USING A CRITICAL REFLECTION PROCESS TO CREATE AN EFFECTIVE LEARNING COMMUNITY IN THE WORKPLACE

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Abstract

Learning circles are an enabling process to critically examine and reflect on practices with the purpose of promoting individual and organizational growth and change. The authors adapted and developed a learning circle strategy to facilitate open discourse between registered nurses, clinical leaders, clinical facilitators and students, to critically reflect on practice experiences to promote a positive learning environment. This paper reports on an analysis of field notes taken during a critical reflection process used to create an effective learning community in the workplace. A total of 19 learning circles were conducted during in-service periods (that is, the time allocated for professional education between morning and afternoon shifts) over a 3 month period with 56 nurses, 33 students and 1 university-employed clinical supervisor. Participation rates ranged from 3 to 12 individuals per discussion. Ten themes emerged from content analysis of the clinical learning issues identified through the four-step model of critical reflection used in learning circle discussions. The four-step model of critical reflection allowed participants to reflect on clinical learning issues, and raise them in a safe environment that enabled topics to be challenged and explored in a shared and cooperative manner.

Key words: learning circles, critical reflection, learning environment, pedagogy

Introduction

Effective clinical learning experiences are strategic and crucial in assisting nursing students ~~to~~ apply knowledge and skills learnt in the academic context. Students need to be responsive to diverse populations, different models of health care delivery, an aging population and increased incidence of chronic conditions. The ultimate goal of advancing clinical learning is the preparation of competent and safe nurses to provide high quality care for patients, families and communities in a rapidly changing health context.

Student engagement in practice communities enables them to learn about professional behaviour, attitudes and practice in the changing health care delivery landscape. Clinical learning models (e.g., preceptor, facilitation, clinical education units) identified the literature (Budgen & Gamroth, 2008., Henderson, Twentyman, Heel & Lloyd, 2006; Rowan & Barber, 2000) are varied and based on the organisation of care, costing model-and number of experienced staff willing to fulfil teaching roles. Facilitating student learning relies on the effectiveness of registered nurses (RNs) in the clinical settings who work with students on a day to day basis. RNs need to provide quality teaching/learning opportunities, appropriate support, role-model clinical leadership behaviours including effective in problem-solving and decision-making skills, organize for students to be part of a team and promote a positive work culture. We have argued elsewhere (Walker, Cooke, Henderson & Creedy, 2011a), the factors central to successful clinical leadership in relation to undergraduate nursing education are transformative leadership principles, including active engagement by the nurse unit/ward manager, to enhance collaboration and build relationships to create teams that deliver quality patient care.

This paper outlines the adaptation and development of a learning circle strategy to facilitate open discourse between local RN clinical leaders, clinical facilitators and students, to critically reflect on

practice experiences to promote a positive learning environment. An evaluation of the learning circle strategy with various stakeholders (Walker, Henderson, Cook & Creedy, 2011b) indicated that the four-step model of critical reflection assisted in supporting transformational leadership principles for enhancing the clinical learning environment. This paper reports on a sub-study of the larger program of research which aimed to identify the nature and outcomes of the critical reflection process.

Literature

Learning circles have been used in a range of industries including health care for some time (Ishikawa, 1982; Scriven, 1984; Wade, 1999), as an enabling process to critically examine and reflect on practices with the purpose of promoting individual and organizational growth and change. It is this critical reflection aspect of learning circles that sets them apart from other discussion forums. Noble, Macfarlane & Cartmel' s (2005) learning circle innovation and particularly their four-step model of critical reflection was adapted for use within the clinical setting involved in undergraduate nursing education. The four-step model of critical reflection is non-prescriptive and is aimed at challenging participants to *think otherwise* in relation to theory and practice (Noble, et al., 2005). It is this open-ended interpretation of the model which enabled its easy adaptation to the context of clinical learning in nursing.

The four-step model of critical reflection presented by Noble, et al., (2005) provides a practical approach to critical reflection. They describe critical reflection as "the ability to reflect honestly on one's own practice in a manner that allows multiple perspectives and approaches to inform [practice]" (Noble, et al., 2005, p. 14). Thus a critically reflective practitioner is one who engages in the construction rather than reproduction of knowledge. The four-step model challenges participants to explore and develop critical reflection skills by deconstructing current practice, confronting issues, theorising by considering practices at all levels of the organisation; and thinking otherwise by considering approaches outside

dominant discourses, to construct other ways of thinking about, and practising (Noble, et al., 2005, p. 16).

Noble, et al., (2005) tested the four-step model of critical reflection via a pilot project conducted in six child care centres that provided practice placements for 8 undergraduate (early childhood) students over one university semester (a total of 48 students). During this period regular time and space were allocated for open discourse between practitioners, academics and students, to critically reflect on learning experiences. Results indicated that students were more engaged in practice and their sense of professional identity revealed an enhanced understanding of: "engagement in collaboration and team building; development in critical thinking skills; acknowledgement that improved critical thinking skills led to enhancement of practice, and; development of advocacy, leadership and innovation" (Noble, et al., 2005, p. 44).

Our use of the learning circle strategy also demonstrated positive results including enhanced communication and understanding in relation to undergraduate nursing student clinical education and improved organisation learning culture (Walker, et al., 2011b).

Methods

This study sought to encourage nursing and student participants to actively deconstruct, confront and challenge existing ways of thinking to contribute to effective clinical learning through a learning circle strategy. The study received ethics approval from both Griffith University's and the participating Hospital's human research ethics committees.

The four-step model of critical reflection (Noble, et al., 2005) utilised in the learning circle approach

provided a practical framework for nursing and student participants to apply new ideas into their practice, enhance their own leadership capacity, and contribute to the clinical learning culture. The model was adapted and re-labeled to promote understanding by participants:

1. *Break apart* (or deconstruct) our practice into pieces and question what is considered 'normal', 'proper' or 'accepted'.
2. *Confront* any of the difficult or 'untouchable' topics that these questions raise.
3. *Explore* (or theorise) these issues by asking yourself: what are the possibilities? How could we do this differently? Who or what can I refer to for advice?
4. Think of *alternatives* (think otherwise). Put their pieces back together to create better ways of thinking about and doing our practice.

Participants and setting

A series of learning circles were conducted during in-service periods (that is, the time allocated for professional education between morning and afternoon shifts) over a 3 month period between August and October 2009 (before, during and after scheduled semester undergraduate clinical placements). The use of the in-service period between the morning and afternoon shift was imperative to ensure interested staff were able to participate at their convenience during working hours.

A total of 19 learning circles discussions were conducted in the two acute care hospital wards. A total of 56 nurses, 33 students and 1 university-employed clinical supervisor consented to participate in the learning circle discussions. Participation rates ranged from 3 to 12 individuals per discussion. Staff and students could participate in as many learning circles as possible and many attended multiple times and as such 86 registered nurses (including some clinical nurses who have a greater leadership role in clinical settings) and 8 endorsed and/or enrolled nurses participated in 19 learning circles over a 12

week period. Thirty-seven final-semester third year students and 12 second-semester second year students participated in the learning circles while on clinical placement. One clinical facilitator supervising second year students on placement also attended a discussion.

Ward leaders such as the nurse unit manager and clinical nurses were supportive of the study, and promoted participation in the learning circles to nursing staff and students. Some clinical nurses were able to occasionally attend learning circle discussions. However, nurse unit managers were unable to attend due to the demands of their role during the change of shift.

Learning circle strategy

An intervention protocol was developed to guide learning circles (see Table 1). The protocol outlined a series of generic steps for the researcher to follow to ensure a process for facilitating the four-steps of critical reflection was used consistently. The process allowed participants to share personal experiences, or discuss issues related to a scenario and/or published research prepared by the researcher. This was an important consideration, as it was possible for each discussion to involve staff and students who had not yet attended learning circles, as well as participants who had joined discussions on one or more occasions. Although the researcher facilitated the learning circles, the discussions were not prescribed as it was considered important that the format of learning circle discussions be flexible and open-ended to promote a welcoming and relaxed environment for participants. Guidelines regarding learning circle participation were outlined, and included use of appropriate language and respect for colleagues' opinions.

Data collection and analysis

Field notes were kept by the researcher during each learning circle. These hand written notes taken during the sessions documented the main discussion points for dissemination to participants via email. They provided a chronological record of events as well as a means for noting thoughts and ideas about the research process and people involved. The field notes summarized the content of the learning circle discussions as they related to the key issues identified from a critical appraisal of the content and were emailed to all participants for confirmation. This critical appraisal of the content was done using consensus coding to enhance the trustworthiness of the design (Judd & Perkins 2004). The process was informed by DeSantis & Ugarriza's (2000) description of the aspects of consensus coding. Two persons simultaneously undertook a content analysis of the learning circle discussions and categorized the participants' responses into key issues (DeSantis & Ugarriza, 2000).This was done jointly and any differences were discussed and determined at this time (DeSantis & Ugarriza, 2000). Ten themes emerged from this inductive content analysis.

Results

Ten themes emerged from content analysis of the learning circle discussions and are: communication and feedback, preparation, acknowledgment and support, clinical placement models, bullying, scope of practice, inconsistent expectations, hierarchy, moral integrity and inclusiveness, feelings of uncertainty and vulnerability. The nature of each of these ten themes is clearly detailed in Table 2 that provides an full account of them with verbatim discussion quotes and notes taken during learning circles.

Discussion

The themes confirmed the contemporary and historical influences on clinical learning in nursing outlined in the literature including: communication and feedback during clinical learning activities (Andrews, et

al., 2006; Levett-Jones, Fahy, Parsons & Mitchell,. 2006; Walton, Smith, Gannon-Leary & Middleton, 2005); preparation, acknowledgement and support for clinical learning (Brammer, 2006; Walker, Cooke & McAlliser, 2008); clinical placement models (Andrews, et al., 2006; Brammer, 2006; Clare, Edwards, Brown & White, 2003; Goldsmith, Stewart & Fergusion, 2006; Lambert & Glacken 2005; van Eps, Cooke, Creedy & Walker, 2006; Walker et al., 2008); scope of practice (Donaldson & Carter 2005; Fox, Henderson &Malko-Nyhan, 2006; Henderson, Cooke, Creedy & Walker, 2006; McCarthy & Murphy 2008; Ramritu & Barnard 2001; Walker et al., 2008) and; professional relationships and bullying (Barnett et al., 2008; Duddle & Boughton 2007; Henderson, Ctreedt, Boorman, Cooke & Walker., 2010; McNamara 2007; Roberts, Demarco & Griffith, 2009). Importantly, the four-step model of critical reflection enabled participants to confront the issues encorporated in the ten themes in a positive and constructive manner and as such warrants further discussion.

The learning circle process provided ~~for~~ participants with a sense of security created that enabled them to voice their concerns around the ten theme areas that emerged. This was evidenced through the frank disclosure of incidents (as exemplified in Table 2) related to:

- being frightened or intimidated (*My first prac was a disaster....first time I'd seen a naked man. He'd been in an accident and had broken everything...I panicked...it was the most embarrassing prac ever!"*);
- getting 'into trouble' or humiliated in front of others (*Another [nurse] participant remembers getting into trouble with the Clinical Facilitator for not asking the Five Rights before giving an IV flush. This occurred in front of the patient so she remembers it as being quite a humiliating experience.*);
- being isolated (*Student participant raised the issue of advocacy for students. Recalled a situation when a bad thing happened to a student and the hospital-employed Clinical facilitator*

"sided with the ward" and the student had to "take one for the team". The student felt the process was not objective. "It seemed one against many".).

These personal disclosures confirmed that participants felt 'psychologically safe' in the learning circle setting. Psychological safety is a key requirement for speaking up and engaging in learning (Nembhard & Edmondson 2006). Indeed the key component to successful, inclusive working relationships is speaking up without fear of negative repercussions (Nembhard & Edmondson 2006). Entering the clinical environment is stressful for students and the learning circle approach was therefore instrumental in creating a democratic, blame-free environment for dialogue where participants felt equal and their contribution respected. Being able to voice any concerns in a safe and supportive environment had a positive impact on students.

The application of the four-step model of critical reflection including support from clinical unit-based nurse leaders and distribution of discussion summaries to participants), were powerful in assisting all participants to take a leadership role in clinical learning (Student – "*My participation [in the learning circles] has made me more confident. I speak up more and ask for help and the nurses are really keen to help."*; Nurse – *"This experience has made me think about how students feel much more than before. It's a reminder how intense learning is. I'm more aware of how they're feeling.").* Learning circle discussion and application of the *four-step model of critical reflection*- during the everyday process of undergraduate nursing clinical placements in busy ward settings may have also contributed to reducing negative behaviours such as the perpetuation of hierarchy and bullying while promoting shared participation and inclusiveness

From the initial steps of the four-step model of critical reflection, participants were challenged to *explore* and think of *alternatives (*or *think otherwise)*. For this to occur, nursing staff and student participants had to engage with, share and acknowledge the ideas and opinions of others. A cross-section of nursing's hierarchy from undergraduate nursing students, their independent clinical facilitators, registered nurses, and clinical unit-based nurse leaders such as clinical nurses and the occasional nurse educator were able to recognise each other's perspectives and concerns. This mutual recognition was evident in the achievement of consensus during the later steps of the four-step model of critical reflection: to *explore* the identified issues and think of *alternatives* to create better ways of thinking about and doing practice. Table 2 identifies simple yet significant examples of this process in addressing the well documented difficulties around clinical placements (*Strategies to deal with intimidating or intimidated students – listen to the student, include them in the conversation rather than just telling them what to do*), and providing advice on effective communication skills such as the use of tentative, respectful questioning techniques prior to the commencement of clinical placement (*Communication in-service should be incorporated into each student placement (via orientation?) as well as reiteration on the ward (learning circle?) during the placement to enable effective and appropriate staff - student communication)*.

The role of the nurse unit/ward manager is pivotal in influencing the learning environment with a clear association between positive nursing role-models and a supportive learning environment (Walker et al., 2011a). Field notes indicate that although the Nurse Unit Managers (NUMs) were often not available to share in the discussions, their support of the learning circle particularly their encouragement of staff to be included, was instrumental in establishing learning circles as an accepted norm during the three month research period. The promotion of inclusiveness by leaders allows others to participate in discussion and decisions to voice their perspectives (Nembhard & Edmondson 2006).

The learning circles in this study provided nursing staff and student participants with an allocated time and space to be oriented to and participate in democratic discussion. Through democratic participation, participants felt psychologically safe to disclose personal experiences and engage in the learning experience without fear of retaliation (Nembhard & Edmondson 2006). For critical reflection to be both pragmatic and transformative, participants need to be oriented to the skills required to synthesise, analyse and evaluate experiences and ideas within a group setting (Burton 2000, Mackintosh 1998).

Conclusion

The learning circles were successful in enabling nursing staff and student participants to come together in a facilitated and democratic space to deconstruct practice, confront and explore difficult issues and topics, and think of alternative ways of doing things. Importantly, they motivated staff and students to apply new ideas into their practice. The role of the nurse unit manager in supporting, encouraging staff to participate in learning discussion was crucial in ensuring the success and effectiveness of the learning circle strategy. While greater participation by the NUMs could have served to accelerate the four-step model of critical reflection in the limited research time period, their overt support was still successful in motivating staff to take initiative.

Learning circles provided the time and space for local communities of practice to develop, with an emphasis on participation, co-operation and co-production of knowledge surrounding clinical learning. The establishment and reinforcement of guidelines for participation enabled participants to better articulate their experience and promoted a democratic space where all participants could share their views. The positive response by nursing staff to the learning circles and four-step model of critical reflection may have been due to the provision of dedicated time and space to develop new knowledge and skills and that the focus related to issues relevant to them and their clinical setting. As such, a

permanent schedule of learning circles may result in the development of self-managed communities of practice. Ideas could be forwarded to clinical unit-based nurse leaders for consideration and possible action, thereby ensuring the legitimacy of nursing staff views, and the emergence and perpetuation of an empowered work culture. This would require organisational support and may require changes in human resource management, to acknowledge learning circles/four-step model of critical reflection via the organisation's mission statement, and introduction of the model to new nursing staff during orientation.

Embedding the theoretical underpinnings of the four-step model of critical reflection in nursing curricular and teaching methods, might also enable an easier transition in its practical application during clinical learning in health care facilities. As well, a more expansive and longitudinal research approach with a larger sample over multiple sites might provide a more in-depth understanding of how and in what ways the four-step model of critical reflection can create an effective and lasting clinical learning culture.

Limitations

Participants in the learning circles were not able to attend every session. Nursing staff and student attendance at learning circles was dependent upon staffing levels, patient load, emergencies and/or competing professional development/clinical learning activities. Attendance was highest when staffing levels were optimal and there were no urgent patient care events. However all participants were informed of every learning circle discussion through the emailing of the summarized field notes.

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Table 1

Discussion Summary Example

Process	**Four-step model of critical reflection**	**Summary example – based on field notes** 8 x participating staff – all RNs 4 x third year students
		Application
Practice: Questions to stimulate critical reflection Think about a significant clinical experience as a student, RN buddy, supervisor or co-worker. Why was this experience significant to you? Was it a successful or challenging experience? Why? What could have been done differently?	1. *Break apart* (or deconstruct) our practice into pieces, and question what is considered 'normal', 'proper' or 'accepted'. 2. *Confront* any of the difficult or 'untouchable' topics that these questions raise	***Question****: Think about a significant clinical practice experience.* Following a full minute of silence…….. <u>Issue#1: Communication gaps</u> ***Discussion*** A Student feels there are many 'gaps' or 'broken links' between students, the uni and RNs – a communication breakdown. RNs unsure of student's scope of practice. Students unsure about the hierarchy Students feel it is easier to say less. RNs feel it is normal to have students on the ward….take it for granted - however would like more information before the placement re. students' scope of practice and learning goals. RNs are not clear about what students expect of them and what they should be teaching. <u>Issue#2: Model of clinical supervision</u> ***Discussion*** An RN recalls that when she was a student she had one Buddy RN throughout her placement which made the experience more consistent. She felt she had better feedback re. her progress. Student added that different facilitators have different expectations, which create anxiety for students. Students agreed that sometimes they feel more like the focus is on assessment than on learning. <u>Issue #3: Feedback systems</u> ***Question to RNs*****:** *Are you asked to evaluate the clinical placement?* - Majority of RNs reported that they gave students feedback but were not evaluated about their experience. ***Question:*** *What about constructive feedback (for deficits)?* An RN recalls being a buddy to a student who she felt had a language barrier (and was unsafe?) and found it difficult to teach him. She referred her concerns to the Clinical Facilitator. ***Discussion*** Students felt constructive criticism, delivered in a sensitive way, was valuable. It's the way feedback is delivered that is important. Tentative language and a sensitive approach is less confronting. Direct or forthright approaches can destroy growing confidence. Students attended a staff communication in-service session conducted by Terry Slater which they found valuable. <u>Issue #4: Student engagement</u> ***Discussion***

RN feels that student attitude is important. Recalls a time when two EENs were on the ward during a placement (as part of the requirements for the Bachelor of Nursing) and made it clear to staff that they didn't have anything to learn.

Question: Why do you think students might project this attitude?

- Insecurity. Feeling they have a lot to prove.

Some ENs and ENNs don't tell ward staff during their placement to reduce their perception of increased expectation.

Student undertaking nursing as a second career, shares an experience from a previous placement where she was told she was 'over-confident' because she was comfortable talking with staff and patients. Felt that an assumption was made that she should behave in a certain way because she was a student.

Conclusion

The discussion was starting to warm up….and time is up!

Consider the hierarchy hangover from nursing's religious/military beginnings.

What impact does this still have? Think about traditions and rituals.

Possibilities: The challenge for change. Application of the four-step model of critical reflection

What would be the things you would change if you could?

Is there more than one solution?

How could you lead the change you would like to see?

What resources and/or skills would you need to lead this change?

3. *Explore* (or theorise) these issues by asking yourself: what are the possibilities? How could we do this differently? Who or what can I refer to for advice?

4. Think of *alternatives* (think otherwise). Put their pieces back together to create better ways of thinking about and doing our practice

Response to issue #1

Idea

Students are provided with the means to be well prepared for placement by the School of Nursing (SoN).

The SoN also notifies senior staff (nurse unit managers/educators) on the ward re. approaching clinical placement, including year group, scope of practice, and letter from course convenor.

This information should be forwarded to all nursing staff prior to arrival of students, to enable nursing staff to be better prepared.

Response to issue#2

Note from Rachel (facilitator)

The preceptor model is indeed the best clinical model. However it is also the least efficient in terms of accommodating large student numbers, and so is not exclusively used in Brisbane where there is greater pressure on clinical placements due to larger student numbers. Regardless of the clinical model, a supportive environment has been identified as important for the transfer of learning in the clinical context.

Refer to reference:

Henderson, A., M. Twentyman et al. (2006). Students' perception of the psycho-social clinical learning environment: An evaluation of placement models. *Nurse Education Today, 26*(7): pp. 564-571.

Response to issue#3

Idea

Communication in-service should be incorporated into each student placement (via orientation?) as well as reiteration on the ward (learning circle?) during the placement, to enable effective and appropriate staff - student communication.

Response to issue#4

Idea

Strategies to deal with intimidating or intimidated students might include listening to the student and involving them in the conversation, rather than ignoring them or just telling them what to do.

Table 2

Themes and Specific Discussion Examples

Theme	Date (2009)	Discussion examples via direct participant quotes and notes taken by learning circle facilitator
		•
Communication and feedback	July 29	• "Students hard to give feedback to...student surprised about negative feedback...I spent a lot of time and effort trying to assist the student."
	August 12	• Re. feedback to students: Most nursing participants said they didn't discuss the deficits...only the positives.
	August 17	• Student feels there are many 'gaps' or 'broken links' between students, the uni and RNs – a communication breakdown
		• The way feedback is delivered is very important. Tentative language and a sensitive approach is less confronting. Direct of forthright approached can destroy growing confidence.
	August 26	• RNs also tend to have rushed (coded?) communications with each other during shifts due to busy environments and assumed decision-making processes which students are not aware of.
		• Some RNs find it difficult or have forgotten how to articulate their decision-making process.
		• Student often need to make decision in a step-by-step or A + B + C process whereas the decision-making process becomes easier with experience, RNs can jump from A to Z.
	September 9	• There is a gap. Rather than speak directly to the student the RN Buddy goes straight to the Clinical Facilitator to report a problem.
		• Students can be taken aback if suddenly they are approached by the Clinical Facilitator with negative feedback from an RN Buddy/Buddies, especially if the RN Buddy/Buddies have told them they are doing well.
		• Providing feedback to the student can be difficult for the RN Buddy if the student seems bored or indifferent – why bother?
		• ...there is a line between giving students a fair go and being honest about their abilities.....
	October 12	• Clinical Facilitators don't often come and seek feedback about the student from me.
	October 14	• Good communication is really important. It's not only what we say, it's how we say it...
	October 26	• "My participation [in the learning circles] has made me more confident. I speak up more and ask for help and the nurses are really keen to help."
		• "You have to ask for help if you need it."
Preparation, acknowledgement and support	July 28	• "[On my prac at _____]...nurses did not acknowledge students....they allocated themselves and walked away from students...that's all I remember of prac there."
	July 29	• "Approachability...they pushed you a bit...they involved you...they encouraged me."
	August 4	• "It blows me away that these preceptors spend so much time with you and help you..."
	August 17	• RNs would like more information before the placement re. students cope of practice and learning goals
		• RNs reported that they gave students feedback but were not evaluated about their experience.
	August 24	• How's prac going? "Awesome! I have increased confidence. I'm taking more initiative. The staff are great. They are proactive with education. I feel valued and part of the team."
	October 12	• "It's great that these younger nurses get an introduction to working with students. When I started I received no preparation. I just arrived at work and was told 'You're working with a student'."
		• "I'm more confident [after attending learning circles] when working with student. I think of myself as a role model.

Clinical placement models	August 4 August 17	• "It's hard for students to go with different preceptors everyday...but it can be good as you learn different things from different preceptors...hard to build a relationship for assessment when dealing with different people every day..." • An RN recalls that when she was a student she had one Buddy RN throughout her placement which made the experience more consistent. She felt she had better feedback re. her progress.
Bullying	August 12 August 20	• Participant generally has very good experiences in clinical placement. Only one Clinical Facilitator was "rough.....disinterested...and bitchy". • A student participant (who is also an EEN) felt "put down" and treated as if her EN skills were not recognised. She felt "dehumanised". She wanted to be treated as any RN would treat another RN.
Scope of practice	August 17 August 24 September 2 September 7	• RNs unsure of students scope of practice • "It's great when RNs trust you to do things on your own (within your scope). You feel like you are contributing to the team." • Students often frustrated when their RN buddy won't let them direct the shift independently (with their scope of practice. • RNs have to restrain themselves from getting involved and find [the process of allowing the student to direct the shift] stressful. • If the RN Buddy has confidence in the student they are quite happy to let them work independently with their own patient load. Students feel more relaxed and generally perform well. • Students tend to make errors when they feel they are being assessed (example with Clinical Facilitator – described as 'intimidating' – doing a medication round with student. Student was nervous and making errors but when working performing the medication round with RN Buddy, performed well. • It is OK to push students to take a patient load (with support) depending on their year/semester level and scope of practice. • Some students are reluctant to take a patient load preferring to always observe. • Some students don't like working outside their conform zone and want to care for the same patients every day...they are probably nervous but they'll never learn.... • Students get very nervous when not directly when not directly supervised because they can get into trouble at uni for working outside of their scope of practice [particularly during preparation and administration of medications].
Inconsistent expectations	August 17 October 12 September 7 October 12	• RNs are not clear about what students expect of them and what they should be teaching. • Student added that different facilitators have different expectations which create anxiety for students. • "Clinical Facilitators don't often come and seek feedback about the student from me." • Sometimes the RN Buddies are better at judging the student's performance than the Clinical Facilitator • Clinical Facilitators don't often come and seek feedback about the student from me.
Hierarchy	August 5 August 12 August 17	• "...being a student some staff didn't talk to me, but once I became a grad they did." • A participant recalled her experience as a re-entry student where she was working with 2 RNs working outside their scope of knowledge and practice. When the student challenged them she was very firmly put in her place 'as a student'...."it was very disappointing..." • Students unsure about hierarchy...feel it is easier to say less. • Student undertaking nursing as a second career shares an experience from a previous placement where she was told she was 'over-confident' because she was comfortable talking with staff and patients. Felt than an assumption was made that she should behave in

		a certain way because she was a student.
Moral integrity	August 4	• "First prac at a nursing home or interim care unit...told EN (?) that a patient needed to be changed...told to leave it until the next shift (Which started in half-an-hour). [As a student]...I was told not to do things by myself but was concerned for the patient's welfare...felt very distressed and concerned about the lack of care from staff...kept seeking help..."
	August 24	• "It's great when RNs trust you to do things on your own (within your scope). You feel like you are contributing to the team."
	September 23	• RN shares her experience working as an AIN. She was in charge of an entire floor on her own with remote support on Christmas eve. One resident fell and broke their hip and another died.
Inclusiveness	August 4	• "Students bring fresh, humane eyes....which remind us we are dealing with people." • "I try to allocate students things to do even though it's going to take extra time." • "...it makes a difference when [the buddy] gives you time....appreciate Buddy RN setting aside time to help student learning..."
	August 12	• Another participant disclosed that she learns a lot from students and that students provide a great deal of support for staff on the ward.
	August 20	• It's quite common for students to pick up errors such as medication errors.
	August 24	• "Working with students enable us to question out practice." • Another RN describes the process of working with students as an 'adjustment'...and adjustment to the students' level of confidence, knowledge, and level of experience. • RN - "You develop a feel by observing the student. Do they stand back? Are they gung-ho?" • To RNS - How does it feel to be questioned? .....*laughter*...."How dare you!" "We expect questions...we worry when there are no questions...sometimes the timing of questions is inappropriate..." • "It's great when RNs trust you to do things on your own (within your scope). You feel like you are contributing to the team."
	August 31	• Student: It's great when RNs [buddies] trust you to do things on your own (within your scope). You feel like you are contributing to the team.
	September 23	• Workload has a significant impact on the ability of the RN Buddy to work with students which influences the quality of the student's leaning experience.
	October 14	• "This experience has made me think about how students feel much more than before. It's a reminder how intense learning is. I'm more aware of how they're feeling."
	October 26	• The sessions [learning circle discussions] have enabled more senior/experience RNs to remember what it's like to be a student and be more patient, inclusive and encouraging.
Feelings of uncertainty and vulnerability	August 5	• "...very scary and intimidating having a different nurse each day...even as a grad it's really scary..."
	August 12	• Another [nurse] participant remembers getting into trouble with the Clinical Facilitator for not asking the Five Rights before giving an IV flush. This occurred in front of the patient so she remembers it as being quite a humiliating experience.
	August 20	• Student participant raised the issue of advocacy for students. Recalled a situation when a bad thing happened to a student and the hospital-employed Clinical facilitator "sided with the ward" and the student had to "take one for the team". The student felt the process was not objective. "It seemed one against many".
	September 2	• RN – "My first prac was a disaster....first time I'd seen a naked man. He'd been in an accident and had broken everything...I panicked...it was the most embarrassing prac ever!" • RN – "I fainted on my first day."

	• RN – "I still get nervous when being watched for assessments/competencies. If you know you're being watched you tend to exaggerate your actions."
September 7	• Students tend to make errors when they feel they are being assessed (example with Clinical Facilitator – described as 'intimidating' – doing a medication round with student. Student was nervous and making errors but when working performing the medication round with RN Buddy, performed well. • Students get very nervous when not directly when not directly supervised because they can get into trouble at uni for working outside of their scope of practice [particularly during preparation and administration of medications].
September 16	• "I am scared of being wrong and being 'brought down'."
September 23	• "....I do try to be approachable for students. I feel a bit of anxiety when my practice is observed by students."
October 14	• "I feel uncomfortable when a student asks questions I don't know the answer to."