

PROMOTING AN EFFECTIVE LEARNING ENVIRONMENT WHILST CONSIDERING THE REALITIES OF A PRACTICE SETTING

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ABSTRACT

The clinical experience which students of the undergraduate nursing program at Central Queensland University experience is a fundamental part of their education. The role of the nurse educator is crucial in promoting a conducive learning environment in the clinical setting. This paper will discuss strategies encompassed within a Clinical Learning Cycle implemented by nurse educators at Central Queensland University to facilitate learning in the clinical setting.

INTRODUCTION

The quality of nursing education is significantly dependent upon the quality of students' clinical experience (Napthine, 1996 cited in Nolan, 1998). For students at Central Queensland University, clinical practicums occur in a variety of health care organizations throughout Queensland. Placements include medical, surgical, and paediatric areas, and specialty areas such as operative room, accident and emergency, maternity, coronary care and intensive care. Students engage in the practicum in a supernumerary capacity under the direction of a clinical teacher or facilitator or, in the later part of their program, by agency preceptors. The teaching of students during the practicum is an interactive process, which requires involvement of many players in the clinical organizations existing outside of the university environment. The relationships established amongst these players can do much to promote an environment conducive to learning for students in a climate which is often fraught with challenges. As argued by Reilly & Oermann (1992),

"...the psychosocial climate in which the teaching and learning take place is a major contributing factor to the learning responses of students and ability of the teacher to carry out educational responsibilities. The climate for learning may support these individuals, impede them or limit options for learning" (p. 109).

If the clinical setting is not conducive to student learning then desired learning will be lost (Perry, 1988; Lumby, 1998 cited in Nolan, 1998). Additionally, there will be a decreased application of skills learnt (Franke et al., 1995 cited in Nolan, 1998). Central to establishing effective relationships is the nurse clinical teacher who, for the purpose of this discussion, is termed the clinical facilitator.

The main focus of this discussion considers the strategies employed by clinical facilitators which are aimed at promoting learning in the clinical setting. The strategies implemented can make or break the clinical experience for students. The School of Nursing and Health Studies at Central Queensland University adopts the approach of the Clinical Learning Cycle (Cox, 1993) to guide the clinical facilitator in their role. This cycle is an organized sequence of events which include preparation, briefing, clinical experience, and debriefing.

A PLANNED APPROACH TO CLINICAL TEACHING AND PREPARATION

Preparing students for the clinical experience can be a challenge for the facilitator, particularly when dealing with the novice student – a beginner with no experience of the situation in which they are expected to perform (Benner, 1984). For undergraduate nursing students at Central Queensland University, clinical practicums commence in the second year of the program. The extent of the practicums consist of a 40-hour block in weeks 4 and 7, and an 80-hour block in weeks 11 and 12 of the first semester. A similar pattern is repeated in the second semester of the second year. For the beginning student, the initial clinical practicums occur without the student having had extensive preparation for the experience. Some students rarely know what to expect. They may be unfamiliar with the culture of the environment, and few may have practiced many nursing clinical skills. Some may have never experienced the hospital setting. Under these circumstances, anxiety may ensue. For the majority of students there is rarely a sense of belonging. The time they spend in the clinical setting is transient, and whilst participating, they are not a part of the organizational workforce. Additionally, they are supernumerary. Considering this, the most fundamental function

to be undertaken by the facilitator is adequate preparation. This is the first component of the Clinical Learning Cycle (Cox, 1993). There is much emphasis made to facilitators regarding their responsibility for preparation which includes the preparation of themselves, the organization, and the students. Much of the initial preparation of students will, however, be the responsibility of the School.

Preparation of self as a facilitator

All facilitators must first be personally prepared for their role. These individuals have to take a very active part in the education of students in the clinical setting and so are selected on the basis of their expert clinical knowledge and skills, their commitment to tertiary-level nurse education, their understanding of the Scope of Nursing Practice within Queensland, their communication skills, their understanding of adult learning, and their willingness to teach. These facilitators are generally seconded from the relevant clinical organization for the practicum, or they may be contracted only for the period of the facilitation. On most occasions facilitators will be working with students in clinical areas of which they are not usually a staff member in their role as a registered nurse. Hence clinical areas may not only be foreign to the student, but also to the facilitator. Because of this, it becomes important for the facilitator to prepare sufficiently so as to understand the clinical area, know what learning opportunities are available for students, and to establish some relationship with staff in the clinical area prior to the commencement of the practicum. To prepare for their role, all facilitators must attend workshops. These workshops include content which clarifies their roles, exposes them to the curriculum, and portrays strategies to facilitate learning in an ever-changing environment. Additionally, all facilitators are provided with extensive resources to assist them in their role including a facilitator guide and a student study guide. These guides include weekly content which details the concepts that students are introduced to on campus. The facilitator can then identify learning opportunities in the clinical setting that are consistent with what students have been exposed to on campus.

The pre briefing clinical resource package

As part of their personal preparation facilitators are directed to the Pre Briefing Clinical Resource Package (PBCRP) (Reid-Searl, 1998).

This is a package which all students must access prior to the commencement of their practicum. Having the facilitators exposed to this resource enables them to have an understanding of what information the students will already have about their practicum. The PBCRP is available in both CDROM and print format. It is an informative package divided into three sections of information relating to the clinical experience. The first section includes information about clinical work in general – including objectives, preparation requirements for clinical activities, what to wear, what to take, behavioural expectations, language used, codes of conduct, and assessment expectations. The second part focuses on the clinical agencies. Each acute healthcare agency, which students may encounter in the facilitated relationship, is included. The information includes the specific organization's mission statement, learning opportunities, how to get there, where to buy food, accommodation issues, and any other specific information which the student may need to know before their placement commences. The third part of the package includes the specific area of clinical work that the student may experience including surgical, medical, paediatric, obstetric, mental-health and aged-care. This part introduces students to orientation activities, terminology, and relevant resources to access prior to the placement. In all, the package provides students with the information needed prior to them commencing their clinical practicums.

Much thought went into the PBCRP's design and the potential usability for students – the aim being to have a resource which students could readily access in their own time and which provided consistent and updated information. The CD ROM has been designed in hypertext in which words are linked by association (Tripp & Roby cited in Gillham, 1998). The structure of hypertext is such that the content is comprised of multiple, separate information nodes which contain various forms of media (Oliver & Herrington, 1995) and the student can access information from these nodes (Oliver & Herrington, 1995). Becker & Dwyer (cited in Oliver & Herrington, 1995), believe that hypertext facilitates a student-centred approach and creates a motivating and active learning environment, whilst the browsing and exploration it supports are behaviours frequently associated with higher -order learning (Thuring, Mannemann, & Haake, 1995 cited in Oliver & Herrington, 1995).

The flexibility and the choice available through hypertext respects the principles of adult learning as the student can choose when and what to access depending on their needs. They can decide how long to spend on particular tasks and topics, which in turn enables them to choose when to proceed and when to pause (Small & Grabowski, 1992 cited in Oliver & Herrington, 1995, p. 57). The learner's independence can be fostered, and scheduling can be flexible, thus allowing the student to work at their own pace (Bachman & Panzarine, 1998).

Visits to the clinical setting – collaboration and clarification

In the process of preparation, the facilitators are encouraged to make a personal visit to the clinical areas prior to the commencement of the practicum. These visits can be used to promote collaborative relationships. One of the first strategies that facilitators are encouraged to implement is that of clarification of roles with individuals at the ward level. Ahern (1999) argues that the clear role boundaries are achieved by the prioritisation of role categories so that "...optimal clinical teaching leads to optimal student learning and, ultimately, optimal client care by the student" (p80). The categories for the facilitator at Central Queensland University could be described as that of a professional colleague involved in the partnership of education for undergraduate nurses; a carer involved with the management of those clients to whom the student has been allocated; and a facilitator responsible for identifying learning opportunities, promoting a conducive learning environment; and assessing students clinical performance (adapted from Davis et al., 1996 cited in Ahern, 1999). When role clarity has occurred it serves not only as a strategy for the effective functioning of the system, but also as a means of avoiding role conflict (Clifford, 1996 cited in Ahern, 1999). Lack of role clarity can exist for educators when in the clinical settings (Patterson & Groening, 1996; Van Ort & Putt, 1985; Weinholts & Ostmoe, 1987 all cited in Ahern, 1999) and this can be related to the nurse educator not feeling a part of the actual team on the ward as well from a lack of trust between the educator and practitioner (Davis et al., 1996 cited in Ahern, 1999).

This initial site visit involves much more than role clarification. It is an opportunity for the facilitator to become familiar with the ward's culture, the layout, and the policies and

procedures. Additionally, the facilitator can identify potential learning opportunities for students. Moreover, the staff in the ward can become familiar with the facilitator, the objectives of the practicum, where the students are in terms of experience and skills, what the expectations are in terms of student activities, assignments and client selection, and the practicing of skills. The staff on the ward also have an opportunity to put forward their expectations, to provide input as to where they perceive challenges lie for students and to discuss strategies they would like to employ to help promote a conducive learning environment.

These preparatory site visits promote collaboration and may provide staff with a sense of ownership and responsibility for the teaching of the students. As noted by White & Ewan (1991, p. 145),

"...professional practitioners in the setting are influential in the students' learning, yet insufficient integration of practitioners into clinical teaching can be responsible for lack of harmony and misunderstanding between health care service goals and the learning goals of the educational program".

Without involvement of the staff, the clinical facilitator may not be welcome and ultimately the acceptance of the students may be halted. As implied by Reilly & Oermann (1992, p. 114), "...every clinical setting has its own cultural values, norms, and expected behaviours. This cultural dimension serves to control the behaviour of various individuals in the setting and provides sanctions for those who deviate". It could be suggested that new entrants, such as students and facilitators, are expected to learn some of these behaviours and accommodate them accordingly if they are to be accepted into the organization. The lack of acceptance can influence student stress which, for many nursing students, may be apparent in relation to undertaking a clinical practicum (Barnes, 1987; Fox et al., 1963; Kleehammer et al., 1990 all cited in Stephens, 1992, p. 314). Hence a major objective is to make the experience in the clinical setting as smooth as possible by creating an environment that is low-risk, comfortable, and non-judgmental.

From the initial site visit, and with input from the agency staff, the facilitator can put together orientation activities and specific objectives relevant to the particular area. With input from agency staff the objectives enable the student to be clear as to what they can achieve. Because students are situated in a variety of settings, preparing objectives for the unique clinical

situations is relevant. These objectives still meet with the overall curriculum objectives set by School and are appropriate to the concepts and theories taught in the on-campus learning environment.

The preparation of the facilitators with the agency does not end with one preparatory site visit; rather the School encourages facilitators to meet with agency staff the day prior to the commencement of the practicum. This gives the facilitator an opportunity to negotiate client selection that is relevant to the student level. In negotiating the suitability of clients, the facilitator may then meet with the clients – seeking their permission and informing them of the planned activities for the following day. Importantly, staff in the agency are left knowing which clients the students will be assigned to. This then ensures continuity of information being passed between shifts, promotes an understanding of what activities students will be involved with, and prevents the overlapping of activities between regular staff and the students. During this time the facilitator also provides the organization with the names of the students on the ward, the time that they will be arriving, and a list of skills that the student has completed up until the point of the commencement of the practicum. This strategy saves confusion, promotes organization, and leaves agency staff aware of the students' projected involvement in care. Following the preparatory visits to the clinical setting the facilitator can then plan to brief students – the next phase in the clinical learning cycle (Cox, 1993).

The briefing – preparing students

The briefing session becomes an important element for each clinical rotation in preparing students for the day's events as well developing future effective communication amongst group members. Facilitators are encouraged to meet with the students on the day of the practicum but prior to the commencement of any activities. Even though students share the common factor that they are Central Queensland Nursing students, many will not know one another. Hence a 'getting-to-know' activity can be an important part of the briefing session. The relationships established at this time can promote peer support during the practicum. The value of peer support for nursing students in the clinical setting has been identified as a critical component of a positive learning experience (Campbell, Larrivee, Field, Day, & Reutter, 1994; Hart & Rotem, 1994; Nolan, 1998).

The strategies that the facilitator puts in place for the initial briefing can also promote the establishment of effective relationships amongst students whereby peer support emerges. One of the initial strategies is to organize a meeting place away from the ward, one that is free of distracters, comfortable, and safe. Strategies which the facilitator can employ include arrangement of the room, and icebreaker and 'getting-to-know' activities. The facilitator is encouraged to clarify their role and the student role. Information given out includes objectives, a revisit of behavioural expectations, assignment activities, assessment responsibilities, journaling, and the importance of supporting and caring for one another. These sessions serve as an ideal time to discuss the degree of participation in client care and the scope of practice issues. Whilst some facilitators may choose not to brief students on a daily basis, those who do have the advantage of identifying any influences which may impede the students' readiness to learn. Once the briefing component has occurred students can move into the clinical practice.

Clinical practice

The strategies employed by the facilitator during the clinical experience will be dependent upon the level of the student, their confidence, and their individual learning needs. Prior to participating in the care of clients students are orientated to the environment. In the initial orientation facilitators are encouraged to provide a fair degree of structure in their approach. This promotes direction and security. Orientation programs can provide students with a number of activities to work through as a group.

Once the orientation has passed, facilitators can then assign activities to the students. The facilitator is encouraged to select activities for individual students based upon assessment of each student in terms of needs, experience, characteristics, level of confidence, and competence. The design of all the assignments meet with what the faculty has decided in terms of overall curriculum objectives.

Some students will be given structured assignments, while others less. Some students undertake dual assignments, while others assume multiple-client loads. The concept of dual assignments is often promoted for the beginning students in an effort to reduce anxiety until they feel confident and comfortable working alone. This strategy involves assigning

two students per client. Tornay & Thompson (1987, cited in Fugate & Rebesch, 1992), infer that it is "...particularly appropriate when the level of complexity of care is beyond an individual student's capabilities" (p. 14).

On each day of the practicum the facilitator will inform students of their allocated client – including the client's condition – and together they will plan nursing activities. Client allocation by the facilitator can often be given in advance; this way students have the opportunity to research conditions and activities prior to the delivery of nursing care. Whilst activities during the clinical practicum will change for students on a daily basis, the facilitator constantly ensures that collaboration and communication continue with those in the clinical milieu. This is vital in maintaining a supportive learning environment.

Following each clinical experience the facilitator is encouraged to set time aside where the students can be involved in a debriefing. This is the final strategy in the clinical learning cycle (Cox, 1993).

Debriefing

Debriefing is a follow-up of the students' performance to identify whether clinical objectives have been met. It is an essential element of the clinical learning cycle in which feedback can be given to students in terms of praise, recognition, and direction when needed (White & Ewan, 1991). With all debriefing sessions the ultimate goal includes group problem solving, linking learning, clinical assignments and experience, identifying approaches, reflecting on experiences, and giving and receiving feedback (White & Ewan, 1991). Strategies employed during debriefings include setting up an environment away from distracters, ensuring that adequate seating arrangements are in place and, if possible, having tea and coffee facilities.

The sessions are encouraged to be student led rather than facilitator led, with minimal structure being employed – to encourage students to do the talking. To achieve this the facilitator is encouraged to explain to students what debriefing sessions are about and what issues may be relevant to focus upon. Encouraging students to do the talking promotes thoughts and feelings to be raised, which if left untouched may block further learning. As stated by Matheney (1969, cited in White & Ewan, 1991, p. 173), "...as long as students are

preoccupied with strong emotional reactions, no learning will take place until the feelings have been ventilated or resolved". During the debrief the facilitator is encouraged to act as a supporter and employ active listening skills. This necessitates using the skills of paraphrasing, asking questions to clarify issues, and echoing the feelings implied by the students. The depth of listening requires the facilitator to hear not only what is being said, but also the tones used, the gestures and expressions employed, and the messages which lie beneath what the student is saying. Students are also given time out to complete anecdotal notes in the debriefing sessions. This allows the students to complete a required activity within their clinical hours and to document issues whilst fresh in their minds.

CONCLUSION

The clinical setting is one of the most valuable educational resources available to teachers of undergraduate nursing students (Kermode, 1987). Clinical learning is an integral part of nursing education (Massarweh, 1999). Experiences arising from clinical activities provide opportunities for the type of application, analysis, and synthesis of ideas which produce graduates with a real grasp of what the discipline of nursing is about (Kermode, 1987). The effectiveness of the learning environment is, however, greatly dependent upon the clinical nurse educator – the facilitator of the students. The success of every practicum can be influenced by their level of preparation and the collaboration they promote. Success in promoting an environment conducive to learning for nursing students in an ever-changing ward environment can be influenced by implementing strategies incorporated into a sequential plan of events of the Clinical Learning Cycle which includes preparation, briefing, clinical practice, and debriefing (Cox, 1993).

Whilst these sequential plans of events are implemented by facilitators at Central Queensland University, there is no evidence to suggest that this is the most effective approach. Further research is recommended in comparing other models and approaches used by those promoting learning for undergraduate nursing students in clinical environments – such as the preceptored relationship implemented in the final year practicums of Central Queensland University undergraduate nursing students. It could be suggested that preceptors have little time to implement such a sequential process when dealing with the everyday running of a

ward environment, and yet the approaches that preceptors take to promote a conducive learning environment could be as effective.

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