CONTRACT CLINICAL TUTORS' EXPERIENCE OF WORKING WITH
BACHELOR OF NURSING STUDENTS IN CLINICAL PRACTICE

by

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For my husband Joe, my daughters Colleen and Rachael and son Darrin
for your patience and support.
Love you heaps.

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ABSTRACT

The aim of this qualitative study was to explore four contract clinical tutors' perceptions of their role in facilitating Bachelor of Nursing students' learning in the practice setting of the health sector in New Zealand. Participants were asked to share their personal experiences including the positive aspects and the difficulties and challenges they encountered when working with students.

Contract clinical tutors, are employed because of their clinical experience and expertise to enable students to apply the knowledge learned in theory and the professional competencies learned in the laboratory into the reality of clinical practice. This requires that clinical tutors be familiar with the curriculum so their role as supervisor, teacher, facilitator, guide and mentor can assist the student in fulfilling their learning requirements when in clinical practice. They are not, however, involved in the development or the teaching of the theoretical component of the programme. The difficulties and challenges identified by the contract clinical tutors in this study, resulted in discussion concerning strategies that could be adopted by the faculty to support clinical tutors in their role of ensuring the students receive the best possible learning opportunities when assigned to the clinical areas.

Focus group interviews were chosen as a means of collecting data from four registered nurses currently or previously employed as contract clinical tutors to work with students from an undergraduate degree programme at a small polytechnic.

A two-hour focus group interview was held as a means of uncovering the shared thoughts and experiences of participants. A second focus group interview was conducted to qualify information and elaborate on some issues. From the data collected a number of recommendations were identified which if adopted by polytechnics will enhance quality teaching by contract clinical tutors.

CHAPTER ONE: INTRODUCTION

The purpose of the study was to explore contract clinical tutors' perceptions of their role facilitating Bachelor of Nursing students' learning when in clinical settings. Chapter one describes the purpose of the research and the impact of quality clinical experience on student learning. The development of nursing from training in a hospital setting through the transition to nurse education in polytechnics is explored and finally the impact of changes to the health and education system in New Zealand on the clinical education of students is examined.

In this study Contract clinical tutors were offered an opportunity to express their views about the positive aspects of their work and to identify difficult and challenging situations they may have encountered. A considerable amount of literature explores the perceived problems that students encounter when working in the clinical setting and almost without exception the attitudes and behaviours of the clinical tutors are highlighted as being an important issue for students. However, there is less written from the perspective of the contract clinical tutor who is employed on contract to teach in the clinical setting only and does not participate in the delivery of the theory component.

Maintaining and/or improving the quality of nursing education is the most important concern of nurse educators and the subsequent performance of students as registered nurses in the work-force is often a reflection of the quality of the nursing education programme and the quality of the clinical experience.

Since the transition of nursing education from hospital training schools to polytechnic institutions there has been an ongoing debate on how best to provide students with quality education when in the clinical setting. It was evident from the study by Napthine (1996) that the preparation of clinical tutors does not reflect their importance in the education of the next generation of nurses. Also evident in the literature is the agreement by researchers of the importance of clinical practice. The quality of nursing education depends on the quality of clinical experience (Napthine, 1996). Anxiety that students experienced when confronted with an unpleasant clinical experience could hinder learning and the most frequently discussed subject which influenced students' experience in clinical practice was the clinical instructor (Kleehammer, Hart & Keck, 1990). Students consistently referred to the clinical tutor as the person most critical to effective learning (Campbell, 1994) and the time spent in practice was where students learnt the most (Neville & Crossley, 1993).

Contract clinical tutors or sessional staff are often employed for short periods of activity when students are on clinical placements (Napthine 1996). In New Zealand the sessional or contract clinical tutor is often employed by the Polytechnic and also by the health care provider from within which the students gain their experience. They are frequently seconded by the educational institution because of their local knowledge and their known expertise in a particular clinical area (Napthine, 1996). In spite of limited orientation and their own extensive experience, it has been noted that non-faculty nurses (those who supervise in the clinical setting only) do not often have the opportunity to become fully conversant with the course philosophy or objectives (Myrick, 1988).

If contract clinical tutors are employed to work with students then recruitment and preparation of these individuals should be a priority of the institute. Educational institutions should also ensure the quality of the contract clinical tutors' work experience and teaching skills to maintain quality teaching for students in clinical practice.

Background

Until the 1980s New Zealand nursing students gained clinical experience by undertaking traditional apprentice-style training. This meant most of the students' time was spent delivering nursing care in hospital settings and, for short blocks of two to four weeks, students were taught in the classroom by doctors and tutors employed by the hospital school of nursing. From my own experience I believe that the ability to carry out clinical skills/tasks was the measure of a good nurse and a lot more time was spent in the clinical area as a service provider than the time spent learning the theory. Students attended blocks of classroom theory approximately twice a year but were not always allocated to the clinical area which related to the previous theory component.

Senior staff nurses, charge nurses and tutors took responsibility for students' learning in clinical practice. Qualities of the staff nurse, charge nurse or tutor such as patience, enthusiasm, knowledge, and a non threatening/non judgemental attitude contributed to the student nurses confidence and capability in a situation that demanded that he or she learned on the job. Clinical learning for students was unpredictable and teaching qualities were not always evident within a system where an excessively disciplinary environment could stifle critical thinking and problem solving and where students were taught the 'what' and 'how' but were rarely encouraged to question the 'why'. A natural teaching ability and role modelling, although not overtly obvious, were nevertheless recognised by the student, and were regarded as important.

Students made up a large portion of the work force in hospitals. However, the profession and others began questioning the way nurses were being trained and as a result of this a review of nursing education ensued. The resulting Carpenter Report was published in 1971 and on its recommendation, nurse education began to be transferred from the hospital training schools into institutes funded and monitored by the Department of Education.

This change from hospital-based training which relied on a "service under supervision model of learning" (Ferguson, 1996) to polytechnics allowed for and demanded a structured theoretical programme. Consequently from the late 1970s into the 1980s comprehensive nursing programmes, cited within polytechnics, gradually replaced hospital programmes in New Zealand. The comprehensive education of nurses aimed to provide the nurse with a wide variety of clinical experience including general areas, obstetrics, psychiatry, community health settings and psychopaedics but at the same time the length of time in some general areas was limited. It is therefore of paramount importance that we ensure the quality of supervision when the students are in the clinical setting.

With the change of nursing training from hospitals, where the nurses were paid a salary and allowances during their employment, to the education sector, where students pay tuition fees and are full time students, the focus of their learning changed. Theory is now taught in the educational institution, then the student is assigned to a clinical setting to apply and intergrate the knowledge. Students have become supernumerary which means they are no longer included in agency staffing levels (Booth, 1997).

Initially the students were to be taught the theory and then assigned a clinical placement with a tutor from the polytechnic, to apply the knowledge, for periods of maybe one to eight hours depending on the learning which was to take place. To meet the Nursing Council of New Zealand's clinical hours requirement, and the needs of the student in the learning environment, a more full-time placement arrangement was favoured. The full time week of clinical supervision and the restructuring of the educational sector are two contributing factors for the need to employ contract clinical tutors.

As a result of the Education Amendment Act (1990) and the increasing overseas influence, which recognised the need for an undergraduate degree as the requirement for entry into the profession, the polytechnics in New Zealand were empowered to develop and offer Bachelor of Nursing degrees. These were developed rapidly over a period of three to four years and as a result of this the profession has been presented with challenges for both students and tutors. These challenges include the diversity of clinical placements and access to some clinical placements as well as the way in which students are taught to apply theory in clinical practice.

Students presently spend approximately two to four weeks in any clinical area, and during this time they may be supervised by a clinical educator from the Polytechnic and a buddy. The buddy is a registered nurse practitioner who the student is assigned to for a duty and preferably for a week. The student works along side the buddy who takes on the informal guiding and teaching role. The buddy role is similar to the preceptor role which is the experienced nurse who facilitates student learning in the clinical area in addition to their regular assigned nursing function (Armitage & Burnard, 1991) and

socializes the student into the nursing role (Letizia & Jennrich, 1998). The polytechnic remains responsible for the students learning.

The previous apprentice type system, where nurses learnt mostly from senior staff and the occasional visit from a tutor from the hospital school of nursing, has been replaced by a system where the nurse educator takes responsibility of working along side the student in the clinical setting. This may require that the nurse educators cover three to four different areas. Because of changes in staffing levels and contracts with hospitals who provide the clinical placements it has been necessary to increasingly use contract clinical tutors, to work with students in clinical practice but not be involved in the teaching of the theory within the polytechnic. Both the health and education sectors have been and are continuing to undergo changes brought about by altered fiscal policies. In the education sector the changes had an effect on human resources. What began as a reasonable abundance of staff in the 1970s-1980s and the dubious luxury of teaching to a number of small groups, suddenly became a smaller group of staff required to teach larger classes. This resulted in a change to the way students were assigned to the clinical practice setting and the limited availability of nurse educators to continue into the clinical setting with students. Experienced practitioners were therefore employed to supervise and work with the students.

The learning environment in the clinical setting can be either a positive or negative experience for students. Having been involved in nursing education for a number of years and been part of the changes to nursing education and curriculum development it is evident to the researcher that an optimum learning environment in the clinical setting must be provided to ensure students gain quality clinical experience. Clinical teaching

is seen as integral and necessary part of nursing education, it therefore becomes the responsibility of the clinical teacher to structure learning experiences which provide the opportunities and resources for the student to become clinically competent. This chapter has provided an overview of the development of nursing education from hospital training schools to the present comprehensive education of nurses in Polytechnics. This study has developed from my interest as a nurse educator and my belief in the importance of clinical education in nursing. The concerns that have evolved over the years as a result of reduced hours students have in clinical practice in the hospital setting, and the changing focus of responsibilities of nurse educators has subsequently seen the development of the role of the contract clinical tutor.

Contract clinical tutors referred to in this study are tutors who are employed on contract to supervise students from the Bachelor of Nursing programme when they are working in clinical practice but are not involved in the teaching of the theory component. The tutors' conditions of employment did not require a completed degree. They are required to be current in clinical practice and available at specific times but are not required to participate in any teaching instruction or staff development. Their expertise and familiarity with the clinical setting is highly valued but they are also required to assist the student apply theory to practice and assess competence of students professional development and clinical performance without an in-depth knowledge of the curriculum.

For the purpose of this study the participants are referred to as contract clinical tutors. They are also referred to in some literature as clinical teachers and sessional teachers. The term nurse educator refers to registered nurses employed by the Polytechnics to teach in the theory as well as the clinical component.

The remainder of this thesis is organised into four further chapters.

Chapter Two explores the literature with the focus on the importance of a quality clinical practice environment for student learning. It provides a broad overview of the literature on clinical practice and its contribution to nursing education, followed by the clinical teachers' and students' perspective.

Chapter Three describes the research design and the method used to select the participants for the study. The advantages of focus group interviews are examined as a method of data collection. Ethical implications involved in the study are described, and rigour in qualitative research is discussed. Thematic analysis as the method of data analysis is described.

Chapter Four discusses the findings of the analysed data and illustrates the way in which thematic analysis is used as a means of analysing the information. Focus group interviews provided the researcher with valuable data and comments made by the participants were then compared and contrasted with literature from previous studies.

Chapter Five provides the reader with an overview of the conclusions from the study, the limitations of the study and recommendations which came from the participants.

CHAPTER TWO LITERATURE REVIEW

Clinical teaching.

Clinical instruction provides students with the opportunity to put theory into practice and to develop theory from practice. This chapter begins with an overview of the literature related to the importance of clinical teaching in providing students with a supportive environment where they can safely integrate theory into practice in the reality of the practice setting. The quality of clinical teaching and the characteristics of the clinical teacher are discussed from the perspective of the clinical teacher and the student.

Although it has been widely acknowledged that clinical practice for students is an integral component of nursing education it is also a necessary process of providing the students with the opportunity to apply the professional skills learnt in a laboratory setting to the reality of practice but with the support and guidance of a clinical teacher.

In spite of this the role of the clinical teacher has not been clearly explained. Crotty (1993) reported, through interviewing twelve nurse teachers, that they believed their clinical activity was one of developing the clinical environment and supporting clinical staff who do the clinical teaching.

Studies on clinical teaching have concentrated on effective and ineffective clinical teachers behaviours from the students point of view. The ability to communicate knowledge and expertise was a quality rated highly by students in a study by Bergman

and Gatskill (1990). A study comprising thirty four students from three levels of a baccalaureate programme aimed at determining the perceptions of characteristics of effective clinical teachers was found to shift as the student progressed through the programme (Sieh & Bell, 1996). The ability to correct and comment on written assignments, make specific suggestions for improvement of performance and assist the student to link theory to clinical practice were also regarded as valued characteristics of an effective clinical teacher (Pugh, 1988).

Clinical teaching is seen as the "core of nursing education" (Ferguson, 1996) and clinical teachers are required to provide an optimum learning environment and learning experiences to help students integrate theory and practice. The clinical setting provides the most valuable educational resource (Kermode, 1987). The rich variety of experience can produce students who can readily apply theory to practice and quickly understand what the discipline of nursing involves. The major activities of nursing practice are essentially "hands on" and are acquired, reinforced and consolidated in the actual delivery of care to real people (Naphthine, 1996). The student acquires the characteristics of professional roles and values so the nurse educator must be responsible for creating an environment conducive to learning (Wong & Wong, 1987).

The quality of clinical teaching and the characteristics of the clinical teacher are significant to the students' experience in clinical settings and can be a major influence on the quality of the experience for the student. A supervisor familiar with the clinical setting was seen as an advantage by students in a study by Hart and Rotem (1994). Clinical supervisors seconded from the hospital were found to be willing and knew the staff and students. However, it has also been found that supervisors who were

unfamiliar with the curriculum and presented with unrealistic objectives not in line with the curriculum philosophy , had a negative influence on the students (Hart & Rotem, 1994).

Casual or sessional clinical teachers as described by Duke (1996) are qualified nurses who work on a sessional basis with students in clinical areas.

The sessional teachers who are often brought in for short spells of time and are unfamiliar with clinical competence are nevertheless still required to evaluate students' success in meeting clinical requirements. Findings from a study of eighteen Australian nurses who were employed as sessional clinical teachers highlighted characteristics of oppressed group behaviour, and role conflict (Duke, 1996). These characteristics had resulted from loss of self esteem which had affected their confidence in their observation and decision making. These were particularly evident when the clinical teacher was required to managed the nurse, teacher and carer roles. They often felt unprepared for the complexities of the teaching role (Duke, 1996).

The change in the role may contribute to stress and strain of sessional clinical teachers. Conflict and stress may result especially if the clinical teacher is insecure about their teaching abilities, especially in relation to making final decisions about student success (Duke, 1996).

Myrick (1988) points out that inadequacy and role conflict may be experienced by 'sessional hired clinical teachers' who are frequently inexperienced teachers and unfamiliar with the nursing curriculum. When investigating the state of clinical teachers in Australia it was found that when clinical teachers are employed they have usually been seconded from the clinical institution within which the students gain their experience and are hired for short periods of activity when students are on clinical placement (Naphine, 1996). The employment in Australia of sessional clinical teachers for short periods of activity when students are in clinical areas also creates problems in relation to recruitment and retention of staff. The use of sessional staff is also a result of budgetary constraints. The funding does not allow full employment for these teachers (Duke, 1996). Similar parallels can be made in the situation in New Zealand. Contract clinical tutors have been employed by most Polytechnics as the one to eight or one to ten ratio and the restructuring of the health and education sectors have necessitated the nurse educator remaining in the Polytechnic to teach the theory while other students are allocated to clinical placements.

There are, however, benefits to be gained in employing contract clinical tutors. The issue of familiarity of the clinical area was rated highly by students. Hart and Rotem (1994) reported that students felt the relationship supervisors, who were seconded from the clinical setting, had with the staff meant there was no resentment of students and the registered staff employed to supervise students were better able to match students with clinical staff. Being allocated a supervisor who was familiar with the clinical setting was seen as an advantage to some students. At the same time supervisors who were not members of the teaching staff and were unfamiliar with the curriculum could be a disadvantage to student learning (Hart & Rotem, 1994). Students perceived a nurse

teacher as “credible” when teachers could demonstrate that they had specialist knowledge and expertise in their subject and were able to apply their expertise (Steven, 1992). Currently in New Zealand clinical instruction remains primarily the responsibility of the nurse teachers who teach the theory component and are employed by the Polytechnic. However, most have at some time employed registered nurses to the position of contract clinical tutors.

Extra contract clinical tutors are on occasions employed by word of mouth or from the unsubstantiated belief that because a registered nurse was a good clinician she/he would make a good clinical teacher. Napthine (1996) suggests that it is a myth to assume that the good clinical nurse will have knowledge of teaching and learning principles or that she/he will be a good teacher.

It was found in an Australian study that clinical teachers have limited opportunities to be part of curriculum development, nor do they have opportunities to learn the skill of adult teaching. They are required to prepare in their own time and familiarise themselves with the course requirements, clinical objectives and summative assessments required for the clinical unit. They are employed to teach, guide, facilitate and evaluate nursing students with limited information about the students level of knowledge and ability. In spite of limited orientation and their own extensive experience, these non-faculty clinical teachers often do not become fully conversant with the course philosophy or objectives of the nursing curriculum which guides their practice. (Myrick, 1991; Ferguson, 1996).

The expectation is that contract clinical tutors also be responsible for facilitating learning through tutorials and assessment of competences. Unless the contract clinical tutor has had sufficient preparation and an understanding of the learning outcomes of the module or unit, it is likely that final decisions related to student assessment of competencies will be hindered by lack of confidence in both their abilities as teachers and in their own professionalism (Duke, 1996). Research undertaken in Australia confirmed that staff employed in clinical settings are often unclear about the student's role and how they may contribute to student learning experience (Hart & Rotem, 1994).

There is considerable literature which suggests that assessment and teaching of clinical competence by people who are not currently in practice is not justifiable in nursing today (Burns, 1994; Berkett, 1995). Wong and Wong (1987) also discussed the lack of preparation available for most clinical teachers and the low prestige associated with clinical teaching in nursing. If nurse educators acknowledge the importance of quality clinical practice for students they have a responsibility to provide opportunities to support the clinical teachers especially in areas of course philosophy and student evaluation to ensure the theory taught is then effectively applied in the clinical setting.

Polytechnic staff in New Zealand are continually exploring various options of how best to provide quality clinical experience which will enable students to learn in the clinical setting. In some areas this includes clinical staff taking over the responsibility for student learning, as "buddies", and educators withdrawing from the clinical areas entirely. A more acceptable scenario is that the buddy and the clinical teacher develop a more collaborative venture between education and practice. Collaboration among health care professionals is not new but the benefits of working together to meet a

common goal are as important today as ever. In an environment of advanced technology, and cost cutting, both in health and education, the principles of collaboration and cooperation may need to be further explored.

Although the environment within which the student works to gain clinical experience may be unpredictable, challenging and stressful, students reported that positive interpersonal relationships, developed between clinical teachers and the students, and contributed towards reducing anxiety (Yong, 1996).

The role of the nurse teacher in clinical settings has a major impact on the success or otherwise of students achieving in nursing programmes. Clinical teaching occurs in the proximity of the patient, individual or group setting and has long been regarded as a significant and essential component of professional education (Wong & Wong, 1987) and a necessary part of any educational process in nursing (Kotzabassaki, Panou, Dimou, Karabnagli, Koutsopoulou, and Ikonou, 1997).

Key elements of this process include:

- supporting the development of the ward learning environment
- providing information
- helping students relate theory to practice

(Davies, White, Riley & Twinn, 1996).

Maintaining and/or improving the quality of nursing education is the most important function of nurse educators and the quality of nursing education relies heavily upon the quality of students' clinical experience. Nurse educators need to be aware of theories of learning to ensure students derive maximum benefit from clinical placements (Jinks, 1991). This awareness should begin early along with the development of the curriculum.

Various writers express concern at clinical staff being responsible for clinical teaching. Webster (1990 pg 17) suggests that nurse teachers "need to share the clinical teaching responsibility so as not to demoralise clinical staff and loose cooperation." The buddy role which has developed in most New Zealand clinical settings should be supported by nurse teachers in order that the theory practice gap may be bridged. Of concern is the question of how nurse education in the clinical setting can best be achieved. The role of practitioners has been clearly defined in spite of the major impact they may have on the student and on the environment in which student learning takes place (Davies, White, Riley & Twinn, 1996).

The use of clinical staff as buddies is widely used in New Zealand and, in spite of an environment which is already over stretched, and recent changes within the health sector, they still provide an important liaison role offering support to the student and maintaining relationships within the clinical setting. The environment within which the student works to gain clinical experience may be unpredictable, challenging and stressful so the interpersonal relationships developed between the clinical teachers, the student and the buddy can contributed to a positive learning experience for the student.

In New Zealand a common option for employing registered staff for the position of contract clinical tutors is that a nurse who is an expert in clinical practice is either approached by nurse teachers or replies to advertisements for clinical teachers. Informal interviews are conducted and the majority of institutions endeavour to prepare new staff by providing short orientation programmes.

The preferred qualification in New Zealand for employing contract clinical tutors is registered as a nurse with a Bachelor of Nursing degree completed or in progress, recent experience and expertise in the clinical setting and a commitment to nurse education. Involvement in the programme ranges from group meetings with staff, attending student sessions for clinical preparation, facilitating tutorials in the practice setting and also encompasses the daily management of clinical teaching and evaluation of students' professional and clinical performance.

The clinical teacher is responsible for providing the safe environment by recognising and supporting the student when they are confronted with new and unknown situations. The expectation is that the clinical teacher will be the nurse and the teacher, and that they will be clinically and academically credible to provide the learning experiences that motivate and assist the learner (Sieh & Bell, 1994). Students are not service providers but are confronted with a variety of situations in a clinical setting, where their knowledge of what to do in a given situation can be challenged. The clinical teacher must be able to confidently assist the student to apply the knowledge in a safe environment.

A study carried out by Duke (1996) shows that role conflict was a problem identified by sessional clinical tutors and that the juggling of relationships with student, patient and school of nursing became a challenge. The role conflict occurred when teachers needed to let students attempt procedures but found it difficult to stand back.

Having examined the literature related to the value of clinical practice for student learning, the students perspective will now be explored.

Students' perspective

The clinical learning experience provides students with the opportunity to consolidate knowledge, be socialised into the professional role and acquire professional values (Wong & Wong, 1987). With the move toward student-centred learning and empowering students in the learning environment, Osborne (1991) maintains that teachers of nurses should create the educational clinical environment which is conducive to student learning. The literature offers an extensive view on clinical experience from a student's perspective, and it has been recognised that the clinical learning experiences of students is an important part of any programme (Sieh & Bell, 1994; Napthine, 1996).

Since nursing education transferred to polytechnics, a process which began in 1973, there has been debate and discussion about clinical supervision of students and the perceived discrepancy between what is taught in the classroom and what is practised in the clinical area (Forrest, Brown, & Pollock, 1996). Research from England indicates that separating tutors and clinical teachers, far from solving the problem of the theory-practice gap, actually compounded it (Marriott, 1991). In addition the clinical teacher role in the United Kingdom was found to be both inefficient and expensive (Akinsanya, 1993).

Students perceived that a major role of the clinical teacher was to smooth the entry for students into the clinical environment and facilitate the relationship between students and staff (Watson, 1997). Attributes identified by students as being important to their

clinical learning included knowledge, clinical competence, teaching skills, relationships and personal characteristics (Reilly & Oermann, 1992).

The students identified caring teachers as being non-judgemental respectful, patient, available, dependable, flexible, supportive, open, warm, genuine and 'being there'. (Miller, Haber & Bryne, 1990). Students are fragile and vulnerable and are often unsure of their role especially in the presence of doctors, senior staff, patients and families. Nurse educators therefore must anticipate these students' concerns as a high level of stress may interfere with learning. Support from clinical teachers is rated highly by students and although nurse educators recognise the significance of clinical experience to student learning only a small percentage of senior nurse educators remain involved in clinical teaching (Wong & Wong, 1987).

In a study by Clark and Ruffin (1992) the emotional demands, and unfamiliarity when using technical equipment, also contributed to students' anxiety when working in the clinical setting. Interpersonal conflicts with other staff and insecurity about professional skills and competence were found to be the most stressful situations among a group of students interviewed from a programme in a University in California six weeks after the start of their first clinical experience.

Characteristics of a good supervisor were also identified by students in a study by Fowler (1995) as those who had a sound knowledge base, and teaching/supervising and relationship skills. Students stated they wanted to be valued as an individual, for teachers to value their own role and show it, and to demonstrate effort and put

themselves first (Fowler, 1995). Relevant knowledge and ability to share it were qualities also identified by students in a study by Fairbrother and Ford (1998).

In the study by Kotzabassaki et al, (1997) students rated highly 'best' characteristics of clinical teachers as those who enjoyed nursing, were self confident, dynamic, energetic and who encouraged a climate of mutual respect. Other valued characteristics included the ability to listen attentively, answer questions precisely and being organised and accessible to students. In a replication study by Nehring (1990) results showed that both faculty and students agreed that the best clinical teachers were good role models and demonstrated clinical skills and judgement. Clinical teachers who were organised and accessible, provided appropriate evaluation and feedback and were able to assist the student without taking over were valued by students (Reeve, 1994). The relationship with clinical teachers is highly rated by students, and was found to be more important than professional competence in a study by Li (1997). Student learning is also more likely to occur in an atmosphere of caring and mutual respect, not fear and intimidation (Hayes-Christiansen, 1988).

The 'worst' teachers were unable to direct them to the literature, corrected them, belittled them and could not demonstrate empathy, provide constructive feedback or stimulate student interest. These teachers may be critical of students in front of others and be unable to support and encourage them (Kotzabassaki et al, 1997).

Windsor questioned students on what they thought facilitated their learning in the clinical setting. Students acknowledged that "quality of learning was affected by the quality of the students' preparation, characteristics of the instructor and the variety of

clinical opportunities to which students were exposed” (1987, pg 150). Instructors who provided emotional support in a non threatening atmosphere were more conducive to learning and instructors that created anxiety for the student were likely to use derogatory comments and did not provide constructive feedback (Windsor, 1984).

A more recent study to identify difficulty/challenging situations encountered by students in Australia found that students were more concerned about ‘the emphasis on doing’. They felt that they were viewed badly if not actively doing something (Cooke, 1996).

A strong link was also identified between pre-clinical instruction and supportive facilitation during and after their clinical experience (Cooke, 1996). The findings in this study showed that facilitators can assist students to effectively deal with these situations through specific teaching strategies (Cooke, 1996).

It is evident that anxiety-producing clinical experience may also contribute to decreased learning (Kleehammer, Hart, & Keck, 1990). Data from both junior and senior student nurses over a period of four years found that anxiety may allow them to see only one way of doing things, the way they were taught. The clinical teacher with experience can highlight for the student the competencies required for safe practice and with increased confidence the student can then modify procedures and at the same time develop their own nursing style.

Students demand quality teaching not just supervision in a clinical setting. Students found that nurse teachers from the educational setting had difficulty in developing a

clinical role. Also evident from this exploratory study into the clinical role of the nurse teacher in a nursing programme in England was that although many of the nursing teachers thought it desirable to develop their clinical role and remain clinically competent, most saw it as unlikely that they would be given the opportunity to do so (Clifford, 1996).

As the literature has shown, students have been proactive in their discussions about the qualities and abilities they believe clinical teacher should have (Fowler, 1995; Jinks, 1991). However, there is little evidence in the literature to suggest that students prefer tutors who have taught the theory to be also available to teach in clinical practice. Students do prefer nurse teachers from their educational institutional to be available in the clinical area and to visit them to see how they were progressing, to show interest and help with problems (Lee, 1996). They considered that the nurse teacher role should be to provide support to staff in the clinical area to enable trained nurses to be 'ideal clinical teachers' (Clifford, 1993). Concerns also identified by students were interpersonal conflict with other staff and the insecurity about professional skills (Williams, 1993). Students also described the caring, teaching/learning interaction as a process characterised by a pervasive climate of support, and they perceived the holistic concern both academically and personally as an essential dimension of the caring interaction (Miller, Haber & Bryne, 1990).

Student nurses wanted their instructors to challenge them by asking good questions and giving them honest feedback about their performance. This was highly valued also given by agency staff and patients even though the student may not feel that they had done so well (Windsor, 1987).

Neville and Crossley (1993) did find, however, that students preferred to have a ‘tutor link’ with the college. The theory tutor working in clinical settings with students can offer their understanding of the education process and the ability to teach and facilitate learning (Jarvis, 1983). Having considered the students’ perspective on clinical teaching, it is now valuable to explore the literature regarding the perspective of clinical teachers themselves

Clinical Teachers' Perspective

The changes in the way education programmes are delivered has placed differing and often competing demands on nurse educators and questions continue to be asked as to whether nurse educators can or should be expected to maintain their own competence in clinical practice (Kershaw, 1990; Stitt, 1994).

The role of nurse teachers in educational institutions has also changed to include the area of research, publishing and scholarly endeavours designed to ensure that tutors and faculties are at the forefront of knowledge development and expertise of the discipline (Dyson, 1995). The increase in managerial and administrative responsibilities for nurse teachers and their own professional development to achieve higher degrees has added additional strain to their time and energy. Crotty (1993a) in a survey of two hundred and one nurse teachers also identified the complex and multifaceted role of the nurse teacher in educational institutions.

Osborne (1991 pg 28) suggests there is a danger of nurse teachers "spreading themselves too thinly in their attempt to fulfil all of the roles expected of them". This may result in poor quality experience for both the teacher and the learner. Instead it is suggested that the nurse teacher should maintain educational skills and develop relations with clinical staff (Osborne, 1991). However, it was noted by Berkett (1995) that assessment and teaching of clinical competence by people who are not currently in practice is not justifiable in nursing today.

Reports from nurse educators in a study by Jowett, Walton, & Payne, (1994) were concerned about keeping up with their own skills in nursing and had difficulty meeting the demands of their role. Teachers do, however, identify the potential benefits of maintaining their practice. These included keeping in touch with changes in clinical practice and improving relationships with trained staff (Baillie, 1994). Responsibilities included dealing with the changes in nursing education, and meeting the academic demands of their role. The clinical teacher has direct immediate responsibility for ensuring the students' clinical experience leads to clinical competence. However, the nature of the clinical role of nurse teachers has been summed up as 'just visiting', 'liaison' and 'support' and nurse teachers in some instances found they were losing their skills in clinical practice and perceived their contact in the clinical setting as a "token gesture" (Clifford, 1993 pg 603).

All of the above factors, combined with the variation of experience and changes in the way clinical experience is provided in bachelor programmes has reduced the opportunities for tutors who teach in the theory component of the programme to also teach in the clinical setting.

The complexity of the teacher's role has been described as; the individual teacher being required to teach in the classroom, instruct, facilitate in clinicals, publish on a prolific basis, research clinical and academic matters, participate and chair numerous committees, act as student adviser, plus be actively involved in the community issues and be at the leading edge of nursing knowledge (Myrick, 1991).

Though nurse teachers are still able and encouraged to work with students in the clinical setting, it is becoming increasingly difficult for them to provide consistent quality clinical education in some areas of clinical practice. Administrative tasks appear to dominate the working life of the nurse tutor and although ninety-nine percent of respondents in a study by Lee (1996) agreed that clinical teaching was important only thirty-one percent indicated that this was part of their current role. Nurse educators find teaching in the classroom and in the clinical area most satisfying however, excessive paperwork, endless meetings, lack of credibility in the clinical area and too little patient contact were given as reasons for perceived frustrations by nurse educators (Lee, 1996).

The economic restraints brought with it shrinking resources, a profit philosophy, added to this the costs of clinical training access. These all contributed to further loss of teaching staff in polytechnics. Nurse teachers are required to teach across a wide variety of subjects and courses along with the expectation that tutors should be multi skilled and deliver high quality teaching. In light of economic demands, the current one to eight or one to ten teacher/student ratio instituted in some polytechnics may now be regarded as a fragile luxury, which is unlikely to remain, and the opportunity for tutors to work in clinical settings with students will reduce even further.

Another factor which may contribute to tutors not working with students in clinical practice is the undervaluing of clinical teaching by educationalists. Malek (1993) found that clinical teachers had a low status in relation to the nurse educators, a situation aggravated by the perception that the role was an easy option and that nurse educators put clinical in a low priority to other areas of their work. Clinical teaching is deemed as

low status and even punitive within the modus operandi of the university setting (Myrick, 1991). Nurse teachers felt it desirable to develop their clinical role (Luker, Carlisle & Kirk, 1994, cited in Clifford, 1993) and many expressed concern about keeping up their own skills (Clifford, 1993, Jowett, 1994). It is generally agreed that nurse teachers should be expected to maintain their competence and that they need to be aware of current developments in practice (Lee, 1996; Gerrish, 1992).

The role of nursing students has always been challenging and sometimes frustrating. The pressure on students today is even greater and since the education of nursing moved into tertiary institutions and particularly since the change of student allowance in 1991, a number of students have got additional responsibilities including work and family commitments. Support and caring must be demonstrated between faculty and student (Reilly & Oermann, 1992).

In summary, therefore, the literature focuses on the perceptions of students, the characteristics of educators and the role functions of the teacher in the clinical setting (Kanitsaki & Sellick 1989; Watts, 1990). As clinical experience is considered to be an integral and necessary component of nursing education, (Reilly & Oerman, 1985; Pugh, 1988), there is a need to examine the contract clinical tutors' own views of their experience. Clinical tutors, whether nurse educators or experienced nurse clinicians who teach in the clinical setting only, all contribute to shaping the students' socialisation into the nursing profession.

It is apparent that there has been limited research conducted into the perceptions of the contract clinical tutors in New Zealand. Understanding how contract clinical tutors

perceive and conceptualise their role and the difficulties inherent in that role, is necessary for future planning of the clinical component of the nursing curriculum.

The literature is divided on the concept of the tutor who teaches the theory also teaching in clinical practice, but whichever view is taken, it is increasingly evident that institutions throughout New Zealand, responsible for the education of nurses, are exploring alternative ways of facilitating student learning in clinical practice. It is important therefore to hear the contract clinical tutors' own story, from their perspective.

CHAPTER THREE:METHOD

This study was designed to explore the role of contract clinical tutors from their perspective, to contribute to a wider understanding of their role, and included the positive experiences of their work and the difficulties and challenges they faced when working with students in the clinical setting. An exploratory qualitative research design was used. Although the literature has abundant information about clinical teaching and is strongly representative of the students' perspective there is limited research giving the view of the clinical teacher who does not teach the theory component of the nursing programme.

This design was selected because it gave me an opportunity to understand the experiences of the participants and to explore with them the issues of concern. With the participants recommendations, suggestions could be made which would contribute to the quality of teaching in clinical practice. Focus group interviews were chosen as the data collection process.

Focus group interviews

Focus groups interviews were chosen to obtain more definitive information through a dynamic group interactive technique (Kingry, Tiedje & Friedman, 1990) and to provide access to data that is not easily obtained from individual interviews (Morgan, 1988). Focus groups can be used effectively for gathering insights and opinions, perceptions and attitudes from participants' everyday experiences in a defined area of interest (Brooks, Fletcher & Wahlstedt, 1998).

Focus groups have been increasingly popular as a means of data collection in qualitative research, and although this group was small, it was felt still the preferred method of collecting information because it could significantly stimulate new ideas and high levels

of energy in discussion (Twinn, 1998). Focus groups can provide depth, richness and complexity to the phenomena to be explored (Morse, 1991). Focus groups were also used because they allow the opportunity to generate a great amount of interaction on the topic in a limited period of time (Krueger, 1988).

Focus group interviews came from a social science perspective in the 1930's (Krueger, 1988). The extensive use of focus groups to collect data was used mostly in marketing research, but increasingly focus groups have been used in qualitative research, particularly nursing research.

Krueger (1988) identifies five characteristics of a focus group: (a) people who (b) possess certain characteristics (c) provide data (d) of a qualitative nature (e) in a focussed discussion.

In this study, the focus group members were all contract clinical tutors for one polytechnic nursing programme, who were willing to provide information about their experiences and discuss issues of common interest. Some literature indicates participants should ideally be strangers to each other (Morgan, 1983), and the size of the group would be best between four and twelve people (Krueger, 1988). The fact that this study was based on a group of four participants who knew each other did not adversely influence the study. The small group allowed the interviews to be conducted by the researcher without the assistance of a moderator.

Focus groups are a cost effective way of gathering information. Forrest, Brown and Pollock (1996) used focus groups to supplement individual interview information in their study of the clinical role of the nurse teacher in the clinical area. Cost effectiveness was stated as the reason and eight focus groups were used. In this study, the use of focus groups proved cost effective. Only two focus group meetings were needed.

Focus group participants

To provide a specific context and focus for discussions, which would allow shared interests and concerns to emerge, participants needed to be contract clinical tutors for the one polytechnic. To increase the possibility for change to occur, if necessary, based on potential suggestions from the group, my own polytechnic was chosen as the specific context.

To gain an understanding of current or recent experiences, participants needed to have recent employment in a health care setting where our students gain clinical experience, and to have been employed by the polytechnic to work with Bachelor of Nursing students within the last three years.

Ethical Considerations

The rights of human subjects in nursing research was well documented. These include the right not to be harmed physically, psychologically or emotionally, the right to self determination, full disclosure and informed consent and the right to privacy and confidentiality (Polit & Hungler, 1993). This study was designed to ensure these ethical considerations were observed.

As the study was being undertaken as part of a thesis for Master of Arts (Applied), ethical approval was obtained from the Victoria University of Wellington Human Ethics Committee and from the institution at which I am employed.(see Appendix1 &2)

The application for ethical approval addressed the following issues;

The principle of self determination meant the participants had the right to decide voluntarily whether to participate in this study and the right to withdraw from participation at any time, without penalty (Seaman, 1987). As the potential participants were or had been employed by the nursing faculty, written permission needed to be gained from the Head of Faculty for the researcher to access the potential participants.

To overcome undue influence which can be imposed on research participants it was planned to invite an intermediary who would make the first contact with potential participants by phone. This would include a brief explanation of the research, followed by an information letter (see Appendix III) which would be posted to them. The information letter outlined the purpose of the study, how the interviews would be conducted and the ethical considerations, including how tapes and transcripts would be protected during the study and how risks to participants would be protected.

The decision to use focus groups meant participants were known to each other. It would therefore be necessary to ask participants to keep the identity of the other

members of the group confidential. The transcriber would also need to sign a confidentiality form (see Appendix IV).

A separate consent form (see Appendix V) also contained information related to the participant's right to withdraw from the study and that current and future employment would not be affected in any way. This information would be verbally reinforced at the time of the first interview.

Confidentiality would be further ensured by the securing of tapes, disks and transcribed information in a locked place at the researcher's home. A list of linking codes with participants names was to be stored separately. All written information was to be destroyed and tapes wiped at the completion of the study. Disks were to be kept for five years then deleted.

Ethical approval was granted by both Ethics committees. To ensure that ethical standards were maintained all identified ethical considerations were observed throughout the study.

Recruitment of participants

Permission was gained from the Head of Faculty to access the contract clinical tutors' employed by the polytechnic.

As I had a collegial, but not line responsibility, relationship with the contract clinical tutors, another colleague acted as intermediary in approaching potential participants and distributing an information sheet. The participants were known to the researcher and all had worked with students within the past three years.

The information sheet described the purpose of the study and how the research data was to be collected. Participants were asked to phone me if they wished to ask any questions or clarify any part of the process, and to confirm their wish to participate. A delay in the response from potential participants prompted me to request the intermediary to contact them again and this brought four responses.

The Participants in the Study

The participants were New Zealand Registered Nurses with a combined total of 80 years experience in a variety of areas of nursing including medical, surgical, acute care, gerontology and mental health. The most senior participant in the group had had approximately thirty years nursing experience. The remaining three had had twenty, twenty three and eight years and had worked in a variety of areas within the hospital and community settings.

The participants had become contract clinical tutors in different ways. Two had answered an advertisement for contract clinical tutors. One demonstrated her interest in clinical education by forwarding her Curriculum Vitae to the faculty and only one was contacted by the institution because of her local knowledge and expertise in a specific area. Two members of the group had completed a Bachelor of Nursing degree. The remaining two had no post registration academic qualifications.

Focus group process

Over a period of days I made contact with the participants to arrange a suitable time and place to mutually suit each person. A conference room near the education institution proved a suitable venue and a date and time was agreed upon.

I prepared the environment to ensure it was as comfortable and as relaxed as possible. As the group were arriving the participants and I began talking informally. This 'small talk' is regarded as essential to create a friendly atmosphere (Krueger, 1988). At the first meeting a consent form was handed to each participant, and an opportunity was again given to ask questions about the research, or clarify any issues related to the consent form.

Participants were then reminded that the two-hour long first interview would be taped and a pre-test of the tape recorder was briefly carried out. I also explained that I would be jotting brief notes. Written notes are essential although note taking should not interfere with the spontaneous nature of the group interview (Krueger, 1998). The purpose, methodology and data analysis was briefly explained again to the participants.

The interview were organised around areas of particular interest while still allowing considerable flexibility in scope and depth (Polit & Hungler, 1989).

The initial open-ended question provided the basis for the participants to begin a conversation and although I made an effort to allow participants to express their views without interruptions, some control was kept on the interview by paraphrasing comments made, and focusing the conversation when an issue was raised which required further clarification. The open ended questions focused firstly on the positive aspects of the role then continued into the challenges including assessment and questioning of students in the clinical setting.

During the interviews the researcher and participants took special care to avoid using names of staff, students or patients, and any reference to specific areas of work or people was avoided in the final written report.

Although slow to start the interviews quickly became relaxed. All participants had considerable information to offer. Prior to the discontinuing of this meeting a time and venue was arranged for a second focus group interview. At the second interview held four weeks after the first the extensive amount of data collected and collated from the first interview, was discussed. At that stage four themes had been identified and these were explained to the participants. An opportunity was given for them to comment and their opinions were sought regarding the appropriateness of the themes which were generated from the data. The second focus group interview was not intended to be as

long as the first but it did provide the opportunity for some reflection by the participants in relation to what they had said before and to add to some issues that the researcher wanted clarified.

Rigour in Qualitative Research

Rigour is described as striving for excellence in research through the use of discipline, adherence to detail and strict accuracy. Lack of rigour may result from poorly developed methods, inadequate time spent collecting data, poor observations and failure to give careful consideration to all data obtained (Burns & Grove, 1995).

Specific elements of rigour are;

Accuracy and appropriateness

The audit trail

Verification of the study. (Denzin & Lincoln, 1994).

These elements were relevant to the study in the following ways.

Accuracy and appropriateness of data. This was obtained by taping both the interviews, transcribing the taped interviews and then offering the participants the opportunity to discuss the themes that were developed from the analysed data. Appropriateness of the data was met by selecting participants who had current or recent experience in the contract clinical tutor role and by ensuring that the discussion focused on this.

The audit trail. This requires careful documentation, including the transcriptions and the notes taken by the researcher. The findings are set out with sufficient questions from the interviews to illustrate the themes identified.

The verification of the study. Following the analysis of the data the participants were provided with the resulting themes and had the opportunity to verify that these themes reflected their own experience.

Data Analysis

The focus of the study was to understand the experiences of contract clinical tutors. The information from tape recorded interviews was transcribed and analysed by way of thematic analysis. Thematic analysis requires that the researcher carefully reads all notes, transcripts and personal comments and becomes intimately familiar with the contents (Talbot, 1995). The researcher listened continuously to the taped interviews and read the corresponding transcripts to help develop initial insight and understanding and to confirm where there might need to be further clarification. Reading and re-reading the transcripts a number of times assisted the researcher get a sense of the tutors' experiences as a whole. It also enabled the researcher to gain increasing understanding of the dynamics of the information.

The recognition of common themes is the essence of thematic analysis and this is achieved by underlining and highlighting the transcribed key statements made by the participants, that are significant. (Talbot, 1995). The researcher then coded these and listed the identified codes into clusters by similarities (Burns & Grove, 1995). When themes had been identified the participants were given the opportunity to validate these at the second interview. This is important to see whether they recognise a description of their own experience. This is viewed as a powerful indicator of credibility when using thematic analysis. (Wilson, 1993).

CHAPTER FOUR: FINDINGS

This chapter describes the themes that were created from the transcripts of two focus group interviews. Participants' own comments are presented and compared against existing literature.

Though the focus groups were small, participants had the opportunity to discuss commonalities and differences in their experiences. From these experiences four themes were identified.

1. Being effective
2. Working with others
3. Maintaining connections
4. Approaching learning

1 Being Effective

The participants acknowledged the importance of the teaching role in clinical practice and challenging experiences both positive and negative were discussed extensively. The discussion within the group gave a clear insight into the desire by the contract clinical tutors to provide the best learning opportunities for students but this meant expanding their knowledge in a variety of clinical settings and at times being pushed beyond their comfort zone. One participant described the situation as

All of a sudden you are expected to work with first year students then within a few weeks or even within the same clinical week you may be working with second and then third year students.

One tutor found this difficult at times, trying to expand her knowledge from one level to another. The participant felt that she had the knowledge

but trying to relate it to each year at the same time was not so good..

This necessitated trying to find out what theory the student had had, and challenged the individual's professional responsibility (a) towards the student who was usually eagerly anticipating doing as much as possible and (b) towards the clients with whom the student was working. Until contract clinical tutors were satisfied with their own knowledge and competence in the area they were reluctant to allow students to take responsibility. One participant anticipated this problem and visited the area where she was to work prior to the placement. However, this was not always possible if the contract clinical tutor was asked to work for only a few days or at short notice. When this occurred the participants felt that they were at times;

ineffective in their role.

The contract clinical tutor is required to have a strong clinical base, up to date knowledge of nursing practice, be responsible to the students and to the patients, act as a role model for students, and possess personal characteristics such as patience, enthusiasm, a positive non-threatening, non-judgemental attitude (Fowler, 1995). As well as this he/she needs to have an open-mind, be flexible, have a sense of humour, self-confidence, and self-awareness. Students perceived a nurse teacher as credible when they demonstrate specialist knowledge which they can apply (Forrest, Brown & Pollock, 1996). This becomes challenging when the contract clinical tutor is only working with students for short spells of time, and has not previously met them.

In a study by Naphine (1996) it was found that the preparation of clinical teachers does not reflect their importance in the education of the next generation of nurses.

Polytechnics offer varying orientation programmes. Some prefer contract clinical tutors to have post basic qualifications and if possible some adult teaching experience. However, most acknowledge that it is difficult to achieve this standard. The four participants in this study had in excess of 80 years collectively of nursing experience in a variety of areas. In spite of this it was still a challenge to one participant when she was required to apply her knowledge with students that were coming from different levels of knowledge, experience, and confidence. The familiarity of a particular area was of significance to one participant.

I felt that the students were able to value my input. Students had indicated to me that getting help from clinical tutors that have not had the opportunity to keep up their clinical experience is less value.

This was found to be the opinion of the students in a study by (Neville and Crossley (1993) who stated that although they appreciated the link with the teachers from college they also valued the recent clinical experiences which the contract clinical tutor was able to offer. The participants own confidence would be enhanced as a result of their personal knowledge of the clinical area.

Although a study by Li (1997) revealed that students regarded teachers' relationships with students as more important than professional competence, it was also found in a study by Hart and Rotem (1994) that students preferred a supervisor who was familiar with the clinical setting and at the same time be familiar with the curriculum.

Seeing things from a different perspective

All participants felt they had an advantage as a result of their recent clinical practice. Working alongside the practitioners previously, and then experiencing the role change to becoming a contract clinical tutor, brought a change of perspective. They recognised

the expertise of the practitioner and the excellence in relation to their role as practitioner, but they were also made aware of the problems some expert practitioners had as buddies to students. A participant stated that

A buddy may not wish to work with a student or may be willing but not have any preceptor training.

In an environment which has undergone so much change in recent years, if a student is allocated to a ward the staff nurse will almost definitely become the buddy to the student. Students learn best from staff who are friendly, give constructive criticism and are approachable and interested in the student (Cahill, 1996). The contract clinical tutors found themselves having to react to staff in a different way and on a number of occasions. Each of the participants found at some time they had to;

smooth things out to ensure a relationship between the staff and the student that facilitated learning for the student.

The contract clinical tutors recognise the difficulty of trying to get the appropriate buddy and agreed with one participant when it was suggested that they needed to

match personalities.

Although the role of a practitioner in this way has never been clearly defined, the buddy who provides a non-threatening atmosphere conducive to learning is valued by the student. (Klehammer et al, 1990).

Buddies are able to encourage and inspire, provide experience for the student in the real world of nursing practice. Participants in this study found that when asked to have a

student work alongside of them for the duty, most practitioners were very willing. However, one participants stated

they (buddies) don't really want to do this or some practitioners stated I can't do my job and have someone tagging behind me.

In a study by Napthine (1996) a clinical teacher observed that many clinicians go out of their way to assist students without any actual rewards themselves. However, difficulties arise when ward staff do not understand the current curriculum and do not allow students to practise relevant procedures, preferring the student to just watch. A study by Cooke (1995) found that the students felt they were being ignored by staff and at times felt they had to cope with unhelpful staff.

Participants in a study by Booth (1997) noted that tiredness and busyness of staff contributed to practitioners' negative attitude towards having additional responsibility of buddying a student. Participants in this study felt this situation happened a lot, and each of the members of the group agreed it was partly due to the changing situation in the health care system at the time.

Keeping the relationship with the staff is an important part of the role. By approaching the staff these things can usually be ironed out otherwise they can escalate and affect the students learning.

Breaking through the barriers

Participants used the term 'breaking through the barriers' to illustrate the experiences they have when they first meet students on the ward. One participant stated that

the student have a sort of expectation of you. They haven't come across you before and they like to know where you are at and what your expectations are.

As a relationship developed between the contract clinical tutor and the student, the student became more confident and a rapport was established. The establishing of a working relationship between the contract clinical teacher and the student was obviously important to the group and were very aware of the impact of mutual respect between student and teacher. One member of the group stated

It was only when I got to know the student and a relationship was established that I could become functional and helpful to the student and provide opportunities to facilitate learning. However, this process can sometimes take time and as we were only working with students a few days at a time this may not always happen.

As a result of these short spells, students may be less likely to develop enough confidence to approach the contract clinical tutor and learning opportunities can be lost.

The contract clinical tutors felt it was necessary to break down these barriers before they could be effective as teachers. It was satisfying to the contract clinical tutors when students verbalised their appreciation and a student comment recalled from one participant provided positive feedback.

Its great to have you back

the participant felt that

effects of working in a good relationship resulted in getting a good outcome for the students.

At times it was felt that these barriers also existed amongst staff. Students' response to a study by Cook (1996) was that they wanted to be valued and wanted to learn as much as possible from staff during their clinical practice. They wanted to be seen to fit in. However, negative attitudes were found to be evident amongst staff and included the students feeling of non-acceptance, expecting too much, and being ignored by hospital staff (Cook 1996).

Finding a Happy Medium

Often the situation in which practitioners work is stressful and the workload excessive, but they have an important role in providing learning opportunities for students. Contract clinical tutors recognised difficulties encountered when the student wished to work with the buddy and was keen to practise professional competencies when opportunities became available. The group generally agreed with one comment.

At times it is a difficulty knowing when to stand back, when to let the student continue with the work, and when to step in and assist. Some students seem to make a point of not wanting to work with me, but I made sure that I worked with all the students, so that I know where they are practically. That for me was a big learning experience. It is hard to keep your hands off. You want to get in and 'do', but you know you have to stand back and allow the students the opportunity. You have to find that happy medium.

Another participant added that

At times the staff are so busy, and are sometimes taking shortcuts. I don't expect students to do this, so I like to work with them, as students have the luxury of taking their time and doing things thoroughly.

Nurse teachers when questioned about helping students to link theory and practice in a study by Davies, White, Riley and Twinn, (1996) expressed concern that students were picking up bad habits in the practice setting and were not being taught to apply basic principles to practice.

Clinicians may also be reluctant to allow students to carry out certain learning opportunities if the contract clinical tutor was not there. This may stem from a very real sense of professional responsibility to their patients and the student, especially if they do not know the student's capabilities, or what preparation or supervision they require (Naphine, 1996).

Feeling Undervalued

Clinical teachers in a study by Naphine (1996) felt the non-valuing came from the academic institutions. Factors that may also contribute to these feelings of being undervalued stemmed from a clear dichotomy between theory and practice which is not helped by attitudes of nurse academics (Naphine, 1996). Not valued, however, are such things as the role of the academic and the extent to which it is changing, although in New Zealand the situation that is still more likely to occur is that nurse educators who teach theory continue into clinical practice with students. Contract clinical tutors generally thought that the student preferred the stability of a person working with the student for a full week. Each participant acknowledged the benefits of the student working in an area for the week and if the students were in one area for two weeks the contract clinical tutor had on a previous occasion swapped shifts so they could continue working with the same group of students. This enhanced familiarity of the area for the student as well as the positive relationship which had developed with the contract clinical tutor.

One participant stated that

At times I have felt that the hospital setting seemed to inhibit us from actually being proactive with students. I have experienced the feeling of being kind of in limbo and not being used to my full potential.

Another participant stated

I do feel undervalued, like I could be a lot more than what I am. You sort of felt a hindrance in the background and you just walk around.

Being prepared

Participants felt that to be an effective contract clinical tutor they had to be prepared. One participant felt that lack of preparation in some aspects of the role hindered their ability to provide valuable learning opportunities. Although orientation sessions are part of the preparation for the role, non-faculty staff do not become conversant with the philosophy and may not have the qualifications beyond their initial registration (Duke, 1996).

The participants of this study felt the preparation for their responsibilities of facilitating student learning were an important aspect of the clinical teacher's role. Two of the group attended orientation sessions, but would have liked more time and an opportunity to link with nurse educators more frequently. One member of the group had attended an orientation day and she felt

The orientation day was helpful, we were all made welcome on that day.

The remaining three had had individual orientations although one person who had not had an orientation at the time of employment stated.

*it was a matter of finding out for myself, and if you didn't know I would ask.
That's what I tell the students to do too.*

One participants also expressed the need to have an example of a care plan and other information on the documentation related to student assessment.

It is a matter of finding these things out as you go along, how you are meant to handle things and who to go to.

This “learning as you go” was also a theme identified in a study by Ferguson (1996). Clinical educators referred to in this study discussed the progress they had made in relation to their developing confidence in the role.

All participants felt that their role in providing opportunities to support students and facilitate learning was an important one. It is generally felt the students wanted

consistency of information.

The participants felt particularly helpful when they were able to contribute to student knowledge and when they saw the students gain confidence and develop a trust with them. A participant stated

It's nice when a student comes to you to share what's going on with them, and it makes you sort of feel special when they've got problems and they actually say I need some help. It is particularly satisfying when you are in a busy ward and you actually function as a part of the ward with your student, and they are

having valuable learning times and you are contributing towards how the ward is functioning.

The contract clinical tutors identified difficulties which arise, when learning opportunities are available for the students.

The buddy may ask if the student would like to do a procedure. If the student lacks confidence they may prefer to watch and not ever get the opportunity to actually do the procedure, or they may contact the tutor.

The contract clinical tutors generally felt that the locator system available for students to contact the clinical tutor was a good one but as one participant stated

learning opportunities were missed if the student did not contact me.

One participant actually provided a teaching session to students on the use of the 'locator', though she still felt a lack of confidence on the part of the student may be the reason the student did not make contact.

Sometimes the student hasn't tried to locate me at all, they have just got on and done it. They feel that they need to, because the ward seems so busy and they seem to be under pressure. They want to get involved and they want to get in on the action, but it would be helpful if they could just realise that we could help the situation a lot of the time and take some of the pressure off in a busy ward.

One experience quoted by a participant illustrated how the contract clinical tutor provided learning opportunities for a student.

I was in a busy ward where the buddy's group was a very busy group, so I assisted her. The student then said 'you've helped in this area, I won't have anything to do for the rest of the day'. But because of my recent clinical practice in the area I knew that things would settle down a little later and the buddy would then be able to spend more time taking the student through some things. The student actually rang me later and thanked me, and said it was really good that I did that. I felt that I had facilitated learning opportunities for the student, because I could see that the buddy was going to be frantic for some time.

2 Working with Others

Fitting in

Discussion arose within the group about the process of developing a good working relationship with students and clinical staff and the nurse educator. One participant talked about the feeling that she was being

played off against the nurse educator.

This could have been a result of the student's first experience on the ward, lack of confidence, and not being familiar with the person who was going to be working with her that week.

But one contract clinical tutor found this quite challenging. She stated that

some students could be quite negative about what is happening or not coping with the fact that you are the casual tutor, and that you will be with them for the whole week. They would say 'this is not how we were taught by our usual tutor'.

I was certainly able to cope with this by just discussing with students the importance of being adaptable and versatile, but also maintaining standards and meeting competencies.

The contract clinical tutors discussed the change in their role, from clinician to contract clinical tutors and not being a member of a team. They all agreed that this left them with a feeling of being a bit in the dark. One participant said

Yes, I haven't felt completely supported.

This feeling of not being supported in their role was also identified in a study by Ferguson (1996) as not belonging. The members in this study spoke of not being part of a team, just being an extension. These feelings of being unsupported was not such a problem to the contract clinical tutors when they were working in a familiar area

The confidence of working in a familiar area was highlighted.

Doing what we do best in an area that we are familiar with, and as you go on you gain the rapport and confidence of the student. Working in a familiar area means you know the staff and their capabilities, and the resources that can be accessed, but particularly it is useful that we are able to network and make contacts.

In spite of this working in an unfamiliar area was not found to be a real problem. This is probably due to the experience the contract clinical tutors had had and the length of time they had each worked in the health care system. However, the participants agreed they did have to rely on other people more, when working with students in an area where they had not previously worked before.

Just getting to know what resources are available in the area and getting to know the staff a little better, is important in these situations.

One participant found the prospect of working in an unfamiliar area somewhat unnerving and stated

I used to go in the day before especially if I was to work in area where I had not worked for a while.

Contract clinical tutors agreed that the policies and procedures were of great help and they frequently encouraged students to use them. Overcoming the problem of working in an unfamiliar area, was dealt with by one group member in the following way

When I was working in a number of areas, I went around each department and introduced myself, and orientated myself to the area. Because it is totally unfamiliar for students they get worried about the little things, like where the staffroom is, where to access the various resources, so the contract clinical tutor was better able to direct them. You are answerable to so many people, aren't you, the staff, the students, the polytechnic. You have to fit in to a mould so that you can achieve the best outcome for the students.

In a study by Forrest, Brown and Pollock, (1996) it was found that some students considered that if ideal clinical supervision was provided by trained nurses, there would be no need for any contact with nurse teachers. However, the participants of this study were aware of the impact the buddy can have on the students clinical experience, and getting the right buddy with the right student was alluded to on a number of occasions.

I'm thinking of an instance where a student worked with a buddy who was not keen to have the student. I wish she had been a bit more up-front but because I

didn't know the buddy or the student, and the buddy had been rostered on with the student, I was not aware of the problem till the following day. After discussion with the student who was quite prepared to carry on, it was decided to change buddies. I could see that the student was not getting anything from the buddy and the learning opportunities would be limited.

In most areas the resources were great, the staff are so good, they talk with the students, even do small tutorials. It makes our job much easier.

Liaison between clinical staff, students and polytechnic staff was an important issue to participants.

The more information and knowledge you can have the better, and it is that consistency of information that you are giving your students that is important. The main things that students want is consistency. They don't want the odd person coming in. It happens sometimes with the buddies and can't be avoided, that is a familiar complaint and I say to the students "You have to adaptable and flexible while caring for patients too and that's where I think clinical tutors can help the student to make connections. I was the stable person for the whole week, whereas the buddies change and have days off. The idea of having the same contract clinical tutor for the whole week is a very good one.

This consistency is also valued by the students who are finding their way around in the first week and begin to develop a feeling of belonging by the third week, they also state that staff are more likely to put more effort into them if they know you are in the area for three weeks (Hart & Rotem, 1994).

Matching expectations

Participants recognised the importance of developing a relationship with the students with whom they worked. Each felt that as a trust developed between contract clinical tutor and student the student is more likely to come to them with any problems. Students reported that the instructors in clinicals “who cared about them as individuals”, provided feedback both positive and negative and with whom they felt free to answer questions were qualities that they felt were important to them (Windsor, 1987).

Students’ ability to learn and reach their potential in clinicals is often dependent on their motivation. Contract clinical tutors were very much aware of the opportunities that provide learning for students in clinicals, and although they were required to supervise students in areas they are not familiar with, each participant felt that the student’s attitude to learning had a major impact on the outcome of the learning experience. In spite of the philosophy of the programme to empower student learning, they are not able to choose their contract clinical tutor, the buddy with whom they work, or the area in which they work, but contract clinical tutors found the students are mostly positive about learning in the clinical setting. This motivated and positive aspect to learning was explained by one participant as

They (the student) are showing initiative and that’s what we really try to encourage.

Access to learning resources was regarded as a problem for students.

Often they (the students) want to look up books in the office, but they felt it was too busy and they were intruding.

3 Maintaining Connections

As the students gained confidence, they begin to make connections. One participant stated for example, that

if a patient has a high temperature, the student can put the information together to make the right decision. They are in the right environment to learn and they take the opportunities. It does depend on the student's motivation as well. They may recognise there's a patient with diabetes, they know roughly what it is all about, but they are keen to find out more, and when they do they do it amazingly well.

Motivation to learn and a positive attitude were rated highly amongst students in a study by Booth (1997), and this depended upon positive interaction with practitioners, educators and peers (Booth, 1997).

This student motivation was recognised by one participant when

at the beginning of the week the students were really keen and asked a lot of questions, and as the week progressed they were starting to do things, taking responsibility.

One participant noted this especially with third year students who are actually pointing things out about the patients that other staff had not picked up.

It is good to see them keen and motivated and showing their initiative.

It was also good for me. I liked the way it makes me keep one step ahead.

One participant described the transition of students from year one to three as

seeing them building in confidence and developing a sound knowledge base. Recently I was working alongside a year three student who I had worked with as a contract clinical tutor only months earlier, and I couldn't believe how far she had come, from a shy not too confident person she was now taking a large workload and managing it with confidence. Suddenly she had professionally grown.

Special features that contact clinical tutors enjoy was working with students for the full clinical week, or two consecutive weeks. However, they have all had the experience of being called on for a single day. Apart from the lack of continuity for students, the contract clinical tutors had difficulty in following up where each student was at and be able to make constructive comments to students.

It takes you the first day to find out what students had been doing and what their objectives for the week are, their level of knowledge, any previous experience they may have had, their capabilities or what experiences they need in a particular area. And then if there was ten students on, there was no continuity of supervision or education.

Similar frustration's were experienced by clinical teachers in a study by Clifford (1996) who said they spent approximately two to four hours in clinical practice over a number of wards and described their experience as "just visiting" liaison, and support".

Assessment of students provided a challenge for the contract clinical tutor's knowledge and abilities, knowing what they could do to assist the student, not wasting time on the first day, and then finding out by the second or third day that the student has been struggling for two days. One participant stated

I found the verbal hand-over was good.

another said

I was asked to work for one day and a written summary of each student's progress was left for me. I felt I could competently take over and be helpful for students without too much time delay.

Following through.

Participants experienced frustration in relation to assisting students to meet clinical competencies. Working closely with students over a number of days was an advantage. One participant explained how she and the student had been working well together, identifying problems the student was having, and working through them.

We had become quite focussed to achieve the outcomes. It was very satisfying. However, another tutor then took over and signed everything off. I felt quite annoyed, because I like to finish something, and I put all the work in and I should have been able to follow it through. I think the student would have appreciated it too. However, mostly the student wants to just get it signed off.

The contract clinical tutor felt that she had worked hard to assess the student's capabilities and analysed her level of competence, planned how the competencies would be met, and was not able to follow through..

I have actually swapped duties with another tutor, so I could follow through with the student but this is not often possible.

Assessment of Clinical Competence

Assessment of clinical competencies are of concern to both nurse teachers, and students (Davies et.al, 1996). Practitioners and clinical teachers are frequently unfamiliar with the requirements of assessment on clinicals, the level of competence the student should be at, and are often unfamiliar with assessment documentation or its relevance to the curriculum.

The question often asked is: What do we expect the student to be able to do at a given level in the programme, and how do we prepare them for this. Where does the learning/teaching aspect of the students clinical experience begin/end and the assessment of competencies to ensure safe practice. Duke (1996) found role conflict evident in a study of sessional teachers and it appeared their lack of educational qualifications meant they often felt unprepared for the complexities of the teaching role.

Participants in a study by Duke (1996) were also aware of and commented on problems related to student's personal lives. This was thought to put severe pressure on the evaluation role of the tutor making it difficult to look beyond the student's well-being to the well being of the client.

Students at times can be so concerned with getting these competencies ticked off that the actual learning is not taking place. An example described by one participant illustrated this concern.

I worked with a group of students who rather than getting to know the patients regarded them as things to be ticked off. The significance of the reasons for clinical practice were completely overtaken by the need to meet competencies. As a contract clinical tutor I find it difficult if I was relieving for two days and the students are conscious of a time frame for having competencies marked off,

they hold it in your face so they can get it ticked off. On occasions I have had to say no, I am not happy to do that, especially if I have not previously worked with the student. It is understandable when you are their third tutor in a week, that the response you get from students is sometimes negative, and unless you have worked with them before students will either respond to you in a positive way or they may take a while to take you seriously. These are situations that will very likely disrupt valuable learning opportunities.

The importance of continuity of supervision for students was discussed in a study by Fowler (1995). Being approachable, showing interest in the student, and being able to meet regularly were qualities valued by students. Positive feedback was highly valued by students in a study by Windsor (1987). Students regarded the clinical instructor as an important resource person, and they wished to be free to ask questions without being embarrassed or harassed (Windsor, 1994)

Contract clinical tutors also recognise the frustration that students experience when trying to get competencies and care plans completed. However, one participant said

I don't mind the competencies because it gives me something to look at early in the week. From this you can assess how far the student has come, and what other requirements they need. It is difficult though when you haven't been part of the development of the competencies, and have not had more input into the care plan. Diligent students are able to reflect on their practice and will often take the care plan home and come back with it near completed the next day.

Evaluation of competencies must be rigorous and consistent. (Naphthine, 1996). Students suggested that ward staff are in a better position to assess students. (Naphthine, 1996). This was due to the staff from the university coming in only once a day and

raises the important issue of the teacher not getting to know the students well enough to assess clinical competencies.

Questioning

The issue of questioning was discussed with the participants. They each agreed that their approach to questions generally followed a pattern of

asking students to look for the normal and identify the variants, and what actions would the students take to deal with them.

There are certain ways you can ask a question of a student that will help them to explore all sorts of things.

Evidence from a study by Sellappah, Hussey, Blackmore, and Murray (1998) showed that although there was a variation in the number of questions asked by clinical tutors, they were predominantly low level questions and the recommendation was that clinical teachers should be taught how to ask questions, particularly high level questions, which will facilitate the development of critical thinking, decision making and problem solving in students.

4 Approaching Learning

Getting together

Participants all agreed that the ability to meet as a group would be helpful. Group tutorials are usually of value to students. One participant referred to the

heaps of talk that was generated from small group discussion and sharing of information.

The students all ask each other questions and feed off each other. It's the best environment. The important thing is balance, isn't it? Sometimes the students will say Gosh we seem to be off the ward all the time. They want to get on and do the practical. When you hear some of the stuff that comes out, though, students may get the wrong idea when talking amongst themselves. Sharing the experience in small groups can be helpful with the tutor there to correct any problems.

Participants all felt they were at a disadvantage not being able to spend more time in tutorial situations as there were occasions when the students would have valued time out. The important thing is balance. One contract clinical tutor stated that

What I heard some of the students saying concerned me as they had obviously got the wrong idea and a debriefing session or a time out to share experiences would be of value on a regular basis.

These sessions should not necessarily be at the end of the week. Sometimes students may not come in for the last day of clinicals and you don't know whether they are not coming because of a stressful situation that may have occurred during the week. We sometimes make assumptions about their non-attendance.

The contract clinical tutors in this study describe the importance of working with students who are motivated and had a positive attitude towards their work. Students stated that a positive attitude was important in clinical practice and agreed that students had to be positive and share experiences with other students they found to be positive as

well. Understanding this issue of students attitude was explored by the group. One participant felt that some students needed a lot of encouragement and some had little motivation. Her appreciation for the profession meant she went in to the contract clinical tutor's role thinking.

Yes, I am here for you, just use me whichever way you can.

She quickly realised that for a large percentage of students this was just one part of their lives.

Many students work many hours of employment to financially support themselves through the programme, a number are solo parents or married, with family commitments, and some students will go off clinicals, straight to another job, home to bed, and then back on clinicals the following morning at 7 am.

Wanting not giving

As mentioned earlier, the student approach to learning may not be as positive as expected, and contract clinical tutors recognise that students are now not being paid to work. One participant said of the students:

they want, they don't give.

They recognise that the student is in the clinical area to learn by the application of theory to practice, and are supernumerary to staff. Students want instructors to 'challenge them', expect a lot and ask good questions. (Windsor 1987) The contract clinical tutors expectation of the level of knowledge of a third year student was that.

I expected the student to have a good knowledge and have objectives relating to the area where she was working. If a student did not know, she would encourage the student to read the information and verbalise it before she cared for patients. By year three though "I think the students are demonstrating competence and they can care for patients with minimal input from the contract clinical tutor or buddy.

Sharing information and seeking advice about issues in clinicals was an important area of discussion by these contract clinical tutors. At times when a student became distressed the contract clinical tutor felt there was never anywhere suitable to take the student, even for a short time out. Contract clinical tutors felt at times they would have benefited if they could get together with another tutor and talk about how to deal with some situations or how to enhance a learning situation for a student.

It's always in the corridor, isn't it? Everyone's listening and sometimes you just want some support or an opportunity to discuss how to deal with a situation, tutor to tutor.

Feelings of isolation and being in no-mans land was described by clinical teachers in a study by Ferguson (1996). They felt that there was not the opportunity to share ideas and experiences with fellow colleagues.

Student, buddy and contract clinical tutor should have the chance to discuss how the day has been for the student, but often the positive comments come just to the contract clinical tutor. The negative comments are at times discussed after the student has left the area. If a student had a problem during the week, it was not always dealt with at the time but instead it was discussed a later with the contract clinical tutor and not always the tutor who had worked with the student.

It was never able to be dealt with in any satisfactory way.

Contract clinical tutors would have preferred that the buddy raised these issues during the student experience so it could be acted upon at the time. If buddies raised problems regarding students, contract clinical tutors usually asked the buddies to

get on to these things as they happen.

The contract clinical tutors all agreed

that the student may never learn from a situation if it not acted on immediately, instead the typical polytechnic student label follows him or her around the area, and we are left feeling like we haven't really done anything.

Positive comments were often received from patients and where possible the contract clinical tutor passed the information on to the student. This positive feedback it was felt by the participants is very important to students. In a study by Windsor (1987) students found positive feedback highly valued by staff and patients even when they knew they had done well.

The positive feedback either through writing a good assessment or by way of verbal compliments should always be forwarded to the student.

The students have dealt with the upheaval now in the clinical area, they just want to be there for the learning.

The upheaval alluded to in this study was as a result of the changes and restructuring of the health care system which had an impact on staffing in most clinical areas.

Being there for the learning

A process of debriefing or 'talk down time' as it was referred to by the participants was felt to be an important part of being there for the learner. The ability to be able to meet as a group where experiences can be discussed in a safe congenial environment was valued. It was generally felt that this opportunity of a talk down time should be adopted in all areas of nursing but particularly valuable for students. One participant recalled an example of a student who was recently nursing a young person who was terminally ill.

I was asking her how she was coping as she had quite a heavy group this week, and it turned out she was upset, not just by this week, but what had happened last week as well. So it would have been ideal for her had she had the opportunity to talk with her group of peers. She hadn't in fact talked to anybody about it.

Students do in fact get very involved with the clients. They build up a good rapport with the clients because they have got more time to spend with them, and something happens, they don't actually get involved in voicing it because they are not part of the permanent staff.

This qualitative study gave the contract clinical tutors an opportunity to discuss their positive experiences and the difficulties/challenges they encountered when working with students.

A thematic approach to analysis has provided the researcher with the opportunity to identify issues or themes and group ideas in ways that reflected the contract clinical tutors experiences. The themes identified parts of the whole phenomena of clinical teaching by individuals who facilitate student learning in clinical settings only, and viewing all themes provides understanding of the whole experience.

Limitations.

For this study focus groups proved to be an effective method of gaining information from a small group. The study was limited however, by the number of participants and in spite of their extensive experience and willing contribution a larger group may have provided a wider range of information. The participants were also selected from a small community so care was taken to protect their identities as far as possible. Nevertheless all participants were willing to have the group recommendations conveyed to the faculty.

In spite of the size of the study the findings indicated important areas which nurse educators should be aware of to ensure the quality of learning opportunities for students in clinical practice.

CHAPTER FIVE: CONCLUSION

The purpose of this study was to explore the positive aspects of the role of contract clinical tutors and the difficulty/challenging situations encountered by them when working with students in clinical practice. The focus group interviews enabled the participants to discuss all aspects of their role and their discussions were analysed and findings described. Analysed findings were compared to findings in relevant literature.

This chapter describes the conclusions and recommendations which have evolved from the discussions with contract clinical tutors. Four recommendations which can influence the effective development of the role are discussed and, if implemented, should assist the contract clinical tutor to provide quality supervision when working with students.

The changes in nursing education has brought challenges to nurse educators, some of which have created a division between educators and practitioners. These include the specific roles of each, and the added responsibilities perceived by the nurse educators.

Clinical instruction is important and should not be delegated to the least experienced and least prepared (Karajuhe, 1986). Literature indicates that classroom teaching has become a symbol of increased status while clinical teaching has come to be viewed as some kind of punishment (Karajuhe, 1986). Nurse teachers afford clinical teaching a low priority (Crotty, 1993).

Contract clinical tutors recognised areas of concern which need to be addressed to ensure the quality of clinical supervision. Although this study was limited by the small number of participants, the findings indicated important areas which their nurse educator colleagues should be aware of to ensure the quality of learning opportunities for students in clinical practice. Findings from this study can still provide us, in our

locality with direction on how the contract clinical tutor role can be developed. Through networking with other Polytechnics it is evident that nurse educators in New Zealand still continue into the clinical setting with the student. However, there is an increasing trend in some nursing education institutes to use clinicians to work with students and for the nurse educators to remain in the academic arena. Innovative roles such as joint teaching/service posts and lecturer practitioner roles have been suggested as possible ways forward (Davies et al, 1996) but the debate will continue especially in light of the changing clinical environment. Although the literature which focuses on the student perspective rarely differentiates between the nurse educator and the clinician, the qualities which the students rate most highly in a clinical tutor are being approachable, being effective role models, having and sharing knowledge and able to give support to clinicians. The teacher's relationship with students is rated as more important than professional competence (Li, 1997). However, it is also evident that knowledge of the curriculum, and being familiar and consistent are valued by the student (Hart & Rotem, 1994). The clinical teacher has been identified as the person most critical to effective learning by the student (Campbell, 1994) and is vital to the development of students' understanding of practice.

It is evident from the findings from this research that contract clinical tutors' experiences when supervising students in clinical areas were influenced by institutional and organisational constraints. For example, they may be called on to relieve at short notice to work with students with whom they are unfamiliar, and at times may only work with the student for one day. This compromises the tutors' credibility and does not provide the best environment to accommodate student learning.

The positive aspects of the role were highlighted by the participants and included the benefits they felt they could bring to the position of familiarity of the area and the experience gained from their role as practitioner. They felt that by being up to date with the management of patient care they could be helpful to students. Participants felt

valued when they had developed a trusting relationship especially with the student but this also extended to the support and interaction between themselves and the clinical staff with whom they had previously worked.

Consistency was highly valued by contract clinical tutors. All agreed that the most effective way to meet the needs of students and maximise their effectiveness in the role was by working with the same students for the whole week and preferably for longer. In spite of the positive aspects being highlighted contract clinical tutors often came up with ways of doing things better. They felt disadvantaged on a number of occasions when they were brought in for one or two days at short notice to relieve and felt that they were unprepared to take over from the previous person unless there was some form of hand-over, preferable written. They were also aware of the frustration and anxiety experienced by the students when confronted with a third tutor in as many days. Role change and conflict was described in a number of ways by the participants including the change from practitioner, the hands on role, to the clinical teacher role that of facilitating student learning but allowing the student to do the work in a safe environment. The impact of the role change was discussed in relation to interaction with buddies who in some situation they had previously worked alongside. Role conflict also resulted from the participants having many masters. They are responsible to the Polytechnic with whom they are employed, the hospital in which they are working, clinical staff and nurse educators and most importantly the students. Although the issues raised within the group were varied there was general agreement in most areas.

It is evident that when there is a need to use experienced registered nurses to fulfil the role of clinical teacher, all parties involved in nursing education must contribute to meeting the needs of the students.

A benefit resulting from this study was the opportunity it provided for the participants to talk with one another and recognise that they were not alone in some of their concerns. This forum gave the group the opportunity to gather collective strength thereby reducing the feelings of isolation. Four recommendations resulted from their discussions

RECOMMENDATIONS

Having identified the aspects of the contract clinical tutor's role which have been most positive and the difficulties and challenges inherent in the role, consideration must be given to how to support the individuals who take on this role. The focus group members identified four specific areas where improvements could be made:

- 1 Collaboration.
- 2 Staff development
- 3 Communication
- 4 Orientation

Collaboration

The importance of linking theory to practice is paramount to nurse educators, but the process by which this happens is complex and difficult. The challenge for nurse educators is collaboration with all people involved with the students clinical experience and this must include clinicians who are employed for short spells of times to work with students in clinical settings. This collaboration must include effective communication and consultation among nurses to endorse, support and encourage one another (Barnes, Duldts & Green, 1994).

Nurse educators need to take responsibility for facilitation of the collaboration between teachers employed by the Polytechnic and the buddies who are required to work with students week after week. Each must respect the role of the other to ensure the best quality experience for nurse students.

Nurse educators and contract clinical tutors need to participate in further study to clarify roles, to identify actual and intended benefits for students. Forums should be

established with the clinicians, contract clinical tutors, nurse educators and the students to ensure effective liaison and exchange of ideas and to ensure the learning outcomes and competencies for the clinical component are clearly understood by all parties.

Guidelines should be developed collaboratively to clearly define the role and responsibilities of the contract clinical tutor/buddy and the nurse/tutor. The experience of the clinician who is seconded into the role of contract clinical tutor continues to be of value to the education of students and impacts on their professional growth and development (Litizia & Jennrich, 1998). At the same time they assume the responsibility and the challenge of guiding supporting and teaching students (Litizia & Jennrich, 1998). It therefore should be the responsibility of nurse educators to collaborate with contract clinical tutors and clinicians to provide positive outcomes for students. Students require a positive relationship with clinicians, and therefore a liaison between the educational and clinical institutions must be strengthened especially in relation to evaluation of students performance (Hart & Rotem 1994).

Collaboration between nurse teachers, clinical teachers employed on contract and clinicians should include enhancing knowledge of the curriculum especially the competencies specific to clinical practice units and the Standards of practice provided by the Nursing Council of New Zealand. Continued effective liaison with participants established through a process of collaboration will promote the development of planned learning experiences and prevent the 'ad hoc' arrangements the students can confront when they walk into a busy clinical setting.

Students need also to be part of the collaboration process to reduce the 'mystique' and uncertainty of why they are there, what they can do and what they cannot do. Although students may still be taught isolated skills, the development of a holistic approach to client care has required a more collaborative approach to clinical education, and a

changing health environment necessitates the students working effectively as collaborative team members with other professionals, clients and their families.

Clinical nurse tutors continue to have a vital role on facilitating learning opportunities in the clinical settings, clearly there are rich opportunities for developing collaboration models. Contract clinical tutors should also be able to participate in meetings with nurse educators on a regular basis and these should also include practitioners and nurse students.

Collaboration between all nurse groups that contribute to the quality of education for nursing students while in clinical practice can only result in tremendous benefits for the students and the nursing profession.

Staff Development

Provision of staff development for clinical tutors should include access to a locally available Certificate of Adult Teaching, and workshops to encourage updating of clinical teaching skills and thereby increase teacher effectiveness in clinical practice. Contract clinical tutors need to be able to give constructive feedback to students in clinicals, through assessments and evaluations, and the way this feedback is given will influence how students perceive these teaching strategies (Cooke, 1996).

Contract clinical tutors will continue to be utilised on a casual basis, it is therefore necessary that faculties provide the type of professional development that can help them to develop the necessary teaching skills and confidence to adequately perform in their role (Duke, 1996). The participants in this study agreed that they could benefit from learning about teaching methods with a focus on adult learning.

If we value the expertise of the contract clinical tutors and the importance of clinical practice for the student, all participants who are involved with the teaching of students should also be aware of the changes in the profile of students. The increase in mature aged students is significant in New Zealand. Some students have not been involved in formal education for a number of years, but may bring maturity and life experience.

The participants in this study acknowledged the change of the student profile in nursing in New Zealand and found from their discussions with students that they are often juggling school, work and family demands. Students are therefore in the clinical setting to learn. This has provided a challenge to contract clinical tutors who are familiar with the traditional methods of teaching but may not have been exposed to interactive collaboration methods of learning. It is therefore incumbent on faculty staff to provide the type of professional development which will equip the sessional clinical tutor with teaching skills and confidence to perform their role (Duke, 1996).

Communication.

Debriefing

Debriefing was described by the participants as talk down time. Participants felt this time is valued by students and often considered a positive learning experience. Some students have expressed concern having to attend debriefing sessions. Students in a study by Hart and Rotem (1994) found these sessions laborious and resented having to leave the busy learning environment of a ward when they did not feel they were learning anything from other students.

Contract clinical tutors, however, felt they had a positive response when they provide sessions for groups they were working with. The students were keen to share their experiences and participants felt there was considerable learning taking place during

these times. These sessions provide students with the opportunity to reflect on their practice in a safe congenial environment. Students value feedback on their progress and performance.

Debriefing provides the students with the opportunity to discuss their experiences, reflect on their own practice and offer feedback to peers (Hart & Rotem, 1994). Interpersonal effectiveness is a characteristic consistently rated as being most important by students (Marriott, 1991).

Contract clinical tutors in this study discussed the importance of communication in relation to other clinical tutors working with them. All the participants had at some time been asked to relieve for short spells of times, sometimes not for a full week. Contract clinical tutors were keen to receive some form of hand-over, a brief summary about the student's progress. This they felt would greatly contribute to how they could give better value to the students and "competently take over" and be helpful to students without a delay. Participants recognised that the students wanted to use the time they had in clinicals wisely, and they were eager to contribute.

Sharing information and seeking advice about issues in clinicals was important to the contract clinical tutors. Participants felt isolated and needed to figure things out for themselves. Not having opportunities to share ideas and experiences with fellow colleagues was also highlighted in a study by Ferguson (1986). The participants strongly supported that there be an area in the clinical setting where tutors could meet with tutors and tutors could meet with students. Situations do arise with students which necessitate taking the student away from the area. Contract clinical tutors felt that some of these situations had not been dealt with in a satisfactory way.

Clinical practice can be stressful for students. Students' anxiety when working in the clinical setting has been widely documented. Students expressed fear of making

mistakes and their vulnerability in an unfamiliar environment as anxiety producing (Kleehammer, Hart & Keck, 1990). Survival rather than learning becomes the emphasis, so a trusting relationship between teacher and student is an important prerequisite to reducing stress. If problems do occur the student and tutor need a safe place to discuss and resolve the issues

A concern expressed by participants was in relation to students “picking up bad habits”. This problem was highlighted in a study by Davies et al, (1996). Students prefer constructive criticism and not to be corrected in such a way that it belittles them, nor is it appropriate to correct the student in front of the client unless client safety is compromised so a safe place away from the clinical environment can be used to discuss student progress and allow them time in a supportive environment to reflect on their practice, and establish goals to meet learning outcomes.

Orientation

Preparation for the role. Davies et al, (1996) found widespread dissatisfaction and anxiety in relation to the extent to which practitioners were prepared. Practitioners were frequently unfamiliar with the assessment documentation (Davies et al, 1996). and their own preparation was lacking in relation to an overview of the course, particularly the theoretical component.

Participants in this study generally agreed their orientation to the clinical role had been minimal. Two members gained benefit from a brief orientation, though felt there could have been more.

Although there was a useful exchange of information at the orientation day contract clinical tutors would have benefited from a follow up session after they had worked with the students.

To ensure the theory and practical link the contract clinical tutor must be aware of the philosophy and aims and objectives of the curriculum and has an opportunity to discuss the learning outcomes of the specific units related to theory and practicum. For example there is no point in explaining the learning outcomes of a practicum unit if the theory unit which is the prerequisite is not discussed. Contract clinical tutors should be also aware of the teaching strategies which are appropriate in enabling the transfer of learning (Jinks, 1991) and an understanding of educational theories available.

Summary of recommendations.

Although the positive aspects of their role were discussed the difficulties and challenges encountered by the participants appeared to be of greater concern and were highlighted in the focus group interviews. This may be due to the fact that this was the first opportunity for a forum of this group and the first chance for views to be expressed. The recommendations should therefore provide suggestions to enhance the quality of clinical teaching.

The findings have indicated the need for collaboration. This should include all people involved in supporting the student in the clinical environment. Liaison with clinical staff and clinical teachers both before and after the students experience should include defining the role and responsibility of the clinical teacher, buddy and student. The second recommendation to enhance the capabilities of contract clinical tutors is staff development. Although the participants in this study were highly skilled in the clinical area were they had worked only two of the four participants had completed the Bachelor of Nursing qualification and only one of the members of the group had had any educational qualifications. Financial constraints may be a contributing factor as the conditions of employment do not provide financial assistance toward the Certificate of adult learning. It is, however, important to encourage the type of professional development which will contribute to acquiring the teaching skills to adequately perform their role.

A third recommendation was the need for communication. Communication with students, clinicians and nurse educators is needed on a regular basis, to overcome the feelings of isolation and for the exchange of ideas and issues. Debriefing sessions with students is highly valued by the participants. This may assist them to gain confidence from the student interaction, but the need for debriefing was also encouraged between colleagues.

The final recommendation is for orientation. Preparation for the role was important to the contract clinical tutors. Those who had the opportunity to attend a half day orientation found this helpful, but felt they could have done with more. A follow up to this orientation would have been helpful after they had been in the clinical area with students. Becoming familiar with the documentation and how to use it was an area that the participants felt they could have had more instruction on and what to expect from students in relation to writing of nursing care plans and documentation related to assessment.

Although recommendations are from a small study they should be viewed positively as a means of gaining insight into the effectiveness of the role of contract clinical tutors and highlights the need for continued research and preparation of all personnel involved in the clinical teaching of nurse students.

As the student begins to gain confidence in the clinical environment and learn to be part of the profession they begin to develop high expectations of themselves and their abilities to perform well. However, in an unpredictable and at times hostile environment, their conceptions about nursing and their clinical learning experience may be challenged (Yong, 1996). The literature is extensive on what students find most helpful in the clinical setting, and the nurse educators view is also widely discussed.

There is a need now for nurse educators to be aware of both the student's voice and the discussions of the contract clinical tutors and use the recommendations as a basis for future actions. By listening to their concerns and adopting suggestions from this study nurse educators can enable changes to be made which will effectively support contract clinical tutors in their role and thereby provide quality education for future nurse student.

APPENDICES

CONTRACT CLINICAL TUTORS: EXPERIENCES OF WORKING WITH
BACHELOR OF NURSING STUDENTS IN CLINICAL PRACTICE

Dear Clinical. Tutor

My name is Ann Bride. I am presently undertaking a thesis as part of a Master of Arts (Applied) at Victoria University of Wellington. I am also the Programme Manager of a Bachelor of Nursing Programme.

My interest is providing quality education in clinical practice for students.

You are invited to participate in this research study which will explore contract clinical tutors perception of their role in facilitating Bachelor of nursing students learning. Both positive aspects of the work of contract clinical tutors and difficult and challenging situations which they may encounter will be explored.

Your participation is entirely voluntary, and your decision whether or not to participate will not affect your current or future employment in any way.

If you agree to participate in this study you will be asked to take part in two focus group interviews with the researcher. The interviews would last approximately one and a half hours each time and would occur at a place and time agreed upon by the group.

The interviews will be semi-structured and taped and then transcribed. The information will be analyzed by me and issues requiring further discussion will be raised at the second focus group interview.

The tape and transcript will be coded so that no information that could identify you would be included, and will only be available to me, the transcriber and my academic supervisor. The information (tapes, disks and transcripts) will be kept in a locked place and tapes and transcripts will be destroyed at the end of the study. Disks will be retained for 5 years. When writing up the thesis some parts of the interviews may be quoted but no information that could identify you individually would be included.

You may refuse to answer a particular question or ask that the tape be stopped at any time during the interview.

I hope you will agree to participate in this study

I will answer any question you may have. Please contact me at Ph 7589145 in the evenings.

Signature.....Date.....

If you wish to discuss this research with my supervisor you may contact her , Dr Pamela Wood, Department of Nursing and Midwifery Victoria University of Wellington, PO. Box 600 Wellington. Ph 0800 108 005.

CONTRACT CLINICAL TUTORS: EXPERIENCE OF WORKING WITH
BACHELOR OF NURSING STUDENTS IN CLINICAL PRACTICE

I.....have accepted the task of transcribing the
research data collected by Ann Bride in order to complete Master of Arts. (Applied) at
Victoria University of Wellington

I understand that the data gathered for this research is confidential, and I agree to take
all necessary steps to ensure that any material on audio-tape or computer disk
containing data from interviews relating to the research will be:

- a   Heard only by me, and transcribed to disk in private
- b   Stored safely until returned to the researcher
- c   Treated as confidential

Signed .....Date .....

CONSENT FORM FOR RESEARCH

I..... have read/had explained to me the purpose of this research to be undertaken by Ann Bride and understand that it is part of a thesis for a Master of Arts (Applied) from Victoria University of Wellington..I have had the opportunity to ask questions about my participation in this research and have had the questions answered satisfactorily.

I understand that my participation is entirely voluntary and my decision whether or not to participate will not affect my current or future employment in any way.

I understand that I am free to withdraw from this research at any time up to the data analysis stage.

I understand that in the event of unforeseen circumstances the researcher may discontinue this research

I understand that information from the transcribed interviews may be modified by me with assistance from the researcher so no identification of the time, place, incident or people involved can be identified.

I understand that as I am participating in focus group interviews, my identity will be known to other group members, but that we will be agreeing to keep information and identities confidential.

I understand that the transcriber and the supervisor of the researcher will have access to the tapes and transcripts.

I understand that tapes and disks and transcribed information will be kept in a locked place at the researcher's home during the research and on completion tapes and transcripts will be destroyed and disks retained for five years.

I understand that a separate consent process may be undertaken at the end of the study, to release to the Head of Faculty any strategies we identify for enhancing quality teaching by Contract Clinical Tutors

I, ...hereby consent to take part in this study.

I am aware that I can contact the supervisor, Dr Pamela Wood, if I have any concerns,at Victoria University of Wellington

Signed .....

Date .....

Signed.....Researcher

Date.....

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