AUSTRALIAN LEARNING & TEACHING COUNCIL

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Final Report

Enhancing student learning in the workplace through developing the leadership capabilities of clinical supervisors in the nursing discipline

2011

Lead Institution:
Queensland University of Technology

Partner Institutions:
Mater Health Services
Royal Brisbane and Women's Hospital
The Prince Charles Hospital

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The Australian Learning and Teaching Council is an initiative of the Australian Government Department of Education, Employment and Workplace Relations

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Executive Summary

The purpose of this project was to build the leadership capacity of clinical supervisors in the nursing discipline by developing, implementing and systematically embedding a leadership model into the structure and practice of student supervision. The University worked in partnership with three major metropolitan hospitals in Queensland to develop a framework and professional development program incorporating leadership and clinical supervision.

Specific project objectives were to:

- conceptualise a leadership model of clinical facilitation and supervision;
- develop a sustainable Clinical Education leadership framework for capacity-building of staff involved in the clinical facilitation and supervision of undergraduate nursing students;
- develop a resource pack for universities and health care facilities/services;
- embed the resource pack in the health facilities' intranet systems for sustainable access and use and made available online for universities and health facilities across Australia to use and adapt;
- extensively trial the leadership model of clinical facilitation/supervision across three large metropolitan health services;
- empower clinical supervisors to lead general nursing staff in mentoring and coaching nursing students in ways that foster effective and positive learning experiences;
- measure the success of the re-conceptualised model in terms of students' clinical learning outcomes and clinical experiences, supervisor and buddy job satisfaction, and improved attitudes of nursing staff to student mentoring; and
- investigate, through discussion and debate at a national forum of coordinators of the clinical components of nursing courses, challenges, benefits and strategies for implementing the model at universities and health services nationally.

The three phases of the project were completed on time over two years. Phase one involved the development of a clinical education leadership model and capacity building framework. Phase two involved the implementation of the clinical education leadership model and phase three saw the evaluation of the clinical education leadership model.

The project achieved its primary goal of embedding a leadership model in the health service-university interface that will advance the clinical learning of Australian nursing students, and have the potential to advance workplace learning for students more generally.

The Leadership and Clinical Education (LaCE) program consisted of two structured workshops complemented by individual personal development projects undertaken by participants. Participants were supported in these activities with a purpose-built website that provides access to a wide variety of information and other learning resources. Quantitative and qualitative evaluations indicated that the approach was highly valued by participants, as it promoted useful peer dialogue, sharing of experiences and personal development in relation to assisting leadership development and student learning in the workplace.

The LaCE program provides an ideal springboard for introducing the development of well-trained leaders into the clinical workplace. The resources developed have the potential to provide ongoing support for clinical supervisors to improve the learning of undergraduate nursing student. The challenge will be to achieve continued innovation within clinical education through sustainable leadership programs.

Acronyms

ALTC	Australian Learning and Teaching Council Ltd.
CF	Clinical Facilitator
CLES	Clinical Learning Environment and Supervision Instrument
ClinEdQ	Clinical Education Queensland
DEEWR	Department of Education, Employment and Workplace Relations
LaCE	Leadership and Clinical Education
LaCE 1	Leadership and Clinical Education – Iteration 1
LaCE 2	Leadership and Clinical Education – Iteration 2
LaCE 3	Leadership and Clinical Education – Iteration 1
MHS	Mater Health Services
NSC	National Stakeholder Committee
NICL	Nash Inventory of Clinical Leadership
PAG	Project Advisory Group
QHealth	Queensland Health
QUT	Queensland University of Technology
RBWH	Royal Brisbane and Women's Hospital
RCNA	Royal College of Nursing Australia
TPCH	The Prince Charles Hospital

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1.0 Introduction

This document provides a final report on the Leadership Project LE8-809 “Enhancing student learning in the workplace through developing the leadership capabilities of clinical supervisors in the nursing discipline”.

This is a collaborative project conducted in the disciplines of leadership and clinical education from October 2008 to September 2010, supported by a grant from the Australian Learning and Teaching Council Ltd.

The project addresses the ALTC program priority of enhancing learning and teaching through leadership capacity-building in the clinical nursing discipline structure and community of practice.

1.1 Background and ongoing challenges

Clinical experience is a core element in undergraduate nursing education. Students consistently report that clinical placement plays a large part in their decisions to pursue careers in nursing beyond graduation. Despite the importance of learning in clinical settings, experience in the real world does not automatically translate to a positive student learning experience or mean that development of professional knowledge and skills will occur effectively.

Factors that are key to the promotion of optimal learning in the clinical setting include supportive practice environments (Calpin-Davies, 2003; Chan, 2004; Chun-Heung & French, 1997) which incorporate effective supervisory relationships (Saarikoski & Leino-Kilpi, 2002; Field, 2004), a positive learning culture (Pearcey & Elliott, 2004) and collegial relationships where students are perceived as part of the nursing team (Papp, Markkanen, & Von Bonsdorff, 2003). Research such as that by Saarikoski and Leino-Kilpi (2002) highlights the importance of the *people* dimension to the effectiveness of clinical experience and consequently, the quality of students’ learning.

There is a growing body of literature outlining strategies and sustainable models that aim to maximize learning in the clinical setting (e.g., Clare, et al., 2003; Edgecombe, Wotton, Gonda, & Mason, 1999; Mannix, Faga, Beale, & Jackson, 2006; Richardson, et al., 2000; Wellard, Williams & Bethune, 2000). However, this previous work has focussed on structural elements of clinical education delivery rather than the capacity of the people who are providing it.

1.2 Aims of the project

The overall aim of the project was to improve the quality of student learning in the clinical setting through strengthening the clinical leadership capacity of staff involved in the clinical facilitation and supervision of undergraduate nursing students. More specifically, the project objectives were to:

- conceptualise a leadership model of clinical facilitation and supervision;
- develop a sustainable Clinical Education leadership framework for capacity-building of staff involved in the clinical facilitation and supervision of undergraduate nursing students;
- develop a resource pack for universities and health care facilities/services;

- embed the resource pack in the health facilities' intranet systems for sustainable access and use and made available online for universities and health facilities across Australia to use and adapt;
- extensively trial the leadership model of clinical facilitation/supervision across three large metropolitan health services;
- empower clinical supervisors to lead general nursing staff in mentoring and coaching nursing students in ways that foster effective and positive learning experiences;
- measure the success of the re-conceptualised model in terms of students' clinical learning outcomes and clinical experiences, supervisor and buddy job satisfaction, and improved attitudes of nursing staff to student mentoring; and
- investigate, through discussion and debate at a national forum of coordinators of the clinical components of nursing courses, challenges, benefits and strategies for implementing the model at universities and health services nationally.

1.3 The project team

The project team was made up of representatives from the four participating institutions bringing together academic and clinical leaders from Queensland University of Technology, Mater Health Services, Royal Brisbane and Women's Hospital and The Prince Charles Hospital.

Project Team:

Professor Robyn Nash (Project Leader)	Queensland University of Technology
Dr Sandy Sacre	Queensland University of Technology
Ms Pauline Calleja	Queensland University of Technology
Ms Jillian Mannion	Queensland University of Technology
Ms Donna Bonney	Mater Health Services
Adjunct Associate Professor Robyn Fox	Royal Brisbane and Women's Hospital
Ms Jenny Teo	The Prince Charles Hospital

Project Coordinator:

Ms Jennifer Lock	Queensland University of Technology

1.4 Project advisors

The project involved a project advisory group and an independent external evaluator.

The **Project Advisory Group** comprised individuals with specific expertise in various aspects of clinical nurse education. Its members were:

Professor Stephen Billett	Griffith University
Ms Cheryl Burns	Clinical Education Queensland
Professor Phillip Della	Curtin University of Technology
Ms Lesley Fleming	Royal Brisbane and Women's Hospital
Ms Theresa Harvey	Queensland University of Technology
Ms Susanne LeBoutillier	Queensland Health
Mr Ross McDonald	Queensland Nursing Council
Associate Professor Janice Orrell	Flinders University
Mr Matthew Payne	Mater Health Services
Dr Deborah Peach	Queensland University of Technology

External evaluator:
Evaluation consultant, Dr Paul Chesterton was appointed as the project's external evaluator in March 2010. He interacted regularly with the project team leaders and visited QUT in August 2010 to meet with and interview project team members on an individual basis.

Other people:
The project team would like to thank guest speakers who presented at each of the second LaCE workshops sharing their leadership journeys with participants.

Ms Anne Copeland	Wesley Hospital
Professor Helen Edwards	Queensland University of Technology
Adjunct Associate Professor Lesley Fleming	Queensland Health
Adjunct Associate Professor Caroline Weaver	Queensland Health

The project team acknowledges the support of staff from the School of Nursing and Midwifery, Queensland University of Technology who attended workshops and provided valuable feedback and support to LaCE participants.

The project team acknowledges the contributions and support of staff from Ramsay Health Care through the leadership of Ms Dee May, Gradplus Workforce Planning and Development, Queensland.

The initial trial website was developed by Learning Designer, Mr David Emmett. The revised final website was developed by Ms Jenny James from Wasp Creative.

The updated literature review was produced by Mr David Ross.

1.5 Project participants

Fifty-nine clinical supervisors participated in the Leadership and Clinical Education (LaCE) program from a range of different institutions including the public and private health sector across Queensland.

1.6 The significance of the project

The future of the nursing profession depends upon the development of well-trained leaders. Facing an ageing, and therefore retiring, workforce it is important that the nursing professional proactively promotes nursing leadership as a career path (Sherman & Bishop, 2007). Attaching nursing students to clinical supervisors with leadership skills will provide students with not only a supportive learning environment, but also practical and clinical real-world leadership models (Mahoney, 2001). The LaCE program provides an ideal model and framework for introducing such development in the clinical workplace. With improvements in nursing leadership, so too are there likely to be improvements in workforce recruitment and retention, delivery of quality care and organisational financial stability (Swearingen, 2009). Furthermore, the development and attainment of leadership positions by nurses will help ensure the profession has an influence in the future health environment (Mahoney, 2001). Continued innovation within nursing can only be achieved through leadership that promotes inspiration, excellence, mentorship, direction, innovation and development (Mahoney, 2001; Pintar, Capuano & Rosser, 2007).

2.0 Project Approach

The review of literature in the area of leadership, clinical education, clinical facilitation, clinical learning and teaching and workplace learning informed the development of a leadership model for clinical education and a framework to build the leadership capacity of clinical supervisors.

2.1 Literature review

Enhancing student learning in the workplace through developing the leadership capabilities of clinical supervisors in the nursing discipline.

The widely accepted practice of clinical placements for nursing students is considered core to the undergraduate nursing experience. Perhaps not surprisingly, this experiential learning, or learning through placement experience, is often deemed by students to be more meaningful than that received in classrooms (Lambert and Glacken 2005). Clinical education focuses on, and is located in, the so-called 'real world' of professional practice where learning is by necessity holistic and requires the transfer, reorganisation, application, synthesis and evaluation of previously learned acquired knowledge, along with the acquisition of new knowledge and skills (McAllister et al. 1997, 6). The clinical setting promotes the integration of the theoretical and skills based components of the curriculum and the reorganisation of knowledge so that it may be applied to problem solving and clinical decision making for real patient situations. In addition, Benner highlighted another important element to clinical teaching and learning which she described as the uncovering of the "complexity and richness of the practice that we want to teach" (Benner 1989, 25). In other words, through its emphasis on the relationship between theory and practice, clinical education can, and should, assist students to not only apply theory but also to search for ways that nursing theory can emerge from the rich texture of practice.

Students consistently report that clinical placement plays a large part in their decisions to pursue careers in nursing beyond graduation (Shih & Chuang, 2008). Despite this, real-world experiences do not automatically translate to positive learning experiences, or to the development of well-rounded neophyte professionals. There are considerable differences for students between learning in the classroom and learning in the clinical setting. Whilst classroom sessions are relatively controlled and somewhat anonymous for students, the clinical environment is unpredictable, turbulent, dynamic, close and personal (White and Ewan 1991, 3). The presence of patients, their families, nursing staff and other health professionals, and the direct contact that students have with these groups, make learning in the clinical setting potentially stressful and anxiety provoking whilst at the same time an incredibly positive and rewarding experience. The nursing environment is one of advancing technology, political influences, demands for cost-effectiveness, workforce shortages and increasing reliance on flexible working conditions such as part-time and contractual employment (Smedley & Penney, 2009). The provision of quality clinical placement experiences is therefore becoming more complex.

The clinical learning environment has been described by Dunn and Hansford as "an interactive network of forces influencing student learning outcomes in the clinical setting" (1997, 299). This definition highlights the *social* context of students' clinical experience and the potential impact of issues such as organisational/ward culture

and relationships between students and staff on the quality of student learning whilst on 'prac'. A plethora of literature exists to describe the reality of clinical practice for undergraduate students, and the difficulties surrounding the actuality of initiating and sustaining clinical environments that are conducive to learning (Clare, Brown, Edwards, & Van Loon, 2003; Clare, White, Edwards, & van Loon, 2002; Dunn & Hansford, 1997; Edmond, 2001; Mosley, Mead, & Moran, 2004; Nash et al., 1999).

An early study by Beck (1993) explored the experiences of 18 undergraduate nursing students' first encounter in the clinical setting. Six themes emerged from this study: Pervading anxiety, Feeling abandoned, Encountering reality shock, Envisioning self as incompetent, Doubting choices, and Uplifting consequences. Comments such as "diarrhoea from nervousness", "I was left alone with a real patient", "I felt totally stupid" and "had I made a mistake in choosing a nursing career?" portray some of the issues impacting on students' sense of ease/unease at being in the clinical environment. Similar findings have been reported by Neil et al. (1998) with respect to first year students. Nolan (1998) studied a group of second year students and found that, whilst anxiety at *being there* was still reported as an issue, students also talked about becoming more confident and more involved with patients' perspectives. These findings are consistent with previous research by Windsor (1987) who explored the perceptions of third year students regarding their clinical experience and proposed a three stage model of development: Anxiety and obsession with the rules, Transition period identifying the roles of nurses, and Becoming comfortable with performing nursing tasks.

Dunn and Hansford (1997) identified five areas that influenced undergraduate students' learning in the clinical setting: staff-student relationships, nurse manager commitment to teaching, patient relationships, student satisfaction, e.g. opportunities on the ward for learning, and hierarchy and ritual, e.g. organizational and/or ward culture. Of these five areas, student satisfaction was consistently identified as the most reliable index of clinical learning environment. Results from the study indicated that student satisfaction was both a cause and an effect of a positive learning environment. A productive, stimulating and supportive environment created more satisfied students, and more satisfied students facilitated the achievement of a more effective clinical learning environment (Dunn and Hansford 1997, 1306).

More recent research by Saarikoski et al. (2002) identified that positive ward atmosphere and effective clinical supervisory relationships with staff were the *most* important factors contributing to the quality of clinical learning among the second and third year nursing students who participated in their study (N=416). Similar results were found by Atack et al. (2000) who used a phenomenological approach to gain an understanding of the lived experience of students and staff within a clinical practice unit. Findings from the student interviews in the Atack et al study (2000) highlighted the importance of staff-student relationships in terms of creating a positive learning experience in the practice setting. Elements of this included the notion of students being treated as colleagues, students feeling more comfortable in dealing with staff, being part of a team and staff involving students more directly in decision making about patient care. The findings from both students and staff also highlighted the issue of supervisory relationships (Atack et al. 2000). Students indicated that observations made as early as the first day of prac about staff's willingness to teach students often set the tone for the rest of the experience on the unit. From their perspective, staff talked about the importance of students not missing learning opportunities and indicated that they took on the roles of educator and/or coach especially if the instructor was not readily available.

Factors that have been shown to influence optimal learning in the clinical setting include supportive practice environments (Calpin-Davies, 2003; Chan, 2004; Chun-Heung & French, 1997; Nash, 2005), effective supervisory relationships (Field, 2004; Saarikoski & Leino-Kilpi, 2002), a positive learning culture (Pearcy & Elliott, 2004), and collegial relationships where students are perceived as part of the nursing team (Papp, Markkanen, & Von Bonsdorff, 2003). Numerous strategies and sustainable models that aim to maximise learning in the clinical setting are already available (Clare et al., 2003; Edgecombe, Wotton, Gonda, & Mason, 1999; Mannix, Faga, Beale, & Jackson, 2006; Richardson, Fentiman, Nash, Lemcke, & Vakararawa, 2000, July; Wellard, Williams, & Bethune, 2000). However, this previous work has focussed on structural elements of clinical education delivery rather than the capacity of the people who are providing it. Research such as that by Saarikoski and Leino-Kilpi (2002) highlights the importance of the *people* dimension to the effectiveness of clinical experience and consequently, the quality of students' learning.

Clinical supervision

As noted in the Clinical Supervisor Support Program discussion paper (HWA 2010), there is an abundance of names for the clinical supervision role in Australia. The paper notes that "different terms are used by different professions, and sometimes within a profession. Terms also vary across educational institutions and the terms used in Australia are sometimes different to those used in other countries" (p. 8).

Although many variations now exist, two basic models of clinical supervision have been commonly used in Australia for the purpose of educating nursing students in the clinical setting: clinical facilitation and preceptorship (Grealish and Carroll 1998). Essentially the clinical facilitation model involves a facilitator (employed by the university or 'seconded' through an arrangement with a health care facility) working directly, i.e. on a *supernumary* basis, with a group of students (typically on a 1:8 ratio) in a clinical setting (McKenna and Wellard 2004). The facilitator's responsibilities usually include student briefing and debriefing, the assessment of students' learning needs, organisation of the learning activities, clinical teaching/supervision of students' practice, close liaison with health care agency and university staff, consultation with students' regarding their progress and evaluation of their performance.

The preceptorship model generally involves a practising registered nurse providing on-site individual clinical supervision on a 1:1 basis for a particular period of time which may be an 8-hour shift, 3 days per week, a 2-week clinical block, etc. Due to the changing work context over the past decade, the preceptor role has become less formalised and, in many instances, is now somewhat synonymous with the clinical nurse 'buddy' role. The preceptor/'buddy nurse's responsibilities are similar to those of the supervision model however, unlike the supervision model, preceptors continue to carry their normal clinical workload and are usually not responsible for pre/de-briefing students or the formal evaluation of students' performance (activities that would be undertaken by clinical facilitators).

Clinical Facilitators

Within the nursing context, the term *clinical facilitator* has commonly been to denote the role that is undertaken by the person charged with the key responsibility for students' learning in the clinical setting. Definitional issues notwithstanding, there is broad agreement that clinical facilitators have a crucial role which encompasses coaching, role modeling, counselling, inspiring, assessment, liaising and supporting

the professional growth and development of students (Andrews 2003; Andrews and Chilton 2000; Baillie 1992; Bain 1996; Clifford 1993; Crotty 1993; Davies et al. 1999; Grealish 2000; Lee 1996; Ohrling and Hallberg 2001; Quinn 1995; Spouse 2001).

A number of descriptive and interpretive studies have been conducted to investigate clinical educator/mentor characteristics that are perceived by student nurses to facilitate learning. From the findings of these studies it can be seen that characteristics such as being prepared/organized and confident about the role, enjoyment of nursing and demonstrating clinical competence were identified most frequently. Notably, Nehring (1990) and Kotzabassaki et al. (1997) found that the *most positive* characteristics of a mentor include the creation of a positive non-threatening environment, competence of the instructor as a clinician and as an instructor and the provision of constructive feedback. Similar findings were also reported by Davies (1993), Glover (2000) and Langridge and Hauck (1998). However, Lee, Cholowski and Williams (2002) replicated earlier research by Mogan and Knox (1987) which investigated and described characteristics of 'best' and 'worst' clinical educators.

Unlike Mogan and Knox (1987), but consistent with Kotzabassi et al. (1997), Lee et al. (2002) found that interpersonal relationships were rated as the most highly valued characteristic by both Australian students and clinical educators. Nursing competence and evaluation were rated second and third highest by both groups, but there was a difference in the order in which these were rated by the two groups. Students rated evaluation and nursing competence as the second and third most highly valued characteristics, whereas clinical educators rated these characteristics in the reverse order. Interestingly, teaching ability and personality characteristics were ranked second lowest and lowest by both groups (i.e. rated 4th and 5th out of five subsets of effective clinical educator characteristics).

Similar trends were found by Beitz and Weiland (2005) in their survey of junior and senior baccalaureate nursing students to investigate students' perceptions of personally and professionally inviting teaching behaviours of nursing faculty. In general, students rated clinical faculty highly for effective teaching behaviours. Consistent with previous research, students' qualitative comments highlighted characteristics such as supportiveness, mutual respect, role modeling, clinical competence, interested in clinical teaching and gives positive feedback as important to the quality of their clinical learning.

Preceptors

In the majority of clinical placement programs, the nursing student is paired with a ward nurse who acts as a preceptor/'buddy'. Research has shown the preceptor plays one of the most important roles in the clinical experience of nursing students (Nash, 2005; Nash et al., 1999). Much of students' informal learning happens within this student-buddy nurse context. Nurse preceptors see their role as creating a trusting, helpful and secure learning environment, providing guidance and information, exposing students to experiences, teaching decision-making and priority management, instilling professional values, focusing on student goals and acting as role models (Bourbonnais & Kerr, 2007; Danielsson, Sundin-Andersson, Hov, & Athlin, 2009). In overall terms, then, it can be said that the role of the nurse preceptor is to ease the transition of student nurses into professional practice (Bain, 1996).

Willingness to teach, openness to new learning experiences and confidence within the role are therefore preceptor qualities (Campbell, 1984). Unfortunately, most nurse

preceptors are faced with the dilemma of how to provide a stimulating and supportive learning environment for student nurses while also providing optimal care to their patients in their already busy work schedules (Leyshon, 2005; Nelson, Apenhorst, Carter, Mahlum, & Schneider, 2004; Ryan-Nicholls, 2004).

Precepting takes extra time, energy and responsibility (Hautala, Saylor, & O-Leary-Kelley, 2007; Yonge, Krahn, Trojan, Reid, & Haase, 2002). It entails demands on a preceptor's personal skills and strength in order to adapt to student needs, capacities, motivations and learning styles, as well as the frustrations of lacking time while working at a slower pace and continually explaining and supervising (Danielsson et al., 2009; Henderson & Malko-Nyhan, 2006). Stress can result from feeling responsible for students' work habits, their nursing care and their mistakes (Yonge et al., 2002). Further pressure comes from the difficulty of the preceptor's possible own view of the students as unsuitable, difficult, lacking in skills or confidence and have unrealistic expectations (Danielsson et al., 2009; Yonge et al., 2002). Nurses who find themselves as preceptors are often unprepared for the role and understandably ambivalent about taking students under their wing.

In contrast to this, however, preceptors often comment that the role brings many intrinsic rewards (Campbell, 1984; Henderson & Malko-Nyhan, 2006). Precepting encourages and offers the opportunities for professional development, growth and ongoing learning (Carlson, Pilhammer, & Wann-Hansson, 2010; Danielsson et al., 2009; Henderson & Malko-Nyhan, 2006; Lillibridge, 2007). It gives the opportunity to teach others, and thereby improve one's own nursing knowledge base (Campbell, 1984; Dilbert & Goldenberg, 1995). The rewards can also include the feelings of making a positive difference (Lillibridge, 2007), contributing to students' development (Danielsson et al., 2009) and gaining personal satisfaction (Dilbert & Goldenberg, 1995).

Preceptor Leadership

From Australian nursing students' perspectives, preceptors that are good role models are also the most effective (Lee, Cholowski, & Williams, 2002). Jackson (2001) states that a good preceptor and role model should have confidence, competence, excellent communication and teaching skills, ability to cope with stress and problems, and a willingness to share experience and correct self-identified bad habits. Another Australian study of nursing students also found that purposefulness, competence, effective communication, teaching skills, consistency, organisation, support, motivation and approachability were desirable leadership characteristics in preceptors (Zilembo & Monterosso, 2008). This would suggest that the skills required for preceptors are also those required for leadership. The precepting role, though, is not typically conceptualised in terms of leadership – rather, it tends to be seen in terms of specific tasks and designated functions that need to be carried out.

The generalised preceptor training programs that do exist, although not necessarily focusing on leadership, have been shown to increase preceptors' comfort with their role and develop many of the skills required for leadership (Hallin & Danielson, 2008; Henderson & Malko-Nyhan, 2006; Hyrkäs & Shoemaker, 2007; Singer, 2006). In many such programs there are three common elements that could be implemented across any leadership development program. These elements include: aligning and leading people through change; developing a shared vision and defining the path to achieve this vision; and personal qualities of motivation, inspiration, self-awareness and self-belief (Driscoll & Cooper, 2005; Kouzes & Posner, 2007; NHS Institute for Innovation and Improvement).

Aligning & Leading People through Change

A common theme in the research as to why preceptors were dissatisfied with their role centred on lack of support. In one study a preceptor reported “very often I feel I’m operating in a vacuum and on my own” (Hautala et al., 2007, 67) – the type of experience that acts as a source of stress. Preceptors should be supported by a clinical facilitator or clinical supervisor who acts as the conduit between the student’s academic institution and the health care service. The supervisor can support and aid preceptors through their various preceptor-related challenges both professionally and personally (Spence, Cantrell, Christie, & Samet, 2002). Usher et al. (1999) concludes that it is up to the clinical supervisors, and those in similar positions, to provide and promote preceptor recognition within the clinical setting and support preceptor development.

Supervisor training programs that develop the leadership and support skills relevant to this area are therefore vitally important. Support can include periodic monitoring of the students’ progress and development, identification of student problems, raising awareness of preceptor stress, identification of support strategies and the provision of clear student guidelines (Dilbert & Goldenberg, 1995; Hautala et al., 2007). Elements that assist in creating a supportive environment for optimal leadership development include: recognition of ideas or success, development of contracts that outline roles and responsibilities of preceptors and clinical facilitators, clear performance criteria and critical appraisals, monitoring, fostering team innovation, introducing new and improved ways of doing things, shared governance and shared decision-making, and promotion of a shared vision (Ayer, Knight, Joyce, & Nightingale, 1997; Eisenbeiss, van Knippenbuerg, & Boerner, 2008; Spence et al., 2002; Thyer, 2003).

Achieving a Shared Vision

The learning environment of the nursing student needs to be supportive and positive and should be framed in a way that optimises implementation of leadership skills. To ensure this occurs, the health care environment needs to embrace and support the development of leadership at the nurse preceptor and clinical facilitator level by implementing processes that allow these nurses, from every position level, to contribute to the clinical placement process. Effective precepting relies upon organisation- or institution-wide support via the design of practices and routines that demonstrate a shared vision (Carlson et al., 2010). Such recognition of the importance of the preceptor role appears to act as a significant encouragement, with absence of recognition associated with decreased role satisfaction (Henderson & Malko-Nyhan, 2006) whilst formal acknowledgment has been viewed as an incentive to continue in the role (Danielsson et al., 2009; Dilbert & Goldenberg, 1995; Usher et al., 1999).

Of course a shared vision implies not only that the organisation recognises the preceptor, but the preceptor recognises the organisation. Programs to develop preceptor leadership must therefore both meet the needs of the preceptors and encourage identification and respect of organisational goals (Pintar, Capuano, & Rosser, 2007). Pintar et al. recommend that specific contracts be formed that detail the shared vision so that both the preceptors and organisation as a whole are aware of their respective responsibilities

Preceptor Personal Qualities

Unfortunately, the promotion of staff into leadership roles based on their clinical experience, rather than leadership qualities, appears to be a common problem in the nursing field (Sanders, Davidson, & Price, 1996). It should not be assumed that all nurses are 'natural' leaders and will immediately incorporate desired leadership qualities into precepting roles. Rather, as Mahoney (2001) states, the development of leadership for many nurses will require taking on a body of knowledge, developing new skills, and actively practicing those skills. The expertise required to teach, guide, facilitate and evaluate students within complex, unpredictable, and often chaotic environments is often overlooked (Paton, Thompson-Isherwood, & Thirsk, 2009). Such qualities can be held by any member from the full spectrum of staff from most junior to senior. Therefore, the ability of a nurse to have leadership skill should not be confused with management position, or a nurses position within their organisational hierarchy (Stanley, 2004).

Although limited informal or formal training is undertaken by preceptors and clinical facilitators before they take on their roles, very few training programs include modules that are specifically aimed at developing good leadership skills (Leyshon, 2005; Spence et al., 2002; Swearingen, 2009). Given the advantages in providing training and resources that promote leadership development in preceptors and clinical supervisors, it makes sense to clearly identify what the key elements of a good leadership program should be. Preceptors are described as experienced professionals who mould nursing practice through teaching, supervision, sharing of experiences and acting as a role models (Lillibridge, 2007; Mahoney, 2001). To fulfil these tasks preceptors must have a sense of confidence and critical awareness of themselves (Henderson & Malko-Nyhan, 2006; Hyrkäs & Shoemaker, 2007). Preceptors state their decisions to take on the role are based upon opportunities to assist new staff, teach, improve teaching skills, share knowledge and gain person satisfaction (Dilbert & Goldenberg, 1995) due to the challenges, rewards and growth achievable through the role (Campbell, 1984). Cumulatively, this would suggest that the skills and competencies required of preceptors and clinical facilitators include notions such as 'mentoring', 'coaching' and 'facilitating', which are all forms of leadership.

Transactional & Transformational Leadership

While there are several studies that have investigated supervisor training, development of competency standards for supervisors and evaluation of supervisor processes (Getz, 1999; Hyrkäs, Appelqvist-Schmidlechner, & Kivimäki, 2005; Severinsson & Hallberg, 1996), few studies have focused on the leadership styles of supervisors or preceptors and what effect these styles have on the student nurse's learning experience. Two main leadership styles mentioned in recent literature are transactional leadership and transformational leadership.

Transactional leadership refers to a leader-follower relationship in which the focus is on meeting the immediate self-interested needs of each partner (Bass, 1999). It is often seen in bureaucratic, hierarchical organisations where innovation and creativity is stifled due to the difficulties in 'controlling' the performance and actions of subordinates. In some ways, those who lead the health care system can be classified as transactional leaders, as their emphasis is often focused on providing a safe environment for patients in which a strict adherence to processes is considered vital in order to achieve this standard of safety (Thyer, 2003).

Transformational leadership, on the other hand, is concerned with developing skills, confidence and motivation to achieve the organisation's goals and vision through a longer-term process of engagement with all staff. The leader moves the follower beyond self-interests to a degree of maturity, self-actualisation and concern for the well-being of others (Bass, 1999). This is achieved by leaders fostering an environment of innovation, creativity, empowerment, problem-solving and decision-making, open communication, positive reinforcement and ownership (Vandenberge, Stordeur, & D'hoore, 2002).

Not surprisingly, nursing students have been found to favour the transformational leadership style (Zilembo & Monterosso, 2008). The literature describes a broad range of skills and qualities that are prevalent in transformational leaders, including the development of critical thinking, change management, group work and active listening skills, questioning, paraphrasing and communication techniques, and decision-making strategies (Morgan, 2005; Nelson et al., 2004; Rubel & Atieno Okech, 2006; Sloan, 1999; Thyer, 2003; Wallumbwa, Avolio, & Zhu, 2008). Empowerment is one of the key outcomes of good transformational leadership and can be achieved through the development of the key skills outlined above.

An example of how the preceptor's experience can be linked to specific characteristics found in good transformational leaders can be found in the study by Lillibridge (2007). This study aimed to gain a greater understanding of how the nurse preceptor perceived their role and how they defined the preceptor experience. Five main themes were identified which included – "making it worthwhile for the nurse", "making a difference", "engaging in the process", "I love being the preceptor but …" and "accepting the role, taking responsibility".

"Making it worthwhile" focuses on the nurse preceptor's need for reward in undertaking the preceptor role – the perceived rewards are both personal and professional in nature, and are linked to positive reinforcement, intrinsic motivation and change management. "Making a difference" describes the nurses' feeling that they are actively contributing to the learning experiences of their students, indicating that nurse preceptors are taking ownership of the student learning process, one of the perceived rewards of "preceptoring". The third theme, "engaging in the process", relates to nurses' perception of themselves as role models, and their creation of positive learning activities for the students. This can link with the transformational leadership characteristics of innovation and creativity which are necessary to achieve the goal of good quality, positive learning experiences. "I love being a preceptor but ..." and "accepting the role, taking responsibility" link with empowerment and the need for nurses to be good problem-solvers and decision–makers, functioning in an environment that includes clinical facilitators and nurse managers.

There can be a mistaken belief that leaders are born and cannot be trained. On the contrary, the skills required to be a transformational leader can be taught. McDaniel and Wolf (1992) state that essential components to creating a taskforce of transformational leaders include creating a work environment where nurses are comfortable being inquisitive, thinking critically and questioning the status quo as well as developing support structures, such as journal clubs and problem-solving groups, that encourage transformational qualities. Danielsson et al. (2009) described a year-long nurse preceptor programme that, although not overtly stated as intending to create transformational leaders, is an example of the capability to coach participants to develop transformational styles of leadership. Over the year it was reported preceptors tended to change their views of their role from one of teaching and controlling to one of increased focus on student goals. There was also noted a change from focusing on the rewards of personal growth and being acknowledged to

focusing more on being a companion in the students' development (Danielsson et al., 2009).

The Need to Develop Preceptor Leadership

Although more than 20 years have elapsed since nurse education moved into the tertiary sector, concerns about the nature and quality of clinical education continue to be raised by key stakeholders including health and education providers (Clare et al., 2003; Clare et al., 2002), government (Heath, 2002) and the tertiary education sector itself (Boxer & Kluge, 2000; Conway & McMillan, 2000; Tanner, 2002). Unless the cultural milieu which surrounds students' clinical experience is supportive of their learning and underpinned by strong clinical leadership, longer term outcomes from innovations focussing on the more structural elements of clinical education delivery will be difficult to achieve. It is clear from current research that preceptors and clinical facilitators consider their role in the clinical placement experience to be one of mentorship, role modelling, and leadership. However, it is also clear there is a gap in the training and preparation processes for these nurses, with leadership being highlighted as a key deficit.

The future of the nursing profession depends upon the development of well-trained leaders. Facing an ageing, and therefore retiring, workforce it is important that the nursing professional proactively promotes nursing leadership as a career path (Sherman & Bishop, 2007). Attaching nursing students to preceptors with leadership skills and positions will provide students with not only a supportive learning environment, but also with practical and clinical real-world leadership models (Mahoney, 2001). With improvements in nursing leadership, so too is there likely to be improvements in workforce recruitment and retention, delivery of quality care and organisational financial stability (Swearingen, 2009). Furthermore, the development and attainment of leadership positions by nurses will help ensure the profession has an influence in the future health environment (Mahoney, 2001). Continued innovation within nursing can only be achieved through leadership that promotes inspiration, excellence, mentorship, direction, innovation and development (Mahoney, 2001; Pintar et al., 2007).

This project aimed to build the leadership capacity of clinical supervisors in the nursing discipline by developing, implementing and systematically embedding a leadership model in the structure and practice of student supervision. This project is based on the conviction that the key to sustainable outcomes lies in the development of clinical education leadership capacity as a significant catalyst for cultural change, in order to effectively support quality student learning within the work unit environment. (see Appendix 1).

2.2 Leadership and Clinical Education (LaCE) model

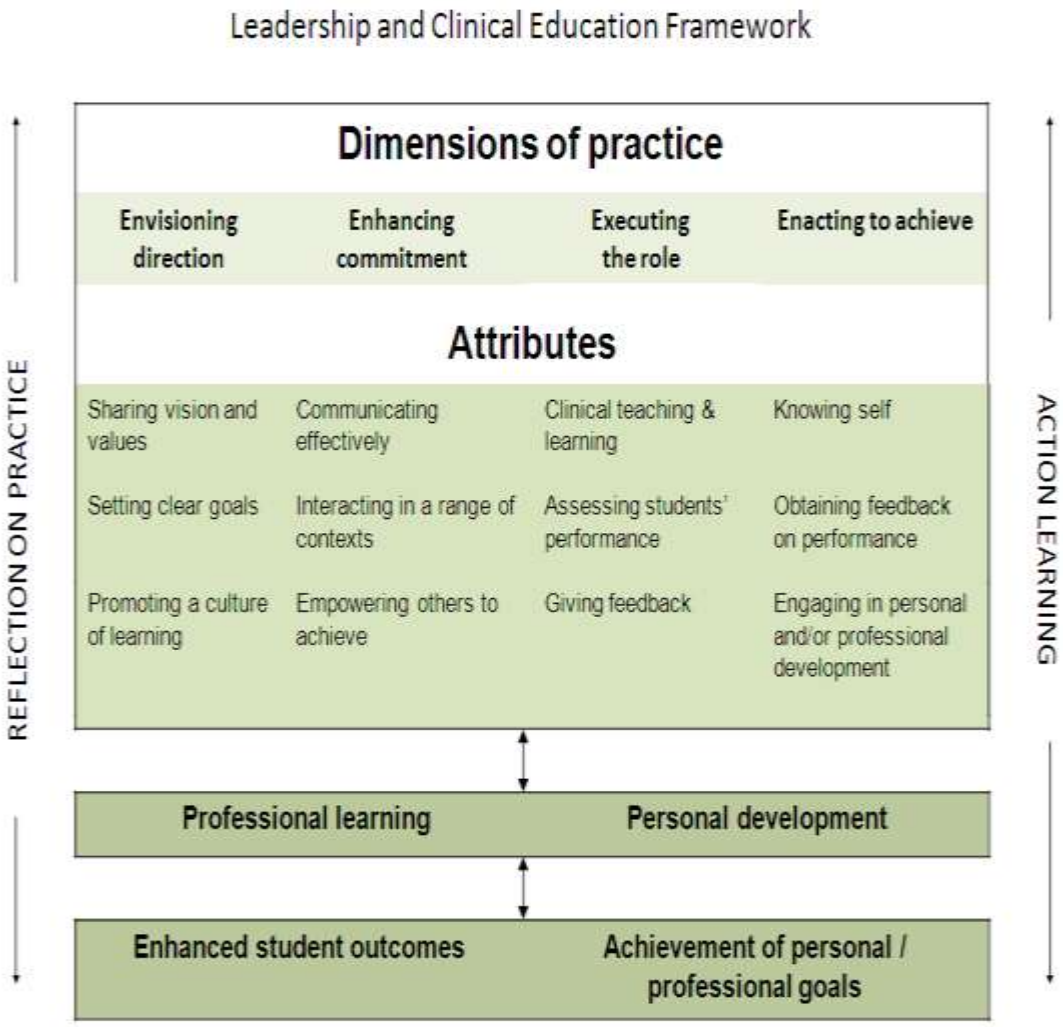
A model of leadership and clinical education was developed integrating the concepts of leadership and clinical supervision. A succinct definition of leadership is "any behaviour that influences the actions and attitudes of others to achieve certain results" (ALDC 2007). With further reference to Ramsden, 1998; Kouzes & Posner, 1997-2007; and Bennis & Nanus, 1987, leadership can be seen as, "inspiring shared vision, challenging the process, enabling development and sustaining commitment." Clinical facilitation can be defined as "a goal oriented dynamic process in which participants work together in an atmosphere of mutual respect in order to learn through critical reflection" (Burrows, 1997). With further reference to Lee et al., 2002;

Tang et al., 2005; Lambert, 2007; Robinson 2009, clinical supervision can be seen as promoting a learning culture, facilitating learning, providing support and developing competence.

Leadership and clinical supervision perspectives are incorporated into the LaCE framework through the four dimensions of practice (see Figure 1):

- **Envisioning** direction – providing direction by the sharing of vision and values, setting clear goals and promoting a culture of learning;
- **Enhancing** sustained commitment – demonstrating sustained commitment by interacting effectively in a range of contexts, working collaboratively and empowering others to achieve;
- **Executing** the role – fulfilling the role by clinical teaching and learning, problem solving and decision making and innovating for improvement; and
- **Enacting** self development – ongoing development of knowledge and skills in clinical education through knowing oneself, obtaining feedback on performance, engaging in personal and professional development.

Figure 1:
Leadership and Clinical Education Framework – Dimensions of Practice



2.3 LaCE program

The LaCE framework underpins the three interconnected components of the LaCE program (see Figure 2):

- **LaCE Workshops (2)** – to provide the opportunity for information sharing, discussion on key topics, reflection on the outcomes of Personal Development Projects and peer networking;
- **Personal development projects** – to provide participants with the opportunity to put principles into action through undertaking a small personal improvement project on a topic/area of their choice; and
- **Online LaCE Toolkit** – to provide participants with resources designed to support their clinical education leadership journeys.

Figure 2:
Leadership and Clinical Education program components

2.4 Methodology

The project methodology was developed around three phases using the action research approach informed by the work of Argyris, Putnam, and McLain Smith (1985) and Kemmis and Wilkinson (1998):

- development of a clinical education leadership model and capacity building framework;
- implementation of the clinical education leadership model and implementation of the revised clinical education leadership model; and
- evaluation, review, dissemination and reporting.

2.4.1 Development of a clinical education leadership model and capacity building framework

Phase 1 involved the following:

- Integrative review of literature on issues and practice with respect to leadership within the context of clinical education;
- Development of a prototype leadership model of clinical facilitation and capacity building framework based on Ramsden's three academic leadership functions – Seizing opportunities and realizing them in practice; Leading the way; and Teaching (1998, 93);
- Focus group discussions with key stakeholders to provide feedback on the capacity building framework; identify issues, gaps and suggested modifications; and discuss factors that will assist/hinder successful implementation and strategies to facilitate the process;
- Development of capacity building resources; and
- Liaison with external evaluator, Project Advisory Group and National Stakeholder Committee (NSC) regarding project planning, and evaluation and dissemination strategies.

Most of Phase 1 of the project was completed in June 2009 with an interim review of literature, development of a prototype leadership model and a capacity building framework. Exploratory focus groups were conducted and the development of resources commenced.

By expanding the scope of the Project Advisory Group (PAG) to include members with a national perspective (see Appendix 2), the role of a National Stakeholder Committee was incorporated into the Project Advisory Group. The formation of one advisory body ensured a more focussed approach and avoided duplication of roles and responsibilities.

Identification of a project evaluator occurred during Phase 2.

2.4.2 Implementation of the clinical education leadership model

Phase 2 (Cycle 1) was as follows:

- Piloting of the model (and supporting resources) within one of the partner hospitals;
- Reflection on outcomes and revision of the model and/or supporting resources as indicated; and
- Discussions with PAG regarding outcomes of model pilot, subsequent revision of the model, and implications for dissemination and evaluation.

Phase 2 (Cycle 2) was as follows:

- Implementation of the revised model and supporting resources within all of the partner hospitals;
- Integrative reflection on outcomes and recommendations for future action; and
- Liaison with PAG and NCS in relation to outcomes of full implementation of the model and planning for final evaluation, dissemination and reporting.

Phase 2 of the project was completed in July 2010 with the piloting of the model and supporting resources completed in December 2009. The pilot program involved

participants from all three partner hospitals and feedback from participants and the PAG was incorporated into the revised model and resources.

Web based resources were reviewed throughout the program. In May 2010 the website was re-developed with more friendly visuals, resources and project samples. ePortfolio and discussion forum functions were removed as these were not sustainable and communication and feedback initiated via email was preferred by participants.

Evaluation consultant, Dr Paul Chesterton, was appointed in March 2010 to undertake an independent evaluation of the project. Dr Chesterton reviewed documentation with the project team and provided an evaluation plan (see Appendix 3).

Planning for a national forum for clinical nursing coordinators in universities and industry commenced in May 2010 to take place in August 2010.

A preliminary literature review was updated in January 2010 to include a comprehensive review of the most recent research in leadership and clinical education.

Stakeholders were kept informed of the project's progress through bi-monthly newsletters (see Appendix 4).

2.4.3 Evaluation, review, dissemination and reporting

Phase 3 was as follows:

- National forum for PAG and NSC, including nursing course coordinators, Heads of Schools of Nursing and Clinical Education Liaison Officers;
- Production of generalisable guidelines, strategies and recommendations for the development and implementation of the clinical education leadership model;
- Independent evaluation of effects of model on student clinical experiences, supervisor confidence, job satisfaction (as relates to student mentoring role) for Registered Nurse buddies supported by clinical supervisors;
- Submission of paper to relevant journal and abstracts to two targeted conferences; and
- Final Report to PAG, NCS and to ALTC.

Phase 3 of the project was completed in September 2010. A National Forum to launch new resources and ideas was successfully held on 31 August 2010 (see Appendix 5). Representation from nine industry bodies, 10 universities and the ALTC ensured a broad dissemination of the LaCE program. Feedback from Forum participants was collated to identify strategies for the dissemination and continuation of the LaCE program more widely. The Forum also demonstrated strong linkages with ALTC projects in other areas of clinical education (see Section 4.4).

3.0 Trialing and Revising the Model

The Leadership in Clinical Education (LaCE) program consisted of two structured workshops complemented by individual personal development projects undertaken by participants. Participants were supported in these activities with a purpose-built website (www.lace.org.au) that provided access to a wide variety of information and other learning resources.

3.1 The online toolkit

The LaCE online toolkit has been developed to assist clinical supervisors to advance their knowledge and skills through the incorporation of leadership perspectives within their role. The web based resources are underpinned by theoretical perspectives that relate to leadership and teaching and learning in the clinical setting.

The web based resources are organised according to the dimensions of practice from the LaCE framework that include, envisioning direction, enhancing sustained commitment, executing the role and enacting self-development. The online toolkit provides information resources and thinking points, teaching strategies, exercises and further reading. As well as information that assists LaCE participants to prepare their Personal Develop Plans, there is a suite of LaCE resources that can be adapted for the delivery of the program from any provider of education and training.

Figure 3:
Screen shot of LaCE website home page.

3.2 Workshop 1

The broad aims of Workshop 1 are to: (see Appendix 6)

- Explore the connection between leadership and clinical education;
- Discuss the LaCE Framework and its applicability to clinical education;
- Equip participants with a toolkit to enhance their clinical education role through the incorporation of leadership concepts and principles;
- Support participants in preparing a LaCE personal development project plan.

During workshop 1, participants explore the concepts of leadership and clinical education and become familiar with the LaCE framework by engaging in scenario-based discussions and sharing experiences with colleagues (see Appendix 7).

3.3 Personal Development Plan/Project

The completion of the Personal Development Plan (see Appendix 8) assists participants to plan the professional development activity, the outcomes of which are presented at Workshop 2. A suggested starting point is obtaining feedback on their own performance from students and staff and also through a self-assessment process (see Appendices 9a, 9b, 9c).

Before completing the Personal Development Plan, participants are also asked to think about their strengths with respect to clinical education and to identify a specific area of interest for improvement and how they might address this. Once goals have been set, they are asked to consider how they will know they have achieved their goals.

3.4 Workshop 2

The broad aims of Workshop 2 (see Appendix 10) are to:

- Share experiences and reflections on leadership practice in clinical education gained from the implementation of LaCE Personal Development Plans;
- Further develop a personal repertoire of practical strategies relevant to challenges of clinical education; and
- Continue to build networks and resources which will support personal and professional leadership development.

During Workshop 2 participants hear from guest speakers who share their leadership journeys and provide insights into the complexities of the health workplace environment. Participants present the outcomes from the projects they develop through their personal development plans with reference to the LaCE resources. Reflections on the concept of leadership are also shared.

3.5 Piloting the program (LaCE 1)

The Leadership and Clinical Education (LaCE) program was piloted in October/ November 2009. The purpose of piloting the model and supporting resources with clinical supervisors was to test the effectiveness of the model within one of the partner hospitals, to reflect on the outcomes from the pilot and revise the model accordingly.

In order to reach the number of participants needed, clinical facilitators from all three hospital partners were invited to attend. Twelve participants attended the first workshop, and three participants attended the second workshop. The program was carefully evaluated using a combination of quantitative and qualitative measures (see Chapter 6).

3.6 Revising and implementing the program (LaCE 2)

The Leadership and Clinical Education (LaCE) program was revised in light of the evaluations conducted during LaCE 1. The quantitative tools used in LaCE 1 were unsuccessful in capturing change that had occurred for the participants from the beginning to the end of their involvement in the program. This became clear because the quantitative findings did not match the qualitative findings. After much searching for more suitable measures, it was decided to develop a purpose-specific scale for the project, the Nash Inventory of Clinical Leadership (NICL) (see Appendix 11). The program itself remained essentially unchanged although the LaCE 2 participants had the benefit of some sample Personal Development Plans/Projects from LaCE 1 and this assisted in the scoping of their projects. In addition, the online toolkit had been developed further with a growing set of resources. The revised and refined program was implemented in the form of the second LaCE program in March/April 2010.

3.7 Revising and implementing the program (LaCE 3)

The Leadership and Clinical Education (LaCE) program was again refined after LaCE 2 and implemented in the form of LaCE 3 in June/July 2010. Although the evaluation measures were not changed from LaCE 2, the online toolkit had been significantly enhanced for LaCE 3 after engaging the services of a website designer. In addition, there were several new exemplar Personal Development Plans/Projects that were able to be shown to the participants (see Appendix 12). The larger number of participants in LaCE 3 posed some new challenges and benefits. There were more ideas to be shared, but the logistics of having all participants presenting in the second workshop meant that careful time-keeping was essential.

Candice Barter project presentation

Leonie Harradine project presentation

4.0 Feedback from Key Stakeholders

Ethics approval to conduct research for this project was obtained from the lead institution and all partner institutions as follows:

- University Human Ethics Committee, Queensland University of Technology;
- Human Research Ethics Committee, The Prince Charles Hospital;
- Institutional Review Board, Royal Brisbane and Women's Hospital; and
- Human Research Ethics Committee, Mater Health Services.

Key stakeholders including, QUT clinical facilitators, LaCE participants, QUT academic staff and project partners participated in focus groups, interviews and discussions. Also, the Project Advisory Group met twice. Feedback from these activities assisted the project team to identify important issues and to gauge the strengths and limitations of the project along the way.

4.1 Project meetings

Members of the Project Advisory Group were identified from across Australia. Their expertise is in various aspects of clinical education and strategic interest in the further development of this field of practice. Members were asked to comment on the activities and outcomes of the project not only from a 'local' perspective, but also in terms of potential national applicability of the LaCE model and capacity building framework. Terms of reference for the Project Advisory Group were developed outlining its responsibilities.

The first meeting of the PAG was held 10 December 2009. Discussions in the meeting highlighted the importance of providing support, for example, time release, to clinical staff who teach and mentor students so that participation in the LaCE program was encouraged directly (through attendance at workshops and completion of the Personal Development Plan) and indirectly (through the use of online resource material). The PAG noted that the evaluation of the program through the use of qualitative and quantitative data was crucial to support the sustainability of the program beyond the project (see Appendix 13).

The second meeting of the PAG scheduled to take place 26 May 2010 did not proceed due to the unavailability of a number of members. Information was disseminated to members electronically and included feedback and outcomes from the first and second iteration of the LaCE program, revisions to the LaCE model, evaluation indicators and plans for a National Forum.

The third and final meeting of the PAG was held 15 September 2010. Members provided very positive feedback on the project in a general sense and praised the success of the National Forum. They were enthusiastic about the effectiveness of the focus on leadership in building the supervisory skills of clinical facilitators. There were suggestions that the LaCE model has applicability to interprofessionalism and advised the project leader to seek out possible opportunities for further funding from the ALTC to develop the program in allied health disciplines (see Appendix 14).

4.2 Focus groups

In Phase One of the project, a series of focus group discussions were held with nursing staff at all partner institutions who facilitate off-campus clinical practice for nursing students. A total of 30 clinical facilitators attended these discussions.

In order to elicit as much information as possible from participants, the questions used to frame these discussions were purposively kept few in number and semi-structured in nature, for example:

- What does the role of clinical facilitator mean to you?
- What has attracted you to 'take on' the role?
- What are the key challenges that you face as a clinical facilitator?
- If there was a 'Clinical Facilitation Skills Kitbag' what, ideally, would be in it?
- Suggestions regarding professional development for clinical facilitators?

The key themes identified from these discussions were as follows:

Role of the clinical facilitator:

- Helping students put theory into practice;
- Educating future nursing professionals; and
- 'Bridges the gap' between university and clinical practice.

Attractions of the role:

- Opportunity to develop the nurses of the future;
- Personal development opportunity – may be a 'pathway' to teaching?
- Enjoy teaching; and
- Personal satisfaction – it's great to see them (students) growing as professionals.

Key challenges:

- Difficult situations with staff/students;
- Insufficient recognition of the role by other staff and/or the organisation; and
- Uncertainty regarding clinical education skills base.

Clinical Facilitations 'Skills Kitbag:

- Advanced communication skills, e.g. rapport building, negotiation, conflict resolution;
- Facilitating reflection on practice;
- Giving feedback on performance;
- Getting feedback on performance as a clinical facilitator; and
- Identifying core values re clinical education.

Other suggestions:

- Strong endorsement regarding the value of supporting clinical education / clinical facilitators;
- Workshops would be good but difficult to attend; and
- Online support with just-in-time resources.

This feedback was pivotal to the development of the LaCE model and supporting resources ensuring that they would be designed to meet the needs of clinical facilitators. Some of the key challenges and necessary skills identified from these focus groups were ultimately evident in the project topics that LaCE participants investigated, especially in the area of giving and receiving feedback (see Appendix 12).

4.3 Interviews and discussions

In Phase Three of the project, interviews were conducted with project team members from all partner institutions, LaCE participants and academic staff. A total of 19

subjects were interviewed. Interviewees responded to a series of questions in an informal atmosphere.

Samples questions included:

- What are your overall comments about the LaCE program?
- What did you enjoy most/least about participating in the LaCE program?
- What were the key learnings you gained as a result of participating in the program?
- What are the overall strengths/weaknesses of the LaCE program?
- Should LaCE be continued in the future? If so, in what way?

4.3.1 LaCE participants

Participants' reflections highlighted the effects that the LaCE program had on their practice especially creating more focus on student learning and creating a positive learning environment.

The summary of the key themes identified by LaCE participants from these interviews were as follows:

Overall, the program:

- Promoted innovative ideas in leadership in nursing;
- Encouraged thoughtful reflection on the role and raised awareness of the importance of the role and its connection to leadership;
- Supported learning about similar and more complex issues experienced by other facilitators in other places;
- Took personal learning to the next stage by getting focussed on an area to improve; and
- Was well structured with something for everyone (experienced and inexperienced).

Effect on practice:

- Change in the feedback given to students – more formalised (written), more balanced (both positive and negative), involved students more in the process, involved buddy nurses more in the process;
- Ensuring the best for students by formalising processes more e.g. preparing an orientation pack including policy information, early identification of preceptors who will be working with students;
- Looking at the role more as a leadership role and taking more initiative e.g. forwarding information to more senior people in the organisation;
- Gave a big picture outlook; and
- Showed the importance of creating a positive learning environment with a focus on staff as well as students e.g. providing more positive feedback, improving relationships, increasing interaction, gaining more respect.

Strengths:

- Brought people together from different hospitals and systems and so exposed each other to diverse situations and approaches;
- Format of the template for the personal development plan to assist with project;
- Good time of day and length of time for professional development; and
- Information on the website was really useful and used initially to determine direction to take with project;

- Participants' presentations;
- Self-direction to undertake projects;
- Guest speaker who talked about her work practices and how she has been successful;
- Social aspects, listening and taking in information in a relaxed environment;
- Projects were very simple and common place things;
- Using the framework allowed for identification of gaps where improvements could be made; and
- Can tell others about the LaCE website and refer them to it.

Limitations:

- Clearer links between Workshop 1 and Workshop 2;
- Knowing if your idea is relevant and has enough scope (pilot group had no examples);
- Timeframe full day workshops ideally 8 weeks in between;
- Difficult to do in work time; and
- Personal circumstances prevented participation in second workshop and completion of the project.

Participants who attended interview sessions had continued to be engaged with the LaCE program after they had completed it. Their projects enabled them to develop a useful resource in their own local context and some of them were continuing to enhance and further refine their project material. The website provided ongoing access to resources.

4.3.2 QUT academic staff

QUT academic staff from the School of Nursing and Midwifery attended the project presentations during Workshop 2. This was a demonstration of support for the clinical facilitator role and an important activity to engage academic staff with the LaCE program.

The summary of the key themes identified by QUT academic staff from interviews about the LaCE program were as follows:

Overall comments:

- Good to have a connection between the University and the health agencies themselves;
- Nice to see that the University is interested in developing the people involved with students and therefore indirectly the students;
- One of the most successful and useful program I have observed especially from the viewpoint of getting meaningful results;
- Project presentations were very enjoyable;
- It was impressive what participants got out of the program. This was especially evident by the project presented; and
- Heightened the awareness of participants of being leaders in the nursing profession.

Strengths:

- Showed that University staff are interested in what Clinical Facilitators are doing and that it could be taken further;
- Collaboration between "us" and "them";

- The enthusiasm of participants to share their experiences and speak to other about it and for others to want to be a part of it;
- Increased awareness of the processes, how to improve them and therefore streamline student experiences; and
- A collegial approach was evident with everyone committed to supporting and assisting students towards a good educational experience.

Limitations:

- More formal recognition for what has been done by sessional staff; and
- How can the program be sustained?

QUT academic staff reflections on the LaCE program highlighted the importance of building and maintaining connections between universities and healthcare institutions. Clinical facilitators felt a heightened awareness of being leaders in the nursing profession.

4.3.3 LaCE project partners

Project partners from the healthcare industry acknowledged the importance of university involvement in the professional development of clinical facilitators. There was potential for the LaCE program to be incorporated into existing professional development programs with broader application to preceptors and supervisors of graduate nurses.

A summary of the general comments from LaCE partners from interviews were as follows:

- The program complements existing programs within the hospital and it is important to have a university involved in providing professional development;
- Clinical facilitation needs to be developed as a career path as it is a big step up from the preceptor program;
- Could be targeted at an even broader audience, including preceptors and others who work directly with the supervision of students;
- Could also have a broader focus, in that it could assist with the skills needed to be a leader in the supervision of students as well as new graduate nurses;
- Program is important to demonstrate that hospitals are supportive of a culture of learning;
- It may be necessary to provide a “hook” for staff to engage with the program... need to be explicit about any potential to link this to further study or qualifications;
- Higher standards may be achieved if facilitators are acknowledged as transformational leaders, therefore assisting students in understanding what is required of them as a professional nurse;
- Changes in behaviour across the team e.g. very focussed and thinking along different lines;
- Offshoots from working with the framework were that gaps in practice could be more easily identified; and
- Renewed interest in the clinical facilitation role and more staff coming forward to take on this role.

Comments by LaCE participants, QUT academic staff, and industry project partners consistently showed the strong connections that the project has achieved between the university and healthcare institutions. These connections have the potential to

continue to build and support clinical facilitators to increase their leadership skills and therefore enhance student learning.

4.4 National Forum

Delegates at the National Forum assisted the project by providing suggestions for the broader application and dissemination of the LaCE program and supporting resources. Overall comments were very positive.

Overall comments on LaCE program and resources:

- Website is excellent and appealing;
- Framework is excellent and can be developed across a number of fronts;
- Wonderful and empowering for facilitators/clinical supervisors;
- Worthwhile project to encourage and promote the quality roles of facilitators as leaders;
- Great initiative that we can all take on board and use;
- Fantastic initiative, good resources, not too time intensive and participants have clearly produced some excellent outcomes;
- Very encouraging that participants saw they were better able to support and facilitate student learning as a consequence of the program;
- An excellent program that is simple but effective; and
- Beautifully links industry and academia to break down barriers and create collaborative ventures.

Feedback was provided by delegates on the further dissemination and transferability of the LaCE program to other contexts. They also commented on the applicability of the LaCE program within their own institutions and incorporating it into existing programs.

- Set up as a joint partnership between health agencies and universities – may not need funding as can be incorporated into professional development activities;
- Extend the focus from undergraduates to new graduates;
- Look at formal recognition of clinical facilitator roles – currently the clinical facilitator role is evolving so it needs to be made attractive as an end point (financially);
- Support CFs to attend workshops and encourage new ideas in the practical context;
- Share the resource/model to build a national profile for LaCE across a range of disciplines;
- Resources will provide a useful reference to deal with issues that arise during clinical placement;
- Continue this conversation in multiple universities and multiple disciplines by directing them to information about the project;
- Clinical work areas need to access funding of clinical facilitator positions as an investment into the nursing workforce of the future; and
- Can be utilised by all CFs as a benchmark for learning and as a minimum requirement for professional development as a facilitator.

5.0 Feedback and Results

Three iterations of the LaCE program were conducted in 2009 and 2010, each iteration consisting of two workshops, personal development projects and use of the LaCE website (see Chapter 3). The first iteration was a pilot and the second and third iterations comprised the program proper. The results of these iterations are reported here.

5.1 Pilot measures

The questionnaires used to pilot the model and supporting resources assessed participants' "Leadership Values and Attitudes" (see Appendix 15) and "Career Strengths" (see Appendix 16), and there were an additional two questions assessing their pre- and post- (first) workshop confidence. The questionnaires used were available on the Centre for Coaching and mentoring website http://coachingandmentoring.com. The Leadership and Values scale comprised 12 items, with response options ranging from 1 (this is not me) to 5 (this is definitely me).

Of the 12 participants, seven completed questionnaires that assessed their leadership values and attitudes and career strengths, and there were an additional two questions assessing their pre- and post- (first) workshop confidence. Qualitative feedback was also collected from participants who reflected on how their clinical facilitation had improved as a result of participating in the LaCE program.

5.1.1 Student measures

Following the piloting of the model, student outcomes were also measured by using an adaptation of the Clinical Learning Environment and Supervision Instrument (CLES) (Saarikoski & Leino-Kilpi, 2002) (see Appendix 17), and 13 students who were all doing their practicum at The Prince Charles Hospital agreed to participate. The "ward atmosphere", "learning on the ward", and "supervisory relationship" subscales of the CLES were used, comprising 19 items in total.

5.2 Pilot results

Test scores on the quantitative scales indicated that the group was relatively inexperienced but enthusiastic and high in leadership potential. Their Leadership Values and Attitudes scores were in the high range (45-55), (*Mean* = 52, *SD* = 4.61). On Career Strengths, they were assessed across 21 skill area items (e.g., mentoring students, setting standards of care, developing staff) on both their ratings of their level of expertise and personal interest. Response choices on expertise ranged from 0 (Never done this) to 5 (Expert) and response choices ranged from 1 (low) to 3 (high). On Career Strengths (Expertise), they scored between competent (3) and skilful (4) on average, with a Mean average score across the 21 skill areas of 3.81. However, on Career Strengths (Personal Interest), they scored close to high with a mean average score of 2.73. The combined test scores indicated that the group was relatively inexperienced but enthusiastic and high in leadership potential. Examples of qualitative participant feedback included:

> 'the program gave me a general feeling that we all share similar goals and problems'
>
> 'my facilitation has improved as I have gained confidence in the skills I possess and learnt a lot from my colleagues that I can use on a daily basis'
>
> 'I got a better understanding of leadership qualities and the clinical education process'
>
> 'networking and discussion of common speed bumps was thought provoking'.

5.2.1 Student results

The "ward atmosphere", "learning on the ward" and "supervisory relationship subscales of the CLES were used, comprising 19 items in total. Response options on all items ranged from 1 (fully disagree) to 5 (fully agree), and there was also an open comments section at the end. The respondents consisted of 10 students on their second clinical placement and three who were on their fourth placement. Two were male and 11 were female; seven were international students and six were domestic students; seven were from non-English speaking backgrounds and six were not. The students ranged in age from 19 to 55, with the Mean age being 29.92 years (*SD* = 10.42).

Analysis using an independent samples t-test was conducted in order to compare students (*N* = 7) who had been supervised by Clinical Facilitators who had completed the workshops with students (*N* = 6) who had been supervised by Clinical Facilitators who had not completed the workshops. There was no significant difference between the two groups of students on their perceptions of ward atmosphere, *t* (11) = .78. *p* = .44, learning on the ward *t* (11) = .59. *p* = .56, or the supervisory relationship, *t* (11) = 1.75. *p* = .10. The students who had been supervised by Clinical Facilitators who had completed the workshops were all supervised by two of the three CFs who completed both workshops. The other group of students were all supervised by one, very experienced CF. The experience of this CF may account for the non-significant results, although the small sample size must also be acknowledged. There was also the possibility that a ceiling effect may have occurred, with the mean item scores all tending to be relatively high (i.e. between "agree" and "fully agree") (see Table 1).

Table 1:
Differences between students supervised by Clinical Facilitators who had completed the workshops and students supervised by Clinical Facilitators who had not completed the workshops on CLES sub-scale scores

Subscale	Students supervised by Clinical Facilitators who had completed the workshops (*N* = 7)		Students supervised by Clinical Facilitators who had not completed the workshops (*N* = 6)		*t*	*Sig. (2-tailed)*
	Mean sub-scale total (SD)	Mean item score	Mean sub-scale total (SD)	Mean item score		
Ward atmosphere	21.71 (2.13)	4.34	20.26 (2.65)	4.05	.78	.447
Learning on the ward	25.14 (1.95)	4.19	26.00 (3.16)	4.33	.59	.562
Supervisory relationship	29.14 (11.00)	3.64	37.50 (3.88)	4.68	1.75	.106

5.3 LaCE 1 and 2 participants

There were 47 nurse clinicians, who attended one or both of the two LaCE workshops in the LaCE 2 and 3 iterations (21 at LaCE 2 and 26 at LaCE 3) held in 2010. LaCE 2 and LaCE 3 each consisted of two workshops approximately six weeks apart. All 47 completed the Nash Inventory of Clinical leadership (Clinician form), with 25 completing the questionnaire at both workshops. Most of the participants were over 30 years of age, with only 5 in the 20-29 year age group; 17 in the 30-39 year age group; 13 in the 40-49 year age group; 11 in the 50 years and over group; and one who did not specify. Participants came from several different clinical facilities throughout Queensland, with the largest number (N=18) coming from Ramsay

Healthcare. They had been registered for between three and 47 years, with the mean number of years registered being 16.42 (SD= 9.99 years). They had been working as clinical supervisors for between zero and 20 years, with the mean being 3.69 years (SD = 4.26 years). There were a couple of participants who were just starting out as clinical supervisors. Out of this beginning group, 25 participants attended both workshops, with seven of these completing the follow-up questionnaire.

5.4 Qualitative measures

In addition to completing the Nash Inventory of Clinical Leadership (NICL; see Section 5.5), participants completed items which addressed demographic information and open ended items inviting them to list what they liked most, and least, about being a CF. Participants were also asked to give qualitative feedback about their experiences with the LaCE program.

5.5 Nash Inventory of Clinical Leadership

Participants completed the Nash Inventory of Clinical Leadership (NICL) (see Appendix 18). The NICL was developed for the purpose of this project and consists of 56 items, including 14 items on each of four sub-scales. Response choices are scored on a 6 point likert scale, ranging from 1 (completely disagree) to 6 (completely agree). The sub-scales assess skills and abilities in the following areas: providing direction and promoting clinical learning; facilitating effective working relationships; clinical teaching; and role development. Each subscale was tested for internal consistency and each was found to be highly reliable with Cronbach's Alphas ranging from .895 to .957 (see Table 1).

5.6 Analysis of results

Participants tended to rate themselves fairly highly on most of the items. Pre- and post-LaCE program means of subscale scores were quite similar and all in the range between 'somewhat agree' and 'completely agree' (see Table 1). However, it is worth pointing out the lower minimum mean in the second subscale which would seem to indicate that at least some participants were tending to rate themselves lower on that sets of items pre-LaCE. Two-tailed t-test analyses were conducted to compare pre-LaCE mean scores with Post-LaCE mean scores on each of the four ICL sub-scales. Although there was a trend for improvement in confidence across all sub-scales, only the increase on the first sub-scale, 'providing direction and promoting clinical learning', was statistically significant (see Table 2).

Table 2:
Pre- and post- mean subscale scores on the NICL (N=25)

Subscale	*Cronbach's Alpha (Pre-Post)*	*Pre-LaCE Mean*	*Pre-LaCE SD*	*Post-LaCE Mean*	*Post-LaCE SD*	*t*	*Sig. (2-tailed)*
Providing direction and promoting clinical learning	.908 - .913	5.05	.55	5.48	.39	-5.42	.000*
Facilitating effective working relationships	.931- .957	5.10	.52	5.45	.52	-3.29	.003*
Clinical teaching	.943- .949	5.19	.53	5.59	.42	-3.82	.001*
Role development	.895- .905	5.32	.48	5.64	.34	-3.20	.004*

*Significance: $p < .005$

5.7 Qualitative results

Qualitative feedback was also collected from participants who reflected on how their clinical facilitation had improved as a result of participating in the LaCE program. Examples of participant feedback included such comments as:

> 'The program gave me a general feeling that we all share similar goals and problems.'
> 'My facilitation has improved as I have gained confidence in the skills I possess and learnt a lot from my colleagues that I can use on a daily basis.'
> 'I got a better understanding of leadership qualities and the clinical education process.'
> 'Networking and discussion of common speed bumps was thought provoking.'

5.8 Discussion of results

The subscales relating to providing direction and promoting clinical learning and facilitating effective working relationships seemed to be the ones where participants were least confident at the outset, especially in relation to working relationships with clinical staff. At baseline, participants were reasonably strong on the skills relating to clinical teaching and confident in their role development, especially the way in which they regarded their role and perceived students to regard the role. They tended to enjoy their roles as clinical supervisors and saw them as leadership roles as well as important, respected and influential positions. However, they were relatively uncertain about their ability to engender teaching confidence in other clinical staff. While they were quite confident in their abilities to teach students, they were relatively disinclined to seek feedback about their own performance. This was certainly an area of potential for professional development in these individuals.

Follow-up scores on the NICL indicated that participants were feeling much more confident across most items in the scale after having completed the LaCE program, with highly significant increases on all sub-scales. It should be noted that there was a slight ceiling effect in the data which probably resulted from the fact that these participants were fairly confident and experienced clinical supervisors to start with. It can be difficult to detect a significant change in such a group, especially with a relatively small sample size. However, the scale was sensitive enough to detect the improvement that most participants experienced in their confidence across the four sub-scales.

6.0 Summary of Outcomes and Achievements

6.1 Project outcomes

The six outcomes listed below were specified in the original project proposal:

- A transferable leadership model of clinical workplace supervision of students.
- Empowerment of clinical supervisors through a distributed approach which addresses two levels of the structure of clinicians that both directly influence the quality of the clinical experiences and learning of nursing students;
- Enhanced leadership capacity of clinical supervisors operating at the university-workplace interface to facilitate quality learning and teaching in the nursing discipline;
- Strategic change within the system of clinical supervision and facilitation in a way that will promote quality learning experiences for students and quality teaching experiences for those who are supervising, teaching and mentoring students in the clinical workplace;
- Cultural change through improved recognition of the importance of clinical teaching and of the teaching leadership role played by clinical supervisors and registered nurses in healthcare environments; and
- A transferable set of strategies and resources that will serve as effective mechanisms for the development and embedding of good practice in terms of adapting the leadership model of clinical supervision to a range of workplace settings, particular those aligned with the health professions.

6.2 Project achievements

Major achievements throughout the life of the project have included:

- Full conceptualisation of a *leadership model* of clinical facilitation and supervision, including the development of a sustainable Clinical Education leadership framework for capacity-building of staff involved in the clinical facilitation and supervision of undergraduate nursing students;
- *Extensive trialling* of the leadership model of clinical facilitation/supervision across the three large metropolitan health services that were partners in the project;
- Conduct of three iterations of the *LaCE program* which were completed from late 2009 through to mid 2010;
- Development of a detailed online resource pack, the *LaCE website*, www.lace.org.au, for universities and health care facilities/services;
- Encouragement of industry partners and other universities to *embed the resource pack* in their intranet systems by providing a link to the LaCE website for sustainable access and use and to make it available online for universities and health facilities across Australia to use and adapt;
- *Empowerment of clinical supervisors* to lead general nursing staff in mentoring and coaching nursing students in ways that foster effective and positive learning experiences;
- *Measurement* (quantitative and qualitative) of the success of the re-conceptualised model in terms of clinical supervisor appreciation and application of their leadership roles in the specific areas of: providing direction and promoting clinical learning; facilitating effective working relationships; clinical teaching; and role development;

- Full *project team meetings* and bimonthly *newsletters* were effective in disseminating information about the project to stakeholders and ensuring that the program was championed on site by the project partners;
- A full *literature review* providing a comprehensive review and inclusion of all available recent research in leadership and clinical education;
- The LaCE program has been endorsed by the Royal Collage of Nursing Australia by attributing 8 Continuing Nurse Education (CNE) points towards the continuing professional development of nurses in Australia under the Life Long Learning Program (3LP);
- Several *conference papers* presented detailing the work of the project (see Chapter 7);
- Preparation and submission of a paper entitled *"Enhancing student learning in the workplace through developing the leadership capabilities of clinical supervisors in nursing"* to the journal, *Nurse Education Today;*
- Project information entered on the *ALTC Exchange* website; and
- Investigation, through discussion and debate at a national forum of coordinators of the clinical components of nursing courses, of the challenges, benefits and strategies for implementing the model at universities and health services nationally.

6.3 Factors ensuring success

There have been numerous factors that have ensured success in achieving planned project outcomes and disseminating these outcomes in such a way as to maximise the sustainability of those outcomes. These have included:

- Having consistency in quality project coordination, by retaining the services of an excellent Project Coordinator from early in the life of the project;
- Excellent and regular communication between members of the Project Team, between the Project Team and Coordinator, between the Project Coordinator and the Project Advisory Group and other key stakeholders;
- Enthusiastic support and participation of the clinical coordinators at each of the clinical partner facilities, as well as one health service that was not officially a partner;
- Full engagement by the clinical facilitators/supervisors who participated in the program and shared their journeys with other participants and attendees at the National Forum; and
- Great interest and excellent attendance at the National Forum, which will help to ensure sustainability of the project outcomes.

6.4 Factors impeding success

There were a range of challenges that were met throughout the project and these are detailed below, along with an explanation of how they were overcome:

- *Some technological difficulties* were initially experienced with the LaCE website. It was realised that the functionality of the eCommunication tools were not being utilised and the site was somewhat unstable. Consequently, the resources were migrated to an associated university website, which was purpose-built and designed by a professional web-designer. This site has proved to be very stable and visually appealing. In addition, QUT staff can easily update the site and refresh the contents from time to time in the future;
- Initially there were some difficulties in accessing a reasonable *number of participants* for the LaCE program. Consequently, only 12 participants attended the first iteration. In order to ensure that there were full programs for

the subsequent iterations, a multi-pronged approach was implanted including: promotion by the project leader in university forums; championing by project team members in partner institutions; telephone follow-up to *partner facilities to ensure* email invitations were sent; direct phone reminders; and communications and delivery of the program onsite at a partner institution;

- Ensuring continued *commitment from participants* through from Workshop 1 through to Workshop 2 and the presentation of outcomes from the personal development project was a challenge in the first iteration of the program. This was often not because participants lost interest or didn't have time to work on their projects, but rather it was due to difficulties with rostering so that they had the appropriate shifts to be able to attend both workshops. Certain strategies were used to assist participants to formulate their personal development plans early (soon after Workshop 1) and therefore return to Workshop 2 and complete the program. In addition, the Project Coordinator kept in close contact with the partner facilities and participants to help maintain their commitment; and
- *Ethical clearance* for the project was slow in being approved at one of the partner institutions. This required a lengthy re-submission process as well as *working around* the intermittent scheduling of ethics committee meetings. Even though this Human Research Ethics Committee had no ethical concerns with regard to the project, more information on the project was requested and supplied, and eventually ethics approval was obtained.

6.5 General lessons learned

There were many lessons learned throughout the life of the project and most of the lessons were positive. They included:

- *Don't underestimate the enthusiasm* and energy of the people that the project was designed to help. At the outset of the project, the team wondered if busy clinical facilitators/supervisors would have the time and energy to invest in being involved in a leadership development program. What the participants showed was that, once they saw the benefits of such a program to their daily work, they were prepared to find the time and enthusiasm to engage in the program in ways which surpassed our expectations;
- In relation to time and rostering constraints of participants, we also learned that *advanced planning* and notification was required in order to access clinical staff to participate in the LaCE program as student rotations and hospital rosters are scheduled well in advance;
- Continuous communication and contact with participants especially from on-site champions was essential to the *retention of participants* in the program from Workshop 1 to Workshop 2. These on-site champions were able to encourage participants with their personal development plans and assist in finding backfill so that they could attend the program;
- We learned that an interactive *online functionality* for the LaCE website was not needed and did not seem to appeal to participants who had limited time in which to engage online. For this reason, as well as stability, we migrated the site to a simpler and more visually appealing QUT-associated site;
- *Expanding* the offer of the program to other interested institutions increased participation levels in the LaCE program and resulted in potential for much broader dissemination at the conclusion of the project;
- After using some existing scales, we learned that there were no existing scales that were entirely suitable for measuring the kinds of change that we were expecting to find in our participants as a result of engaging with the

LaCE program. We learned that the best thing would be to *design our own scale* – the result was the Nash Inventory of Clinical Leadership (NICL), which served its purpose very well and was psychometrically sound. The subscales were stable and reliable, as was the scale overall, and we were able to show a statistically significant improvement in leadership confidence in participants attending the program; and

- As suspected earlier in the life of the project, it was necessary to increase the part-time commitment of the *Project Coordinator* from 50% to 80% as the project reached its period of peak activity and finalisation (workshops, evaluation, final report and national forum). This resulted in successful outcomes for the project.

7.0 Dissemination of Findings

7.1 Dissemination and communication of project activities

The Project Team and Project Coordinator began work on dissemination activities quite early in the life of the project and these will continue well into 2011. Papers have already been presented at several conferences with some accepted papers still to be presented. In addition, a full paper has been submitted to a peer-reviewed journal and is under review. Details of these and other dissemination activities are presented below. In addition, a National Forum was held in August 2010, with the specific aim of raising awareness of the project, the LaCE Program and its associated resources, and dissemination of the project's findings.

The full-day ***Leadership and Clinical Education National Forum*** was held at QUT on Tuesday 31 August 2010. This was widely advertised throughout clinical and university networks across Australia. It was provided free of charge to interested parties and a resource pack (including a Program Guide and USB stick containing all the program resources) was provided to each attendee (see Appendix 19). The Forum allowed us to launch the new website and associated resources, and also to present the findings of the project and disseminate how the outcomes were achieved. In total 53 people attended, including 24 people from industry, 28 from universities (17 from QUT and 11 from other universities) and one representative from the ALTC (Siobhan Lenihan) who kindly introduced the Forum and gave participants an overview of the ALTC Leadership for Excellence in Teaching and Learning Program. Attendees came from five Australian states and even New Zealand, and both regional and urban centres were represented (see Appendix 20).

The forum featured:

- An overview of the project and demonstration of resources from the Leadership and Clinical Education (LaCE) Program from Professor Robyn Nash, Project Leader and Assistant Dean, Teaching and Learning, Faculty of Health;
- Project Presentations from three of the LaCE program participants (Candice Barter, Leonie Harradine, Kerri Phillips-Smith);
- Guest Speaker Professor Amanda Henderson, 2007 ALTC Associate Fellow, Professor in the School of Nursing and Midwifery, Griffith University, who delivered a stimulating presentation, in which she discussed her team's work on the "Leading for Effective Partnering" project, funded by the ALTC. The aim of this project is to apply a "learning circle" model as a conduit to develop leadership capacity and promote quality clinical learning and teaching. The project has involved students and staff involved in undergraduate clinical education at Griffith University and three hospitals in Brisbane;
- Guest Speaker Associate Professor Sue Jones, Dean, Teaching and Learning, Faculty of Health Sciences, Curtin University of Technology delivered her presentation entitled "Academic Leadership for Fieldwork Coordinators", on another ALTC Leadership for Excellence in Teaching and Learning Program funded project. This project, currently underway, involves collaboration between staff at Curtin and Charles Sturt universities. The aim of this project has been to design, pilot and implement an academic leadership development program for field coordinators from a wide variety of Education and Health Science disciplines; and

- A discussion by the attendees of future opportunities for the dissemination and use of the LaCE program and resources, in the environments in which they were working. In general, attendees were very positive about the possibilities of using the program and its resources in a range of settings nationally and internationally.

Guest speakers, Professor Amanda Henderson and Associate Professor Sue Jones presenting at the National Forum.

Papers that have so far been presented or published include the following:

- Nash, R., Sacre, S., (2010). *Developing the leadership capabilities of clinical supervisors in nursing*. Paper presented at the Inaugural Innovate and Educate (ClinED Qld) Conference, Brisbane, 11–12 March, 2010;
- Nash, R., & Sacre, S. (2010). *Enhancing student learning in the workplace through developing the leadership capabilities of clinical supervisors in the nursing discipline*. Poster presented at the 3rd International Nurse Education (NETNEP) Conference, Sydney, 11–14 April, 2010; and
- Nash, R., Sacre, S., Calleja, P., Mannion, J., Fox, R., Bonney, D., & Teo, J. (2010). Enhancing student learning in the workplace through developing the leadership capabilities of clinical supervisors in the nursing discipline. Poster presented at the Mater Education 10th National Leadership & Learning Conference, Brisbane, 16–17 September, 2010.

Papers or posters that have been accepted and will be presented later in 2010 or 2011 and papers that are under review are listed below:

- Nash, R., & Sacre, S. (2010). *Developing the leadership capabilities of clinical supervisors in nursing*. Paper to be presented at the ACEN Conference, Perth, 29 September–1 October, 2010;
- Nash, R., & Sacre, S. (2010). Developing the leadership capacities of clinical educators: a joint university/industry partner initiative. Paper to be presented at the Magic in Teaching Education Conference, Marriott San Francisco Airport, Burlingame, California, 19–20 October, 2010;
- Nash, R., Sacre, S., Calleja, P., & Lock, J. (2010). *Enhancing student learning in the workplace through developing the leadership capabilities of clinical supervisors in the nursing discipline*. Paper to be presented at the 27th Ascilite Conference, 5–8 Dec, 2010; and
- Nash, R., Sacre, S., Calleja, P., Ross, D., & Lock, J. (under review). Enhancing student learning in the workplace through developing the leadership capabilities of clinical supervisors in nursing, *Nurse Education Today*.

7.2 Linkages to other ALTC strategic priority areas

The National Forum allowed the Project Team to make links with related ALTC-funded projects being conducted in Queensland and Western Australia by Professor Amanda Henderson and Associate Professor Sue Jones. In addition, the uploading of the LaCE program resources and details onto the ALTC Exchange has meant that current and future ALTC members of the Exchange can make contact with the team and exchange ideas.

Clearly, the project has an important relationship with other ALTC projects in the program area of Leadership for Excellence in Teaching and Learning. In addition, there are many possible synergies with Priority Program projects and projects that are specific to health disciplines, particularly those with a clinical training focus.

Other ALTC fellowships and projects that have been noted to have potentially relevant linkages with the current project include:

- ALTC 2006 Associate Fellowship: Professor Fiona Lake, with Margaret Potter, Derrick Webley, and Chris Norman, *Application of a clinical staff development model (Teaching on the Run) to allied health and other professional audiences and to rural and remote settings,* The University of Western Australia (Lead), Curtin University of Technology, Murdoch University, The University of Queensland, the Health Departments of Western Australia and Queensland; and
- General Investigation 2007: Martin Smith, Sally Brooks, Anna Lichtenberg, Peter McIlveen, Peter Torjul, & Joanne Tyler, *Career development learning: Maximising the contribution of work-integrated learning to the student experience*, University of Wollongong (Lead), Flinders University, Monash University, RMIT University, University of Southern Queensland.

In relation to the new ALTC commissioned Strategic Priority Projects, the topic most likely to have some connections with this project is: “Principles for assessment and assurance of graduate learning outcomes”. This is because in many disciplines, assessment and assurance of graduate learning outcomes is to a large part determined by clinical educators. The importance of their leadership skills in ensuring the provision of good learning and assessment outcomes for students of health disciplines cannot be overestimated.

8.0 Evaluation

8.1 External evaluator

An external evaluator, Dr Paul Chesterton, was engaged to assist with the evaluation of the project. The independent evaluation report focussed on the extent to which project outcomes were achieved.

The scope of evaluation assistance involved:

- Providing advice on evaluation approaches and techniques, tailored to meet the specific needs and contexts of the project;
- Reviewing and providing feedback on evaluation data gathered and data analysis reports prepared by the project team;
- Conducting interviews of project team members regarding their experience and perceptions of project processes and outcomes; and
- Preparing an independent evaluation report to be included with the final report to ALTC.

8.2 Indicators of achievement

Specific indicators were developed by the external evaluator in consultation with the project team for each of the listed outcomes.

A transferable leadership model of clinical workplace supervision of students:

- Production of the model;
- The extent to which it is seen as appropriate and potentially effective by key stakeholders;
- The extent to which it is seen as transferable by other potential users;
- Satisfactory results from trialing in other settings; and
- Extent to which the program is adopted by Ramsay Health for professional development.

Empowerment of clinical supervisors through a distributed approach which addresses two levels of the structure of clinicians that both directly influence the quality of the clinical experiences and learning of nursing students:

- The extent to which the two levels have been addressed; and
- Evidence of empowerment – examples of positive changes in clinical supervisor practice associated with exposure to the training.

Enhanced leadership capacity of clinical supervisors operating at the university-workplace interface to facilitate quality learning and teaching in the nursing discipline:

- Perceptions of positive changes in supervisor leadership capacity; and
- Examples of positive changes in supervisor leadership capacity.

Strategic change within the system of clinical supervision and facilitation in a way that will promote quality learning experiences for students and quality teaching experiences for those who are supervising, teaching and mentoring students in the clinical workplace:

- Examples of strategic change that will or are intended to promote quality learning experiences for students and supervisors, teachers and mentors.

Cultural change through improved recognition of the importance of clinical teaching and of the teaching leadership role played by clinical supervisors and registered nurses in healthcare environments:

- Examples of changes in hospital settings that reflect improved recognition of clinical teaching and of the teaching leadership role played by clinical supervisors and registered nurses in healthcare environments;
- Changes in role descriptions of clinical supervisors that reflect improved recognition of clinical teaching and of teaching leadership; and
- RCNA endorsement.

A transferable set of strategies and resources that will serve as effective mechanisms for the development and embedding of good practice in terms of adapting the leadership model of clinical supervision to a range of workplace settings, particular those aligned with the health professions:

- Production of the strategies and resources;
- Reactions of others in related workplace settings to the strategies and resources – critical peer review in terms of transferability and potentially effective adaptability; and
- Case studies emerging from workshop program.

The indicators for each outcome provided evidence that the deliverables for the project had been completed. The findings in the independent evaluation report also demonstrated the achievement of project outcomes.

8.3 Conclusion

This project has been enjoyable and rewarding for the project team and participants. The LaCE program is a comprehensive and excellent beginning in the journey to find sustainable models that effectively support clinical supervisors in the achievement of quality clinical education. It is important that the LaCE program continues to be developed, expanded and adopted more widely into multidisciplinary contexts.

Professor Robyn Nash presenting at the National Forum

Delegates at the National Forum

9.0 Appendices

Appendix 1: Bibliography

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Appendix 2: Terms of Reference – Project Advisory Group

PROJECT ADVISORY GROUP
TERMS OF REFERENCE

Establishment:

The Project Advisory Group is established by the Project Team.

Terms of Reference:

The responsibilities of Project Advisory Group will be to:

- provide the project team with stakeholder feedback and expert advice and assistance throughout the course of the project
- promote participation of stakeholders in focus groups and piloting of leadership resources
- offer information regarding appropriate networks/contacts
- offer information regarding specific contexts in which the project outcomes will operate
- provide feedback following the piloting of the model in relation to what aspects may need to be modified for the model to work effectively in a national context
- offer advice as to what additional or adapted resources might need to be made available for the model to be able to be rolled out nationally across nursing schools
- identify strategies for implementing the model at nursing schools across Australia

Membership:

Membership will comprise individuals with specific expertise in various aspects of clinical nurse education. Representation provides a national perspective on the application and implementation of the leadership model and framework developed.

Representation will include delegates from:

- nursing practitioners
- coordinators of nursing courses
- Heads of Schools of Nursing
- nursing educators in both academic and industry sectors
- professional groups with interests in clinical nurse education

Meetings:

The Project Advisory Group will meet following the piloting of the model (November/December 2009) and following the roll out of the model (June/July 2010).

Appendix 3: Terms of Reference – External Evaluator

EXTERNAL EVALUATOR
TERMS OF REFERENCE

Introduction:

The external evaluator will serve as an investigator to evaluate the ALTC leadership project, '*Enhancing student learning in the workplace through developing the leadership capabilities of clinical supervisors in the nursing discipline'.* The external evaluator will evaluate whether the nominated project outcomes identified in the project proposal are achieved.

Project Description:

The overall aim of the project is to improve the quality of student learning in the clinical setting through strengthening the clinical leadership capacity of staff involved in clinical facilitation and supervision of undergraduate nursing students.

This project will embed a leadership model in the health service-university interface that will advance the clinical learning of Australian nursing students, and have the potential to advance workplace learning for students more generally.

Qualities:

The qualities expected of the evaluator include:

- evidence of ethical conduct of evaluations, for example, an affiliation with Australasian Evaluation Society Inc
- project evaluation experience in higher education, and ideally in the area of teaching and learning projects
- a broad understanding of the health discipline area
- skills in quantitative/qualitative data analysis, as appropriate to the project
- high level oral and written communication skills
- independence from QUT and partner institutions
- capacity to meet project evaluation timelines
- willingness and capacity to work with the Project Team and Project Advisory Group, as required

Functions:

The specific functions of the external evaluator will be to:

- provide advice on evaluation approaches and techniques, tailored to meet the specific needs and contexts of the project
- review and provide feedback on evaluation data gathered and data analysis reports prepared by the project team
- conduct interviews with project team members
- provide an independent evaluation report to be included with the final project report to the ALTC.

Newsletter 1
January 2010

LaCE Project

Lead Institution:

QUT

Partner Institutions:

Mater Health Service Royal Brisbane and Women's Hospital
The Prince Charles Hospital

Project Leader:

Prof Robyn Nash

Project Team:

Dr Sandy Sacre
Ms Pauline Calleja
Ms Jill Mannion
Ms Donna Bonney
Ms Robyn Fox
Ms Jenny Teo

Project Advisory Group:

Prof Stephen Billett
Ms Cheryl Burns
Prof Phillip Della
A/Prof Lesley Fleming
Ms Theresa Harvey
Ms Susanne LeBoutillier
Mr Ross McDonald
A/ Prof Janice Orrell
Mr Matthew Payne
Dr Deborah Peach

Project Coordinator:

Ms Jenny Lock

Project Evaluator:

TBA

"Enhancing student learning in the workplace through developing the leadership capabilities of clinical supervisors in the nursing discipline."

Leadership and Clinical Education – LaCE

Late in 2008, QUT's Faculty of Health, along with Mater Health Services, the Prince Charles Hospital and the Royal Brisbane and Women's Hospital were successful in being awarded an Australian Learning and Teaching Council Leadership grant for a project entitled *'Enhancing student learning in the workplace through developing the leadership capabilities of clinical supervisors in the nursing discipline'.*

Professor Robyn Nash (Project Leader) and the project team have developed the Leadership and Clinical Education (LaCE) initiative to assist clinical facilitators/ supervisors to advance their knowledge and skills through the incorporation of leadership perspectives within their role.

The project is progressing well and the Year 1 report to the ALTC has been completed, demonstrating that the project is on track and meeting anticipated outcomes. The second tranche of funding for the project has been received by QUT.

The first meeting of the Project Advisory Group (PAG) took place in December. The PAG provided valuable advice on dealing with some of the challenges that the project may encounter.

Progress Update – LaCE Workshop 1

The first phase of the project has been concerned with the development of a clinical education leadership model and capacity building framework. The model and framework underpin the components of the LaCE program which includes:

- Two 4-hour workshops
- A personal development project
- Online resources
- A mentoring opportunity

Dimensions of practice within the LaCE framework include establishing direction, enacting to achieve, executing the role and enhancing commitment.

Currently the project is at the beginning of Phase 2 which involves the implementation of the model and framework that has been developed.

Implementation commenced with the conduct of LaCE Workshop 1. Part of the workshop engaged participants in the discussion of a 'real world' complex student learning scenario. Suggested strategies to resolve the scenario were overlaid onto the dimensions of practice creating a synergy between theory and practice.

Feedback received from participants in the workshop highlighted the importance of creating opportunities to work with colleagues on the challenges faced by individuals on a daily basis.

Progress Update – LaCE Workshop 2

"The LaCE program gave me a general feeling that we all share similar goals and problems."

"My clinical facilitation has improved as I have gained confidence in the skills I possess and learnt a lot from my colleagues that I can use on a daily basis."

LaCE Workshop 2 enabled participants to reflect on leadership practice in clinical education through sharing the outcomes of their Personal Development Plans.

Guest speakers, Ms Anne Copeland and Ms Caroline Weaver, focussed on their own personal leadership journeys and spoke about the practical strategies that are relevant to the challenges of clinical education.

Participants gained confidence in their decision making skills and acknowledged the importance of learning from colleagues. They identified key areas of their practice to develop from ways of providing prompt feedback to students to dealing with difficult personalities to re-affirming the importance of reflective practice.

Feedback provided to participants by staff members involved in clinical education assured them that plenty of support is available to facilitators.

Participants completed evaluations of their LaCE experience.

Project Leader Profile

Professor Robyn Nash has over 30 years of experience as a nursing professional and educator. Over the course of her clinical and academic experience, she has observed the problems that arise for student nurses and their clinical teachers when students are on practicum. She has also observed which strategies are helpful and which ones are less helpful. She has led a range of teaching and learning initiatives relating to the improvement of student experiences that have been instigated in the Faculty of Health.

In her current role as Director of Academic Programs in QUTs School of Nursing and Midwifery, she is directly engaged on a regular basis with the key regulatory body for nursing in Queensland – and, in particular, with all matters to do with the approval of course providers and accreditation of all nursing courses leading to registration, endorsement and enrolment.

In 2009, Professor Nash was awarded an ALTC Teaching Excellence Award in recognition of her contribution to enhancing the quality of learning and teaching in higher education.

This project has been made possible by the support of the Australian Learning and Teaching Council Ltd, an initiative of the Australian Government Department of Education, Employment and Workplace Relations.

The views expressed in this publication do not necessarily reflect the view of the Australian Learning and Teaching Council Ltd.

Contact Details

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http://www.foliospaces.com/view/view.php?t=O2yXnAASwNS5PaUe1Idd

Coming Events

LaCE Program 2

Workshop 1:

Monday 1 March 2010

Workshop 2:

Monday 19 April 2010

Appendix 5: National Forum Flyer

Leadership and Clinical Education
National Forum
Launching New Resources and Ideas

Tuesday 31 August 2010, 9.30am – 3.00pm
Q208, 44 Musk Avenue, Kelvin Grove Campus, QUT

(Morning tea and lunch will be provided)

The forum will present the findings from an Australian Teaching and Learning Council funded project. The project entitled "Enhancing student learning in the workplace through developing the leadership capabilities of clinical supervisors in the nursing discipline" is a collaboration between Queensland University of Technology, Mater Health Services, Royal Brisbane and Women's Hospital and The Prince Charles Hospital.

The forum features:

- Guest Speaker **Professor Amanda Henderson**, 2007 ALTC Associate Fellow, Professor in the School of Nursing and Midwifery, Griffith University.
- A demonstration of resources from the Leadership and Clinical Education (LaCE) Program from **Professor Robyn Nash**, Project Leader and Assistant Dean, Teaching and Learning, Faculty of Health, QUT.
- Project Presentation from **LaCE program participants**.
- Guest Speaker **Sue Jones**, Dean, Teaching and Learning, Faculty of Health Sciences, Curtin University.
- A discussion of future opportunities for the dissemination and use of the **LaCE program and resources**.

The forum will be highly relevant to academic and clinical staff with an interest in connecting universities and industry, as well as to leaders in learning and teaching and clinical practice and those responsible for developing continuing professional development programs in health disciplines.

Guest Speakers have extensive experience in clinical education and interprofessional learning with acknowledgement to the support of the Australian Learning and Teaching Council.

Registration is free and available online at http://www.hlth.qut.edu.au/news/lace-national-forum

For information please contact email jennifer.lock@qut.edu.au

Appendix 6: LaCE Workshop 1 Flyer

Leadership and Clinical Education (LaCE) Program

Workshop 1

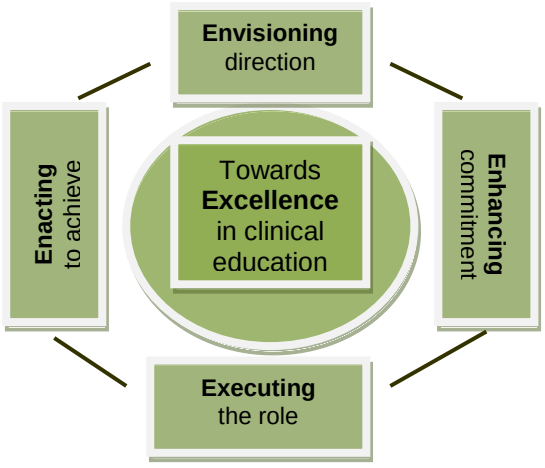
The broad aims of Workshop 1 are to:

- Explore the connection between leadership and clinical education
- Discuss the LaCE Framework and its applicability to clinical education
- Equip you with a toolkit to enhance your clinical education role through the incorporation of leadership concepts and principles
- Support you in preparing a LaCE personal development project plan

Good teaching involves the capacity to interact effectively with learners and learning environments in order to facilitate high-quality learning outcomes. As stated by Ellis (2000), 'learning arises not through interaction, but in interaction' (p. 209). In the clinical environment, the clinical facilitator's role is pivotal in influencing, or leading, these processes.

Good leaders have the ability to:

- Unlearn old habits, roles or behaviours and re-learn new ones
- Constantly question what they're doing and how they're doing it – re-inventing themselves as they go
- Reflect deeply on what happens to them – seeing it as a significant opportunity for learning, change and leadership growth.



We hope you will enjoy the LaCE program and find the experiences useful as you begin… or continue… your leadership and clinical education journey.

AUSTRALIAN LEARNING & TEACHING COUNCIL
Promoting excellence in higher education

Appendix 7: Clinical Education Scenarios

Leadership and Clinical Education (LaCE) Workshop

Clinical Education Scenario A Part 1:
You are facilitating a group of third year students on their final clinical placement in an acute surgical ward. Emma is a student who has been receiving variable feedback from her buddy nurses in her first week of a four week placement. Of note are concerns that Emma has significant deficits in clinical skills technique and application of her knowledge to a patient's situation.
When you have spoken with Emma about her performance at the end of the first week she reacted in two ways. For the issues surrounding her clinical skill performance Emma has discounted this as a major issue and stated that every situation was a learning experience and that she expects proficiency would come after she is graduated and 'doing skills' all the time. Of particular concern are her proficiency with IV medications and infusions and wound care technique. For the issues surrounding application of her knowledge to a patient situation Emma became upset and defensive and blamed the surrounding context and other people's actions for her inability to make the correct links at the time of patient care. You have just spent time working with Emma and notice that both of these issues not only affect her time management (takes 45 mins to draw up one IV antibiotic, contaminating three IV lines in the process and losing a large amount of the antibiotic in the process of priming the IV line), but that patients are also noticing her difficulties and commenting on them to you. You now need to give Emma feedback and decide on a plan to help Emma improve.

Clinical Education Scenario A Part 2:
It is now the middle of week 2, three days after you last worked with Emma. The buddy nurse Emma is working with comes to speak with you and states she never wants to work with Emma again, she seems stressed and agitated and tells you she has had to stop Emma on a number of occasions for basic patient safety issues when mobilising patients, doing medications and contaminating wounds during dressings. She states she is so far behind in her workload as a result that not everything that should be done on time (including medications) will be done. This nurse in the past has been a supportive buddy nurse and has received good feedback from students she has been working with.

Clinical Education Scenario A Part 3:
As you are walking through the ward you see Emma stomping out of a 4 bed bay, you call her name but she ignores you and walks into the dirty utility room. You enter the bay to investigate further and talk to the first patient who states he has told Emma he does not want her providing care for him any longer. The patient in the next bed says "Me too. She doesn't seem to know what she's doing and hurt me today again when doing my dressing". You ask if they need anything at the moment but both decline. You go and speak to Emma, but she dismisses what the patients have said saying that they were expecting too much of her anyway.

Appendix 8: Personal Development Plan Template

LaCE Personal Development Plan

What would I like to improve?	
What are my strengths? limitations? feedback I've received from others?	
What is my improvement goal?	
What do I want to achieve? Why do I want to achieve it?	
What is my improvement plan?	
What must I do to achieve that desired state? What resources will I use?	
How do I plan to evaluate the outcomes?	
How will I know I've achieved my goal/s? What indicators will I use?	

Adapted from the **'Quality personal development plan template'**, http://www.self-improvement-mentor.com/personal-development-plan-template.html

Appendix 9a: Feedback on Clinical Facilitation Tool: Student

Feedback on Clinical Facilitation Tool: <u>Student</u>

The Leadership and Clinical Education (LaCE) initiative aims to enhance the quality of students' learning in the workplace. One aspect of that relates to the role played by Clinical Facilitators. Your Clinical Facilitator has requested feedback on his/her performance in that role. This tool is designed to assist you in providing feedback. You are invited to rate the *performance* of your Clinical Facilitator on each item using the 1-4 scale (1 = 'Not at all' and 4 = 'To an extremely high level'). Your responses are **completely anonymous** and will **not influence your clinical assessment** in any way.

Dimensions of the role	**Feedback on performance**				
Providing clear direction **The person who has requested this feedback typically:** →	**Indicators**	Not at all 1	2	3	To an extremely high level 4
	▪ Gave me a clear idea of the goals to be achieved	1	2	3	4
	▪ Maintained clear direction in working towards the goals to be achieved	1	2	3	4
	▪ Actively promote a culture of *learning* among students and staff	1	2	3	4
	▪ Acted as a positive educational and clinical role model	1	2	3	4
	Comments:				

Dimensions of the role	Feedback on performance				
Engaging participation **The person who has requested this feedback typically:** →	**Indicators**	Not at all 1	2	3	To an extremely high level 4
	▪ Communicated clearly	1	2	3	4
	▪ Interacted respectfully and sensitively with students and clinical staff	1	2	3	4
	▪ Enabled a sense of teamwork between students and clinical staff	1	2	3	4
	▪ Was able to resolve issues/conflicts	1	2	3	4
	▪ Gave me constructive feedback that inspired my commitment to further improvement	1	2	3	4
	Comments:				

Dimensions of the role	Feedback on performance				
Facilitating outcomes **The person who has requested this feedback typically:** →	**Indicators**	Not at all 1	2	3	To an extremely high level 4
	▪ Used helpful strategies to enable me to learn	1	2	3	4
	▪ Ensured that I had adequate opportunities to achieve the required learning outcomes	1	2	3	4
	▪ Ensured that I had adequate feedback on my progress	1	2	3	4
	▪ Made decisions were fair and equitable	1	2	3	4
	▪ **Was organised and efficient in carrying out the day-to-day activities**	1	2	3	4
	▪ Encouraged me to reflect on my personal strengths, limitations, knowledge and skills regarding clinical education	1	2	3	4
	▪ Helped me to identify realistic, yet challenging, professional/personal goals for myself	1	2	3	4
	▪ Encouraged me to seek additional opportunities to improve my clinical learning	1	2	3	4
	Comments:				

Thank you for your feedback

Feedback on Clinical Facilitation Tool: Clinical staff

The Leadership and Clinical Education (LaCE) initiative aims to enhance the quality of students' learning in the workplace. One aspect of that relates to the role played by Clinical Facilitators. This Clinical Facilitator has requested feedback on his/her performance in that role. This tool is designed to assist you in providing feedback. You are invited to rate the *performance* of this Clinical Facilitator on each item using the 1-4 scale (1 = 'Not at all' and 4 = 'To an extremely high level'). Your responses are **completely anonymous**.

Dimensions of the role	Feedback on performance					
Providing clear direction	**Indicators**	Not at all 1	2	3	To an extremely high level 4	Not sure/ not applicable 5
The person who has requested this feedback typically: →	▪ Provides a clear idea of the goals to be achieved	1	2	3	4	5
	▪ Maintains clear direction in working towards the goals to be achieved	1	2	3	4	5
	▪ Actively promotes a culture of *learning* among students and staff	1	2	3	4	5
	▪ Acts as a positive educational and clinical role model	1	2	3	4	5
	Comments:					

Dimensions of the role	Feedback on performance					
Engaging participation **The person who has requested this feedback typically:** ⟶	**Indicators**	Not at all 1	 2	 3	To an extremely high level 4	Not sure/ not applicable 5
	▪ Communicates clearly with students and staff	1	2	3	4	5
	▪ Effectively builds and maintains rapport with students and staff	1	2	3	4	5
	▪ Interacts respectfully and sensitively with students and clinical staff	1	2	3	4	5
	▪ Facilitates a sense of teamwork between students and clinical staff	1	2	3	4	5
	▪ Resolves issues/conflicts quickly and effectively	1	2	3	4	5
	Comments:					

Facilitating outcomes **The person who has requested this feedback typically:** →	**Indicators**					
	▪ Uses a range of strategies to enable students to learn and, where appropriate, assists others to do the same	1	2	3	4	5
	▪ Ensures that students had adequate opportunities to achieve the required learning outcomes	1	2	3	4	5
	▪ Ensures that students have adequate feedback on their progress	1	2	3	4	5
	▪ **Organised and efficient in carrying out day-to-day business**	1	2	3	4	5
	▪ **Is readily accessible to students and clinical staff**	1	2	3	4	5
	▪ Effectively delegates clinical support/supervision to clinical staff	1	2	3	4	5
	▪ Gives constructive feedback to students and clinical staff	1	2	3	4	5
	Comments:					

Any other feedback you would like to share?

Thank you for your feedback

Appendix 9c: Self Assessment of Clinical Facilitation Tool

Self Assessment of Clinical Facilitation Tool

This tool is based on the Leadership and Clinical Education (LaCE) Framework. It is designed to assist your self-assessment of how you are going on each LaCE Dimension and provide directional pointers for continued improvement.

We invite you to rate yourself on each item using the 1-4 scale (1 = 'Not at all' and 4 = 'To an extremely high level').

Dimensions	**Self-reflection Guide**				
Envisioning direction Within the context of clinical education, *Envisioning* encompasses the ability to articulate a vision/direction for clinical education, provide clear goals and standards and promote a culture of learning	**Indicators**	Not at all 1	2	3	To an extremely high level 4
	▪ I have a clear understanding of my personal and educational values	1	2	3	4
	▪ I have a clear vision of the educational goals I am striving to achieve and articulate this to others	1	2	3	4
	▪ I maintain clear direction in working toward educational goals that align with the standards and expectations of the university and the organisational setting in which students are placed	1	2	3	4
	▪ I actively promote a culture of *learning* among students and staff	1	2	3	4
	▪ I strive to act as a positive educational and clinical role model for students and staff	1	2	3	4
	Comments:				

Dimensions	Self-reflection Guide				
Enabling sustained commitment Within the context of clinical education, *Enabling* encompasses the ability to communicate effectively with students and staff in clinical education activities, interact in a range of contexts and empower others to achieve.	**Indicators**	Not at all 1	2	3	To an extremely high level 4
	▪ I communicate clearly with students, clinical staff, health facility and university staff	1	2	3	4
	▪ I am able to effectively build and maintain rapport with students and staff	1	2	3	4
	▪ I interact respectfully and sensitively with students and staff	1	2	3	4
	▪ I facilitate a sense of teamwork between students and clinical staff	1	2	3	4
	▪ I resolve conflicts in a positive manner	1	2	3	4
	▪ I give constructive feedback that inspires commitment to further improvement				
	Comments:				

Dimensions	Self-reflection Guide				
Executing the role Within the context of clinical education, *Executing* encompasses the ability to facilitate quality clinical learning, assess students' performance and manage the day-to-day business of clinical facilitation.	**Indicators**	Not at all 1	2	3	To an extremely high level 4
	▪ I am aware of my personal philosophy of learning and teaching	1	2	3	4
	▪ I use a range of contemporary clinical learning/teaching strategies in my practice and assist others to do the same	1	2	3	4
	▪ I use a systematic process to assess students' performance which is informed by the collection of data from multiple sources, evaluation of data and drawing of informed conclusions.	1	2	3	4
	▪ I ensure that students receive constructive feedback on their performance.	1	2	3	4
	▪ I deal with problems/issues by seeking out and analysing relevant data, identifying the best way forward and actively monitoring the outcomes	1	2	3	4
	▪ **I** organise **my daily schedule effectively to ensure that I am accessible to students and clinical staff**	1	2	3	4
	Comments:				

Dimensions	Self-reflection Guide				
Enacting self-development Within the context of clinical education, *Enacting* encompasses the ability to self-assess one's performance and facilitate self-improvement through continuous professional learning.	**Indicators**	Not at all 1	2	3	To an extremely high level 4
	▪ I am aware of my personal strengths, limitations, knowledge and skills regarding clinical education	1	2	3	4
	▪ I am aware of my personal leadership style and its impact on others	1	2	3	4
	▪ I systematically seek feedback on my performance from students, peers and clinical / university staff	1	2	3	4
	▪ I have high expectations of my performance as a clinical teacher and set realistic, but challenging, personal improvement goals for myself				
	▪ I use opportunities for personal and/or professional development to enhance my practice Comments:	1	2	3	4

Appendix 10: LaCE Workshop 2 Flyer

Leadership and Clinical Education (LaCE) Program

Workshop 2

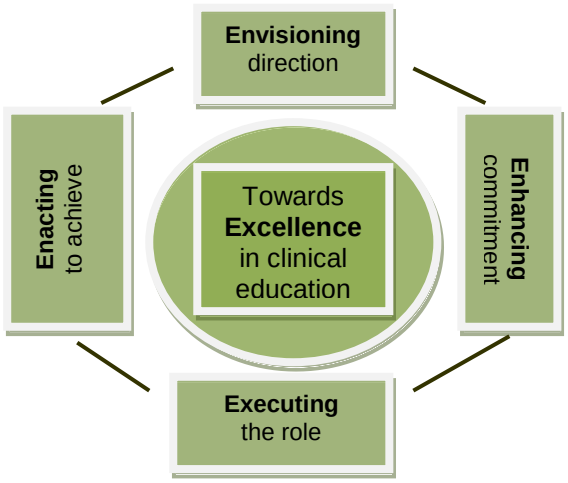
The broad aims of Workshop 2 are to:

- Share experiences and reflections on leadership practice in clinical education gained from the implementation of LaCE Personal Development Plans
- Further develop your personal repertoire of practical strategies relevant to challenges of clinical education
- Continue to build networks and resources which will support your personal and professional leadership development.

Good teaching involves the capacity to interact effectively with learners and learning environments in order to facilitate high-quality learning outcomes. As stated by Ellis (2000), 'learning arises not *through* interaction, but *in* interaction' (p. 209). In the clinical environment, the clinical facilitator's role is pivotal in influencing, or *leading*, these processes.

Good leaders have the ability to:

- Unlearn old habits, roles or behaviours and re-learn new ones
- Constantly question what they're doing and how they're doing it – re-inventing themselves as they go
- Reflect deeply on what happens to them – seeing it as a significant opportunity for learning, change and leadership growth.



We hope you will enjoy this second (and final) workshop in the LaCE program, and find the experiences useful as you continue your leadership and clinical education journey.

AUSTRALIAN LEARNING & TEACHING COUNCIL
Promoting excellence in higher education

Appendix 11: Sample Personal Development Plan/Project

LaCE Personal Development Plan Report : Ms Leonie Harradine

Title: Prompt assessment of student attributes

1. Introduction

The second year CP3 group is a two week placement requiring timely assessment to ensure accurate evaluation of student performance. This was my first encounter with this group as previously I have facilitated CP4 and CP5 over 4 weeks and CP1 over 2 weeks.

During orientation I explained to the students my expectations of their performance for assessment including **Safety, Professionalism and Knowledge.**

Due to the short time on placement, the CF needs to have the skills and tools to promptly assess and evaluate students within the first few days of the practicum.

This will enable:

- timely feedback to students to allow for improvement in performance including verbal feedback, anecdotal notes and learning contracts
- minimize time spent on one issue and one student thus allowing equal time for other students
- minimise stress in the job therefore enhancing the 'enjoyment' factor

2. Personal Development Plan (implementation)

- Identified Issue

  - Increased self-confidence in my decision making process for evaluating student performance
  - My ability to promptly assess and evaluate students performance within the first 2-3 days of practicum

- Goal

  - Concise and accurate decision making on student performance within the first 3 days of practicum
  - Produce high quality assessment to facilitate the students learning and enable them the opportunity to gain achievement on the clinical practicum
  - Achieve ongoing job satisfaction
  - Produce and implement an assessment and evaluation tool to reflect my objectives

- Strategy/-ies adopted

  - Developed a criteria for assessment by identifying the most important student attributes
  - Produce a simple tool to document my assessment and evaluation of students
  - Utilise the tool with the CP3 group
  - Revaluate tool after this group to reflect benefit and make adjustments

The 3 attributes I utilised were:

1) **Safety**

- working within scope of practice: determined by the learning institution
- follow direction: listening, engaging, attitude
- identify a rationale for doing task: problem solving and critically thinking
- satisfactory English communication and comprehension in health care setting
- did they need constant prompting

2) **Professionalism**

- Appearance: uniform, hygiene, jewelry, did they maintain that standard?
- Behaviour: enthusiastic, confident, terrified, shy, body language, self directed learner, organised
- Communication: eye contact, listening, engaging, smiling, crying, team player, talking with buddy nurses, comfortable in environment, explaining to patient

3) **Knowledge**

- Relevant to year level
- Relevant to previous experience
- Relevant to health care setting
- CP3 should be able to:
  - ✓ Demonstrate sound knowledge of medications and be able to correlate these medications to the patient's condition
  - ✓ Explain interventions and treatments and correlate to their patient's condition and reason for admission

- Evaluation

  - Reflect of my performance: comfortable and confident with student assessment
  - Do I have a clear picture of each student's ability by end of week one?
  - Have these issues become evident in the second week and not the first ?

3. Analysis of outcome/s

- Feedback from university
- Feedback from by co-workers
- Feedback from students

4. Conclusions/Recommendations

- Utilising a simple tool to ensure accurate documentation of student's performance enables the CF to be confident with their assessment skills resulting in greater job satisfaction

- Prompt assessment allows for timely intervention including verbal feedback, AN and LC to assist the student in improving their performance thus facilitating their ability to achieve a satisfactory level, particularly on shorter clinical pracs

- Skills assessment was not incorporated in this project as they can be very dependent on previous experiences however I do assess and evaluate the students on their skills although I consider that if student has these attributes: safety, professionalism and knowledge, then most skills can be taught in the clinical setting.

Created by Leonie Harradine: 29/11/09

Student	Safety	Professionalism	Knowledge	Comments
	Scope of practice ☐ Follow direction ☐ Rationales ☐ Language ☐ Prompting ☐	Appearance ☐ Behaviour ☐ Communication ☐	Drug categories ☐ Correlates with conditions ☐ Diseases ☐ Interventions ☐ Treatments ☐	
	Scope of practice ☐ Follow direction ☐ Rationales ☐ Language ☐ Prompting ☐	Appearance ☐ Behaviour ☐ Communication ☐	Drug categories ☐ Correlates with conditions ☐ Diseases ☐ Interventions ☐ Treatments ☐	
	Scope of practice ☐ Follow direction ☐ Rationales ☐ Language ☐ Prompting ☐	Appearance ☐ Behaviour ☐ Communication ☐	Drug categories ☐ Correlates with conditions ☐ Diseases ☐ Interventions ☐ Treatments ☐	
	Scope of practice ☐ Follow direction ☐ Rationales ☐ Language ☐ Prompting ☐	Appearance ☐ Behaviour ☐ Communication ☐	Drug categories ☐ Correlates with conditions ☐ Diseases ☐ Interventions ☐ Treatments ☐	
	Scope of practice ☐ Follow direction ☐ Rationales ☐ Language ☐ Prompting ☐	Appearance ☐ Behaviour ☐ Communication ☐	Drug categories ☐ Correlates with conditions ☐ Diseases ☐ Interventions ☐ Treatments ☐	
	Scope of practice ☐ Follow direction ☐ Rationales ☐ Language ☐ Prompting ☐	Appearance ☐ Behaviour ☐ Communication ☐	Drug categories ☐ Correlates with conditions ☐ Diseases ☐ Interventions ☐ Treatments ☐	
	Scope of practice ☐ Follow direction ☐ Rationales ☐ Language ☐ Prompting ☐	Appearance ☐ Behaviour ☐ Communication ☐	Drug categories ☐ Correlates with conditions ☐ Diseases ☐ Interventions ☐ Treatments ☐	
	Scope of practice ☐ Follow direction ☐ Rationales ☐ Language ☐ Prompting ☐	Appearance ☐ Behaviour ☐ Communication ☐	Drug categories ☐ Correlates with conditions ☐ Diseases ☐ Interventions ☐ Treatments ☐	

Appendix 12: List of Personal Development Plans/Projects

LaCE 1

Name	Topic
Leonie Harradine	Prompt assessment of student attributes
Suzanne Johnston	Difficult conversations, difficult personalities
Calaegh Robertson	Communicating, managing and dealing with difficult students in response to learning issues.
Kirsten White	Developing my personal competence

LaCE 2

Name	Topic
Carolyn Hart	Leadership skills for students and graduates
Bo Janoschka	Improving communication with a large student group
Liz Jones	Tools for performance management focusing on feedback
Carol Letson	Promoting student-centred learning
Kathyrn O'Reilly	Communication of feedback and motivation
Mel Robinson	How to communicate with non-native English speaking students?
Jan Taplin	Performance Management Process for providing initial informal feedback
Christine Williams	Enhancing the experience of students who are English second language speakers.

LaCE 3

Name	Topic
Candice Barter	Student Orientation for Neurosurgery and Plastics Nursing
Joveyl Bautista	Ward Preceptors – Supporting the Student in a Ward Environment
Eileen Brown	Checklist of what Students are capable of doing for the nurse and what he expectations are of students each shift
Julian De Maria	Student assessment or Student allocation to patients on the wards for the different year levels?
Megan Harden	Emergency Nursing Preparedness for Graduates.
Rachael Jackson	**How to give students negative feedback (addressing underperformance).**
Sondra McAuley	Improving preparedness of staff to receive, orientate and facilitate students.
Billy Jovanovic	Effective supervision in clinical settings
Gail Moy	Provide Student Centred Peri-Operative Elective Placements
Kerri Phillips Smith/Kelly Atkinson	Advocate Peer Review and Knowledge Expansion through an Online Discussion forum, for Oncology Novice Nurses
June Saunders	A checklist/survival guide for new facilitators
Joan Sparkes	A role description for international support facilitators.
Shelley Watson	An orientation package to meet the learning needs of students. ("To provide a smooth transition for undergraduate students into the critical care setting by providing an information pack").

Appendix 13: Project Advisory Group Meeting 1 Minutes

PROJECT ADVISORY GROUP MEETING
MINUTES

A meeting of the Program Advisory Group was held in Room 441, Level 4, Synergy Building (88 Musk Avenue), Kelvin Grove Campus, at 10:00am on Thursday 10 December 2009.

PRESENT:
Professor Robyn Nash (Chair)
Professor Stephen Billett
Ms Lesley Fleming
Ms Naomi Hebson (in place of Ms Cheryl Burns)
Ms Susanne LeBoutillier
Mr Matthew Payne
Dr Deborah Peach

APOLOGIES:
Professor Phillip Della
Ms Theresa Harvey
Mr Ross McDonald
Associate Professor Janice Orrell

PRESENT BY INVITATION (Project Team Members):
Mr David Emmett
Dr Sandy Sacre
Ms Jennifer Lock

1. WELCOME

1.1 The Chair welcomed members of the Project Advisory Group and members introduced themselves.

1.2 The Chair spoke to the Project Summary provided to members that provided an overview of the project and described the most important element of the project as the incorporation of leadership principles into the clinical facilitation role which is responsible for the clinical education of students.

1.3 Members supported the Terms of Reference drawn up for the Group. The Chair acknowledged the important contribution of members especially towards refining and improving project outcomes.

2. CHAIR'S REPORT

The Chair reported on the following:

Status of the Project
The project is two years in duration and the first year progress report and financial acquittal has been approved by the ALTC. The second tranche of funding has been released.

Program Content
A Leadership and Clinical Education (LaCE) framework has been developed to support the LaCE program that includes workshops, Personal Development Projects and an online toolkit. The first iteration of the program has been completed with 11 participants from the three partner institutions. Feedback from the program was positive with more analysis of data collected to take place. There were fewer participants available for the second workshop and it was suggested that there may be a need for further support (online or face to face) between the workshops. A survey to measure the student clinical experience has been distributed to students. Two more iterations of the program are planned for early next year.

3. DISCUSSION ITEMS

3.1 Members raised the following points in discussion:

- The role of the clinical facilitator can vary in different contexts and was described as requiring a high level of engagement in partner institutions.
- The alignment of student nurses with experienced nurses is very valuable and it was noted that clinical facilitators in the local setting are senior expert clinicians.
- In order for educators to maintain credibility in the workplace, it is important that there is constant engagement both direct and indirect.
- There are challenges with such a vast workforce to ensure a close match between student and preceptor and many institutions are at capacity to provide supervision to students on clinical placement. Support must be provided to staff to teach and mentor students.
- The education that occurs in the workplace should not be described as 'informal' as many powerful learning experiences can occur as a result of an excellent relationship between the student and preceptor.
- Collection of data has commenced in order to evaluate the project. The importance of using qualitative information should be highlighted as this can also be depicted as quantitative.
- The sustainability of the LaCE program beyond the project requires further consideration from the viewpoint of, time for release of staff, responsibility for ongoing use of the resource and training and applicability to a range of contexts and disciplines.

4. ITEMS FOR INFORMATION

4.1 The following items were provided to members for information:

- Terms of Reference
- Project Advisory Group
- LaCE Framework
- Flyers for Workshop 1 and 2
- Web link to LaCE online resource

5. NEXT MEETING

The next meeting of the Project Advisory Group will be held in March 2010. Another meeting will also be scheduled around June 2010.

Appendix 14: Project Advisory Group Meeting 3 Minutes

PROJECT ADVISORY GROUP MEETING
MINUTES

A meeting of the Program Advisory Group was held in Room 604, Level 6, O Block D Wing, Kelvin Grove Campus, at 2.00pm on Wednesday 15 September 2010.

PRESENT:
Professor Robyn Nash (Chair)
Professor Phillip Della
Ms Susanne LeBoutillier
Associate Professor Janice Orrell

APOLOGIES:
Professor Stephen Billett
Ms Cheryl Burns
A/Assoc Prof Lesley Fleming
Ms Theresa Harvey
Mr Ross McDonald
Mr Matthew Payne
Dr Deborah Peach

PROJECT COORDINATOR:
Ms Jennifer Lock

6. WELCOME

1.1 The Chair welcomed members of the Project Advisory Group to the final meeting for the Leadership project. This meeting was initiated to wrap up the project with PAG members as a follow up to the dissemination forum.

7. CHAIR'S REPORT

The Chair reported on the following:

Status of the Project

- The final report for the project is due to ALTC on 27th September
- The project has been an enjoyable one with many positive aspects expressed by colleagues and participants
- The project team is interested in taking the concepts from the project forward and exploring other opportunities through ALTC and Health Workforce Australia.
- QUT is keen to continue the LaCE program in a local context as a component of workshops with Clinical Facilitators.

8. DISCUSSION ITEMS

3.1 Members raised the following points in discussion:

- The National Forum was enjoyable and profiled the wonderful job the project team had done. The projects demonstrated by LaCE participants were a highlight and it would be great to see these projects expanded outside the local context. It may also be possible to establish a community of practice with participants.
- The definition of leadership linked to clinical education was very well done as many clinical facilitators don't see themselves as leaders.
- Focussing on leadership skills in preference to supervisory skills was innovative and is what is needed to advance the profile of the CF role.
- Taking the project forward in a multidisciplinary context could be a new direction. This fits closely with work in other universities on interprofessional practice. An introductory forum with people in this research area could take this aspect forward.

- Information should be disseminated through ALTC Exchange
- ALTC could be supportive in building on what has already been achieved through ongoing support. Dr Carol Nichol may be interested in the project achievements as ALTC seem likely to move towards more focussed and commissioned studies.

9. ITEMS FOR INFORMATION

4.1 The following items were provided to members for information:

- LaCE Program Guide
- Table of Contents – Final Report
- Project acknowledgements
- Results from LaCE 2 & LaCE 3 outcomes
- National Forum feedback

Appendix 15: Leadership Values and Attitudes Questionnaire

Leadership Values and Attitudes

Name: _____ *Hospital:* _____

Registered Nurse (number of years): _____ *Clinical Facilitator (number of years):* _____

This questionnaire is designed to help you identify your key leadership values and attitudes and the degree to which you practice these. The more honest you are in this self evaluation, the more valuable the results for your growth and development.

Your responses will identify your strength and effectiveness as a leader in today's challenging workplace environment.

To what extent would you describe yourself in relation to each of the following:

1. **Demonstrates a sustained passion to succeed**
   A. This is not me
   B. Sometimes this is me
   C. This is definitely me

2. **Sets high standards**
   A. This is not me
   B. Sometimes this is me
   C. This is definitely me

3. **Inspires others to assist students to learn**
   A. This is not me
   B. Sometimes this is me
   C. This is definitely me

4. **Stands firm when necessary**
   A. This is not me
   B. Sometimes this is me
   C. This is definitely me

5. **Creates a vision and purpose that others buy into and share**
   A. This is not me
   B. Sometimes this is me
   C. This is definitely me

6. **Takes actions that inspire confidence that the vision is being achieved**
   A. This is not me
   B. Sometimes this is me
   C. This is definitely me

7. **Sets clear and compelling goals that serve as a unifying focal point of efforts**
   A. This is not me
   B. Sometimes this is me

C. This is definitely me

8. Initiates and develops relationships with others as a key priority

A. This is not me
B. Sometimes this is me
C. This is definitely me

9. Relies more on ability to influence than hierarchical relationships

A. This is not me
B. Sometimes this is me
C. This is definitely me

10. Creates a team environment

A. This is not me
B. Sometimes this is me
C. This is definitely me

11. Models consistency between principles, values and behaviour

A. This is not me
B. Sometimes this is me
C. This is definitely me

12. Actively pursues learning and self-development

A. This is not me
B. Sometimes this is me
C. This is definitely me

Appendix 16: Career Strengths Questionnaire

Career Strengths

Registered Nurse (number of years): ——— *Clinical Facilitator (number of years):* ———

These questions are designed to identify your key career strengths.

For each skill listed rate your level of expertise as follows:
0 – Never done this
1 – Very limited
2 – Novice
3 – Competent
4 – Skillful
5 – Expert

Then rate your personal interest in this as follows:
H – My level is ***high*** – I love doing this
M – My interest is ***medium*** – I don't mind doing this
L – My interest is ***low*** – I find this dull or tedious

Clarifying my personal and educational values
Expertise: 0 1 2 3 4 5
Interest: L M H

Setting clear educational goals and articulating these to others
Expertise: 0 1 2 3 4 5
Interest: L M H

Actively promoting a culture of learning among students and staff
Expertise: 0 1 2 3 4 5
Interest: L M H

Being a positive role model for students and staff
Expertise: 0 1 2 3 4 5
Interest: L M H

Building and maintaining rapport with students and staff
Expertise: 0 1 2 3 4 5
Interest: L M H

Interacting productively & supportively with students and staff
Expertise: 0 1 2 3 4 5
Interest: L M H

Facilitating a sense of teamwork between students and staff
Expertise: 0 1 2 3 4 5
Interest: L M H

Resolving conflicts effectively and efficiently
Expertise: 0 1 2 3 4 5
Interest: L M H

Clarifying my personal philosophy of learning and teaching
Expertise: 0 1 2 3 4 5
Interest: L M H

Using a range of clinical learning/teaching strategies
Expertise: 0 1 2 3 4 5
Interest: L M H

Assisting others to help students learn
Expertise: 0 1 2 3 4 5
Interest: L M H

Using a comprehensive approach to the assessment of students' performance
Expertise: 0 1 2 3 4 5
Interest: L M H

Giving constructive feedback on performance
Expertise: 0 1 2 3 4 5
Interest: L M H

Organising my daily schedule to ensure my accessibility to students and staff
Expertise: 0 1 2 3 4 5
Interest: L M H

Being aware of my personal strengths and limitations in relation to clinical education
Expertise: 0 1 2 3 4 5
Interest: L M H

Being aware of my knowledge and skills in relation to clinical education
Expertise: 0 1 2 3 4 5
Interest: L M H

Being aware of my personal leadership style and its impact on others
Expertise: 0 1 2 3 4 5
Interest: L M H

Seeking feedback on my performance from students
Expertise: 0 1 2 3 4 5
Interest: L M H

Seeking feedback on my performance from peers and clinical/university staff
Expertise: 0 1 2 3 4 5
Interest: L M H

Setting realistic, yet challenging, personal improvement goals for myself
Expertise: 0 1 2 3 4 5
Interest: L M H

Using opportunities for personal and/or professional development to enhance my practice
Expertise: 0 1 2 3 4 5
Interest: L M H

Appendix 17: Clinical Learning Environment and Supervision Instrument

Information about this questionnaire

This questionnaire is designed to help QUT gain an understanding of your **current** practicum experience, i.e., in the ward and hospital where you are on your current placement. This information is completely confidential and will in no way affect your assessment. It will only be shared amongst the research team.

Please circle one answer in response to each question.

1. Which CP unit are you currently doing?	CP1	CP2	CP3	CP4	CP5	Don't know
2. Which hospital are you doing your current placement at?	RBWH	RCH	TPCH	Mater Adult Public Mater Children's Mater Private	PAH	Other? Please state: ……
3. What is the name of the ward where you are doing your current placement?	……					
4. What type of ward is this, e.g., medical, surgical, orthopaedic, ICU, coronary care, etc?	…… ……					
5. What is the name of your current clinical facilitator?	……					
6. What is your gender?	Male	Female	Other			
7. What is your age?	……years					
8. Are you an international student?	Yes	No				
9. Are you from a non-English speaking background?	Yes	No				

******Please turn over to complete the final questionnaire ******

Please answer as honestly and completely as you can and make sure you answer every question by circling one of the numbers 1-5 beside each statement, indicating your level of agreement with that statement.

Clinical Learning Environment & Supervision Instrument	Fully disagree	Disagree to some extent	Neither agree nor disagree	Agree to some extent	Fully agree
A *Ward atmosphere*					
A1. The staff were easy to approach	1	2	3	4	5
A2. There was a good spirit of solidarity among the nursing staff in the ward	1	2	3	4	5
A3. During staff meetings (e.g., handovers) I felt comfortable taking part in the discussion	1	2	3	4	5
A4. I felt comfortable going to the ward at the start of my shift	1	2	3	4	5
A5. There was a positive atmosphere on the ward	1	2	3	4	5
B *Learning on the ward*					
B1. Basic familiarisation was well organized	1	2	3	4	5
B2. The staff were generally interested in student supervision	1	2	3	4	5
B3. The staff learned to know the students by their personal names	1	2	3	4	5
B4. There were sufficient meaningful learning situations on the ward	1	2	3	4	5
B5. The learning situations were multi-dimensional in terms of content	1	2	3	4	5
B6. The ward could be regarded as a good learning environment	1	2	3	4	5

*******Please turn over the page. There are a few more questions to complete*******

Clinical Learning Environment & Supervision Instrument	Fully disagree	Disagree to some extent	Neither agree nor disagree	Agree to some extent	Fully agree
C *Supervisory relationship*					
C1. The facilitator showed a positive attitude towards clinical supervision	1	2	3	4	5
C2. I felt that I received individual clinical facilitation	1	2	3	4	5
C3. I continuously received feedback from my clinical facilitator	1	2	3	4	5
C4. Overall, I am satisfied with the clinical facilitation I received	1	2	3	4	5
C5. The clinical facilitation was based on a relationship of equality and promoted my learning	1	2	3	4	5
C6. There was a mutual interaction in the clinical facilitation relationship	1	2	3	4	5
C7. Mutual respect and approval prevailed in the relationship with my clinical facilitator	1	2	3	4	5
C8. The clinical facilitation relationship was characterised by a sense of trust	1	2	3	4	5

Source: Saarikoski & Leino-Kilpi, 2002

Many thanks for your help with this questionnaire and with our ongoing efforts to promote a positive learning experience for nursing students on clinical placement.
If you have any further comments that you would like to make, please do so in the space provided below:

……
……
……
……
……

Leadership and Clinical Education

Nash Inventory of Clinical Leadership

"Enhancing student learning in the workplace through developing the leadership capabilities of clinical supervisors in the nursing discipline"

Name: ……

What is your age (Circle one)?

≤ 20 years	1
21-29 years	2
30-39 yrs	3
40-49 years	4
≥ 50 years	5

Date of today's LaCE workshop: ……

Clinical facility at which you work with students: ……

Number of years you have been a Registered Nurse: ……

Number of years you have been a Clinical Facilitator: ……

What you like most about being a Clinical Facilitator:

……

……

……

……

What you like least about being a Clinical Facilitator:

……

……

……

……

*******Please turn over the page. There are more questions to complete*******

Please answer the following questions as honestly as you can, in relation to how you feel right now, at this point in your career. Circle the number representing your response from 1 (completely disagree) to 6 (completely agree) to the statements on the left. Circle the response which most closely represents your current perceptions about your skills, abilities, attitudes and behaviour. Please avoid leaving any questions blank, circling more than one response, or circling half way between two responses.

A *Providing direction & promoting clinical learning*	Completely disagree	Somewhat disagree	Slightly disagree	Slightly agree	Somewhat agree	Completely agree
I am able to give students a clear vision of the educational goals to be achieved	1	2	3	4	5	6
I am able to give clinical staff a clear vision of the educational goals to be achieved	1	2	3	4	5	6
I am able to align my clinical supervision with the educational expectations of the university	1	2	3	4	5	6
I am able to align my clinical supervision with the educational expectations of the health service provider	1	2	3	4	5	6
I am confident in my ability to promote a culture of learning amongst students	1	2	3	4	5	6
I am confident in my ability to promote a culture of learning amongst clinical staff	1	2	3	4	5	6
I am confident in my ability to create a climate of clinical inquiry	1	2	3	4	5	6
I am confident in my ability to promote a clinical environment that encourages learning	1	2	3	4	5	6
I am confident in my ability to inspire students to actively engage in their learning	1	2	3	4	5	6
I am confident in my ability to effectively supervise students	1	2	3	4	5	6
I am a very effective communicator with students	1	2	3	4	5	6
I am effective at assisting students to become independent learners	1	2	3	4	5	6
I am good at deciding when students need direction vs. when they need support	1	2	3	4	5	6
I am a leader in my clinical service when it comes to promoting clinical learning	1	2	3	4	5	6

*******Please turn over the page. There are more questions to complete*******

B *Facilitating effective working relationships*	Completely disagree	Somewhat disagree	Slightly disagree	Slightly agree	Somewhat agree	Completely agree
I am confident in my ability to facilitate a sense of teamwork between students and clinical staff	1	2	3	4	5	6
I am confident in my ability to quickly establish rapport with students	1	2	3	4	5	6
I am confident in my ability to quickly establish rapport with clinical staff	1	2	3	4	5	6
I am confident in my ability to build students' confidence so that they can perform at their best in the clinical environment	1	2	3	4	5	6
I am confident in my ability to provide feedback to ward staff about their interactions with students, even when it is negative	1	2	3	4	5	6
I am confident in my ability to recognise quickly when a staff member needs assistance with student supervision	1	2	3	4	5	6
I am confident in my ability to engender staff confidence in relation to supervising students	1	2	3	4	5	6
I am confident in my ability to liaise effectively between staff and students	1	2	3	4	5	6
I am confident in my ability to communicate with clinical staff about students' clinical education	1	2	3	4	5	6
I am confident in my ability to advocate for students when necessary	1	2	3	4	5	6
I am confident in my ability to effectively resolve interpersonal conflicts	1	2	3	4	5	6
I am confident in my ability to advocate for improvement in quality learning experiences for students	1	2	3	4	5	6
I am confident that I accurately match the abilities and skills of clinical staff with the learning needs of students	1	2	3	4	5	6
I feel that I am able to be clearly understood by ward staff	1	2	3	4	5	6

****Please turn over the page. There are more questions to complete*******

C *Clinical teaching*	Completely disagree	Somewhat disagree	Slightly disagree	Slightly agree	Somewhat agree	Completely agree
I am confident in my ability to help students formulate their own learning goals	1	2	3	4	5	6
I am confident in my ability to ensure that students have adequate learning opportunities to achieve their goals	1	2	3	4	5	6
I am confident in my ability to accurately assess the learning capabilities of students	1	2	3	4	5	6
I am confident in my ability to accurately assess the learning needs of students	1	2	3	4	5	6
I am confident in my ability to put a specific improvement plan in place when a student is experiencing a learning difficulty	1	2	3	4	5	6
I am good at making myself clearly understood by students	1	2	3	4	5	6
I enjoy my role as a clinical supervisor	1	2	3	4	5	6
I am confident in my ability to be an effective teacher	1	2	3	4	5	6
I am confident in my ability to assist students to critically reflect on their practice	1	2	3	4	5	6
I am confident in my ability to teach clinical skills to students	1	2	3	4	5	6
I am confident in my ability to help students to clearly understand how to build on their strengths	1	2	3	4	5	6
I am confident in my ability to help students to clearly understand how to improve on their weaknesses	1	2	3	4	5	6
I feel confident in my ability to provide constructive feedback to students, even when it is negative	1	2	3	4	5	6
I feel that students see me as a role model and respect me	1	2	3	4	5	6

*******Please turn over the page. There are a few more questions to complete*******

D Role development	Completely disagree	Somewhat disagree	Slightly disagree	Slightly agree	Somewhat agree	Completely agree
I am clearly aware of my strengths in relation to clinical supervision	1	2	3	4	5	6
I am clearly aware of my weaknesses in relation to clinical supervision	1	2	3	4	5	6
I set realistic personal improvement goals for myself in relation t supervision	1	2	3	4	5	6
I actively use opportunities for self-development to improve my clinical supervision performance	1	2	3	4	5	6
I regularly seek feedback about my performance as a clinical supervisor	1	2	3	4	5	6
I use feedback from all sources to continually improve my performance as a clinical supervisor	1	2	3	4	5	6
I see an important part of my role is assisting others to teach students effectively	1	2	3	4	5	6
I have a clear understanding of how my role fits into students' overall learning	1	2	3	4	5	6
I am confident in my ability to promote a clinical environment that encourages learning	1	2	3	4	5	6
I feel confident in advocating for improvement in quality learning experiences for students	1	2	3	4	5	6
I enjoy that part of my role that involves working with staff to create good student learning experiences	1	2	3	4	5	6
In my role as a clinical supervisor, I feel I am at the forefront of future clinical practice	1	2	3	4	5	6
I feel that my role as a clinical supervisor is an important and influential one	1	2	3	4	5	6
I think of my clinical supervisor role as a leadership role	1	2	3	4	5	6

*******Thank you for completing the survey*******

Support for this project has been provided by the Australian Learning and Teaching Council, an initiative of the Australian Government Department of Education, Employment and Workplace Relations. The views expressed in this report do not necessarily reflect the views of the Australian Learning and Teaching Council Ltd.

Appendix 19: LaCE Program Guide

LaCE Program Guide

Leadership and Clinical Education
National Forum
31 August 2010

Enhancing student learning in the workplace through develop
the leadership capabilities of supervisors in the nursing disc

Overview

Late in 2008, Queensland University of Technology's Faculty of Health, along with Mater Health Services, the Prince Charles Hospital and the Royal Brisbane and Women's Hospital were successful in being awarded an Australian Learning and Teaching Council Leadership grant for a project entitled *'Enhancing student learning in the workplace through developing the leadership capabilities of clinical supervisors in the nursing discipline'.*

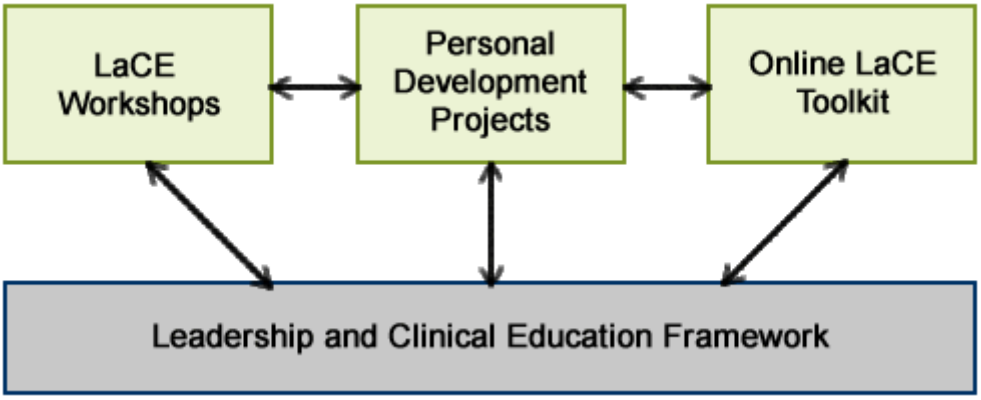
Professor Robyn Nash (Project Leader) and the project team have developed the Leadership and Clinical Education (LaCE) initiative to assist clinical supervisors to advance their knowledge and skills through the incorporation of leadership perspectives within their role.

Purpose of Guide

The purpose of the LaCE Program Guide is to provide organisations with a summary of the program with reference to the resources that have been developed. It is intended that these resources will enable organisations to conduct similar programs for clinical supervisors.

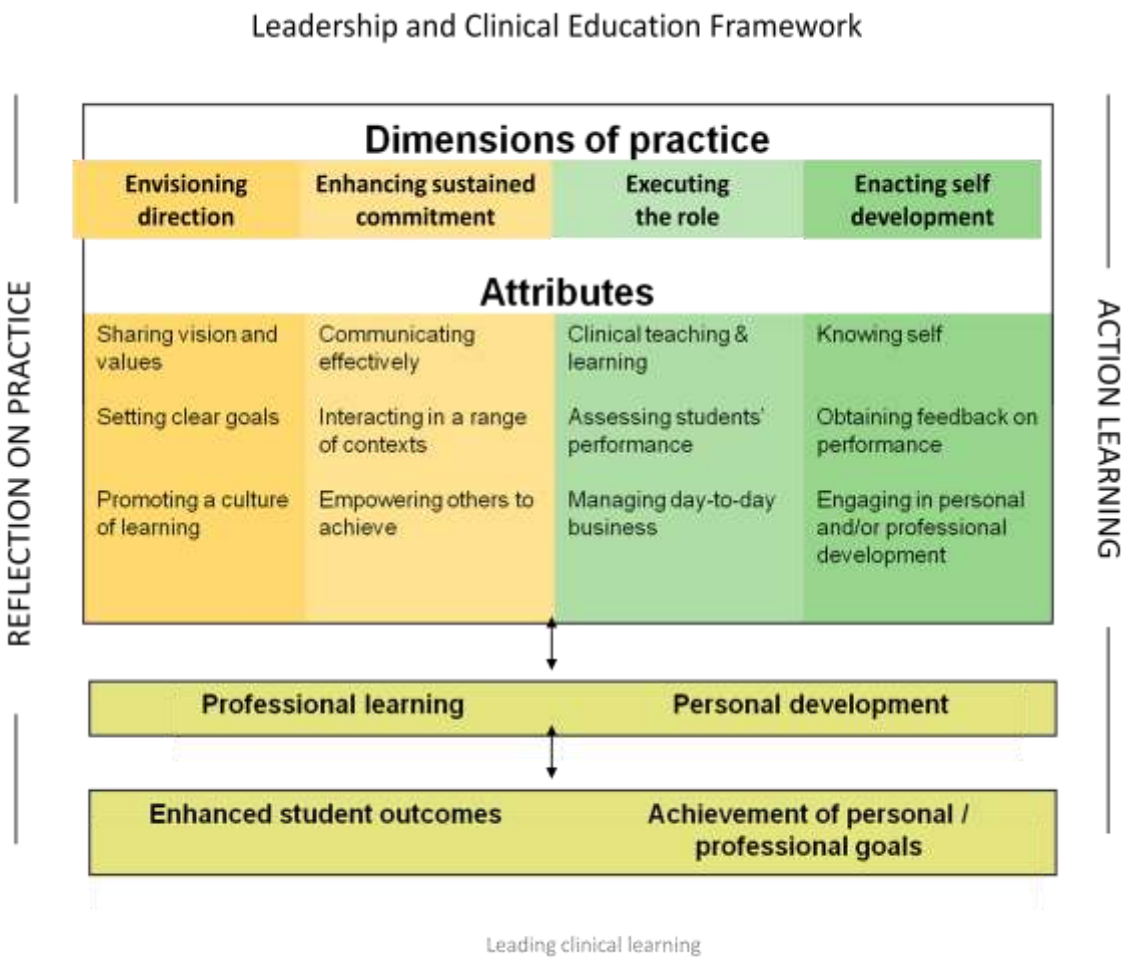
Overall Aims

The primary aim of the LaCE Program is to enhance the quality of clinical education by assisting clinical supervisors further develop their repertoire of leadership skills and capabilities for dealing with the realities of day to day practice. A complementary aim of the program is to facilitate ongoing professional and personal development for all participants. As shown in the diagram below, there are 3 key elements to the program that are collectively underpinned by the LaCE Framework.



LaCE Framework

The LaCE Framework has been developed through an analysis of national and international writings on leadership, educational leadership and, more particularly, clinical education. It is also informed by the dialogue with nurses who undertake the role of clinical education in the clinical setting, e.g. clinical facilitators, preceptors, supervisors. The Framework provides a basis for developing a shared understanding of contemporary clinical teaching in nursing.



LaCE Workshops

The LaCE Workshops provide a forum which explores:

- The nature of leadership;
- Connections between leadership and clinical education;
- A framework for excellence in leading clinical learning; and
- Opportunities for personal/professional development as a leader of clinical learning.

Workshop 1

The broad aims of Workshop 1 are to:

- Explore the connection between leadership and clinical education;
- Discuss the LaCE Framework and its applicability to clinical education;
- Equip you with a toolkit to enhance your clinical education role through the incorporation of leadership concepts and principles; and
- Support you in preparing a LaCE personal development project plan.

Workshop 2

The broad aims of Workshop 2 are to:

- Share experiences and reflections on leadership practice in clinical education gained from the implementation of LaCE Personal Development Plans;
- Further develop your personal repertoire of practical strategies relevant to challenges of clinical education; and
- Continue to build networks and resources which will support your personal and professional leadership development.

The LaCE workshops have been endorsed by the Royal College of Nursing, Australia, and attendance at the workshops attracts 8 RCNA Continuing Nurse Education points as part of the RCNA's Life Long Learning Program (3LP).

Projects

Participants complete a LaCE Personal Development Plan where they must:

- Identify what they would like to improve considering their strengths, limitations and feedback from others;
- Set a goal for improvement by identifying what they would like to achieve and why they want to achieve it;
- Put in place an improvement plan in order to achieve their goal; and
- Evaluate the outcomes of their plan by developing indicators to show that goals have been achieved.

Participants present the outcomes from their plan as a project at Workshop 2.

LaCE Website

The LaCE website www.lace.org.au has been designed to provide 'just in time' resources to embed leadership principles within practice in the clinical setting. The website and online resources are available to universities and clinical settings to support the implementation of the LaCE professional development program.

Resources included on the website are:

- Promotional Flyers;
- Workshop Presentations;
- Program Schedules;
- Evaluation and Feedback Tools; and
- Project Samples.

Evaluation

Participants in the LaCE program complete the Nash Inventory of Clinical Leadership questionnaire at the commencement of Workshop 1 and at the conclusion of Workshop 2. Participants record their perceptions in the areas of providing direction and promoting clinical learning, facilitating effective workplace relationships, clinical teaching and role development. Feedback is also sought on the best aspects of the workshops and any aspects in need of improvement.

Feedback

Feedback sheets provide an opportunity for participants to comment on the Workshop 1 program and include comments on the best aspects of the workshops as well as any aspects in need of improvement.

Reflections

Reflections on the program at the conclusion of Workshop 2 ensure that participants reflect on their practice in the context of the LaCE program including identifying important issues, ways in which clinical facilitation has improved and how these improvements can continue.

Acknowledgements

Australian Learning and Teaching Council

This project has been made possible by the support of the Australian Learning and Teaching Council Ltd, an initiative of the Australian Government Department of Education, Employment and Workplace Relations.

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From LaCE Participants

"Participation in the LaCE program has encouraged me to reflect more on my practice and given me confidence in my decision making and a general feeling that we all share similar goals."

"I now accept that giving good quality feedback is vital – not the fact that the feedback is negative or positive."

"Any issue can be solved/ prevented with access to the right tools and strategies."

"A leader is a positive role model who wants to improve or continues to improve concepts in order to better themselves/others/ healthcare settings."

"Even though I don't relish presenting…This was a good opportunity to develop an idea to improve my facilitator skills and knowledge."
"I felt inspired to continue to learn more and value access to the website for future learning."

"Great presentations that made me reflect on my own practice."

"Networking and discussion of common speed bumps and problems was very thought provoking."

"My clinical facilitation has improved as I have gained confidence in the skills I possess and learnt a lot from my colleagues that I can use on a daily basis."

"LaCE showed us new approaches to encourage critical thinking."
"The exchange of practical information was fantastic."

Appendix 20: National Forum representation and feedback

NATIONAL FORUM – SUMMARY OF FEEDBACK

Attendees:

53 people attended the National Forum including 25 from industry and 28 from universities. 17 of the university attendees were from QUT. There were 10 institutions represented from the industry sector and 10 institutions represented from the university sector. The following table lists the institutions represented:

Industry	University
Australian Learning and Teaching Council	Curtin University of Technology
Caboolture and Kilcoy Hospitals	Flinders University
ClinEdQ	Monash University
Greenslopes Private Hospital	Queensland University of Technology
Mater Health Services	The University of Newcastle
Princess Alexandra Hospital	The University of New South Wales
Queensland Health	University of South Australia
Royal Brisbane and Women's Hospital	University of Southern Queensland
The Prince Charles Hospital	University of Wollongong
Wesley Hospital	Victoria University of Wellington

Overall comments on LaCE program and resources:

- A useful program that has released a variety of ideas that can been developed to meet clinical needs;
- Website is excellent and appealing;
- Framework is excellent and can be developed across a number of fronts;
- Interesting and relevant and has produced good clinical/university outcomes;
- Great program – logistically (time commitments) may be difficult for some to follow on from workshop 1 to workshop 2;
- Excellent for focusing ward/unit related issues and allowing staff development in their areas of speciality;
- Wonderful and empowering for facilitators/clinical supervisors;
- Comprehensive and excellent beginnings of a more portable, transparent program within a variety of settings;
- Worthwhile project to encourage and promote the quality roles of facilitators as leaders;
- Being built on core elements, it should be transferable between settings;
- Values the clinical supervisor/preceptor;
- Able to be utilised by both academic and health employed staff;
- Excellent program for supporting clinical learning and valuing clinical facilitators;
- An excellent beginning – a start to examining the clinical education role;
- Also needs to focus on new graduates as well as undergraduate nurses;
- Very practical information to feedback;
- Allows for the ability to disseminate generic scopes of practice for different layers of nursing;
- Great initiative that we can all take on board and use;
- Excellent method of increasing collaboration and sharing of ideas;
- Will definitely link into the website and advise colleagues to do the same;
- I think the body of the online toolkit is good but not the titles... enacting and envisioning do not tell me self development and promoting culture;

- Fantastic initiative, good resources, not too time intensive and participants have clearly produced some excellent outcomes;
- Very encouraging that participants saw they were better able to support and facilitate student learning as a consequence of the program;
- An excellent program that is simple but effective;
- Very impressive – dialogue between academia and industry apparent;
- Useful new approaches to clinical leadership;
- Very impressive outcomes with clinicians developing their own resources;
- An excellent program which provides relevant resources that can be used to enhance clinical facilitation;
- Especially like the idea of participants reviewing their work and solving problems;
- Great step in the right direction but it is one little 'brick' in the wall; and
- Continue to develop and upscale and expand to be adopted more widely into a multidisciplinary contexts.

Potential improvements to clinical practice:

- Examples show the development of efficient tools that are useful in clinical placement that can also aid buddy nurses/preceptors with assessment for example;
- Examples are all different and all relevant;
- Reflection on practice is crucial;
- The support system developed for all facilitators demonstrates good connections that can be built between a university and health facilities;
- Responsibility can be taken by individual units for clinical education and leadership according to their own unique requirements;
- Publish and present this work so it can be used across agencies;
- Beautifully links industry and academia to break down barriers and create collaborative ventures;
- Ability to share resources;
- Encourages the leadership role and increases the profile of clinical facilitators and buddy nurses;
- Provides better recognition, increases levels of confidence in the role and is an opportunity for professional growth;
- The integration of theory and practice will lead to more valuable clinical learning;
- Empowering clinical facilitators will lead to improved clinical evaluation and student learning;
- Developing the leadership skills of staff in this role can take potentially senior staff to the next level;
- Nurses in the workplace need an opportunity to share their achievements more widely;
- Provides a model to address student and teacher issues and provides attributes to work by;
- Recognition in the organisation that supervision of learners is of great importance and should be supported;
- The quality of the projects were absolutely fantastic and should be used as examples of what can be achieved;
- Increasing participation in the program and showcasing program outcomes and findings;
- Provides a framework to allow easier access to clinical education and support that can be implemented in a timely manner;
- Increase further the synergy between industry, academia and field workers;

- Application of the project to clinical settings in a more formal process;
- Further development through connecting with other projects;
- Prompt assessment of student attributes can be incorporated into any facilitation practice;
- University and sector leadership should be inducted into the true social value of this work in contract to research;
- Engaging nursing and related health accreditation bodies in the question of sustainability;
- Ensuring that there are moments of 'blue sky' thinking;;
- Sets up a framework to start from, allows for dissemination of information;
- Have concerns about what structure the clinical facilitator will use to assess outcomes for nurses and that the expertise (in education) of the clinical facilitator will reflect on the validity, fairness and reliability of the framework; and
- Some critique of practitioners concerns is needed.

Continuation of LaCE program in future:

- Yearly group sessions to continue developing identified issues and develop resources across a range of faculties;
- Consider credit to university courses;
- Offer to industry as well as universities;
- Continue it the same as it is now;
- Make it compulsory for unit volunteers;
- Collaborative workshops between agencies and academic staff;
- Utilisation of CPD points;
- Spread the word;
- Supported funding to continue workshops;
- Make available to all interested parties;
- More joint funding supported by both sectors;
- Set up as a joint partnership between health agencies and universities – may not need funding as can be incorporated into professional development activities;
- Extend on a national basis – opportunities to extend to universities and possibly ANTS state branches;
- Further funding to enable workshops to continue – CNE points;
- Extend the focus from undergraduates to new graduates;
- Epiq – new transition program – incorporating aspects of clinical teaching/assessing of this program;
- Need to validate framework to ensure training is delivered the same in each area;
- Have a team that is dedicated to the program – provide continuous workshops and provide support to institutions;
- Have a guide on the website for supervisors of clinical practice to follow;
- A better version of Certificate IV in Training and Assessment in terms of undertaking a project and reporting back on it – an individualised learning journey;
- Presentation of what topics have been done and what has been achieved would be useful to promote ideas;
- Consider partnership with HWA as a model for use across a wide range of disciplines;
- Requires state and national funding for maintenance and growth;
- Requires clear career progression to promote this role and assist in recruitment and retention;

- Promotion of workshops state-wide and provision of appropriate resources to sustain program;
- Look at formal recognition of clinical facilitator roles – currently the clinical facilitator role is evolving so it needs to be made attractive as an end point (financially);
- Increase exposure (promotional workshops), expand at state level and nationally, funding for future development;
- Providing on-going interaction with participants of the LaCE program;
- Providing more workshops and encouraging more projects that all can benefit from;
- University and host organisation infrastructure needs to be the focus of the 'next steps' to ensure that the continued engagement of facilitators is not detrimental to their careers; and
- Definitely allows for the ability to change practice especially how undergraduate and graduate nurses are supported.

Applying the LaCE program to your institution:

- All aspects could be applied;
- Can be applied to clinical leadership across all disciplines and not just related to clinical facilitators;
- Could be offered to all nurses who have students not just clinical facilitators;
- Not sure how this might be possible;
- Project resources that others have developed would be useful;
- Projects about the education of patients and the orientation of students or new staff would be useful;
- Reviewing current processes that related to student and facilitator preparation;
- Adapt resources to individual areas;
- Support CFs to attend workshops and encourage new ideas in the practical context;
- Pursue strategies to recognise mentors/preceptors more effectively;
- Include in a similar way with key health care providers;
- Look at student preparation and evaluation;
- Provides model to develop educational tools;
- Will use tips for facilitators and introduce resources at preceptor forum;
- All facilitators would benefit from this program. I need to know how much it costs and how to enrol people;
- Share the resource/model to build a national profile for LaCE across a range of disciplines;
- Connect with key people in institutions who are responsible for fieldwork partners;
- Accessibility of online resources to advertise the program and its benefits;
- Increase awareness of the program positives and potential outcomes and see what peers will come up with;
- In-service key topics/outcomes from LaCE;
- Increase awareness of other staff to promote LaCe concepts and improve clinical education/outcomes of education;
- Could consider using the Inventory now and in one year;
- Resources will provide a useful reference to deal with issues that arise during clinical placement;
- Continue this conversation in multiple universities and multiple disciplines by directing them to information about the project; and
- Include in the online orientation program.

Incorporating LaCE into existing programs:

- Can be linked into broader professional development programs;
- Build concepts into our mentor/preceptor program;
- Introduce into current facilitator training held annually;
- Add to e-learning programs;
- Incorporate some ideas into clinical facilitator workshops;
- Assist with setting goals and outcomes;
- Use resources as a basis for training new facilitators;
- Inventory is excellent;
- Clinical work areas need to access funding of clinical facilitator positions as an investment into the nursing workforce of the future;
- Fund facilitators to attend LaCE instead of Certificate IV;
- Work with fieldwork coordinators to incorporate into PD models;
- Many levels/different professions (nursing, medicine, physio) could feed into this lead and build strategies to learn together;
- Incorporate into preceptoring programs;
- Great projects that can be disseminated across a range of staff and health facilities;
- Can be utilised by all CFs as a benchmark for learning and as a minimum requirement for professional development as a facilitator;
- Keep up the momentum and encourage the 'energy';
- Promote the cause through partnership collaboration and development;
- Offline time being paid to do this via study leave – QUT to run it;
- There is no professional progression or increase in pay for facilitators... this needs to be considered;
- Provide direction for career moves and stepping stones to give the incentive to different styles of career development for clinical facilitators; and
- A strong focus on leadership is a strong focus on teaching.... As a person who does not believe I am an expert, I have found that this has helped me be a good teacher. I teach by learning and my strength is based on being approachable. We are all learners if taken out of our comfort zone. It's good for new starters to know this.