of a sudden they all turn up and we're taking all these students ... the facilitators don't give you any of that information, all of our information comes from the students and then because it comes from them you get it last minute.(FG4pg12)

They [clinical facilitators] should come out with their students and explain what the expectation is, what they hope to achieve, dos and don'ts (FG5pg9)

I always have issues contacting the facilitator because they don't come on a daily basis, they don't come every day, so if I'm working with a student today and I've got a couple of days off I need to advise someone, to the facilitator, I can always tell the NUM but their facilitator is hard to contact, we don't see them (FG5pg4)

They [clinical facilitator] go to the NUM ... but why would you go to the person who doesn't work with them [student], you need to go to the floor staff, that's who you need to talk to ... (FG5pg4)

We had an issue with a student who wasn't up to scratch we spoke to the facilitator who finally came in for the final assessment and said we're not happy, in all the paperwork for the student we wrote quite clearly that we weren't happy that it was not achieved. And the facilitator explained to the student, we told the student as well. ...I don't know what the response was because it was on the last day and as soon as the meeting was over the student left (FG5pg4)

4.3.2 Having a regular presence

The RNs wanted CFs to have a regular presence on the wards/units and to be more readily available.

I'd expect them (clinical facilitators) to be available, my experiences have been very different over many years, but I think they should just be available, they should be checking in on them; they should even actually spend some time with them on the floor (FG1pg4)

We had an issue with one of the students and the facilitator came on a daily basis and asked us how the student, that particular person was doing, but that is the only time I have seen that she is coming on a regular basis and discussing(FG5pg4)

Contact the facilitators. We will work with them and I try to identify early, sometimes it's nerves and they take a bit to settle but it's pretty clear if someone isn't where they need to be and get the facilitator as soon as possible. I don't know the role of the facilitator but at the end of the day they need to come and work with them FG5pg4)

I find that the facilitators will help you a little, but it depends on the university and how much that facilitator has been allocated some time (FG1pg2)

4.3.3 Timing of NS interactions

There was discussion in the focus groups about the timing of CFs in accessing NSs, which was perceived not to be appropriate or supportive of the RNs' teaching role:

... they come and they go off with their student, off the ward, and they have their meeting, but they never come and see me (FG5pg4)

... their facilitator only sees them once a week and they always tend to come at lunchtime or when they're starting a shift, Oh we've got to go, so they've missed a vital part of the handover of patients ... then they [students] come back, that's the vital time, you're doing your obs, you're checking the fluid balances, they're skills they're missing out on. And I'm not saying it's the facilitator's fault, I know they have to go through different hospitals, different wards, but I think there's got to be a balance (FG4pg4)

That's often a common complaint that they're taken at inopportune times (FG6pg4).

Especially when they get a patient load, when they're trying to get a sense of what a day's work is and they get the patient load and then halfway through a shift, I've got to go and see my facilitator (FG6pg4)

4.4 More support from some NSs

Some of the NSs who came onto clinical placement were not organised. This appeared to be a common experience reported by the RNs.

4.4.1 Not organised for experience

This included NSs not knowing the focus of their placement or learning activities as these RNs reported:

The students don't know their scope of practice, which they should (FG5pg1)

They know, they get told well before they come to our shift, we just reiterate it but they still..., so it's the students responsibility too (FG.4pg8)

The RNs mentioned the importance of NSs taking responsibility to organise themselves around the shift times. Those NSs who did not turn up on time disrupted the RNs' workflow and required extra time to be briefed about the patients' requirements as these RNs highlighted:

I think the other thing is asking the student before shift work if they are travelling by bus, because a lot of you would've experienced that the bus comes in at 7:20am, that's not acceptable, they need to be here at 7 [o'clock] because you shouldn't have to repeat your handover to a student, I mean once they're a qualified nurse it's not going to be tolerated if you rock up after the shift has started (FG 6pg 11)

We had a student we actually failed because she kept disappearing at 2 o'clock because she had a shift at 3 o'clock. So we sat down with her, Look you can't leave early, if you've got to be somewhere else you need to tell them you can't be there until 4 [o'clock]. ... For the rest of that placement what she would do she would skip off early and then get someone who hasn't been supervising to sign her timesheet on a different day, because they'd seen them but they hadn't seen they left at 2 o'clock. ... (FG5pg11)

RNs mentioned their frustration at NSs not being proactive with their assessments and finalising their reports on time and before the end of the shift:

I find that difficult, the student assessment, it could be a lot easier, but I find that the students ask at the last minute, so it's like, I'm sorry I'm not doing that, even though I've worked with you, but you've come to me at the end of your time and we're leaving in fifteen minutes and I've still got bells going and I've a discharge and an admission come. You need to fill it out from day dot when you start (FG5pg5)

And then their evaluation thing you fill in, it's totally different and they change it and it's like this is not what I've done for.., or they give it to you at the end of your shift and perhaps we should have time at the beginning to do their goals for the oncoming shift and then if they need this paperwork done and we can allocate a time to do it on our shift (FG2pg4)

As NSs may not be allocated to the same RN for every shift the NSs must have their forms signed by the RN during that shift, and not leave it to the end of the placement as this RN mentions:

Because often they'll say that the RN that they work with at the beginning of their placement they never see again, and even at the beginning of the week you might not see them and so they'll say, No I don't want that form, I've got three days off, don't give it to me, give it to somebody else. So then they wait and then they look for someone with a kind face (FG6pg5)

The NSs who came organised and took the initiative to keep their assessments up to date were very much appreciated:

... it's also about them [students] taking a bit of responsibility and getting them [books] checked off through 4 4 their weeks there but often they don't do that, they might leave it to the last minute, not always but there are challenges with that. I've had six books put on my desk when they've got ten minutes to go and the books are empty (FG1pg4)

Some of the students that we've had will say, I've got this to be marked off, at the beginning of the shift. Can you assess me on this sometime during the shift, where others will be like, I need this signed. (FG4pg8)

At the start of the week, I have to have this filled out by the end of the week, can you watch me (FG6pg5)

The recognition of the RNs already busy workload was perceived to be unsupported by those NSs who were not proactive in keeping their documents up to date and to discuss their assessment requirements with the RN at the start of the shift.

4.4.2 NSs must be willing participants

Those NSs who demonstrated a positive attitude towards their placement were perceived to be supportive of the RNs in their T&S role. This included NSs undertaking a range of basic activities on the ward/unit:

I mean if you see a dirty linen trolley, empty it, don't walk past it, talk to a patient (FG5pg14)

They need to be proactive and they need a bit of initiative as well (FG3pg3)

..., nothing frustrates me more when everybody is running and there's a student sitting in the nurses' station Googling. (FG5pg14)

and making the most of learning opportunities:

... They need to be proactive, a team worker, they need to be putting themselves out there and their skills, if they're not good at the start they need to be improving throughout the placement, they need to be actively their best selves. (FG3pg6)

What you put into them is what you get out really, but it also depends on what they [students] want to learn, they have to be a willing participant (FG1pg1)

But it's also on the students as to what they want to learn and what they want to get out of that placement coming there. Like in our ward we have so much we could teach them if

they're willing to learn, you're not going to want to go around and teach someone as much as they can if they don't want to learn kind of thing (FG\$pg9)

It's their responsibility not ours, their learning is their responsibility and they're only going to get out of that placement what they put in basically (FG3pg9)

I think they [students] need to, to have a better understanding of what their, can do, I feel like they come, and yes part of it is the fact that they feel scared to move but another part of it is something that they're in a supervisory role they think that they literally don't do anything, they just watch, and you ask them to do things, I have on a couple of occasions and they go, No I'm only here to supervise, I'm not here to do your work for you, and I'm like, That's fine, if you don't want to do it that's fine I'll do it but I've done it lots of times. So sometimes I don't think that they themselves even understand what supervised means when they come out onto the floor (FG6pg14)

NSs play an important role in supporting the RNs in their T&S role by being proactive in organising their time for the shift, getting their assessments completed and recorded within the shift, and having a positive attitude to their learning. Helping out with a range of activities on the ward, such as emptying linen bags, talking to patients, rather than sitting at a desk behind the computer will make them feel more part of the team and demonstrate a willingness to learn.

Summary

This section has provided the findings from the six (6) focus groups. The positive message is that RNs do recognise their role in clinical T&S and believe that they have an investment in the future of the profession. However, they do not believe that the impact on them of the continuous number and varied preparedness of NSs was recognised by all components of the system. In particular continually having to balance the care and safety of patients with trying to provide the best learning experiences for the NSs. The CFs are an important link to the higher education system, but their presence and support was generally felt to be lacking by many of the RN participants. In particular, the RNs indicated that the CFs needed to have a greater role with those NSs who were not coping in the clinical placement environment. Time was the biggest issue for the RNs to undertake assessments and write reports for NSs. The complexity of the different university systems did not help in this process. Some additional educational/ training preparation on T&S to undertake the role was thought to be useful, especially for RNs new to this role.

Discussion

This study used a sequential mixed methods approach integrating both survey and focus group findings to answer the question: How well recognised, prepared, and supported do RNs perceive they are to T&S undergraduate NSs in the practice environment? This study additionally aimed to identify any potential barriers for RNs to achieve their responsibilities for T&S undergraduate NSs as well as recommendations. The results of this study affirm that RNs perceive their role in T&S NSs to be important, but has become an increasingly more complex, demanding and time-consuming part of their role.

This study provided support for the notion that the participating RNs clearly understood T&S NSs to be an integral part of their role. Indeed a number of RNs cited the Nurses Code of Conduct (NMBA, 2018) in the discussion of their responsibilities to have a teaching role. The RNs in this study voiced the importance of investing in the future nursing workforce to enable practice standards and the public's confidence to be maintained in the quality of the nursing profession. The highest scoring question in the survey was that the RNs believed that it is part of their role (4/5 mean score). Many RNs through the focus groups reported enjoying their role in shaping the next generation of nurses and considered their T&S of NSs as a valuable contribution to the profession.

Although RNs recognised their role in the T&S of NSs, this study has identified a number of issues that were of a concern to RNs especially with regards to the effect this might have on the NSs' learning. In particular this study has highlighted a disconnect between the universities, registered training organisations, nursing schools, CFs, NSs, the workplace and the RNs who are supervising them. Disconnection across these five groups has the most impact on the RNs everyday ability to meet the demands of their primary role in providing safe patient care as well as the quality of the NS's learning. The Australian Nursing and Midwifery Accreditation Council (ANMAC) Standard (2012 8.1) supports a cohesive approach between the education sector and the workplace. Standard 8.1 states that providers demonstrate "Constructive relationships and clear contractual arrangements with all health providers where students gain their workplace experience and processes to ensure these are regularly evaluated and updated".

The system may appear from a distance to be working, however as the study RNs point out, with the constant wave of increasing number of NSs and workplace expectations the system has the potential to fail to deliver on the required quality of future RNs and on the wellbeing of the current RNs. It could be argued that the graduate transition year is already an additional year that has been implemented by health services, as a 'work-around' because the education system had not been able to deliver on providing RNs who are able to immediately meet the workplace requirements.

These issues will be explored under the headings:

- The requirements and impact on RNs to T&S NSs is not sufficiently recognised;
- More support is required to enable RNs to T&S NSs; and
- Some specific preparation would be useful to be better able to T&S NSs'.

The requirements and impact on RNs to teach and supervise NSs is not sufficiently recognised

This section examines the requirements and impact on RNs who T&S undergraduate NSs.

The different education providers academic/education personnel do not appear to have recognised that they have different approaches and expectations of NSs' workplace experience and assessment, which has become increasingly complex for the RNs to navigate and implement. As the findings suggest each university, as well as vocational education programs for enrolled nurses, have different approaches to vocational, undergraduate and preregistration courses, including when NSs commence clinical placement and what the NSs across different year levels can and cannot do in relation to their scope of practice. It is noted that courses can vary in length depending on the academic structures established by the education providers. The Bachelor of Nursing course consists of three years of study for example, while some pre-registration courses can be completed in two years. Recognition of prior learning can also reduce the NS's time. Some universities also allow NSs to undertake a course part-time. This mixture of programs highlights why the participant RNs had trouble keeping track of the NSs' varying skill and knowledge level and indicated that NSs must, as part of their preparation for clinical placements, take responsibility to articulate their current scope of practice and learning needs as the name of the course may not mean anything to the RNs.

The RNs also mentioned the variation in documentation provided by the education providers, in particular the forms used for the assessment of NSs. The variation in assessment forms appears to go unrecognised and when coupled with the different assessment approaches, adds to the complexity of each NS's assessment undertaken by the RN. The ANMAC Accreditation Standards (2012, 5.12) state that there should be "Collaboration between students, health service providers (where relevant) and academics in selecting and implementing assessment methods". Given the variation of approaches it is relevant to include RNs who supervise and train NSs to be included in any selection of assessment forms as well as for consistency of assessment forms across the different education providers. Training by education providers on how to implement the forms and the types of assessment would be appropriate given the RNs' responsibility to assess NSs.

RNs in this study reported a perceived lack of recognition regarding the extent to which they are required to regularly have NSs allocated to them within the work environment, which can be up to 50 weeks per year across most shifts; the increased complexity and acuity of patient care and the limited amount of time allocated within their shift to properly meet the learning and assessment needs of the NSs. The lack of time was a recurring issue across both data sets. Having available time for NSs, in the survey data, was the lowest of all the scores with a Mean of 2.6/5. As identified by Charleston and Happell (2005) the absence of protected time for preceptors and NSs to meet hindered the ability to accomplish connectedness and guarantee a quality experience. Though there is professional development-time each day between the early and late shift that can be used by RNs within the shift to spend time with the NSs going over the day's assessments, this time may often be lost to them, because they are still providing patient care and completing their morning tasks. Having a NS may slow down the normal pace of the day's work. Some RNs indicated

that they end up working later when they have a NS to ensure that all their responsibilities have been met. Further the RN then loses the opportunity to engage in self-directed professional development as they are using that time to fulfil the requirements of the NSs. In addition to the sheer number of NSs for which RNs are responsible, there is the additional complexity of great variability of the level of NSs' abilities and preparedness for the placement. RNs perceived there to be vast differences between NSs' level of preparation for placement, and many suggested that more guidance from the education providers was needed in clarifying NSs learning needs and objectives.

There was evidence from study RNs that they consistently balanced supporting NSs' learning while maintaining patients' care and safety. The extent of the balancing act associated with encouraging independence and development of the NS while also carefully controlling and managing risks to patients were noted as a particularly difficult balancing act and was not recognised by the different personnel across the system. This is further supported by the survey where the participants indicated that they are not equipped to balance risks to patients against the need for independent learning by NSs (3.8/5 mean). This experience was supported by Casey and Clark (2011) whose review of RN teaching responsibilities further suggested that RNs must manage carefully the balance between providing support, guidance and the requirement to make objective unbiased assessment decisions of the NSs' progress with the needs and safety of the patients assigned to their care. This was more pronounced in instances where NSs' clinical skills and/or confidence were lacking; this involved more of the RN's time supervising the NS. Casey and Clarke (2011) and Duffy (2003) note the significant impact of the 'failing NS' on the RNs' workload. Due to this complex balancing act RNs suggested that NSs should be carefully triaged by CFs on how organised and ready they are before their clinical placement. In particular, it was consistently identified that some NSs did not have sufficient English language communication skills required to undertake the clinical placement safely. This finding was consistent with a study by Newton, Pront and Giles (2018) who noted the need for increased support for supervising RNs as well as training regarding linguistic and cultural issues.

RNs are responsible for managing the balance between safe patient care and NSs' learning and teaching. Given the many and varied courses, scopes of practice and NSs previous clinical experience (which may not have been in an acute care setting) they now feel obliged to undertake their own risk assessment of how much T&S each NS they are allocated would be required to maintain that balance. This creates extra work for RNs who are trying to assess the risk to the patients and NSs' learning needs. Forcing the RN to make a choice between delivering quality patient care and T&S of NSs may result in neither of these activities being delivered well.

The RNs were equally concerned about the lack of recognition regarding the difficult task of allocating NSs to RNs. In particular the range of different types of wards and patient care needs, and the varying level of experience of RNs working on these wards introduced a level of complexity with regards to who is allocated NSs. In turn, some reported concerns about the pressure this placed on those nurses (particularly new graduates), as well as on the impact on the NSs' learning. A recognition of the complexity of the RNs' T&S role remains central to preparing and supporting RNs in supervising nursing NSs (Brammer, 2006). At times wards may have more enrolled nurses and new graduate RNs than experienced RNs,

which causes a dilemma for the allocation of the NSs depending on their previous clinical placement experience. In cases such as these, RNs are again required to balance managing both the expectation that they will meet the demands of the shift and the learning needs of the NSs. It was noted that an experienced 3rd year NS would be an advantage on these occasions, unless they still required intensive support and supervision.

The culmination of the factors outlined above with regards to recognition to the complexity of the role should be clarified as to what recognition meant to the RNs. Specifically, the RNs provided some insight into their own understanding of recognition and it is not praise. Rather, RNs' responses suggested that recognition in this context would consist of practical changes that allowed for a more balanced use of time between T&S and patient care. What RNs repeatedly indicated was that they wanted the recognition that T&S NSs is a significant and time consuming aspect of part of their existing day to day role. In addition, this role needed to be balanced with patient care responsibilities. As such, that time associated with T&S NSs needs to be recognised by building this time into their patient allocation. Duffy (2003) identified that staff shortages and increased work pressure do not enable RNs to provide the necessary time to properly assess NSs abilities to the point that this lack of time contributed to 'failures to fail' with the most serious consequence for the quality of work readiness of future RNs, who have not met the required minimum standards and will put patients who are under their care at risk. This disconnection and lack of recognition does not protect the interests of the public or the profession.

More support is required to enable RNs' to teach and supervise NSs.

This section examines the disconnect between the components that make up the system to deliver good learning outcomes for NSs on clinical placement. The system is perceived to have not enabled the necessary support for the RNs at the clinical interface who have a critical role in preparing and maintaining the future nursing workforce. Broadbent et al (2014) concluded that while most nurses had a positive experience preceptoring, more assistance in the form of resource and communication was required from education providers and employers.

The major area the RNs commented on in relation to a perception of not being supported was from some CFs. The survey response supported the perception that the participants do not feel CFs sufficiently recognised the RN role in T&S NSs with the lowest scoring question (mean 3.5/5). There are different models used by the education sector with health services for the use of CFs. Some health services are funded to employ the CFs, which enabled the CF to have direct contact with patients when teaching NSs. In the other model the university employs and allocates CFs to health services. The health services where this study was undertaken used the latter model. The RNs noted that the current employment arrangements of CFs did not allow the CFs to have a regular presence on the wards to provide direct teaching with patients; further, they may cover several hospitals and have a large number of NSs to coordinate. However, their absence was missed and perceived as not being as supportive of the RNs as the role could be. Where the RNs indicated they wanted more support from CFs was first in the assessment of the NSs' readiness and preparation to take responsibility for their learning and assessments before they actually attend clinical placement. Secondly, managing failing NSs more closely, which included more

frequent supervision by CFs, sharing of information about progress, assistance with providing constructive feedback to the NS and writing their assessment report. The RNs indicated that they would prefer a swift removal of the NS from the ward/unit rather than put the responsibility back on the RN to continue providing direct supervision 'just a bit longer'. The third point was improved timing of NSs meetings with CFs so that it did not occur during the shift 'hand-over time' because this meant that if the NS was absent the RN had to repeat the information from the handover and this was time they did not have. The RNs also indicated that support would mean having direct communication between the supervising RN, CF and the NS, rather than via the NS or the Nurse Unit Manager. Nurse Unit Managers are often involved in managing NS issues when they arise within their unit/ward, though they do not undertake the direct supervision of the NSs. It was also suggested that the term CF may not reflect the role of this position where they are education provider employed, because they do not provide direct clinical facilitation. Instead they liaise between the NSs, health service on behalf of the education provider.

The RNs indicated that NSs could be more supportive of the RNs to whom they will be assigned to by being very prepared. The RNs in this study considered that NSs who came well organised with their assessment paper work and prepared for their clinical placement with an attitude that they will participate (a 'can do.....' attitude) and make the most of the learning experience were welcomed, as their contribution to the care of patients was considered to add value to the RNs shift and exhibited a positive approach to their learning. However the NSs who were not organised for the work experience, did not know what their learning objectives and assessment were for that placement or their current scope of practice and portrayed a lack of investment in their own learning increased the time required for RNs to support them. This was exacerbated by NSs who for many reasons were not able to cope with the fast pace of the work environment and needed extra support to reduce their anxiety. This impacted on the RNs' time to meet their own shift objectives and to get off duty on time.

The RNs expressed concern more for the NS than for themselves recognising that going onto the wards can be very confronting especially for the first time. NSs who are capable were seen as an asset, but where there were learning deficits or additional needs then more support was needed.

An interesting point was made by a number of RNs that their ward/unit may provide the NSs with an excellent hands on learning opportunity, but if the NS had not undertaken that particular activity within their program the NS would indicate that they were 'not allowed to do this as we have not been taught it yet'. This caused some confusion for the RN in that they are required to T&S NSs to enable a valuable learning experience, so if the task is one that the RN is clearly more than competent at, why are they not recognised for their ability to teach and directly supervise the NS to undertake this? They saw this as a great loss to the NS's clinical experience. However to ensure that the teaching and learning experience was grounded in current evidence based practice, liaison with the relevant CF would be appropriate.

Some specific preparation would be useful to be better able to teach and supervise NSs.

Though there were some study RNs who were very experienced at undertaking T&S of NSs it was recognised that those new to this role may find it more challenging. The ANMAC Accreditation Standards 8.6 (2012) stated "Academics, nurse clinicians and other health professionals engaged in supervising and supporting NSs during workplace experiences are adequately prepared for this role and seek to incorporate contemporary and evidence-based Australian and international perspectives on nursing practice". Therefore the RNs suggested that it might be beneficial to have some more opportunities to prepare RNs for the T&S role. This also included highlighting to RNs, which may be challenging for some, that they need to be up to date with clinical evidence based practice and not to teach a skill just because this was the way it was always done.

Some suggestions for improving the preparedness of RNs was in the provision of training in how to use the different assessment forms/documentation NSs provided across the different years and universities as well as vocational education providers. How to write informative, constructive and yet honest assessment reports as well as how to provide negative feedback with under-performing NSs. Concerns were raised by RNs that because the process is confusing and overwhelming in a time poor environment that there may be times when NSs are just given a tick when they really had not met the assessment criteria and then passed onto the next RN hoping that this RN would address the deficits. To have at the end of the education process RNs who really were not safe to practice was a genuine concern for some of the RNs.

Summary of Barriers and Recommendations

Issues	Current Barriers	Recommendations
Not sufficiently recognised for the impact of NSs on workload	So many variations on the types of courses that are being run by University Schools of nursing.	NSs should be able to articulate to the supervising RN their current scope of practice and course assessment requirements.
	Different versions of the NCAS assessment forms provided by the University Schools of nursing for the assessment of the NSs.	Schools of nursing coordinate to have one NCAS assessment form. Training/information by education providers for RNs on the types of assessments required for the different cohorts of NSs.
	Limited protected time on a shift for NS T&S.	More allocated and protected time. Patient care hours to include clinical T&S.
	NSs allocated to health services that requires	Clinical placement teams to be more mindful of NSs' travel

	extensive/difficult access to transport, which impacts on the shift time on the ward/units	requirements and how this may impact on NSs' ability to be on placement for a full shift.
More support of RNs to reduce the impact on workload is required.	CFs cannot have direct contact with patients because they are not employed in the CF role by the Health Service, they are employed by the education provider.	Review model of clinical facilitation. CF's title to be reviewed based on model (University or Institutional facilitated) CFs to be more accessible and to have a regular presence on the wards/units.
	NSs who are not ready for a clinical placement or do not attend the whole shift.	Education providers triage NSs before they come onto placements particularly to ensure that they are organised and aware of their responsibilities (know their learning objectives and responsibility to complete documentation).
	RNs do not have time to provide extra support and supervision for NSs who are not coping with the experience of a clinical placement	CFs manage more closely underperforming NSs, which includes more frequent and regular supervision by CFs, sharing of information about progress, assistance with providing constructive feedback to the NS, writing their report and removal of the NS quickly if necessary.
	NS are often pulled away from the ward/area at 'handover time'.	Improved timing of NSs' meetings with CFs so that it did not cross-over shift 'hand-over time'.
	NSs being the conduit for communication between the CF and supervising RN.	More direct communication between the supervising RN, CF and the NS.
More preparation of RNs would be useful to T&S NSs.	Some RNs lacked confidence in undertaking T&S of NSs	Information/training on how to write informative, constructive and yet honest assessment reports as well as how to give negative feedback to under-performing NSs. Modularise current preceptor course to enable more staff to attend in Professional

		Development time i.e as a refresher course.
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Other Recommendations

- Employers and education providers to acknowledge and monitor the increasing number of NSs undertaking clinical placement and the resultant impact on the RNs workload.
- Support RNs to teach NSs new skills even if not undertaken as part of their current course. This would need to occur through liaison with the relevant CF to ensure appropriateness of the learning experience.

Future research

To understand why there are different models of clinical facilitation within health services, including the drivers for the different models. Also of interest is investigations into what is the most cost effective and efficient clinical facilitation model for undergraduate NSs that supports NS learning, patient safety and RN job satisfaction.

Limitations

The survey had a small sample size, low statistical power. N=59. The face validity of this was ensured by working with nurse educators, reviewing relevant literature and using a pilot study. This survey is not however, a psychometrically validated tool.

This study was conducted across two health services within Australia therefore the findings from this study may not be generalizable to other Australian jurisdictions and internationally because the NS clinical placement system may be different.

Conclusion

While the present study recognised the importance of NSs to receive a quality placement experience and the willingness of RNs to T&S undergraduate NSs, it also evidenced an on-going need to connect the different components of the clinical placement system and improve the involvement for the RNs, NSs and CFs. The RNs identified the challenge of balancing a good learning experience for NSs with heavy workloads and ensuring patient safety. To do this well takes time.

This study presents the experiences of RNs who are at the frontline of providing clinical training and supervision to NSs. Their experience, perceptions and expectations may not be the same as those working in the other components of the clinical placement system, however the RNs' voices of the impact of NS placements on them should be respected and listened to, because of the increasing number of NSs on placement with no additional staffing to accommodate this growth. This places more pressure on the current RNs. It is important to note that across the three higher education providers that predominantly placed NSs within health sites in the study, plus, vocational education and private sector the health service has NSs on placement 50 weeks of a year over 24/7 rosters, in most places. There appears to be a perceived lack of recognition of the level of accountability for NSs and emotional costs to the RNs with the potential negative impact on the quality of the NSs' learning, patient care and the work satisfaction of the RNs.

For the clinical placement system to improve the different components must reconnect and work together to simplify the processes to be more consistent where possible, and to clarify the roles and responsibilities across the different stakeholders within each component of the clinical placement system.

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Appendices

Appendix A. Recognition Domain Questions

Question	Mean score	SD
I feel that my direct line manager recognizes my contribution to the teaching and supervision of nursing students	3.85	1.2
I feel that the teaching and supervising of nursing students is acknowledged by my line manager as part of my workload	3.78	1.3
I feel that clinical facilitators recognise my role in the teaching and supervision of nursing students	3.49	1.1
I believe that the teaching and supervision of nursing students is a part of my role as a registered nurse	4.27	1.0
I feel nursing students should not practice unless directly supervised by registered nurses	3.83	1.1
I think that nursing students recognize my role in their teaching and supervision	3.88	1.0
I feel valued by nursing students when providing teaching and supervision	3.90	0.9

Appendix B. Preparedness Domain Questions

Question	Mean	SD
I think that I am equipped to balance any risk to patients against the need for independent learning by nursing students	3.81	1.1
I feel prepared to teach and supervise nursing students in the practice environment	3.88	1.0
I feel prepared to support nursing students in developing their skills	3.90	1.0
I feel confident in my ability to make objective, unbiased assessment decisions regarding the progress of nursing students	4.07	0.9

Appendix C. Support Domain Questions

Question	Mean Score	SD
I feel I have enough time to engage in teaching and supervision of nursing students within practice environments	2.61	1.0
I feel there are adequate supports for RNs taking on teaching and supervision roles or nursing students	2.88	1.1
I feel that the university clinical facilitators support my role in teaching and supervising nursing students	3.20	1.1
I feel supported by line management in my teaching and supervision of nursing students	3.75	1.24



A STUDY IN YOUR WARD:

A survey to review how prepared registered nurses feel to teach and supervise undergraduate nursing students

We aim to understand how well recognised, prepared, and supported registered nurses perceive they are to teach and supervise undergraduate nursing students in the practice environment, including any potential barriers and enablers to achieve their responsibilities for teaching and supervising.

We are inviting you to participate by filling out the survey which will be left in staff areas.

The study will involve:

- Completing a paper based survey
- Responses will be anonymous, and submitted into a sealed box for collection by researchers.

Participation in this study is voluntary.

Dr Lynette Cusack from the School of Nursing, University of Adelaide, and Dr Karleen Thornton from NALHN are conducting this study.

Appendix E. Participant Information Sheet (Pilot Survey)



Government of South Australia
SA Health

NORTHERN ADELAIDE LOCAL HEALTH NETWORK

Participant Information Sheet (Registered Nursing Staff Pilot Survey)

Title	Sustaining the nursing student workforce: Understanding the level of recognition, preparedness and support of registered nurses to teach and supervise undergraduate nursing students in the practice environment.
Short Title	Are registered nurses sufficiently recognised, prepared and supported to teach and supervise undergraduate nursing students in the practice environment?
Protocol ID	<i>[Protocol Number]</i>
Sponsor	Nil
Principal Investigators	<i>Dr Lynette Cusack- Adelaide Nursing School The University of Adelaide. Dr Karleen Thornton. Lyell McEwin and Modbury Hospital, Nursing and Midwifery Education, Research and Practice Development Department. Northern Adelaide Local Health Network</i>
Associate Investigators	<i>Jan Alderman, School of Nursing, The University of Adelaide Nurse Educators, Nursing and Midwifery Education, Research and Practice Development Department. Northern Adelaide Local Health Network: Tina Cockburn; Ellie Prior; Michelle Whitehead; Lisa Jones; Rachael Kirkbride.</i>
Location	<i>Northern Adelaide Health Local Networks, The Lyell McEwin and Modbury Hospital</i>

Part 1 What does my participation involve?

1 Introduction

Registered Nurses at the Modbury Hospital and Lyell McEwin Hospital emergency departments are invited to take part in this research project, “Are registered nurses sufficiently recognised, prepared and supported to teach and supervise undergraduate nursing students in the practice environment?”

This Participant Information Sheet describes the research project. Knowing what is involved will help you decide if you want to take part. Please read this information carefully. Ask questions about anything that you do not understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with a colleague.

Participation in this research is voluntary. If you do not wish to take part, you do not have to. If you decide you want to take part in the research project, please fill out the attached questionnaire and return via the box in the emergency department tearoom.

2 What is the purpose of this research?

This research will be conducted in both the Modbury and Lyell McEwin Hospital. The purpose of this study is to understand how well recognised, prepared, and supported RNs perceive they are to teach and supervise undergraduate nursing students in the practice environment, including any potential barriers and enablers to achieve their responsibilities for teaching and supervising.

3 What does participation in this research involve?

You are invited to participate in filling out the attached pilot questionnaire, it will take approximately 15 minutes, once completed place the questionnaire in the sealed box provided. The questionnaires will be collected and reviewed. Your feedback on the pilot questionnaire will inform the development of the final questionnaire that will be used in a wider survey of Registered Nurses.

4 What do I have to do?

Fill out the questionnaire that has been provided to you and return via the sealed box in the tearoom within the week.

5 Do I have to take part in this research project?

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. You are free to withdraw from the project at any stage. Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your employment.

6 What are the possible benefits of taking part?

There will be no clear benefit to you from your participation in this research. However this research will give you an opportunity to have a say in how well recognised, prepared, and supported you perceive RNs are to teach and supervise nursing students, including any potential barriers and enablers to achieve the responsibility.

7 What are the possible risks and disadvantages of taking part?

We do not foresee significant risk or disadvantage from participating in this research. If you are concerned about any possible risks or disadvantages, please talk with the researchers.

8 What if I withdraw from this research project?

Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your employment.

9 What happens when the research project ends?

When the study is completed, the researchers will collate and analyse the data. Feedback, sessions will be arranged for both Lyell McEwin and Modbury Hospital to identify and discuss any recommendations from the research findings. A report will then be prepared for Nursing Executive. All data will be kept confidential and stored safely. The results may be presented at conferences and published in journals.

Part 2 How is the research project being conducted?

10 What will happen to information about me?

No identifiable information will be collected about any location or individual registered nurse in any stage of this study. All electronic data will be stored on a secure, password protected University of Adelaide computer drive. Individual documents will be password protected using Word 2010 security options. During data analysis, any paper copies will be stored in a locked cabinet in the Chief Investigator's office at The University of Adelaide Medical and Nursing Precinct at LMH. Access to this data during this project will be the members of the research team only.

Data will be stored for a period of five (5) years after publication. Disposal of data collected for this research will follow the University of Adelaide's destruction of confidential data protocol and be carried out by the University Principle Investigator.

11 Complaints and compensation

If you suffer any distress as a result of this research project, you should contact the study team as soon as possible and you will be assisted with arranging appropriate support. Your participation in this study shall not affect any other right to compensation you may have under common law.

12 Who is organising and funding the research?

There is no funding attached to this project and there are no conflicts of interest.

13 Who has reviewed the research project?

All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). The ethical aspects of this research project have been approved by the Central Adelaide Local Health Network Human Research Ethics Committee (CALHN HREC). Hospitals have given approval for the research to be conducted at the Modbury and Lyell McEwin Hospital.

This project will be carried out according to the *National Statement on Ethical Conduct in Human Research (2007)*. This statement has been developed to protect the interests of people who agree to participate in human research studies.

14 Further information and who to contact

The person you may need to contact will depend on the nature of your query. If you want any further information concerning this project or if you have any problems which may be related to your involvement in the project, you can contact the Principal Investigator on 08 81612464 or email tracy.edwards@sa.gov.au

The study has been approved by the Central Adelaide Local Health Network Human Research Ethics Committee (CALHN HREC). If you wish to speak to someone not directly involved in the study about your rights as a volunteer, or about the conduct of the study, you may also contact the Chairperson, Research Ethics Committee,
Email: Health.CALHNResearchEthics@sa.gov.au
Phone: +61 8 8222 6841.

Appendix F. Participant Information Sheet (Survey)



Government of South Australia
SA Health

NORTHERN ADELAIDE LOCAL HEALTH NETWORK

Participant Information Sheet (Registered Nursing Staff Survey)

Title	Sustaining the nursing student workforce: Understanding the level of recognition, preparedness and support of registered nurses to teach and supervise undergraduate nursing students in the practice environment.
Short Title	Are registered nurses sufficiently recognised, prepared and supported to teach and supervise undergraduate nursing students in the practice environment?
Protocol ID	<i>[Protocol Number]</i>
Sponsor	Nil
Principal Investigators	<i>Dr Lynette Cusack- Adelaide Nursing School The University of Adelaide. Dr Karleen Thornton. Lyell McEwin and Modbury Hospital, Nursing and Midwifery Education, Research and Practice Development Department. Northern Adelaide Local Health Network</i>
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Location	<i>Northern Adelaide Health Local Networks, The Lyell McEwin and Modbury Hospital</i>

Part 1 What does my participation involve?

1 Introduction

Registered Nurses at the Modbury Hospital and Lyell McEwin Hospital emergency departments are invited to take part in this research project, “Are registered nurses sufficiently recognised, prepared and supported to teach and supervise undergraduate nursing students in the practice environment?”

This Participant Information Sheet describes the research project. Knowing what is involved will help you decide if you want to take part. Please read this information carefully. Ask questions about anything that you do not understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with a colleague.

Participation in this research is voluntary. If you do not wish to take part, you do not have to. If you decide you want to take part in the research project, please fill out the attached questionnaire and return via the box in the emergency department tearoom.

2 What is the purpose of this research?

This research will be conducted in both the Modbury and Lyell McEwin Hospital. The purpose of this study is to understand how well recognised, prepared, and supported RNs perceive they are to teach and supervise undergraduate nursing students in the practice environment, including any potential barriers and enablers to achieve their responsibilities for teaching and supervising.

3 What does participation in this research involve?

You are invited to participate in filling out the attached questionnaire, it will take approximately 15 minutes, once completed place the questionnaire in the sealed box provided. The questionnaires will be collected and analysed. You will then have the opportunity to take part in a focus group that will discuss the findings in more detail.

4 What do I have to do?

Fill out the questionnaire that has been provided to you and return via the sealed box in the tearoom within the week.

5 Do I have to take part in this research project?

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. You are free to withdraw from the project at any stage. Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your employment.

6 What are the possible benefits of taking part?

There will be no clear benefit to you from your participation in this research. However this research will give you an opportunity to have a say in how well recognised, prepared, and supported you perceive RNs are to teach and supervise nursing students, including any potential barriers and enablers to achieve the responsibility. This feedback will contribute to identify practice/system improvement and education initiatives. The time taken to reflect on your practice and complete the questionnaire may contribute to your continuing professional development hours.

7 What are the possible risks and disadvantages of taking part?

We do not foresee significant risk or disadvantage from participating in this research. If you are concerned about any possible risks or disadvantages, please talk with the researchers.

8 What if I withdraw from this research project?

If you decide to withdraw from the project, please notify a member of the research team so that research staff can document this. Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your employment.

9 What happens when the research project ends?

When the study is completed, the researchers will collate and analyse the data. Feedback, sessions will be arranged for both Lyell McEwin and Modbury Hospital to identify and discuss any recommendations from the research findings. A report will then be prepared for Nursing Executive. All data will be kept confidential and stored safely. The results may be presented at conferences and published in journals.

Part 2 How is the research project being conducted?

10 What will happen to information about me?

No identifiable information will be collected about any location or individual registered nurse in any stage of this study. All electronic data will be stored on a secure, password protected University of Adelaide computer drive. Individual documents will be password protected using Word 2010 security options. During data analysis, any paper copies will be stored in a locked cabinet in the Chief Investigator's office at The University of Adelaide Medical and Nursing Precinct at LMH. Access to this data during this project will be the members of the research team only.

Data will be stored for a period of five (5) years after publication. Disposal of data collected for this research will follow the University of Adelaide's destruction of confidential data protocol and be carried out by the University Principle Investigator.

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If you suffer any distress as a result of this research project, you should contact the study team as soon as possible and you will be assisted with arranging appropriate support. Your participation in this study shall not affect any other right to compensation you may have under common law.

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This project will be carried out according to the *National Statement on Ethical Conduct in Human Research (2007)*. This statement has been developed to protect the interests of people who agree to participate in human research studies.

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The study has been approved by the Central Adelaide Local Health Network Human Research Ethics Committee (CALHN HREC). If you wish to speak to someone not directly involved in the study about your rights as a volunteer, or about the conduct of the study, you may also contact the Chairperson, Research Ethics Committee,
Email: Health.CALHNResearchEthics@sa.gov.au
Phone: +61 8 8222 6841.

Appendix G. Pilot Survey

Research Study:

Sustaining the nursing student workforce: Understanding the level of recognition, preparedness and support of registered nurses to teach and supervise undergraduate nursing students in the practice environment.

Indicate your answer with an X

Survey Questions - Teaching and supervision of undergraduate nursing students by Registered nurses

Part 1. Demographic data:

Please select one option for each section of the following	
A. Gender	<input type="radio"/> Male <input type="radio"/> Female
B. Age group	<input type="radio"/> Less than 25 years <input type="radio"/> 25 – 45 <input type="radio"/> More than 45
C. Have you had previous experience providing clinical training and supervision to undergraduate nursing students?	<input type="radio"/> Yes <input type="radio"/> No

Part 2. Survey Questions:

For each of the questions below, please tick the response that best characterises how you believe or feel about the statement

Note: for the purposes of this study, the term nursing students refers to undergraduate students enrolled in a Bachelor of Nursing

Survey Questions

	1 = strongly disagree	2 = disagree	3 = neutral	4 = agree	5 = strongly disagree
I feel that my direct line manager recognizes my contribution to the teaching and supervision of nursing students	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel that the teaching and supervising of nursing students is acknowledged by my line manager as part of my workload	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I feel supported by line management in my teaching and supervision of nursing students	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel that clinical facilitators recognise my role in the teaching and supervision of nursing students	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel that the university clinical facilitators support my role in teaching and supervising nursing students	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel that the university clinical facilitators sufficiently prepare nursing students to be supervised by registered nurses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I believe that the teaching and supervision of nursing students is a part of my role as a registered nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel nursing students should not practice unless directly supervised by registered nurses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I think that nursing students recognize my role in their teaching and supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel valued by nursing students when providing teaching and supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel prepared to teach and supervise nursing students in the practice environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I feel prepared to support nursing students in developing their skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel confident in my ability to make objective, unbiased assessment decisions regarding the progress of nursing students	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I think that I am equipped to balance any risk to patients against the need for independent learning by nursing students	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel I have enough time to engage in teaching and supervision of nursing students within practice environments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel there are adequate supports for RNs taking on teaching and supervision roles or nursing students	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(a) I have attended / undertaken some form of training to prepare me to engage in clinical teaching and supervision of nursing students within the practice environment – yes / no answer	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
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17. (b) If yes, can you please provide an overview of what this was (e.g. Preceptor program via employer, In service by employer, In service by University)

Additional Pilot Survey questions:

1) Was the survey form easy to complete? Yes No

2) Was the survey form easy to understand? Yes No

3) Approximately how much time did it take you to complete the form _____

3) Which questions did you have difficulty understanding? _____

Any other
comments _____

Thank you for taking the time to complete this survey.

Thank you for participating in this research by completing this questionnaire, it should only take 5 or 10 minutes. Once you have completed the questionnaire please place into the envelope and then into the sealed box provided in the tearoom.

Appendix H. Participant consent form for focus groups



Participant Information Sheet (Nursing Staff Focus Groups)

Title	Understanding the level of recognition, preparedness and support of registered nurses to teach and supervise undergraduate nursing students in the practice environment.
Short Title	Are registered nurses sufficiently recognised, prepared and supported to teach and supervise undergraduate nursing students in the practice environment?
Protocol ID	<i>HREC/18/CALHN/211 SSA/18/NALHN/52</i>
Principal Investigators	<i>Dr Lynette Cusack- Adelaide Nursing School The University of Adelaide. Dr Karleen Thornton. Lyell McEwin and Modbury Hospital, Nursing and Midwifery Education, Research and Practice Development Department. Northern Adelaide Local Health Network</i>
Associate Investigators	<i>Jan Alderman, School of Nursing, The University of Adelaide Nurse Educators, Nursing and Midwifery Education, Research and Practice Development Department. Northern Adelaide Local Health Network: Tina Cockburn; Ellie Prior; Michelle Whitehead; Lisa Jones; Rachael Kirkbride.</i>
Location	<i>Northern Adelaide Health Local Networks, The Lyell McEwin and Modbury Hospital</i>

Part 1 What does my participation involve?

1 Introduction

Registered Nurses at the Modbury Hospital and Lyell McEwin Hospital are invited to take part in this research project that asks the question, Are registered nurses sufficiently recognised, prepared and supported to teach and supervise nursing students in the practice environment?

This Participant Information Sheet describes the research project. Knowing what is involved will help you decide if you want to take part. Please read this information carefully. Ask questions about anything that you do not understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with a colleague.

Participation in this research is voluntary. If you do not wish to take part, you do not have to. If you decide you want to take part in the research project, please fill out the attached questionnaire and return via the box in the emergency department tearoom.

2 What is the purpose of this research?

This research will be conducted in both the Modbury and Lyell McEwin Hospital. The purpose of this study is to understand how well recognised, prepared, and supported RNs perceive they are to teach and supervise nursing students in the practice environment, including any potential barriers and enablers to achieve their responsibilities for teaching and supervising.

3 What does participation in this research involve?

You are invited to participate in a focus group that will be run on your ward at a time and date to be negotiated with the Nurse Unit Manager. Information about the focus groups will be provided via Staff Handover sessions. The focus group will be run by a nurse from the Adelaide Nursing School, and a Nurse Educator from the Nursing and Midwifery Education, Research and Practice Development Department. The focus group will be no longer than 60 minutes.

4 What do I have to do?

Attend a focus group arranged at a location and time that is suitable to the wards. At the focus group you will be asked to sign a consent form. By signing the consent form you consent to the researchers collecting and using information (from focus group) for the research project. The focus group sessions will explore and discuss the findings from the survey in more detail and explore any strategies that may improve systems/education for teaching and supervision by RNs as well as ideas on how better to prepare nursing students to be supervised.

5 Do I have to take part in this research project?

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. You are free to withdraw from the project at any stage. Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your employment.

6 What are the possible benefits of taking part?

There will be no clear benefit to you from your participation in this research. However this research will give you an opportunity to discuss how well recognised, prepared, and supported you perceive RNs are to teach and supervise nursing students, including any potential barriers and enablers to achieve this responsibility. This feedback will contribute to identify practice/system improvement and education initiatives. The time taken to reflect on your practice by participating in the focus group may contribute to your continuing professional development hours.

7 What are the possible risks and disadvantages of taking part?

We do not foresee significant risk or disadvantage from participating in this research. If you are concerned about any possible risks or disadvantages, please talk with the researchers.

8 What if I withdraw from this research project?

If you decide to withdraw from the project, please notify a member of the research team so that research staff can document this. Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your employment.

9 What happens when the research project ends?

When the study is completed, the researchers will collate and analyse the data. Feedback sessions will be arranged for both Lyell McEwin and Modbury Hospital to identify and discuss any recommendations from the research findings. A report will then be prepared for Nursing Executive. All data will be kept confidential and stored safely. The results may be presented at conferences and published in journals.

Part 2 How is the research project being conducted?

10 What will happen to information about me?

No identifiable information will be collected about any location or individual registered nurse in any stage of this study. All electronic data will be stored on a secure, password protected University of Adelaide computer drive. Individual documents will be password protected using Word 2010 security options. During data analysis, any paper copies will be stored in a locked cabinet in the Chief Investigator's office at The University of Adelaide Medical and Nursing Precinct at LMH. Access to this data during this project will be the members of the research team only.

Data will be stored for a period of five (5) years after publication. Disposal of data collected for this research will follow the University of Adelaide's destruction of confidential data protocol and be carried out by the University Principle Investigator.

11 Complaints and compensation

If you suffer any distress as a result of this research project, you should contact the study team as soon as possible and you will be assisted with arranging appropriate support. Your participation in this study shall not affect any other right to compensation you may have under common law.

12 Who is organising and funding the research?

There is no funding attached to this project and there are no conflicts of interest.

13 Who has reviewed the research project?

All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). The ethical aspects of this research project have been approved by the the Central Adelaide Local Health Network Human Research Ethics Committee (CALHN HREC). Hospitals have given approval for the research to be conducted at the Modbury and Lyell McEwin Hospital.

This project will be carried out according to the *National Statement on Ethical Conduct in Human Research (2007)*. This statement has been developed to protect the interests of people who agree to participate in human research studies.

14 Further information and who to contact

The person you may need to contact will depend on the nature of your query. If you want any further information concerning this project or if you have any problems which may be related to your involvement in the project, you can contact the Principal Investigator on email lynette.cusack@adelaide.edu.au

The study has been approved by the Central Adelaide Local Health Network Human Research Ethics Committee (CALHN HREC). HREC/18/CALHN/211 and SSA/18/NALHN/52. If you wish to speak to someone not directly involved in the study about your rights as a volunteer, or about the conduct of the study, you may also contact the Chairperson, Research Ethics Committee,
Email: Health.CALHNResearchEthics@sa.gov.au
Phone: +61 8 8222 6841.

Appendix I. Participant consent form for focus groups

Participant Consent Form

Title	Sustaining the nursing student workforce: Understanding the level of recognition, preparedness and support of registered nurses to teach and supervise undergraduate nursing students in the practice environment.
Short Title	Are registered nurses sufficiently recognised, prepared and supported to teach and supervise undergraduate nursing students in the practice environment?
Protocol ID	<i>[Protocol Number]</i>
Sponsor	Nil <i>Dr Lynette Cusack- Adelaide Nursing School The University of Adelaide.</i>
Principal Investigators	<i>Dr Karleen Thornton. Lyell McEwin and Modbury Hospital, Nursing and Midwifery Education, Research and Practice Development Department. Northern Adelaide Local Health Network</i>
Associate Investigators	<i>Jan Alderman, School of Nursing, The University of Adelaide</i> <i>Nurse Educators, Nursing and Midwifery Education, Research and Practice Development Department. Northern Adelaide Local Health Network:</i> <i>Tina Cockburn; Ellie Prior; Michelle Whitehead; Lisa Jones; Rachael Kirkbride.</i>
Location	<i>Northern Adelaide Health Local Networks, The Lyell McEwin and Modbury Hospital</i>

Declaration by Participant

- I have read the Participant Information Sheet.
- I understand the purposes, procedures and risks of the research described in the project.
- I have had an opportunity to ask questions and I am satisfied with the answers I have received.
- I freely agree to participate in this research project as described and understand that I am free to withdraw at any time during the project without affecting my employment.
- I understand that I will be given a signed copy of this document to keep.

Name of Participant (please print) _____
Signature _____ Date _____

Name of Witness* to Participant's Signature (please print) _____
Signature _____ Date _____

* Witness is not to be the investigator, a member of the study team or their delegate.

Declaration by Researcher[†]

I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Name of Researcher [†] (please print) _____
Signature _____ Date _____

[†] A senior member of the research team must provide the explanation of, and information concerning, the research project.

Note: All parties signing the consent section must date their own signature.

Appendix J. Question guide for focus groups

Focus group cues.

Introduction:

My name is I am conducting research into registered nurses perceptions of their responsibility to teach and supervise undergraduate nursing students.

This is my colleague.....who is also part of the research team

Preparation:

1. Outline study so far and answer any questions.
2. Complete consent forms
3. Ask permission to audio record.

Research questions:

1. Tell me what you think about the role and responsibility of RNs to teach and supervise undergraduate nursing students:
2. How recognised is this responsibility within the health service?
3. How well prepared do you think RNs are for this role and responsibility?
4. How well supported do you think RN are for this role and responsibility?
5. What has been your experience of the allocation process of undergraduate nursing students to you?
6. What is your expectation of the role and responsibility of University clinical facilitators?
7. What would you like to see changed to improve any aspect of this
8. To achieve this change/s what needs to be influenced? (Behaviors that need to change; the relevant decision making process; barriers and enabler for changes ie professional/administration/ education)?

Thank you for participating in this research