Evaluating Clinical Learning Environments: Creating Education-Practice Partnerships and Clinical Education Benchmarks for Nursing

Learning Outcomes and Curriculum Development in Major Disciplines: Nursing Phase 2 Final Report

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For the Australian Universities Teaching Committee

From a Consortium of the:
Flinders University, Adelaide
University of Technology, Sydney
Queensland University of Technology, Brisbane

March 2003
Phase 2 Final Report Focus:

Evaluating Clinical Learning Environments:
Creating Education-Practice Partnerships
and Clinical Education Benchmarks
for Nursing

March 2003
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Published by
School of Nursing & Midwifery, Flinders University, Adelaide, Australia
March 2003

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School of Nursing & Midwifery, Flinders University, Adelaide, South Australia, in conjunction with Department of Education Science and Training.

ISBN: 0 9750725 0 1

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This report is published and disseminated in fulfillment of the reporting requirements of the Australian University Teaching Committee who funded this research project.

The views expressed in this report do not necessarily reflect the views of the Department of Education, Science and Training.
Acknowledgements

The research team gratefully acknowledges the *Australian University Teaching Committee* for supplying the funding to undertake a second phase of research, which enabled the project team to action findings from Phase One of this study. Thanks to Professor Christine Ewan (representing the AUTC) for her guidance and support in this process. Additionally, our grateful thanks must go to all those who participated in this project. Their collegiality and invaluable assistance has developed partnerships and initiated the actioning of best practice. Without the following people this research would not have been possible. They have given commitment, time and assistance, working in the participatory action research groups, reference groups, and/or reading documents. The research team want to thank the following individuals for their contribution:

Tracey Abikhair                               Neil Frazer
Koli Ali                                     Judy Freshwater
Eileen Anderson                               Melanie Frost
Vanessa Anderson                              Robyn Gallagher
Kate André                                    Richard Gil
Tony Azzopardi                                 Antoine Goarin
Anthony Bacharich                             Sue Goldsmith
Angela Bardini                                 Clare Gomez
Jenny Barry                                   Judy Gonda
Kim Baxter                                    Amanda Gorman
Vanessa Bell                                   Janet Green
Melinda Bertoldi                               Nicole Gregory
Jenny Beutel                                   Kate Haines
David Biles                                   Kellie Hammond
Robyn Blue                                    Naomi Harper
E. Blyth                                      Frances Harrihy
Sherry Booker                                 Tracey Hartley
Julie Buckman                                  Kirstie Hastie
Katie Burnett                                 Katie Heath
Didy Button                                   Amanda Henderson
Sharina Cameron                               Sally Henderson
Aaron Cannon                                  Michelle Hern
Fiona Carmichael                              Janet Hewitson
Stewart Clegg                                 Kelli Hook
Ellie Crowther                                Meryl Jenkins
Darren Daff                                   Trish Johnson
Renae Dahl                                    Kevin Kellehear
Vickie De Jong                                Jenny Keller
Tamara Druce                                  Michelle Kelly
Fabienne Edema-Hildebrand                     Amanda Kerr
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Learning Outcomes and Curriculum Development in Major Disciplines in Nursing, Phase 2

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Tyrone Pitsis  Brenda Wilson
D. Pollard  David Wilson
Julie Price  Kate Wood
Kurralyn Rawworth  Karen Wotton
Christine Regter  Helen Wundenberg
Jacquelyn Reynolds  Aileen Wyllie
Fleur Reynolds

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Learning Outcomes and Curriculum Development in Major Disciplines in Nursing, Phase 2
## Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ANCI</td>
<td>Australian Nursing Council Incorporated</td>
</tr>
<tr>
<td>AUTC</td>
<td>Australian Universities Teaching Committee</td>
</tr>
<tr>
<td>CDU</td>
<td>Clinical-Nursing Development Unit</td>
</tr>
<tr>
<td>CEU</td>
<td>Clinical Education Unit</td>
</tr>
<tr>
<td>CLE</td>
<td>Clinical Learning Environment</td>
</tr>
<tr>
<td>DEU</td>
<td>Dedicated Education Unit</td>
</tr>
<tr>
<td>DoN</td>
<td>Director of Nursing</td>
</tr>
<tr>
<td>FMC</td>
<td>Flinders Medical Centre</td>
</tr>
<tr>
<td>EN</td>
<td>Enrolled Nurse</td>
</tr>
<tr>
<td>FUAA</td>
<td>Flinders University, Adelaide, Australia</td>
</tr>
<tr>
<td>NUM</td>
<td>Nurse Unit Manager</td>
</tr>
<tr>
<td>QUT</td>
<td>Queensland University of Technology</td>
</tr>
<tr>
<td>RBH</td>
<td>Royal Brisbane Hospital</td>
</tr>
<tr>
<td>RN</td>
<td>Registered (General) Nurse</td>
</tr>
<tr>
<td>RNSH</td>
<td>Royal North Shore Hospital</td>
</tr>
<tr>
<td>UTS</td>
<td>University Technology, Sydney</td>
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</tbody>
</table>
## Glossary

There is enormous variance in language relating to clinical learning across nursing in Australia. Each research team used different words to describe the persons depicted below. To facilitate common understanding of the benchmarks each term has been clarified with a brief description so readers can replace their own colloquial word to match each descriptor given below. Note: site specific terms are clarified in each of the clinical learning environment evaluation tools within the appendices. In this document the terms used are:

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td><strong>Clinical Learning Environment (CLE)</strong></td>
<td>The CLE is a specific unit within a health service in which students are placed to meet their clinical learning objectives.</td>
</tr>
<tr>
<td>Academic</td>
<td>The nurse academic appointed by the university to facilitate clinical learning for an appointed number of students for the duration of the clinical placement.</td>
</tr>
<tr>
<td>ANCI competencies</td>
<td>The national standards developed by the Australian Nursing Council Incorporated that provide the framework for competent professional practice for Registered and Enrolled Nurses.</td>
</tr>
<tr>
<td>Clinical Contract</td>
<td>The agreement designed and/or endorsed by the student, nurse academic, clinical facilitator and preceptor to assist a student to progress toward satisfactory completion of specific learning objectives they are expected to be able to meet at this point in their education, but they have been unable to satisfy to date.</td>
</tr>
<tr>
<td>Clinical Facilitator</td>
<td>The person that supervises clinical learning within the CLE for an appointed number of students for the duration of the placement. NB. This person may be a university academic or an appropriately qualified nurse, appointed or seconded to facilitate clinical learning on behalf of the university, who holds academic status for the duration of the students’ placement.</td>
</tr>
<tr>
<td>Clinical Placement/Practicum</td>
<td>The component of nursing education that allows students to put theoretical knowledge into practice within the patient/client care environment.</td>
</tr>
<tr>
<td>Clinicians</td>
<td>The nurses working at the nurse/patient (client) interface within the CLE.</td>
</tr>
<tr>
<td>Continuing Education</td>
<td>The organised formal or informal education activities offered within and/or external to the workplace, (clinical learning environment) which enhances professional practice.</td>
</tr>
<tr>
<td>In-service Education</td>
<td>The organised formal and informal educational activities that enhance professional practice within the clinical learning environment.</td>
</tr>
</tbody>
</table>
**Preceptor**  The nurse who works alongside one or two students as a practice-partner/peer support person/buddy/mentor/professional clinical role model for each day of their clinical placement. NB. It may/may not be the person designated with oversight of that student’s practice for that entire placement.

**Student**  The undergraduate nursing student.
Executive summary

Introduction

In 2001 the Australian University Teaching Committee funded several discipline based curriculum reviews aimed at improving teaching and learning across multiple disciplines. The nursing project undertook an extensive and in-depth exploration of the nursing discipline to locate best practice principles in nursing curricula, clinical education, and the recruitment, retention and transition of undergraduate nurses to practice. One key finding was that quality clinical education was profoundly affected by the state of the partnership between the health service and the university. Thus the second phase of this study sought to develop three site specific partnerships in three States of Australia between three universities: Flinders University, Adelaide, South Australia (FUAA), University of Technology, Sydney (UTS), and Queensland University of Technology (QUT), and three major public teaching hospitals, Flinders Medical Centre (FMC) SA, Royal North Shore Hospital (RNSH) NSW, and Royal Brisbane Hospital (RBH) Qld.

These partnerships were aimed to identify the elements of such alliances that optimise clinical learning and specifically identify areas of policy and work practice requiring reorientation to better manage clinical learning environments for undergraduate nurses. In this process six benchmarks were identified as standards against which these partnerships could be measured. Several of these benchmarks focus specifically on the academic/clinician interface in the workplace. Additionally, three site specific evaluation instruments were developed with clinical research partners that evaluate the clinical learning environment and the partnerships that influence teaching and learning within that environment.

Context

The research took place in a climate of tense and difficult work conditions, including industrial action in Queensland, and significant pressures on clinicians at all sites. Even in these trying workplace conditions there was enough goodwill and professional commitment between professionals, to work together to develop partnerships that foster quality clinical learning environments and provide nursing students with clinical experiences that nurture their professional development.

The Participatory Action Research process

This project aimed to construct and refine intentional actions and behaviours to develop these partnerships. Participatory Action Research (PAR) was chosen as the preferred research method because it had the potential to uncover social reality and shared meaning regarding partnerships, while developing and implementing action plans that would create the basis for quality partnerships to be constructed. The details of the research process are elaborated in Chapters 1 and 3 of this report. The generic process used by the three research teams included:
Introducing the project: Gaining in-principle support for the project, discussing data collection processes, and gaining access to potential clinical learning environment partners willing to join the (PAR) process.

Group formation: All sites developed PAR groups and reference groups of informants including academic, student, management and clinician perspectives.

Establishing the group: After ethical approval was received and consent obtained, agreed work patterns for data collection and reporting were established.

The PAR cycles: In each cycle the following phases of meeting, learning, focusing thoughts, engaging ideas, developing action plans and evaluating these actions continued until progress toward the desired outcomes were completed.

The anticipated outcomes: Three Clinical Learning Environment Evaluation Tools and benchmarks for successful partnerships between universities and health services that optimise clinical learning were achieved. The benchmarks need scoring criteria to be developed in the future, so they have meaningful application. Each site had their own specific methods of conducting the research process and these are detailed in Chapter 3.

Benchmark development and use

The term 'benchmark' describes the essential standards against which other standards may be measured (Ellis et al. 2000a; Ellis et al. 2000b). Consequently benchmarking is an ongoing and methodical exploration of, and execution of, best practice, which should lead to continuous quality improvement in performance (McKeown 1996; Mitchell 1996). As Day (2001 p. 39) notes, 'you cannot improve what you cannot measure'. The process this project used to develop the six best practice benchmarks is clearly outlined in Chapter 3 of this document.

The best practice benchmarks for partnerships that facilitate clinical learning are:

1. Partners will develop a shared formal agreement between a university and a health service regarding clinical education of undergraduate nurses.
2. There is effective and timely communication between partners.
3. The rights, roles and responsibilities of persons at every level of the clinical learning partnership are clearly defined.
4. Scholarly teaching by both partners occurs in the clinical learning environment.
5. The partnership elements that promote high quality clinical learning for students are provided within the clinical learning environment.
6. There is regular monitoring of agreed partnership elements that affect learning, teaching and progress of students.

The rationale, potential data source that can be used to verify each benchmark, along with the participants’ good practice criteria are identified for each benchmark and presented in Chapter 4 of this report. The benchmarks have been developed on a platform of shared principles, mutual desired outcomes and commitment to values. Good practice criteria have been scaffolded onto this platform and the next phase of this process is to develop reliable and representative scoring statements for this framework, so benchmarks become measurable. Significant findings and foreseeable problems with the introduction of benchmarking are discussed further in Chapter 4 of this document, but three major concerns have been identified:
lack of perceived benefit at the clinical interface of the partnership;
- dependence on the culture and climate of the Clinical Learning Environment; and
- unwillingness to share/disseminate innovation and best practice benchmarks.

**Recommendations**

A number of recommendations were made regarding partnerships that optimise clinical learning for nursing students based on the research findings and the literature on partnerships, clinical education and benchmarking. They are elaborated in Chapter 4 and include:

**Right reasons**

Universities and health services must recognise they have different purposes, goals and service drivers, therefore they must foster passion and enthusiasm for the partnership at every level, to promote the notion of joint professional responsibility for development of registered nurses and develop a shared vision for student education, and a joint commitment to student learning.

**Increase the stakes**

Stakes are already high for universities, but these need to increase for health services, especially at the level of the clinical learning environment. A few strategies to do this include: joint lobbying for increased funding for student placements; linking that funding to the quality of placements; and increasing shared use of resources, facilities, courses, lectures and continuing education for partnership staff.

**Involve the right people**

Choose the ‘best people’ and empower them to make decisions, manage student matters, monitor student progress, facilitate communication and resolve conflict if it occurs. Provide them with adequate time and support, commensurate to their workload, to ensure desired outcomes are effected.

**Create a strong balanced relationship that is adequately resourced**

The power relationships must be as equal as possible. Both partners should manage the relationship by troubleshooting quickly, cooperatively and with fairness, listening and responding to partners at every level of the partnership, recognising and accepting differences and maintaining flexible responses. Develop the partnership connections at many levels including research, management, education and training, sporting, social, political, media and lobbying. Ensure both partners provide the partnership with sufficient financial and human resources to meet the anticipated outcomes (negotiated at time of agreement). Promote the shared use of resources to sustain and support clinical
education and concentrate limited resources on improving the relationships that impact student learning the most.

**Trust and respect your partner and your staff**

Allow continuity of personnel because this develops mutual trust and reciprocity. Always behave with integrity and respect, and maintain confidentiality. Acknowledge and if possible reward staff of both partners. Aim to understand the pressures and workloads of your partner at every level of the partnership. Search for ways to minimise work and maximise results within the time and resource constraints of both systems.

**Ensure good communication**

Partners at all levels must be accessible and informed. This is done by developing ways to manage communication such as sharing ideas, exchanging information, sharing contact details at all levels - email, phone, fax…etc. Try to understand each partner’s priorities and make an effort to educate both partners regarding desired outcomes of the partnership. All relationships should be characterised by open and transparent communication, clearly defined rights, responsibilities and role clarification at every level of the partnership. Ensure all policy and processes are clearly documented and available to partners in accessible and agreed language.

**Formalise the relationship**

Develop formal agreements and/or ‘Memoranda of Understanding’ that articulate partners’ support for shared decision making, responsible reporting and monitoring mechanisms, commitment to open and transparent dealings, and provide detail of each partner’s shared and individual responsibilities. Identify and respond to issues impeding the partnership and develop policies and guidelines that get reviewed annually to address these issues. Always involve your partner in your organisation’s strategic planning. Universities should involve clinical partners in the examination of the clinical education component of curriculum review.

**At the clinical learning environment level of the partnership ensure:**

- strong partnerships are developed between university academics and clinicians;
- a positive learning climate prevails in the CLE;
- clinicians working with students are recognised, acknowledged and rewarded for their increases workload;
- open and transparent communication between partners is practised;
- preparation of students and clinicians for each clinical placement is flawless;
- put in place good administrative structures and then check them regularly to make certain they are working; and
- accept difference in partnership needs, aspirations, structures and processes and be flexible and responsive to one another’s needs.
Recommendations regarding the use of the evaluation tools

Each site developed a clinical learning environment evaluation instrument that can be used by different partnerships in conjunction with the benchmarks for best practice. The three tools presented in Appendices B, C and D are a work in progress that need to be trialled on a larger scale and modified according to local contexts and partnerships needs.

The FUAA/FMC instrument\(^1\) is focused on evaluating partnerships for learning within the clinical learning environment. Administrative oversight of the tool should be by a pair of nominated representatives, one from each partner organisation. The tool can then be administered to various partners within the CLE in paper or electronic format. The tool focuses on the importance and performance of various partners regarding factors that facilitate effective clinical learning for nursing students. Differences between participating partners’ responses, and comparisons over time will demonstrate areas of the partnership that are working well so these can be acknowledged and rewarded. Should aspects of the evaluation highlight areas that require further development, a meeting will be set up by the administering team to include nominated clinicians, the university academic and/or clinical facilitator, and the Clinical Nurse Consultant/Manager of the clinical unit involved. The purpose of this meeting will be to identify strategies for remedial assistance/action and support to any/all staff, should this be required.

The UTS/RNSH instrument\(^2\) is focused on assessing the partnership by evaluating staff and student perspectives of clinical learning and the clinical learning environment. The tool is developed for use in a variety of health care environments and locations thus the terminology used is generic. Questions for students relate to specific placements being designed for completion after every clinical placement, while staff questions may be administered on an annual basis. The instrument is intended to be self-administered, therefore it is divided into sections so different partners involved in student learning can complete their designated section electronically or on paper.

The QUT/RBH instrument\(^3\) is focused on evaluating the partnership by reviewing elements of the clinical learning environment. The evaluation instrument and its administration is intended to increase collegiality and collaboration between partners, thus the instrument focuses on the broad aspects of the university-health service partnership. It is proposed that it be administered by a review team of individuals representing both partners, who will jointly identify areas of optimal performance and those requiring attention and remedial actions.

Conclusion

The outcomes of this project are a set of researched benchmarks that set the standard for constructing and evaluating the quality of clinical education partnerships. The research process developed three clinical learning environment evaluation tools that meet the needs of both partners. These may be used and adapted by partnerships throughout Australia, with the aim of assuring the quality of clinical education for undergraduate nurses across this nation, aiming to increase their readiness for practice, improve their educational preparation and ultimately refine and develop quality patient care.

\(^1\) See Appendix B
\(^2\) See Appendix C
\(^3\) See Appendix D
Chapter 1
Introduction and research methods

Introducing the research

In 2001 the Australian University Teaching Committee funded the first phase of a Nursing discipline review, which explored curriculum, clinical education, recruitment of nursing students, transition to practice, and retention of graduates in nursing. One aim of that study was to develop contextually appropriate best practice principles for Australian undergraduate nursing education with a focus on improving clinical education outcomes. A major finding was the dissatisfaction with, and need for, more collaborative partnerships between clinical environments and the university that reflected best nursing practice both clinically and educationally (Clare, White, Edwards and Van Loon 2002). The Phase One study contributed to and supports findings from the National Review of Nursing Education (DEST 2002a; DEST 2002b; DEST 2002c; DEST 2002d) which found nurses of all levels and disciplines within the nursing profession want quality clinical learning experiences for undergraduate nurses. The Phase One participants clearly desired more shared responsibility between the tertiary sector and health services for undergraduate clinical education in nursing.

Thus this second phase of the project has taken that recommendation into the research field to investigate the management of partnerships for optimal clinical learning environments through identification and development of best practice strategies, and processes that will improve the quality of clinical education for nursing students.

The research aims

This study investigated optimal learning environments in hospitals to identify the positive and negative elements of these learning environments, and to collaboratively formulate strategies for policy change in both industry and academia.

Specifically the aims of this research were to:
- identify the elements constituting partnerships for optimal clinical learning environments that support student nurses in acute care settings;
- identify areas of work practice reorientation to manage clinical nursing environments, so ensuring optimal learning will take place for students and new graduates in clinical contexts; and
- identify areas of policy review and change in academia and industry to provide evidence that partners may use to manage clinical learning in a cost effective and efficient manner.

This document is the outcome of Phase Two of the project describing:
- three clinical learning environment evaluation tools;
- benchmarks and standards at the academic/clinician interface in the workplace;
- benchmarks for the development of successful partnerships between education and service providers; and
- strategies for work practice reorientation in education and service settings.
The research teams

This Australian University Teaching Committee Teaching and Learning project *Learning Outcomes and Curriculum Development in Major Disciplines in Nursing* is the second phase of a project put forward by Flinders Consulting Pty. Ltd. with a research consultancy team made up of a consortium of three universities. The project was co-directed by Professor Judith Clare, Flinders University, Adelaide, South Australia (FUAA), Associate Professor Diane Brown and Professor Jill White, University of Technology, Sydney (UTS), and Professor Helen Edwards, Queensland University of Technology (QUT). The cross-institutional approach used in Phase One continued in Phase Two to enhance the acceptance of the project results by the tertiary and health service sectors nationally. Each co-director was responsible for an institutional group. The project was managed by Senior Research Fellow, Dr Antonia van Loon based at Flinders University and three project officers Ms Lara Leibbrandt and Ms Helen Fahey-Shelton (Sydney), and Dr Kristina Malko-Nyhan (Brisbane), to ensure data from all three project sites was locally managed, and that the final report reflected the comprehensive nature of the project, yet read as an integrated study.

**Flinders University Adelaide, Australia (FUAA) team:**
Professor Judith Clare, Dr Antonia van Loon (Project Manager) and a reference group of university academics and students.

**Flinders Medical Centre (FMC) PAR and reference groups:**
Associate Professor Brenda Wilson (Director of Nursing), and a reference group from Nursing Executive; Ms Koli Ali and nursing staff from ward 5F, and Ms Julie Buckman and nursing staff from ward 6A.

**University of Technology - Sydney (UTS) team:**
Associate Professor Diane Brown, Professor Jill White, Ms Lara Leibbrandt and Ms Helen Fahey-Shelton (Project Officers) and a reference group of academics involved in clinical practice, clinical facilitators and students from the university.

**Royal North Shore Hospital (RNSH) PAR and reference groups:**
Adjunct Professor Jenny Beutel (Director of Nursing), a Nurse Unit Managers’ reference group; PAR Groups made up of Registered Nurses of various levels from theatres, and wards 4e, 6b, 7c, 8b, 8c, 8d, 9b, 9d, 10a, 10b, and 11a.

**Queensland University of Technology (QUT) team:**
Professor Helen Edwards, Professor Mary Courtney, Ms Robyn Nash and Dr Kristina Malko-Nyhan (Project Officer), a PAR group of third year students, and a reference group of academics.

**Royal Brisbane Hospital (RBH) PAR and reference groups:**
Adjunct Associate Professor Mary Montgomery Ms Robyn Fox, Ms Jenny Dodson, Level 3 and 4 nursing management personnel, and registered nurses from within the medical and surgical divisions of the organisation.
Background to this research

This yearlong second phase of the project built on Phase One of this study, and its clear request for improved partnerships between the university and health sectors to facilitate quality clinical education in nursing. Phase Two focused on how partnerships between service providers and education providers worked to underpin clinical education for undergraduate nurses. Three local partnerships have been developed using Participatory Action Research (PAR) aiming to provide quality benchmarks for optimal clinical learning environments for nursing students, which may be adapted nationally and internationally.

There has been little research conducted to date that synthesises the views of students, academics, managers and clinicians regarding the complexity of professional, organisational and educational elements of an optimal partnership that creates and sustains quality Clinical Learning Environments (CLEs). Phase One of this study found employers and graduates requested more acute care hospital clinical placements that meet both organisational and student learning objectives. It was not deemed enough to just provide more clinical placements, rather the issue was one of the quality of the learning experienced. Participants wanted clinical placements to provide students with quality learning experiences that meet the growing demands placed upon graduates on completion of their studies. They requested increased clinical experience that helped them improve their technical competence, clinical problem solving capacity, time management, medication management, documentation and administrative functions and other practical aspects of nursing. Thus the Phase Two research focused on development of criteria which enabled assessment of learning environments that provided quality benchmarks for clinical learning.

The present system of managing clinical education for nurses cannot sustain the complex demands, expectations and pace of the clinical context and the evolution of nursing knowledge and practice, without the establishment of formal collaborative structures between education and service providers (Clare et al. 2002; Edmond 2001).

The first concerted effort to provide a collaborative optimal clinical learning environment for student nurses occurred in Britain in 1990 when the Directors of Nursing in Oxfordshire Health District in partnership with lecturers at Oxford Polytechnic School of Nursing developed a ‘Clinical Learning Environment Audit Tool’ (Oxford Polytechnic School of Nursing 1990) containing statements of optimum standards, to assess the suitability of a clinical area for student nurse education (Fitzgerald 1994; Lathlean 1992). However, no published research was undertaken to establish this tool or to evaluate the effectiveness or appropriateness of it. Over the last two decades research has been undertaken to develop qualitative and quantitative tools to appraise the student experience of learning environments (Farrell 1993; Lauder 1992; Letizia 1998; Smithers 1988). A variety of instruments have been developed that evaluate and audit clinical learning environments (Balogh 1998; Bell 1993; Callaghan 1997; Chun-Heung and French 1997; Dunn and Burnett 1995; Endacott 1994; Farrell 1993; Fritz 1997; Ghazi 1995; Haigh 1994; Hastings 1991; Reed 1990; Tagliareni and Hastings 1991; Bournemouth University 2002). Other studies evaluated the ward environment and suggested a correlation between the leadership and influence of the charge nurse and the ward environment and the resulting experience reported by both staff and students (Jacka and Lewin 1987; Ogier 1986; Orton 1992). Students were asked if they ‘felt at home’ on the
ward because previous studies had shown that the relationship between the student and the ‘charge nurse’ had a significant influence on the student’s adjustment in the ward (Bezuidenhout 1998; Hyland et al.1988; Kirkpatrick 1989).

Clinicians and students on placement in various clinical venues have identified the link between the attitudes and support of both clinicians and academics and the quality of learning in the ward/clinical unit (Colucciello 1988; Dana 1997; Forrest 1996; Harth 1992; Hodges and Fuchs 1988). There is an essential need for organisational support, professional development and enhanced leadership skills for senior nurses to effectively manage the increasing complexity of their role, which has the potential to contribute to a positive learning environment in the ward/clinical unit (Dodwell and Lathlean 1987). Phase One of this study found that employers and graduates particularly noted the need for acute care hospital clinical placements that meet both organisational and student learning objectives (Clare et al. 2002). Thus Phase Two of this research focused on developing quality benchmarks for those clinical learning environments.

Nursing education in the tertiary sector calls for the quality preparation of beginning practitioners at a competitive cost. Included within generic baccalaureate nursing programs and postgraduate specialty programs are essential placement opportunities for nursing students to learn and enrich their knowledge in various clinical environments, contributing to their overall integration of the art and science of nursing practice. The registered nurse, supported by organisational leadership, is an essential element in the optimal learning environment for the student nurse (Manthey 1995). Phase One data provided evidence that one of the most important aspects of a positive transition experience is the presence of informed, competent and friendly preceptors (Clare et al. 2002). There was evidence that the degree to which clinicians adapt to the preceptor role and provide role modeling, coaching and feedback, is largely dependent upon support and leadership from the senior nurses and Clinical Nurse Consultant (CNC)/charge nurse / Nurse Unit Manager (NUM), and effective team functioning at the ward/clinical unit level (Anderson 1991; Hart and Rotem 1990; Lewis 1998). However, the impact on clinical nurses in terms of supervision of the novice and the attributes inherent in partnerships between service providers and education providers remained poorly understood.

When medical schools were first established in Australia, State governments, in partnership with universities, designated certain hospitals as teaching hospitals and funded teaching posts (often jointly with the university). More recently such funding is an integral part of the Casemix funding, earned by the hospital and allocated by the State government for medical teaching support. No such conditions were attached to nursing when it entered the tertiary sector, even though undergraduate students have 45-50% of their education program in clinical settings. At best, State governments, through Casemix, allocate between $3000 and $9000 per new graduate for education support to hospitals with Graduate Nurse Programs.

Against a nursing background of increasing educational expectations, fiscal burdens and workplace pressures this project has sought to develop benchmarks and standards for collaborative partnerships that provide quality clinical learning environments for undergraduate nurses thus ensuring the accomplishment and competence of the Australian nursing workforce into the future.
The research methodology

Aiming to construct and refine intentional actions and behaviours to develop quality partnerships between universities and health services, it was necessary to use a research method that had the potential to uncover social reality and shared meaning regarding such partnerships. Social reality is produced and preserved by certain norms observed by all associates in given situations (Carr and Kemmis 1986). The resultant shared meaning is constructed and replicated within the cultural group (Webb 1997). Furthermore, implementation of action plans around such shared reality, has the potential to create and further develop quality partnerships as an intentional product of the research process. Participatory action research had the capacity to achieve these outcomes.

Action research developed from dissatisfaction with the ability of positivist research to change the social practices and behaviours of people (Lewin 1941; Shumsky 1956). Participatory Action Research (PAR) enables participants in the field of study to be actively involved in all stages of the research process, from design to final reports (Argyris and Schon 1991; Fals Borda 1979; Freire 1982). In the PAR method, participants actively become part of the quest for information, ideas, and decision-making processes that influence their actions (Holter and Schwartz-Barcott 1993). Such a method presupposes that individuals have the expertise and ability to reflect and alter their thoughts, beliefs, and actions, and change through this process (Reason and Bradbury 2000). Hart and Bond (1995) summarised several criteria that distinguish the PAR method from other qualitative methods making it well suited to the type of research outcome that this project needed to develop. PAR is:

- educative,
- deals with individuals as members of social groups,
- problem focused, context specific, future oriented,
- involves change intervention,
- aims at improvement and involvement,
- involves a cyclical process inter-linking research, action and evaluation, and
- it is founded on a research relationship that involves participants in the change process.

Holter and Schwarz-Barcott (1993 p. 299) add that collaboration between researcher and practitioner, solutions of practical problems, changes in practice, and development of theory as characteristics of participatory action research.

Scientific methods test theories and objective knowledge but they do little to provide an understanding of human behaviour, social life, and the power constructions that permeate work cultures. These are more appropriately researched using qualitative methods that provide practical effectiveness at the level of ‘mundane activity’ (Winter 1987). Reason and Bradbury (2000) note such a paradigm of cooperative inquiry should involve the group in creative thinking to decide what needs to be researched, the method of inquiry, the making sense of findings, and finally, action to effect the desired outcome.

Social reality exists in dynamic frameworks created, maintained and adjusted by people in the course of interaction with each other, and in the case of this study, the work environment (Ghaye 1995). To understand the work environment the nurses working in that environment are best placed to explain embedded meanings within their cultural
context. They can appropriately question the institutionalised practices that may inhibit student learning, and more accurately envisage new and altered ways of working that might enhance quality clinical learning.

Freire (1972 p.136) states the dialogical relationship is characterised by people ‘who meet to name the world in order to transform it’. Lewin proposes that inferences about the behaviours and actions of human beings are more likely to be valid when the persons in question participated in building and testing the processes which surfaced those inferences (Lewin 1952). Participation needed to be full and unhindered if the research was to achieve optimal level of empowerment and validity. It was noted that power bases were rarely equal in dialogical relationships and the researchers had to guard against monopolising the dialogue because of their expertise in making sense out of the data. True participation did take time and effort. Participation may connote beneficial and appropriate methods that are democratic and egalitarian, but participation is increasingly being used as a technique to manipulate situations, diffuse power and mitigate collective control. Often participation in research projects is token and used to become a means to the researchers’ preferred end. To ensure that this did not happen in this project the data were developed with participants and documents returned to them at each stage of the process for verification and authentication of the accuracy of their data and the meaning placed upon that data by the researchers.

The research methods

The research context

The three university sites chose to work with clinical partners who provided clinical education for their undergraduate nursing students. They were:
- Flinders University (FUAA) and Flinders Medical Centre (FMC) in South Australia;
- University of Technology Sydney (UTS) and to Royal North Shore Hospital (RNSH);
- Queensland University of Technology (QUT) and Royal Brisbane Hospital (RBH).

Ethics approval

Ethics proposals were drafted and submitted in February and March 2002 by all three university teams to the respective ethics committees of the six institutions detailed above. Delays occurred in the approval process due to significant changes in Australia’s Privacy Legislation, making access to patients and their records more difficult. All the approvals were granted from FUAA, QUT and UTS Research Ethics Committee by March 2002, but approval from hospital ethics committees were not completed until early June 2002⁴. This 3-month delay led to revision of the time line detailed below:

⁴ See Appendix A.
Table 1.1  Research project timeline

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Clarifying the roles of the research teams

This project worked from three varied sites across Australia thus the model of PAR proposed by Elden and Levin (Elden and Levin 1991) was used to direct the research process. They term the professional researcher as an ‘outsider’ and the local participants as ‘insiders’ who collaborate using ‘cogenerative dialogue’ to produce mutual learning and ‘local theory’ (Elden and Levin 1991 p.129). The insiders have their own models and philosophies regarding clinical learning by which they attribute meaning and understanding to their experiences. The researcher is best able to surface these meanings and make sense of participants’ realities by allowing the participants themselves to interpret their social reality. All theory is influenced by the social setting in which it is created, therefore, participants in the CLE were invited to explain their environment, noting how they wanted it constructed, tested and improved so they could control its quality more effectively. Participants discovered specific insights, gained deeper understanding, and created alternative or new explanations and possibilities that could potentially improve the CLE and their workplace (Argyris and Schon 1978; Brown and Tandon 1983).

The participants brought to the research, expertise and experience of the structures and processes of the contextual setting as well as experiences, values and attitudes regarding clinical learning. How individuals organised and perceived their particular clinical learning environment and the partnerships that effect learning was the initial starting point from which the action research spiral commenced. Each participant brought to the dialogical process different knowledge and expertise. In these partnerships the participant becomes more theoretical about their practice and the researcher more practical about their theorising, resulting in new frameworks of knowing and doing (Winter 1987). The outcome of the research, three ‘Clinical Learning Environment Evaluation Tools’ (CLEET), demonstrate the types of innovative frameworks clinicians have developed to assess the CLE and thus benchmark its quality for replication and/or improvement.

The researchers brought design and analytic skills to structure the inquiry. In this study the researchers provided the technique for the inquiry to help search for answers using a credible method that had the potential to effect change and formulate action from the study findings and process. Each researcher functioned as a facilitator providing consultation, listening to the group’s process, documenting the structures and processes that expedite transformation of the CLE and result in improved quality outcomes (Soltis-Jarrett 1997).
Whyte (1991 p.40) indicates PAR can lead to a ‘rethinking and restructuring of relations’ in the organisation and the impact of this process may be carried into the future of the group. This was a much anticipated and hoped for outcome. It was important to the long-term life of this, and all PAR projects, that collaboration was developed, a perspective shared by Grundy (1981); Carr (1986); Oja (1989); and Street and Robinson (1995). Ghaye (1995) points out collaboration does not imply same roles and equal power relationships, but rather involves rigorous working together on a joint endeavour. Not all participants come in with the same knowledge therefore there are inequalities from the start. However, each participant had unique knowledge of their context of practice and with good facilitation many perspectives and experiences were heard and included into the data.

Inclusive participation has a better chance of leading to strong consensus, which develops solid foundations on which to create change and develop reciprocal partnerships. Participants saw themselves as co-participants thus they were more willing to be active in data provision and were motivated and attentive to the research project. The feedback cycle was shortened, as participants were able to provide quick feedback about the relevance of ideas and concepts.

**Identifying the commencement point for data collection**

The following starting points guided group discussion to gain the requisite data regarding partnerships for clinical learning.

*Participants were asked to identify:*  
- the elements and attributes of such partnerships;  
- the elements and attributes of an optimal clinical learning environment;  
- how these elements and attributes contributed to learning;  
- areas of work practice in academia and industry that promoted and/or inhibited clinical learning;  
- areas of work practice open to reorientation to advance the management of learning;  
- areas of policy in academia and industry that promoted and/or inhibited clinical learning and its management;  
- elements of quality benchmarks for the academic/clinician interface;  
- elements of successful partnerships between education and service providers at the management level; and  
- strategies to evaluate the quality of the clinical learning environment, which are proactive and user-friendly, and not punitive or divisive.

Figure 1.1 below was adapted from the action research cycle first posited by Lewin (1941, 1952) and adapted by Carr and Kemmis (1988). It was used to introduce the PAR process to participants as an explanation of the process to be used to obtain data.

**Summary**

This chapter provides an introduction to the research aims and methods. It has given the background rationale and the methodology used to achieve the outcomes. This report details a brief precis of each team’s processes and outcomes as they undertook to develop a site specific ‘Clinical Learning Environment Evaluation Tool’ and obtain the information required to create national benchmarks for quality clinical learning partnerships. These are summarised in Chapter 3 of this report.
Figure 1.1 The developmental Participatory Action Research cycle used

[Diagram adapted from the work of Lewin (1941, 1952) and Carr and Kemmis (1988)]

1. Collecting literature regarding partnerships and quality clinical learning etc.

2. General action plan commences using above points as a guide. Plan is open to revision and modification.

3. Planned actions implemented There may be several action steps occurring simultaneously as part of one action plan. E.g. Implementing of evaluation tools, policy changes, work practice initiatives etc.


5. Evaluation of progress towards goals, outcomes of actions, process of implementation, reflections, dialogue, meaning making, thinking, learning and understanding.

6. Revised plan with amendments and modifications which will move the project to meet goals and objectives more closely.
Chapter 2
Literature review

Phase One of this project provided evidence that best practice in the management of clinical education could be demonstrated through an expansion of formal collaborative structures between education and health service providers.

There are a few excellent examples of collaborative structures where optimal clinical learning environments have been established, but precisely what structures and practices exist in those environments that contribute to their success in terms of both processes and outcomes remained unclear. Thus the Phase Two literature was reviewed to learn what the clinical education environment and industry have to say about partnerships and effective collaboration, with a view to understanding the known quality indicators and standards that could provide benchmarks for quality clinical learning environments.

Partnerships in clinical education in nursing

The literature concerning partnerships in clinical education in nursing was reviewed first to discover comparisons, determine differences and initiate discussion regarding possibilities for potential transformation in the development of collaborative partnerships.

The goal of clinical education

The ultimate goal of pre-registration nursing education is the development of graduates who are prepared to function as competent beginning clinicians. The ability of newly registered nurses to fulfill this function is dependent on students having the opportunity for ‘real’ world practice, in a context that reflects the true experiences of a registered nurse, and in this way enabling them to link and translate theory into nursing practice. The purpose of planned clinical experience is to enable students to develop clinical skills, integrate theory with practice, apply problem solving skills, develop interpersonal skills and become socialised into the formal and informal norms, protocols and expectations of the nursing profession and the socio-political health care milieu (Conway and McMillan 2000; Hardy 1990; Hutchings and Sanders 2001; Jackson and Mannix 2001; Mahat 1998; Mundt 1990; Severinsson 1998).

Graduates are expected to have competent technical skills, communication skills, and the ability to make decisions in a demanding and complex environment as well as show all of the attributes of caring considered to be essential in nursing. The clinical education program supports students to develop the knowledge, skills, attitudes and values implicit in the Australian Nursing Council Inc (ANCI) competencies (Napthine 1996; Nash et al. 1998). These experiences cannot be successfully simulated in a laboratory setting (Boxer and Kluge 2000; Gomez and Gomez 1987). Grealish and Carroll (2000) note that clinical education is expensive with implications for both the teaching and health service areas. However, it is widely regarded as essential to the successful preparation of registered nurses (Ajiboye 2000; Conway and McMillan 2000; Duke 1996; Dunn et al. 1995; Hart and Rotem 1994; Reilly and Oermann 1992; Tolhurst and Bonner 2000; Williams et al.
2001; Wong and Wong 1987). Furthermore, there is considerable evidence that undergraduate nursing programs are good at achieving their aims and despite the diverse, complex and changing face of health care, registered nurses are well prepared for beginning practice (Bartlett et al. 2000; Boxer and Kluge 2000; Clare et al. 2002; Commonwealth of Australia 2002; Davies et al. 1999; Edmond 2001; Madjar et al. 1997; Reid 1994).

Ironically, although there is widespread agreement that clinical learning activities are at the heart of nursing education and critical to the consolidation of student learning (Infante 1985), the challenge of providing students with optimal clinical education experiences has become overwhelming in a rapidly changing health care environment. Clinical education occurs in a complex and turbulent service environment characterised by heavy workloads and stressful working conditions, partly caused by major difficulties in recruiting and retaining suitably qualified nurses. Consequently, health care agencies expect and need graduates to be work-ready, so they ‘hit the ground running’ (Greenwood 2000a) even though health services accept they have a responsibility for graduate orientation and induction into the workforce (Madjar et al. 1997; Somerville et al. 2000). Such concerns are not new with clinical experiences taking centre stage in most nursing education debates for decades. Sax (1978) conducted a Committee of Inquiry into nursing education in the 1970’s, indicating that clinical education opportunities were not being optimised because of a focus on service requirements at the disadvantage of student learning needs. Greenwood (2000a) supports this view when she indicates that the old system of hospital based education was failing to produce nurses who could cope with today’s complex health care environments.

For graduates to be able to provide optimal health care as competent and reflective beginning clinicians, issues surrounding clinical education need to be addressed. An integrative systematic review completed by Fitzgerald et al. (2001) indicated that while the studies analysed provide insight into many issues, very few studies provide conclusive evidence of best practice initiatives in clinical education and this is an area where further research is required. Furthermore, although many studies refer to best practice being demonstrated when collaborative partnerships are formed, the detailed elements of these benchmarks have not been identified. This investigation of the best practice elements of collaborative partnerships goes some way to redressing this deficit.

**Current models of clinical education**

At present, in Australia, there are several models that are used for undergraduate teaching, or facilitation, in the clinical setting – supervision, preceptorship (Grealish and Carroll 1998) and various modifications of these, for example, the dedicated education unit (DEU) clinical nursing development units (CDU) and clinical education unit (CEU) models. Supervision refers to the situation where a group of students is supervised (on average at a 1:8 ratio) by a clinical facilitator who may be an academic member of staff, employed on a sessional basis by the university, or seconded from a health care agency for the duration of the placement. Preceptorship involves supervision provided through a 1:1 relationship between a designated clinical nurse and the student, which is usually maintained for the duration of the placement (Usher et al. 1999). The facilitation/preceptor model uses a combination of the preceding two approaches. It entails having a facilitator who is responsible for the smooth management of the experiences of a number of students, which may exceed a ratio of 1:8. In addition to
having a facilitator available a student is ‘buddied’ with a clinician (also referred to in a number of sites as a preceptor) for the duration of their placement. The clinician continues in their clinical role, optimally with a decreased workload because of their educational responsibilities. The DEU/CDU/CEU models incorporate a structured partnership between industry and a tertiary institution, close collaboration between clinicians and academics, support and training for clinicians, peer teaching, and extended placements of students in clinical settings (Bell and Proctor 1998; Christian and Norman 1998; Edgecombe et al. 1999; Gassner et al. 1999; Gonda et al. 1999; Greenwood 2000b; Wellard et al. 2000). Preliminary feedback regarding various DEU/CDU/CEU models is positive regarding the development of partnerships based on effective communication, mutual respect, trust, mutual obligation and professional investment (Edgecombe et al. 1999; Gassner et al. 1999; Gonda et al. 1999; Greenwood 2000b; Wellard et al. 2000; Wotton and Gonda 2003).

The evidence-based literature to date is incomplete and inconclusive about the relative advantages of any one particular model with respect to the achievement of desired outcomes, suggesting that no model is superior to any other. However, it is acknowledged that each has advantages and disadvantages based on contextual factors. Each model appears to offer certain benefits in terms of promoting student learning and clinical outcomes, but these benefits are in turn offset by various shortcomings or weaknesses (Close et al. 2000; Drennan 2002; Grealish and Carroll 1998; Naphthine 1996; Nash et al. 1998; Wellard et al. 2000). There is consensus, however, irrespective of the model being used, that all clinical education models are more effective if there is a high degree of collaboration between universities and health services.

**Clinical practice arrangements**

The literature provides a multiplicity of views on preferred hours and duration of clinical education. These views are largely represented in terms of arguments for varying duration and timing of clinical placements to meet educational goals and overcome theory-practice gaps. While there is a recognition that the ability to provide optimal clinical education is dependent on many factors, not the least of which are fiscal constraints, some authors argue that the current clinical educational strategies and time allowed for clinical practice fail to address the reality of practice and must be changed (Andrews and Chilton 2000; Davies et al. 1999; Edmond 2001; Reid 1994). Other themes include the need to rationalise the number of agencies and areas used for clinical placements, to have longer periods of practical placement, and to extend the amount of clinical experience in the final semester to facilitate preparedness for practice (Chapman and Orb 2000; Davies et al. 1999; Ohrling and Hallberg 2001; Severinsson 1998; Yong 1996). However, other studies say the debate should not be focused on the quantity of clinical education time, rather is should focus on the quality of guidance, support and learning achievements afforded during that time (Bartlett et al. 2000; Battersby and Hemmings 1991; Boxer and Kluge 2000; Davies et al. 1999; Edmond 2001; Madjar et al. 1997; Reid 1994; While et al.1995). What is beyond doubt is that a supportive clinical learning environment decreases attrition rates due to culture shock experienced by new graduates, maximises the provision of opportunities to link theory with practice and results in greater confidence and competence in readiness for beginning practice as a registered nurse (Hewison and Wildman 1996; Hopton 1996; Massarweh 1999; Neill et al. 1998; Warner 1999; Yong 1996).
The clinical learning environment

In a review of the literature, Chun-Heung and French (1997) found that the clinical education setting is the most influential in the development of nursing skills, knowledge and professional socialisation, stressing the importance of the learning climate within the clinical education environment. They note that potential learning opportunities are maximised when educational goals are understood and agreed by stakeholders from both the service and education sectors. These authors, who focused on the perceptions of students, noted that a supportive clinical environment is of the greatest importance in optimising the teaching and learning process, indicating it is important for educators and clinical staff to undertake continuing education that supports their clinical teaching and mentorship roles. This view is supported by Calpin-Davies (2003) who indicates that a nurturing and supportive environment can be created when the divergent but compatible organisational aims of the service and educational sectors are merged in a climate that encourages collaborative learning, trust and mutual respect.

Hart and Rotem (1995) highlighted the importance of collaboration and mutual respect between the education and service sectors in the organisation of clinical education, however, there is a dearth of published research which investigates collaborative relationships, particularly those which provide perspectives from more than one group of stakeholders. Efforts began in Britain in 1990 (Oxford Polytechnic School of Nursing 1990) with the development of a clinical learning environment audit tool containing questions that were derived from statements of optimum standards. That tool was designed to assess the suitability of a clinical area for student nurse education, and to provide feedback regarding areas of excellence and those requiring remedial work (Fitzgerald et al. 2001; Lathlean 1992). Similar tools have been developed throughout Great Britain based on guidelines from the English National Board regarding the development of structures and processes for exploring and monitoring organisational performance in the area of clinical education for undergraduate nursing programs (Holroyd and Crow 1993; Liverpool, University of 1998).

In Australia there have been a number of studies conducted that focus on students’ perceptions of the clinical learning environment (Dunn and Burnett 1995; Dunn and Hansford 1997). The study reported by Dunn and Burnett (1995) and Dunn and Hansford (1997) provides descriptions of a clinical learning environment scale that was developed to assess students’ perceptions of a positive clinical learning environment. This study found that interpersonal relationships between the key stakeholders in the clinical education area were crucial to the development of an effective learning environment.

A more recent study conducted in Finland (Papp et al. 2003) provides further insights into students’ perceptions of the clinical environment and concludes that a positive clinical learning environment is demonstrated when there is close and positive cooperation between academic and clinical staff, as reflected in the positive way students are provided with learning opportunities. Conclusions from this study support those reached by Edgecombe et al. (1999), Gonda et al. (1999) and Wotton and Gonda (2003) who reported on the development of a Dedicated Education Unit (DEU) model designed to increase the effectiveness of undergraduate student learning. In evaluations it was found that extensive collaboration between clinicians, academics and students with an inherent recognition of mutuality, respect and trust between all parties enhanced achievement of student learning outcomes and nurtured the partnership between the service and academic sectors.
In recognition of the multi-dimensional and complex social context of the clinical learning environment, Chan (Chan 2001a; Chan 2001b; Chan 2002) developed a Clinical Learning Environment Inventory (CLEI) to examine students’ perceptions of the clinical education milieu in Hong Kong. In the United States, Sand-Jenkin (2000) also reported on their Student Evaluation of Clinical Education Environment (SECEE) Inventory to measure students’ perceptions of their clinical learning environments. An evaluative study of clinical learning environments conducted in Great Britain (Thomas and Pagett 1999) found that one of the most important factors is the use of clinical learning contracts. Interestingly, this is one of the few studies, which expand the evaluation beyond that of the students’ perspective. Other studies (Forrest et al. 1996; Spouse 1998), while exploring the views of a range of key people, focus purely on the role of the nurse teacher in enhancing the clinical learning environment, or the provision of support for clinical educators (Watson 2000).

The team undertaking this study completed a national study during Phase One of this project, which identified best practices in teaching and learning for undergraduate nurses in the clinical environment from the perspective of a range of key stakeholders (Clare et al. 2002). The best practices identified in Phase One of this project are shown in Table 2.1. Practices found to inhibit quality teaching and learning the clinical area were also identified from that study (Clare et al. 2002) and these inhibiting factors are in Table 2.2.

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**Table 2.1** Best practices for undergraduate clinical education (Clare et al. 2002)

- open and accurate communication between all parties involved in teaching and learning;
- quality preceptorship of students for each placement;
- quality mentoring and role-modeling by experienced registered nurses;
- adequate orientation to each new area of practice;
- an environment of practical realism that linked theory to practice by:
  - clear delineation of graduate requirements using ANCI competencies;
  - articulation of specific learning goals by the university and the nursing student; and
  - development of opportunities to achieve practical and cognitive competence in varied skills;
- consolidated clinical learning experiences for continuity of process learning;
- appropriate collaborative assessment of students’ clinical learning;
- continuing development and use of innovative clinical education models that promote teaching and facilitate learning; and
- responsive evaluation of the clinical learning environment to ensure its adequacy to teach students.
Table 2.2  Factors that inhibit quality undergraduate clinical education  
(Clare et al. 2002)

Stressed workplace conditions include but are not limited to:
- staffing shortages;
- inappropriate skill mix to provide students with experienced mentors;
- incapacity to teach while maintaining a full workload;
- technology focused, task driven nursing practice;
- rapid changes in context;
- the economic costs of clinical education to university and service providers;
- the problem of skill competence and work readiness of students;
- the availability of sufficient quality learning environments for students;
- identifying perceived deficiencies in the learning environment;
- lack of quality improvement programs within learning environments; and
- diverse expectations across multiple curricula from various universities and institutions.

Collaborative relationships within the clinical learning environment

Relatively little attention is paid in recent literature to the role of the unit manager and nursing management in terms of clinical education or their influence on the learning environment, although evidence exists that indicates these people play a major role in establishing the learning and organisational climate of the clinical unit, creating and maintaining an atmosphere conducive to learning (Chan 2002; Clare et al. 2002; Dunn and Burnett 1995; Saarikoski et al. 2002). There is also evidence that a positive and facilitative ward/unit atmosphere contributes to a high quality of nursing care provision (Saarikoski et al. 2002). These authors tested a previously developed research CLE evaluation instrument with students in England and Finland and found the unit manager was instrumental in establishing and maintaining a positive and nurturing learning and practice environment.

The importance of the role played by clinicians in clinical education processes is also clearly identified in the literature, both across Australia and internationally, particularly in terms of precepting and mentoring students (Andrews and Chilton 2000; Chenoweth and Lo 2001; Jeffreys 2001; Neary 1997). Clinicians play a critical role in clinical education via their role modeling of quality patient care (Bartlett et al. 2000; Owens et al. 2001). Hart and Rotem (1994) found students valued highly a positive relationship with clinicians and need to feel they belong and are accepted within that team environment. These findings were echoed in Phase One of this study (Clare et al. 2002).

Chalmers et al (2001) and Spouse (2002) indicate that the theory-practice gap which is the subject of much debate within the nursing education literature can be minimised by increasing collaborative partnership structures between the service and education sectors. Spouse (2002) advocates the increased use of various models that support greater intersectoral collaboration. Murphy (2000) draws attention to the importance of collaboration between lecturers and clinicians indicating that the expectation nurse academics should be experts in teaching, research and clinical practice, is unrealistic and
may have led to problems in the past where an individual academic is unable to fulfill all expectations because of these multiple demands. Murphy found that working collaboratively enhanced the clinical education experience for students, academics and clinical staff. Saarikoski et al (2002) speculate that where nursing practice effectively demonstrates a shared sense of caring, through positive relationships between staff and students, students acquire a sense of what nursing is via their own caring experiences, supporting the view that nursing is ‘caught’ as much as it is ‘taught’.

**Collaborative partnerships**

It is readily evident that all clinical practice arrangements are heavily dependent on strong collaborative structures between the tertiary education and service sectors. However, since the transition of nursing education to the tertiary sector a dichotomy has developed. Graduates are seen by those in the service sector as being inadequately prepared for practice as registered nurses (Chapman and Orb 2000), while the education sector believes that the expectations of industry are unrealistic (Greenwood 2000a), creating an environment which is not conducive to collaboration.

The *National Review of Nurse Education* (Reid 1994) recommended that responsibility for clinical education of undergraduate nursing students should be shared by universities and health care agencies. The more recent *National Review of Nursing Education* (DEST 2002d) noted that more funding is required to support clinical education. The discussion paper supported earlier literature and anecdotal reports, noting that greater cooperation is required between the education and service sectors in the planning, implementation and evaluation of clinical education programs. The Report of the *Senate Inquiry into Nursing* (Commonwealth of Australia 2002) also briefly addressed the issue of clinical education. While noting the great variability of programs that are available, the report drew attention to the strong need for greater links through formal, collaborative and effective partnerships between education and health services in all educational aspects nursing, recommending the development of more partnership models. Additionally, the report recommended partnerships be developed between universities to facilitate the sharing of resources and expertise.

Downie et al (2001) defines a collaborative partnership as an association that brings mutual benefits to both or all partners and is based on commitment and trust. For partnerships to work, careful negotiation and agreement on the roles and responsibilities of both institutions must take place. Such partnerships between tertiary institutions and health service organisations are recognised as vital to the outcome of nursing education (Baillie 1994; Barnard and Dunn 1994; Chalmers et al. 2001; Downie et al. 2001; Dunn and Burnett 1995; Gonda et al. 1999; Parkes 1995; Wellard et al. 2000; Williams et al. 2001). These outcomes include the creation of a clinical learning environment that promotes the development of well educated registered nurses capable of providing safe, cost-effective and caring patient services (Dunn and Hansford 1997).

The literature indicates that the culture of universities and health services, as well as relationships between university staff, clinical staff, students and the organisations are all significant determinants of successful and unsuccessful clinical education experiences (Chalmers et al. 2001; Davies et al. 1999). The familiarity of clinical educators with the environments in which they work as clinical educators is also important (Davies et al. 1999).
Learning Outcomes and Curriculum Development in Major Disciplines in Nursing. Phase 2


Realistically, clinical education should take place in nurturing and well-structured environments that are characterised by joint responsibility and management, and effective and open communication (Clare et al. 2002; Glen 2000; Grealish 2000; Mann and Byrnes 2000; Mann et al. 1997; Usher et al. 1999). This needs to be followed by workplace support in the graduate year to facilitate a successful transition. (Battersby and Hemmings 1991; Kelly 1998; Madjar et al. 1997). Somerville et al. (2000) and Spouse (2001) underscore the important influence of clinicians’ attitudes towards students and graduates, stating that this attitude actually influences students’ perception of their ability and hence actual performance.

Pierce (1991) found that positive clinical experiences occur when there is a clearly structured program with good direction, guidance and support from the faculty; when there is good communication between universities and clinical areas; when staff from the university are available during the student placement, and there is follow-up with clinicians regarding the effectiveness of the processes in use during that placement. She found that when students are fully informed about clinical venues and their expectation, when they have good clinical supervision that incorporates a positive attitude from educators and clinicians, when they have constructive feedback and effective orientation and opportunities to observe and participate in high quality nursing, this contributes to their confidence, competence, comfort and self-direction. These findings are supported by Davies et al. (1999) who identify a number of practical strategies designed to support a collaborative partnership model incorporating an improvement of relationships and a streamlining of liaison and administration between universities and health services. Such initiatives include long term joint planning and evaluation, joint establishment of standards and development of mechanisms for the equitable management of students and educational personnel.

In the first phase of this AUTC project, the need for more collaborative partnerships that foster reciprocity and collegiality was identified (Clare et al. 2002). Issues identified as integral to building collaborative partnerships included:
- establishing and convincing both parties of the need to collaborate;
- open and authentic communication;
- building capacity by valuing all members of the partnership equally;
- mutual respect and trust in actions;
- demonstrating professional behaviours at all times;
- deciding the parameters and scopes of the partnership;
- clarifying the desired outcomes; and
- developing the structures and models that sustain and nurture authentic collaboration.

Regardless of what strategies are seen to be essential, and these may vary due to local contextual factors, five essential assumptions underlying collaborative partnership agreements are identified. These include mutual respect, commitment and recognition of each others’ contribution and potential, a clear understanding of mutual responsibilities for the development of a nurturing environment with clearly articulated objectives agreed,
and a constant process of evaluation of the partnership (Clare et al. 2002; Downie et al. 2001).

Literature from disciplines other than Nursing was reviewed to find out what business and industry partnerships had to add to these findings, which would help develop criteria, standards and benchmarks for effective partnerships that facilitate optimal clinical learning.

**Partnerships: What can we learn from industry about effective collaboration?**

In the 1980s and early 1990s, although business leaders recognised the rising importance of partnership development in an increasingly globalised and networked world, the emphasis for managers tended to be on the institution of fundamental change **within** organisations (Linden 2002). More recently, however, the focus of organisational change efforts has shifted to examine relations **between** organisations and their partners (Linden 2002). Within the organisational literature, authors argue that understanding how to manage across institutional boundaries is now as important as understanding management within organisations (Huxham and Vangen 2000; Kanter 1994). Interorganisational collaboration has become a dominant theme for researchers, theorists and practitioners (Pitsis and Clegg 2003).

Partnerships, alliances and other types of interorganisational collaborations are now facts of life in government, institutional and business life (Kanter 1994; Huxham 2000; Huxham and Vangen 2000) and leaders are learning to work across boundaries to form these alliances and coalitions (Linden 2002). Collaboration, the essence of which is **joint** effort and ownership rather than simply **shared** data, joint operations or polite cooperation (Linden 2002), has become a buzzword within public, not-for-profit, and private organisations. Linden (2002), after studying more than twenty collaborative efforts, reassuringly notes that collaboration, rather than being yet one more new-age management trend pursued for its own sake, has a worthwhile goal: improvements in service, value and outcomes for customers, stakeholders and communities.

Effective partnership development is time consuming, resource intensive and difficult (Lasker et al. 2001; Linden 2002). Interorganisational arrangements often fail to meet expectations (Huxham and Vangen 2000). Studies suggest that up to 70% of formal strategic alliances fail or fall short of expectations (Limerick et al. 1998). Recent studies examining partnerships in the field of health suggest that up to half do not survive the first year and those that do often falter prior to completion of their aims (Lasker et al. 2001). As Huxham (1996b p.4) writes, ‘Working with others is never simple!’.

Despite these difficulties, the drive to collaboration continues because organisations recognise that potential advantages outweigh the problems. The desire to save money or increase profits may be one motivation for pursuing alliances, however researchers caution that the serious costs of collaboration may negate apparent financial gains. Recognition that serious issues facing society cannot be tackled by any single organisation working alone and pure self-interest are two motivations which may make the process worthwhile regardless of the cost (Huxham 1996b). As Linden (2002 p.6) writes:
Collaboration is very hard and time-consuming work. Why bother? The answer is this: the public’s most important expectation of government today is to solve complex problems that can only be addressed by collaborating across organizational boundaries. Whether the challenge is pollution, drugs, education, or health care, the answers will not be found within one unit, agency or discipline. When we fully recognize this reality we will be able to provide integrated solutions to the complex problems facing us. The public deserves no less. And the stakes have never been higher.

The ultimate rationale, however, for pursuing successful collaborations may emerge from any of these initial reasons for forming partnerships. This rationale involves the recognition that combining the perspectives, resources and skills of people and organisations, or interorganisational synthesis (Pitsis and Clegg 2003), can achieve outcomes more creative and far greater than could have been achieved by the partners working in any way but collaboratively (Huxham 1996b; Lasker et al. 2001 p. 183). Researchers have called this magnification of achievement the collaborative advantage (Huxham 1996a; Huxham 1996b; Huxham and Vangen 2000) or synergy.

Types of partnerships

Some authors are impatient with attempts to distinguish different patterns of interorganisational relationships and find the use of terms such as strategic alliances, networks, joint ventures etc. inconsistent and confusing. They prefer to call all such relationships collaborations (Huxham 2000). Other authors, however, see value in defining a spectrum of relationships with true collaboration proving the most ideal because it offers such potential for synergy, or collaborative advantage. Descriptions of such spectrums also offer examples of how partnerships may develop, change and strengthen with time and experience.

Himmelman (1996a) defines collaboration as including a continuum of definitions and strategies beginning with Networking, which he defines as ‘the exchange of information for mutual benefit’. This may reflect an initial level of trust and commitment between organisations and is best done at a person-to-person level. An example of this might be the meeting of representatives from two agencies to discuss their goals, community programs and respective service areas. Himmelman’s second stage involves Co-ordination: ‘the exchange of information and the altering of activities for mutual benefit and to achieve a common purpose’. An example of this may be two agencies sharing program schedules and content that are modified to better meet the needs of their common clients. His next stage is Co-operation defined as the exchange of information, the alteration of activities and the sharing of resources for mutual benefit and to achieve a common purpose. This requires greater organisational commitment than the previous two examples and may involve legal arrangements and shared resources. An example may be two agencies share information about program activities, decide to change their content and schedules to better serve their common clients, and share physical space for programs and vans for transportation needs. At the end of Himmelman’s continuum is Collaboration: defined as the exchange of information, the altering of activities, sharing of resources and the enhancement of the capacity of another for mutual benefit and to achieve a common purpose. This enhancement of the capacity of another organisation requires sharing risks, responsibilities, resources and rewards which can all increase the potential of collaboration beyond other ways of working together. Himmelman sees collaboration as a relationship in which each partner wants to help the other partners become better at what
they do. As an example of this he cites the above scenario of co-operation plus the offering of workshops related to their common purposes to each other’s staff in areas in which each organisation has special expertise.

Himmelman notes that any of these four strategies may be appropriate for particular circumstances depending on how well three limitations he cites to working together: time, trust, and turf, can be overcome in order for a common vision, a commitment to share power and responsible and accountable actions can be agreed upon in order for full collaboration to take place (Himmelman 1996a).

Reporting on a study of 37 businesses and their partner companies, Kanter (1994) focuses more directly on the purpose of the partnership between companies and service organisations. She utilises terms already in widespread use within industry. Her concept of a series of stages of relationships building to the strongest and closest partnership mirrors the approach of Himmelman, however Kanter calls the weakest and most distant relationship the Mutual Service Consortia. This is where companies in similar industries pool resources to gain a benefit neither could afford alone, for example new technology. In the middle of the continuum, Joint Ventures allow companies to take advantage of opportunities that require the contribution of both, for example the products of one and the market access of another. At the high end of the continuum, Value-Chain Partnerships involve companies in different industries with different but complementary skills linking to create value for end users (Kanter 1994; Limerick et al. 1998).

Kanter (1994 p.97) believes that rather than being limited by the purpose or anticipated time-span of a partnership, successful alliances need to involve collaboration, which she defines as ‘creating new value together’ versus mere exchange ‘getting something back’. She argues that for all businesses becoming a good partner, which she believes must involve acknowledging and managing effectively the human aspects of their partnerships, is a key corporate asset and offers a competitive advantage. Kanter finds that successful collaborations yield more than benefits for the partners because they are living systems that evolve progressively and open new doors to unexpected future possibilities. She writes,

A business relationship is more than just the deal. It is a connection between otherwise independent organizations that…contains the potential for additional collaboration. It is a mutual agreement to continue to get together; thus its value includes the potential for a stream of opportunities (Kanter 1994 p.98).

**Requirements for successful partnerships**

Not all partnerships have as a stated aim the achievement of collaborative advantage. However, given the difficulties inherent in the collaborative process and the high investment required to make collaborations work in terms of achieving outcomes within expected time frames, it might be argued that the effort is hard to justify unless this collaborative advantage can be achieved (Huxham 1996b). Additionally, collaborations with aims less ambitious than achieving collaborative advantage frequently end in frustration and failure (Huxham 1996c). Huxham and Vangen (2000) use the term collaborative inertia to describe the tendency for collaborative groups to progress more slowly than expected.
The factors listed below have been found to improve the chances of a partnership being successful. These factors have been found to reduce the risk of collaborative inertia and/or to enhance the possibility of collaborative advantage or synergy, the achievement of outcomes through collaboration greater than those which could have occurred had the partners worked independently (Huxham 1996b; Huxham 1996d; Huxham 1996e, Huxham 2000).

Table 2.3 Factors that increase the chances of successful partnerships

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1. **Good reasons**

An agreed vision of what the collaboration is trying to achieve is an essential precursor for taking joint action (Huxham 2000). Some authors state that the *vision and mission*, or the *joint purpose* or objectives and goals, of partners within an alliance need to be stated and understood and shared by all partners (Himmelman 1996a; Himmelman 1996b; Orb 1999; Pitsis and Clegg 2003; Spross 1989) and that if the purpose of the alliance is ill defined, networks tend to fall apart or become ineffective (Limerick et al. 1998). Karasoff, (1998) in her review of the literature, reports that a shared vision is considered fundamental to the collaborative relationship.

Others argue, however, that agreement on goals is not always easily negotiated. While clear goals are invariably raised by participants as being crucial for the collaborative process to move forward, impairing agreement are issues such as difficulties negotiating the often conflicting hidden and overt agendas of individuals and organisations participating in collaborative efforts (Huxham 2000; Huxham and Vangen 2000) and the general nature of the mission. While partnerships may have worthy missions, (for example a partnership between government and community organisations aimed at increasing community employment), intermediary and precise end goals may not become apparent until collaborative work has begun (Waddock 1988). Pitsis and Clegg (2003) even argue that provision should be made for some level of *ambiguity, uncertainty and complexity* within the operating environments of alliances as complexity and ambiguity can lead to innovations in problem solving.

There must at least be enough of a sense of common purpose for collaborations to be initiated in the hope that goals become clearer once the process has commenced (Huxham 2000). Partners also need to agree that the time to pursue a collaborative solution is now (Linden 2002) although too heavy a focus on immediate goals in the short term is not advised as studies demonstrate that alliances work best when they are set up as long-term strategic relationships (Limerick et al. 1998). Kanter (1994) promotes the
importance of *individual excellence*: both partners should be strong, have something of value to contribute and have positive (for example, to pursue opportunities) rather than negative (for example, to mask weaknesses) motives for entering the relationship.

### 2. High stakes

Many authors believe that for an alliance to work, partner organisations and individuals involved in collaborations require compelling reasons to *make* it work. Linden (2002) calls this requirement high stakes. He believes that the consequences of failure of a collaborative partnership need to be unacceptable; that those consequences will attach directly to the staff involved; and that this needs to be visible to others.

This issue of accountability appears frequently within the literature. Pitsis and Clegg (2003) also believe that for *synthesis*, or synergy to be achieved, each partner needs to be held accountable and responsible for outcomes. These researchers argue that to provide stakeholders with voice without responsibility or accountability is counterproductive to the best interests of the project. Other writers point out that as the activities of the collaboration may affect the organisation as a whole, individuals must be held accountable for their actions (Huxham 1996b).

Kanter (1994) details eight characteristics of effective partnerships, three of which are related directly to high stakes:

- **Importance**: the relationship fits major objectives of the partners so they strive to make it work. The relationship is key to the partners’ long term goals;
- **Interdependence**: The partners have complementary assets and skills and neither can accomplish alone what both can together. They therefore need each other;
- **Investment**: The partners invest in each other (for example mutual board service) to demonstrate their respective stakes in the relationship and each other. Tangible signs of long-term commitment such as the devotion of financial and other resources to the relationship are present (Kanter 1994).

Continuing on this same theme of high stakes at the organisational rather than individual level, Limerick (1998) argues that if the survival of the alliance is relatively unimportant for the survival of one of the involved organisations, the stability of the alliance may be jeopardised.

### 3. Right people

‘*Staff the partnership with the best people possible*’ (Waddock 1988 p. 6).

People sit down together, not organisations. How collaborative members perceive stakeholder organisations...is coloured greatly by the behaviours, personalities and interpersonal skills of their representatives. Beyond making the interaction pleasant (not a minor consideration) the ability for people to get along and truly communicate strongly affects the outcomes of the collaborative endeavour. (Sink 1996).

Within the literature there is almost universal agreement that it is vital that the right people are selected to become involved in a collaboration (Huxham and Vangen 2000).
After five years of in-depth research into interorganisational collaboration across a variety of industries, Pitsis and Clegg (2003) conclude that the best projects have been those which employed the best people and were able to keep these people for the duration of the project.

To optimise progress, those individuals within organisations who are directly involved in collaborative activities must possess a degree of autonomy in order to prevent the loss of impetus and energy which may result from the need to continually check back with the parent organisation (Huxham 1996b). Thus, the right people are those who have the authority to speak for their organisations (Linden 2002).

Having the right people involved means both having the most suitable individuals and having representatives from the appropriate organisations and interest groups. Particularly in collaborations within the public and community sector, identification of stakeholders is considered essential (Huxham and Vangen 2000). This is important for both pragmatic and ideological reasons: gaining ownership and avoiding sabotage being the pragmatic reason while the desire to empower stakeholders affected by the collaboration is ideological (Himmelman 1996a; Huxham and Vangen 2000). Additionally, Huxham and Vangen (2000) report that reasons for targeting members apart from stakeholders include the need to provide sufficient resources or expertise for the collaboration to be successful, to ensure the membership is balanced and to ensure an appropriate group size.

Since the people and organisations involved in a partnership provide the raw materials for synergy, arguably the more diverse the participants, the greater the number of perspectives, skills and resources brought to the partnership, and therefore the greater the potential for synergy and improved outcomes (Lasker et al. 2001). This diversity, however, also provides the greatest potential for tension and conflict. Although conflict may foster synergy if differences sharpen partners’ discussions and ideas, if poorly managed it may strain relations among partners (Lasker et al. 2001). It is particularly important that the issue of different organisational and ethnic cultures is addressed diligently as differences may be difficult to manage (Limerick et al. 1998). Pitsis and Clegg (2003), even believe that the development of an alliance culture, (wherein the members of a collaboration design a common culture free from the constraints of the existing cultures in their organisations with shared beliefs, values and ways of doing things and thinking) is of critical importance to synergy.

Huxham and Vangen (2000) report that as collaborative structures are ‘ambiguous, complex and dynamic’, participants need to apply large quantities of patience, managerial skill and goodwill while convenors must recognise the need to ‘nurture, nurture, nurture’ beyond simply the set-up interval, in order to increase the chances of achieving collaborative advantage (Huxham and Vangen 2000 p.790).

**Factors influencing participation of individuals involved in collaborations**

Lasker et al (2001), derive from the literature a list of factors that influence partners’ decisions about how actively they participate in a partnership (Alter and Hage 1993; Butterfoss et al. 1996; Chinman et al. 1996; Lasker et al. 2001). Studies suggest that minimising the drawbacks may be as effective in improving a partner’s participation in providing benefits (Chinman et al. 1996; Lasker et al. 2001).
Table 2.4  Factors that increase involvement in collaboration
After Lasker et al. (2001)

**Positive factors increasing participant involvement in collaborations**

- Enhanced ability to address any issue they consider important
- Acquisition of funds, new competencies and useful knowledge to support their own activities
- Increased exposure to, and appreciation by, other groups in the community
- A strengthened capacity to meet performance goals and the needs of their clients or constituency
- Increased utilisation of their services and expertise
- Enhanced ability to affect public policy
- The development of new, valuable relationships
- The opportunity to make a meaningful contribution to the community
- Sufficient authority and resources, including time, granted to participants by their organisations

Table 2.5  Factors that reduce involvement in collaborations
After Lasker et al. (2001)

**Negative factors diminishing involvement in collaborations**

- Diversion of time and resources from other priorities and obligations
- Reduced independence in making decision about their own activities
- Loss of competitive advantage in obtaining funding or providing services
- Insufficient influence in the partnership’s activities
- Conflict between their own work and the partnership’s work
- Negative exposure due to association with other partners
- Frustration and aggravation with the collaborative process
- Insufficient credit for their contribution to the partnership

Barriers such as short-term financing, performance standards, promotion and tenure policies may also create disincentives for involvement of key people and organisations (Lasker et al. 2001).

**Right leadership**

Several authors emphasise the need for a champion for the process or a civic entrepreneur, someone who has credibility and clout and who makes the collaborative effort a high priority and may take on a convenor role to bring together the partners, call early meetings and begin to establish the partnership (Waddock 1988; Linden 2002).

Other researchers focus more specifically on the characteristics required by the individual/s who take a leadership role in the group. This person may be a participant in the collaborative process in which case he or she requires the skills and expertise necessary for the project as well as those necessary to engage partners and support and coordinate the collaboration process (Lasker et al. 2001). Linden believes that the need for good leadership overlays every other requirement for a successful partnership (Linden 2002).
Table 2.6  Characteristics of collaborative leadership
After Linden (2002)

- Successful collaborators despite being driven to succeed are often modest and humble rather than visionary and decisive.
- They are able to work with partners as peers rather than attempt to assert authority.
- They listen more than talk and are able to ‘pull’ others into a coalition.
- They make it clear that their commitment is to the project and not to personal glory.
- They are systemic thinkers who see how pieces fit together and are able to connect everyday actions with something larger.
- They can identify stakeholders, identify useful roles for parties, anticipate consequences of actions and assist people to see the great potential of their actions.

Lasker et al (2001), also discuss leadership in depth. Like Linden, these authors believe that the type of leadership needed to achieve synergy in collaboration is not the type of leadership most professions produce. Rather than leaders with a narrow range of expertise who speak a language understood only by peers, who are used to being in control and who treat people with whom they work as subordinates rather than partners,

Partnerships…need [boundary-spanning] leaders who understand and appreciate partners’ different perspectives, can bridge their diverse cultures, and are comfortable sharing ideas, resources and power. [They] need strong relationship skills to foster respect, trust, inclusiveness and openness among partners (Lasker et al. 2001 p. 193).

The importance of leadership for synergy is stressed also by Pitsis and Clegg (2003) who detail the need for ‘high emotional intelligence (EQ) leadership’. They define the high EQ leader as one who is able to read the context as well as the stakeholders’ needs, wants and expectations. These authors warn against over-emphasising the importance of getting along rather than getting the task done and make the point that synergy is not about everyone getting along happily all of the time, but rather it’s about ensuring the socio-technical mix is correct (Pitsis and Clegg 2003).

Facilitator
If partners choose to engage a separate facilitator to assist the collaboration process, this person should be external to the group or may be a participant who must be able to change hats as required in order to preserve the integrity of the collaboration process (Gray 1996; Schuman 1996).

4.  Strong, balanced relationships

Kanter titled her 1994 paper ‘Collaborative Advantage: Successful partnerships manage the relationship, not just the deal’ (Kanter 1994) and this theme is echoed repeatedly within the literature on partnerships. Authors admit that relationship building is probably the most daunting and time-consuming challenge faced by partnerships (Lasker et al. 2001). However it remains vital because the key to successful collaborations is the quality of personal and professional relationships among the people involved (Kerka 1997). Reinforcing this point, (Singer 2001), reflecting on a number of collaborative relationships, muses that at times it has appeared her organisation spends more time building and nurturing relationships than getting on with the tasks at hand. In the long term though, project results have been better for this effort.
In the best collaborations, broad connections between many people at many levels are developed (Kanter 1994). Kanter believes that active collaboration is enabled only when companies develop structures, processes and skills for bridging organizational and interpersonal differences. She observes that the most productive relationships achieve multiple levels of integration:

a) *Strategic integration:* this involves continuing, frequent contact among top leaders to discuss broad goals or changes.

b) *Tactical integration:* middle managers or professionals together develop plans for projects or joint activities and identify changes that may enhance linkages between the companies and knowledge transfer.

c) *Operational integration:* allows the people carrying out the day-to-day work to have access to the information, resources and staff they need.

d) *Interpersonal integration:* strong interpersonal relationships help resolve small conflicts before they escalate.

e) *Cultural integration:* requires managers and individuals involved in collaborations to be both teachers and learners in order to develop the communication skills and cultural awareness necessary to bridge their differences.

**Power differentials**

In theory there are no formal authority hierarchies within collaborations and no one can compel any one else to act in any particular way. Action therefore must be achieved through the often time-consuming method of persuasion and negotiation (Huxham 2000). In practice, however, power is often an issue and problems tend to arise when power differentials exist either at organisational or at individual levels (Huxham 2000). Lasker et al, quoting a 1998 paper by Israel et al, note that power differentials may seriously undermine synergy since they limit ‘who participates, whose opinions are considered valid, and who has influence over decisions made’ (Lasker et al. 2001 p.193).

Trust may falter if the partnership favours one partner over another (Limerick et al. 1998). Perceptions of power differences may lead to aggressive rather than sympathetic stances towards each other (Huxham 2000) and if one partner is overpowering or determined to gain control, the partnership will probably fail (Waddock 1988). Ways of facilitating cooperation and consensus building are therefore essential. A practical approach may be to involve in collaborations predominantly middle managers from a large organisation and senior managers from the smaller partner (Huxham 2000). Or members may decide to agree in advance to attempt to reach consensus and to vote only when there are relatively equal power positions. Minority viewpoints must be listened to with respect and adopted if important (Waddock 1988).

5. **Trust and Respect**

Kerka quotes Bendel-Carman to report that ‘The bedrock of collaboration is trust’ (Kerka 1997) and trust is integral to synergy (Lasker et al. 2001; Pitsis and Clegg 2003). Almost universally within the literature the qualities of trust and respect are included as absolute requirements for successful collaboration (Buzzo, 2002; Himmelman, 1996b; Waddock, 1988). Trust between partners is vital to any partnership (Waddock 1988) and to work together effectively, partners need to respect and value the contributions and perspectives of others (Lasker et al. 2001). Trust takes time to develop and cannot ensue unless members’ interests are heard and acknowledged as legitimate by others (Gray 1996).
Partners must behave honourably in ways that justify and enhance trust. They must neither abuse information nor undermine each other (Kanter 1994).

6. **Good communication**

It is only possible for the group to think in a new way if the partners are able to talk to each other and are influenced by what they hear (Lasker et al. 2001). For effective collaboration communication, (including, for example, sharing technical data, information on goals, knowledge about conflicts, trouble spots and changing situations) must be reasonably open (Kanter 1994). If good communication is not effectively maintained within alliances, quality control, the ability to respond quickly to changing customer need and innovation may be sacrificed (Limerick et al. 1998).

Collaborative groups should avoid creating new bureaucracies and instead should design structures to facilitate information exchange, decision making and resource allocation (Kerka 1997).

7. **Formalisation**

Huxham (2000) reports that it is rare to find that the sole manifestation of a collaborative advantage is a regular meeting of a steering group or management committee. Commonly there are at least several layers of committees and there may be working groups, staff employed by the partnership and even a new organisation with its own board where members are notionally accountable to organisations other than those for whom they work. Thus collaborations may be extremely complex entities but in order to be effective even simple alliances require governance structures that support shared decision-making. To be effective this process must be agreed upon by all partners and needs to address the use of legal agreements and memoranda of understanding between agencies, the type of authority, accountability, confidentiality and staffing (Karasoff 1998). Formal status needs to be given to the relationship and clear responsibilities and decision processes should be clarified. The partnership should be structured so that it extends beyond the individuals who formed it and cannot be easily broken (Kanter 1994). This formalisation of procedures that determine partners’ involvement in decision making, how decisions are made and how work is done allows the partnership to continue beyond the tenure of individuals (Huxham 2000; Lasker et al. 2001).

Pitsis and Clegg (2003) report that in their experience the best alliances have simple contracts based on mutual understanding, trust and a commitment to the vision and mission and objectives of the alliance.
What industry says about successful partnerships

In this first decade of the twenty-first century, organisations of all kinds, both public and private, are recognising that they need other organisations to succeed and also that in partnerships with these organisations they can achieve far more than by working independently. This has been called synergy or the collaborative advantage. Ways of forming, managing and ensuring the success of these partnerships have become essential learning for leaders in all areas.

There are many ways of working together but the more motivated the organisation, the more intensively it embraces the principle of collaboration and the more integrated into its entire structure and culture collaborative processes are permitted to become, the more likely the process is to be successful and the greater the potential rewards.

Collaborations are hard work, however. They are resource intensive and time consuming. They have high rates of failure and those that don’t fail completely often fail to achieve desired outcomes within expected timeframes.

Researchers argue that potential rewards of success are great enough to justify the effort and together with practitioners in the field have developed numerous guidelines and frameworks to assist individuals and organisations to form effective partnerships. Below is a condensed list of frequently mentioned factors that have been found to contribute to the success of these collaborations.

Table 2.7 Factors that contribute to the success of partnerships

<table>
<thead>
<tr>
<th>Requirements for Effective Collaboration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Right reasons:</strong></td>
</tr>
<tr>
<td>- Shared vision</td>
</tr>
<tr>
<td>- Desire to undertake collaboration now</td>
</tr>
<tr>
<td>- Positive rather than negative reasons for pursuing collaboration</td>
</tr>
<tr>
<td>- Long term focus</td>
</tr>
<tr>
<td><strong>2. High stakes</strong></td>
</tr>
<tr>
<td>- Compelling reasons for both organisations and individuals to ensure collaboration is successful</td>
</tr>
<tr>
<td>- Participants accountable and responsible for results</td>
</tr>
<tr>
<td>- Partner organisations invest in each other and in partnership</td>
</tr>
<tr>
<td><strong>3. Right people</strong></td>
</tr>
<tr>
<td>- Best individuals</td>
</tr>
<tr>
<td>- Sufficiently empowered to have a reasonable degree of autonomy</td>
</tr>
<tr>
<td>- Stakeholders identified and included</td>
</tr>
<tr>
<td>- Maximise positive factors that enhance participation (see Table 2.8 below)</td>
</tr>
<tr>
<td>- Minimise negative factors that reduce participation (see Table 2.8 below)</td>
</tr>
<tr>
<td>- A champion or facilitator for the process</td>
</tr>
<tr>
<td><strong>4. Strong, balanced relationships</strong></td>
</tr>
<tr>
<td>- Manage the relationship</td>
</tr>
<tr>
<td>- Broad, integrative connections at many levels</td>
</tr>
<tr>
<td>- Actively bridge organisational differences</td>
</tr>
<tr>
<td>- Eliminate power differentials</td>
</tr>
<tr>
<td>- Understand and allow for cultural differences in culture</td>
</tr>
</tbody>
</table>
5. **Trust and respect**
   - Value and respect all contributions
   - Behave with integrity
   - Allow time for trust development

6. **Good communication**
   - Open communication all relevant issues all levels
   - Avoid establishing new bureaucracies
   - Facilitate information exchange

7. **Formalisation**
   - Support shared decision making
   - Address contracts, authority, accountability, confidentiality, staffing and process
   - Ensure work can continue beyond tenure of individuals
   - Consider simplifying contracts

Additionally, the literature on business and industry partnerships indicates there are significant ways the individual level of involvement and commitment to partnerships can be facilitated or diminished within collaborative endeavour. These factors should be able to be transferable to partnerships between education and health service providers, where the joint venture is quality clinical education.

### Table 2.8  Factors that influence the level of involvement of individuals within collaborative projects. (After Lasker et al 2001)

<table>
<thead>
<tr>
<th>Factors that increase involvement</th>
<th>Factors that diminish involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhanced ability to address and issue they consider important.</td>
<td>Diversion of time and resources from other priorities and obligations.</td>
</tr>
<tr>
<td>Acquisition of funds, new competencies and useful knowledge to support their own activities.</td>
<td>Reduced independence in making decision about their own activities.</td>
</tr>
<tr>
<td>Increased exposure to and appreciation by other groups in the community.</td>
<td>Loss of competitive advantage in obtaining funding or providing services.</td>
</tr>
<tr>
<td>A strengthened capacity to meet performance goals and the needs of their clients or constituency.</td>
<td>Insufficient influence in the partnership’s activities.</td>
</tr>
<tr>
<td>Increased utilisation of their services and expertise.</td>
<td>Conflict between their own work and the partnership’s work.</td>
</tr>
<tr>
<td>Enhanced ability to affect public policy.</td>
<td>Negative exposure due to association with other partners.</td>
</tr>
<tr>
<td>The development of new, valuable relationships.</td>
<td>Frustration and aggravation with the collaborative process.</td>
</tr>
<tr>
<td>The opportunity to make a meaningful contribution to the community.</td>
<td>Insufficient credit for their contribution to the partnership.</td>
</tr>
<tr>
<td>Sufficient authority and resources, including time, granted to participants by their organisations.</td>
<td></td>
</tr>
</tbody>
</table>

The literature strongly advises any organisation either involved in partnerships that are failing to meet outcome expectations, or attempting to develop new partnerships, to consider carefully these factors.
Summary

Based on the literature review it is evident the same values and principles that underpin collaboration in industrial and business partnerships are required to build successful alliances between universities and health service providers. It is well documented in the literature and confirmed during Phase One of this study that quality clinical education of nurses is affected by the successful collaborative partnerships between health services and education providers.

A creative synergy occurs when every level of the partnership creates the structures, culture and processes that embrace the principles of collaboration. This requires:

- a shared vision and purpose for collaborating;
- all partners to understanding why they are involved and taking equal responsibility and accountability for outcomes;
- people choosing to be involved in clinical education partnerships must have:
  - requisite knowledge, skills and attitudes to teach effectively; and
  - proper preparation to facilitate students’ clinical learning;
- reciprocal and equal relationships of partners at every level of the partnership based on values of respect, trust and integrity;
- communication that is open, honest, accurate and timely; and
- supported by the establishment of appropriate formal frameworks to share governance.

While there is evidence that supports the view that best practice is demonstrated when collaborative partnerships are formed, detailed benchmarks of best practice inherent in partnerships have not been systematically identified.

The development of benchmarks for quality clinical learning via collaborative partnerships allows ‘best’ practice standards to be detailed, so ongoing and systematic continuous quality improvement can occur. Thus the research from Phase One, which articulated ‘best’ practice standards in clinical education, was actioned within three research environments, so the details of these standards could form the baseline on which to build, improve, evaluate and compare clinical learning environments.

This literature informed the commencement points for the participatory action research process that took place across three sites in South Australia, New South Wales and Queensland and are described in the next chapter.
Chapter 3
The research process

The research aims, teams, background rationale and methodology were introduced in Chapter 1 of this report, so they will not be repeated here. This chapter provides a brief precis of the site specific research cycles used to develop three contextually appropriate evaluation instruments. Additionally, it discusses the process used to develop best practice benchmarks for quality clinical learning.

The process used by all research groups included:

Introducing the project: All three teams commenced by approaching the Director of Nursing or delegates from Nursing executive to gain in-principle support for the project, discuss anticipated data collection processes, and gain access to potential clinical learning environment partners willing to join the Participatory Action Research (PAR) process. Initial discussions ensued until ethics committee approvals had been obtained.

Group formation: All sites developed reference groups of key informants from university academics and students, and nursing management and clinical educators.

Establishing the group: Each group gained ethical approval and began to meet with their respective informants. They obtained consent and set about establishing an agreed work pattern for data collection and reporting back. These early meetings clarified the goals of the researcher, the participants, and the reference group members, so everyone was clear as to their rights and responsibilities.

Continuing the PAR cycles: Each cycle went through the following phases: meeting, learning, focusing thoughts, engaging with ideas, developing an action plan (such as the evaluation tools) and evaluating actions and progress toward the desired outcomes.

Developing the anticipated outcomes: The outcome was the development of three clinical learning environment evaluation instruments and benchmarks for successful partnerships between universities and health service providers that would facilitate quality clinical education for undergraduate nurses.

What follows is a synopsis of the specific processes followed at each research site.

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5 See Appendix A
The PAR Process:
Flinders University and Flinders Medical Centre

Introducing the project

Discussions were held between the research team from Flinders University and members of Nursing executive at Flinders Medical Centre to gain support for the project and discuss the research processes and potential clinical learning environment partners that might be willing to join the participatory research process.

Group formation

Two PAR groups were formed of nurse informants directly involved in clinical education. The first group came from a medical CLE and the second group from a surgical CLE. Additionally, two reference groups were formed. The first made up of academics and students and the second made up of representatives from nursing executive with an interest in clinical education.

Establishing the group

Before commencing the first meeting a letter of introduction was sent to all participants outlining the purpose of the research, the PAR process and the expected time commitment of five meetings lasting 2-3 hours each. Arrangements were made to provide funding to ‘backfill’ staff while they attended focus group meetings. Each meeting had a specific focus and agreed outcome for each of the focus groups. While the two groups met independently of each other, by the third meeting their efforts were combined into one document – a Clinical Learning Environment Evaluation Tool (CLEET).

The PAR cycles

Phase 1 - Developing the CLEET

During the first meeting terms used in the introduction to the research were discussed and defined to ensure that we were working together with mutual understanding. Terms such as learning environment, partnership, clinical education, educator, academic and student were discussed and their meanings in the context of this project were agreed. Then the technique of brainstorming was used to clarify concepts and categories for further discussion.

Phase 2 - Refining and trialling the CLEET

In each successive meeting these concepts and categories were discussed and refined so that by the third and fourth meetings a series of questions had been developed under the
headings of each category. The outcome from the third meeting was a printed evaluation tool, which was circulated to the focus groups prior to the fourth and again prior to the fifth meeting so that changes could be discussed and agreed upon.

*Phase 3 - Evaluating the CLEET and firming the benchmarks*

At the final meeting the members of the focus group expressed satisfaction with the PAR process and gave their consent for their evaluation tool to be placed in an appendix to this final report. Further discussions revolved around developing the benchmarks that emerged during the PAR process.

**Discussion and reflections**

All participants in the PAR process felt consulted and indicated their appreciation for the collaborative process proclaiming it a valuable and collegial endeavour. There were some difficulties experienced due to lengthy delays in ethical approval at the outset, due largely to the need for additional documentation to meet privacy legislation. The researchers provided finances to backfill nurse participants for the PAR group meetings, and consequently these were well attended. Unrelenting workloads influence the commitment and enthusiasm clinical nurses can muster for projects that do not directly affect their daily practice. This must be understood when developing partnerships.

**Summary**

This partnership developed a Clinical Learning Environment Evaluation Tool for use by Flinders University and Flinders Medical Centre. The tool is complete, but needs to be administered in several learning environments across various student cohorts to refine its content and administration, which was beyond the scope of this project. Additionally, as is the case in most PAR processes, practical relationships were developed between partner organisations that can be built on and strengthened to create positive partnerships focusing on quality clinical learning.
Figure 3.1 PAR process - Flinders University and Flinders Medical Centre

**Phase 1 Developing the CLEET**
Data collection meetings using commencement schedule

CLEET Modified based on feedback, Benchmarks thematically analysed

PAR group plus key persons provide feedback re CLEET /Benchmarks

**Phase 2 Piloting and Refining the CLEET**
Draft 2 of CLEET developed over several meetings

Modifications made and CLEET finalised

CLEET piloted in two CLEs

PAR group plus Nursing Executive provide feedback

**Phase 3 Isolating and Firming Benchmark**
PAR group and reference groups discuss benchmarks

Findings disseminated in final report

Develop good practice criteria for benchmarks

Benchmarks and good practice criteria formulated
The PAR process: University of Technology Sydney and Royal North Shore Hospital, Sydney

Introduction

Early in the study the UTS Research team and the Director of Nursing (DON) at the Royal North Shore Hospital, Sydney, negotiated an in-principle agreement to undertake the research cooperatively. Formal authorisation of the hospital’s participation and nomination of group participants proceeded once ethical approval was obtained.

Group formation

PAR Groups

Five Nurse Unit Managers, five Clinical Nurse Educators, four Clinical Nurse Specialists and two Registered Nurses, selected to ensure involvement of representatives from as many Clinical Units as possible, were invited by the DON to participate. Two Lecturers and two Clinical Facilitators were nominated by the university. Two groups of ten were formed initially however pressures within the clinical environment rapidly reduced the capacity of many clinicians to attend meetings. Although most participants remained interested in the process and continued to receive information from the researchers, the decline in numbers led to amalgamation of the groups.

Reference groups

Three reference groups were established.

- Academic Reference Group: consisting of thirteen Academic Liaison Persons;
- Student Reference Group: involving ten third year student representatives; and
- NUM Reference Group: The researchers attended a regular meeting of all NUMs at the Royal North Shore Hospital.

Additionally, two experts: the UTS staff person responsible for administration of student placements, and the RNSH staff person responsible for overall coordination of all student placements, were interviewed as part of the reference process.

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6 At UTS, Clinical Facilitators are nurses employed full or part time by the university to attend clinical facilities, to work closely with CLE staff and to teach and supervise students undertaking clinical nursing experience.

7 ALPs at UTS are academics who work closely with specific clinical units or areas within clinical facilities where students are placed. They provide support, education and feedback to unit staff about students’ learning requirements. They are not present on units at all times but are available by page.
The PAR cycles

Establishing the tool

After an initial meeting covering the project background and aims and desired outcomes of the research, creative brainstorming sessions focused on the characteristics of quality partnerships and quality clinical learning environments and the desired attributes of professional staff working within these environments. The researchers presented an analysis of the literature relating to clinical learning and partnerships which had been examined for content and major themes for discussion, and three evaluation tools were examined:

- The Oxford School of Nursing Clinical Learning Environment Audit Tool (1990)
- The Edgehill School of Health Studies Audit Document (1990)
- The UTS Clinical Learning Environment Audit tool (2002), developed by the Sister School Project team in partnership with the team’s Indonesian colleagues for the Politekes Kesehatan Palangka Raya: Jurusan Keperawatan and Jurusan Kebidanan.

Informed by the literature, the examination of the three tools and by their own experience and expertise, the PAR group participants had two meetings to determine, by consensus, the benchmarks and the early framework and content of the CLEET.

Refining the CLEET

The research team undertook organisation of the tool into a manageable and workable document. Draft versions of the refined tool were presented at two subsequent PAR group meetings in addition to meetings of the Academic and Student Reference Groups and at interviews with UTS and RNSH student placement experts. Responses to the structure of the tool were positive and requests for alterations and additions to the content and suggestions for ways of administering the CLEET were incorporated into subsequent drafts. The final reference group, the NUMs, met after the pilot of the tool and further refinement of the tool was made based on feedback from this group.

Trialling and evaluating the CLEET

The CLEET was piloted in two units at one facility and in three units at a second facility. The researchers found that their increasing familiarity with the tool as the pilots progressed led to greater efficiencies in its administration. While early evaluations took many hours, full evaluation of the final unit was completed in ninety minutes.

Feedback from participants involved in the pilot was universally positive and appreciation that their views were being sought was widespread. Two specific issues were raised which directly led to further refining of the tool:

- In one unit all students answered negatively to almost all questions designed to assess the quality of that placement (for example they were unaware of the identity of their university clinical contact person, did not feel that this person had enhanced their learning experience, and had received no orientation to the unit). However, when asked for general comments about the unit, students were extremely enthusiastic. The students believed there had been no need for involvement of academic staff because every nurse on the unit had been so welcoming and keen to be involved in teaching
that the students had felt part of the team in every way. They believed there had been no need for a formal orientation because within such a welcoming environment they’d been able to orient themselves easily and this had proven a positive learning experience.

- In several units, NUMs and CNEs commented that completing the evaluation would have been more convenient and the process less easily overlooked if they could have performed this online or by email.

These issues, after consultation with the UTS Quality Management Unit, led to the decision to develop a pilot online version of part of the tool and to incorporate into the tool Importance-Performance Analysis. This form of analysis, pioneered as a marketing research technique by Martilla and James (1977), asks participants in the evaluation to grade questions according to how important he or she rates the issue being examined (for example, for a question asking students if they knew how to contact their university clinical support person, students would be asked to indicate how important knowing this was to their learning experience).

Data from this process can be graphed to demonstrate the relative importance and performance of issues examined in individual questions (see Table 3.1). This allows the tool administrator to identify areas of highest concern (those performed poorly within an area rated as highly important), whilst ensuring that excess resources are not directed to an area rated as unimportant. Additionally, Importance-Performance Analysis allows ongoing updating and refining of tool questions (for example, questions about issues all participants rate as low importance may need to be removed while questions focusing on an area participants rate as highly important may need to be expanded).

<table>
<thead>
<tr>
<th>Table 3.1 Importance Performance Analysis (after Martilla and James)</th>
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<tbody>
<tr>
<td><strong>EXTREMELY IMPORTANT</strong></td>
</tr>
<tr>
<td>Concentrate here</td>
</tr>
<tr>
<td>14</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>12</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>10</td>
</tr>
<tr>
<td>IMPROVE</td>
</tr>
<tr>
<td>Keep up the good work.</td>
</tr>
<tr>
<td>8</td>
</tr>
<tr>
<td>6</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td><strong>POOR</strong></td>
</tr>
<tr>
<td>9</td>
</tr>
<tr>
<td>8</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>16</td>
</tr>
<tr>
<td><strong>EXCELLENT</strong></td>
</tr>
<tr>
<td>13</td>
</tr>
<tr>
<td>11</td>
</tr>
<tr>
<td>7</td>
</tr>
<tr>
<td><strong>PERFORMANCE</strong></td>
</tr>
<tr>
<td>Low priority</td>
</tr>
<tr>
<td><strong>SLIGHTLY IMPORTANT</strong></td>
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<tr>
<td>15</td>
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<tr>
<td>17</td>
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<tr>
<td>18</td>
</tr>
<tr>
<td>Possible Overkill</td>
</tr>
</tbody>
</table>

The online version of the questionnaire is still in a pilot stage but can be viewed at the URLs listed below. The password for access to the sites is ‘leep’.

Discussion and reflections

Facilitating full, unhindered participation of all group members proved problematic. Pressures within the clinical environment mean there are many calls on the time and energies of individual clinicians and the researchers understood why this project was not always considered a priority. Particularly during the latter half of the project, a core of committed, enthusiastic clinicians largely performed the work. As a consequence of this, the research team in future will consider publicising projects more widely in the hope of recruiting volunteer participants rather than relying on nominations from research partners.

Despite this, PAR group participants at the final meeting reflected that the research process had felt fully collaborative, constructive, valuable and productive. The research team shares this view. While it is recognised that direct intervention by the researchers early in the tool refining stage could be seen as a departure from Elden and Levin’s 1991 model, the decision to evolve the role of the research team from that of ‘outsider’ facilitator (Elden and Levin 1991) to that of a participant who had been educated enough by the process to that point to be qualified to undertake the procedural ‘nuts and bolts’ of developing the tool structure was taken collaboratively. The researchers had available the time and skills to perform this task whereas most group participants were finding the demands of regular attendance and communication difficult to meet. Both the research team and the clinicians believed that at that stage the most valuable use that could be made of the clinicians’ limited time was in relation to providing creative solutions and ideas and of assessing the workability, reliability and validity of the instrument in a working form.

Summary

The tangible end point of the collaborative process described above has been the development of a Clinical Learning Environment Evaluation Tool for use by both UTS and RNSH in partnership with each other and independently. Less tangible, but more valuable, has been the insight provided by the expert research participants into the relationship between these institutions and the development of enhanced collaborative relationships and ways of working together. The research team anticipates that that the relationships developed and lessons learned during this process will facilitate the strengthening of the partnership between UTS and RNSH. This will result, we hope, in further improvements to Clinical Learning Environments for nursing students.
The PAR Process:  
Queensland University of Technology and Royal Brisbane Hospital

Introduction

The project commenced with several meetings with key stakeholders. These included a meeting with the teams from Queensland University of Technology and Royal Brisbane Hospital including: senior nursing management, identified co-researchers, clinical unit managers, and individuals involved in undergraduate clinical education at both sites.

All participants were provided with information packages that included the aims of the research project, the philosophical approach to the sharing of resources and outcomes inherent in partnerships, preliminary literature findings and areas identified for exploration. The information packages provided information about the underlying theoretical framework of the PAR process and requests for assistance in establishing or participating in the PAR process. The dual aims of identifying best practice benchmarks and developing a Clinical Learning Environment Evaluation Tool (CLEET) were clarified and agreed to enthusiastically by all participants.

Two PAR groups were formed: one from clinicians and unit managers from throughout the Hospital; and one from third year students at QUT. Senior and middle management nursing personnel assisted with the recruitment of individuals for the Hospital based PAR group by promoting the proposed process to staff, and access was provided to students at the University. Two other groups were identified as reference groups to comment on the process and the development of the tool: academics from QUT with experience in clinical education; and staff from RBH who were not involved in the PAR group but who also had experience in clinical education.

Another element of the introductory phase was to come to a common understanding about the focus for the PAR group discussions. It was agreed that the aims stated in Chapter 1 be turned into trigger questions to initiate discussion in the PAR groups.

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Table 3.2 Questions for PAR group process

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>What constitutes an effective partnership?</td>
</tr>
<tr>
<td>2.</td>
<td>What are the most important elements of an effective partnership?</td>
</tr>
<tr>
<td>3.</td>
<td>What influences the partnership positively and negatively?</td>
</tr>
<tr>
<td>4.</td>
<td>What can improve the partnership?</td>
</tr>
<tr>
<td>5.</td>
<td>What is your role in making the partnership work?</td>
</tr>
<tr>
<td>6.</td>
<td>How can you contribute to improving the partnership?</td>
</tr>
<tr>
<td>7.</td>
<td>How can an effective partnership be operationalised?</td>
</tr>
<tr>
<td>8.</td>
<td>How do we know if a partnership is working well?</td>
</tr>
</tbody>
</table>
Group formation

Clinician participation

The first PAR group session was conducted in a venue at the hospital following widespread promotion. Due to a range of problems being experienced which included staffing shortages and intermittent industrial action, attendance was limited. Therefore, it was agreed that several PAR group sessions would be conducted to ensure attendance by the maximum number of participants possible.

Twelve sessions were held with clinical and management staff. The total number of staff attending these PAR sessions was eighteen. Participants identified issues that they saw as central to the establishment of collaborative partnerships. Clarification of values and identification of criteria and benchmarks of best practice commenced from the first meeting. The initial meeting was tape-recorded but subsequent meetings were based upon note taking by the project officer. Ongoing communication with clinical staff was between the project officer and individuals or small groups.

Student participation

Shortly after the PAR process was initiated with clinicians, a similar process was commenced with third year students at QUT. Sixteen students agreed to participate and continued participation in identifying and developing criteria and benchmarks as well as commenting on developments of the tool. After two initial group sessions at which the project officer took notes all communication between students and the project officer was by email.

The PAR cycles

Establishing the tool

The eight questions developed by participants were used to commence the identification of issues and the perceptions of participants about their own and the ideal clinical learning environment. The elements of collaboration and partnership that influence those environments were specifically explored.

Subsequent to the first meeting with participants, a number of statements were drafted that summarized the comments made by individuals in the groups. This information was provided back to the participants for their comments to determine if these statements were an accurate reflection, if additional statements were required or if amendments needed to be made. Advice was also sought from participants and the research team about the format of the tool that was being developed from the statements. Consensus was reached that the aim would be to develop a tool that could be used as a quality assurance check list to evaluate a clinical education environment. Consensus was also reached in broad terms regarding the issues that needed to be included. These were categorized as communication; operational matters pertaining to the clinical education unit; operational issues related to student placements such as orientation; the role of
facilitators; and the issue of attitudes and relationships between key stakeholders in clinical education.

**Refining the CLEET**

There was a cyclic process of consultation with individual participants from the two PAR groups. Refinement of the tool was undertaken by the project officer on the basis of feedback from participants. There was a variable amount of feedback from participants. Some individuals responded immediately with fulsome critical commentary, on up to 6 different occasions which resulted in effective, ongoing communication between the participant and the project officer to ensure clarification of issues. Other participants responded only to comment on one issue or to merely agree that they were happy with the progress of the tool. Some participants chose not to comment any further at varying stages throughout the process.

At the completion of the PAR process there was general consensus among the participants that the tool contained all of the essential elements which would assist in meeting the stated goals. Participants also agreed that elements identified as criteria for use in the tool and the identified benchmarks of best practice in clinical education were complementary and closely linked.

**Trialling the CLEET**

A copy of the final version of the CLEET was forwarded to ten individuals who had not previously participated in its development for their feedback and assessment of the tool. Their comments and suggestions were incorporated in the final draft. Editing of the CLEET was undertaken by the project officer with the guidance and advice of the QUT research project team and members of the reference groups.

**Evaluating the CLEET**

It is proposed that the reliability and validity of the tool will be assessed through the use of it with a variety of student cohorts in a number of venues where undergraduate clinical education is undertaken. While the tool and related benchmarks of best practice have been developed primarily to contribute to the discourse on clinical education, it has evolved into a very useful instrument which could be used by a range of teams to evaluate their clinical learning environment.

**Discussion and reflections**

The contribution by a wide range of stakeholders and the ongoing dialogue inherent in the PAR process has resulted in the development of a tool and benchmarks that reflect the multiplicity of perspectives represented. This tool is designed to promote the collaborative partnership between the higher education and health service sectors which is essential to optimising clinical education. This is unique as the current clinical education literature does not provide any extensive discussion of collaborative partnerships
accompanied by associated benchmarks of best practice and related criteria. Another positive feature of the process was the evolving recognition by participants of different perspectives and a respect for alternate points of view.

While the CLEET and best practice benchmarks has been developed with the guidance of a number of persons, and every effort has been made to clarify terms to prevent ambiguity, there is some concern that it may not be generalisable to a broad range of contexts. However, the issue of generalisability of the CLEET will be investigated and addressed as the CLEET is promoted and trials are conducted in a variety of settings.

The current stresses being experienced in both the health service and education sectors influenced the participation rate by all interested parties in the research project due to time constraints and competing priorities. While all principles of PAR group processes were adhered to, this was achieved through extensive duplication of the process with small numbers of individuals, and it was only through the use of a variety of communication strategies that the cyclic process of cogenerative dialogue, interpretation and feedback could be completed.

**Summary**

The PAR process and the development of the CLEET and related benchmarks were undertaken as a collaborative activity between QUT and the RBH. The project enabled us to build on strong collaborations that already existed between the two organisations. The project occurred during a period of complex industrial activity, however, the enthusiasm and goodwill of all involved ensured that the project progressed. The unique aspect of the tool developed by QUT and RBH is that the process for using the tool embraces the collaborative and collegial nature of the partnership as the evaluation is undertaken by a review team representing both organisations.

**Why develop benchmarks?**

The dual purposes of the PAR groups was to develop an evaluation instrument that could measure the quality of the clinical learning environment, and the development of benchmarks for successful partnerships between education and health service providers that optimise clinical learning for undergraduate nursing students.

The term 'benchmark' was originally used by surveyors to refer to the distinguishing markers that could be used as reference points to locate one’s position on a map (Bergman 1994; Lam 1994). The term has been adopted widely throughout the information technology industry and business world to describe the essential standards against which other standards may be measured (Ellis et al. 2000a; Ellis et al. 2000b). Consequently, benchmarking is an ongoing and methodical exploration of, and execution of, best practice, which should lead to continuous quality improvements in performance (McKeown 1996; Mitchell 1996). Benchmarks provide accurate scientific markers of success that can be measured and monitored so programs can identify gaps in performance and make improvements. If every CLE strives for quality improvement based on objective measures identified in the CLEETs and the benchmarks, the students, and ultimately the patients served by both organisations will benefit. As Day (2001a p. 39) notes, ‘the bottom line is that you cannot improve what you cannot measure’. In a
teaching hospital, improvements in education, clinical care, and research benefit everyone involved, including patients, students, staff, residents, and faculty’.

The literature highlights some of the advantages and disadvantages of benchmarking that were considered during the process of developing the benchmarks. They include:

**Advantages of benchmarking**

The advantages of using benchmarks include (based on the work of Cleary 2002; Day 1996a; Ellis 1997; Murray and Murray 1992; Patterson 1993; Phillips 1995; Simpson 1994; and Tran 2003):

- allows continuous comparison;
- auditing standards;
- raises awareness of expectations and standards;
- improves confidence in adequacy of outcomes;
- provides guidance and direction;
- promotes common understanding between partners;
- identifies strengths, weaknesses and possibilities;
- provides a sense of reliability, equality and fairness;
- improves accountability and transparency between partners;
- ensures consistency in approaches across CLEs;
- identifies resource deficits and areas requiring remediation;
- protects rights of all partners and particularly students;
- there are possibilities to articulate with other accreditation processes;
- promotes definition of curricula into outcomes language for students; and
- highlights inadequacies and pinpoints areas requiring assistance.

**Disadvantages of benchmarking**

Possible threats and disadvantages of benchmarking include (see also Benchmarking Center 1999; Day 1996b; Herman 1993; and Tran 2003):

- danger of ‘one-size-fits-all’ approach to clinical learning;
- insensitivity to socio-cultural and class influences in partnerships;
- requirement of resource allocation to action remediation (if required) - time, people, finances;
- potential for conflict when identifying deficits;
- possibility for punitive and discriminatory reactions to inadequacies;
- probability of discrepancy between what is ‘optimal’ and ‘realistically achievable’;
- potential to become too prescriptive losing flexible approaches to learning;
- risk of becoming a pedantic inspection instead of focusing on the big picture; and
- potential to ‘bureaucratise’ learning which can occur via exposure and experience.

Phase One of this project (Clare et al. 2002) identified several standards of best practice in clinical education and this phase continued that work by identifying the basic standards required to forge successful partnerships between clinical health services and education providers that will optimise student learning. These standards may be adopted and applied by other organisations to build on the positive lessons learnt in this research and avoid
identified pitfalls. The aim of benchmarking is to build on previous success and ensure current best practice continues to improve. The benefits of benchmarking include the focus on the needs of consumers (students and patients), the necessity of developing and adapting industry-best practices, quality testing of clinical learning and teaching, and the capacity of benchmarks to provide to clarify relevant, realistic and achievable goals for future development (Day 2001a; Day 2001b; McNair and Leibried 1993; Wilson and Nathan 2003).

The benchmarking process used in this study

Much of the literature around the process of benchmarking focuses on technical procedures, computer products and management processes (American Productivity and Quality Center 1997; Arabian 1999; Benchmarking Center 1999). However, the need for benchmarks that take into account partnerships that may have divergent work cultures, contexts, objectives, time and resource availability is not well documented. After searching various models a 5-step approach was constructed to complement the nursing process and the PAR process. It was grounded in the work of Ellis (Ellis 1995; 1997; Ellis et al. 2000a; and 2000b) Patterson (1996) and United Kingdom government benchmarking standards available at the following web site http://www.benchmarking.gov.uk/about_bench/theprocess.asp (Benchmarking Center 1999). The steps in that process are presented in Table 3.2.

<table>
<thead>
<tr>
<th>Step 1</th>
<th>Planning</th>
<th>Our benchmarking process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify the subject area to be reviewed</td>
<td>The clinical learning environment</td>
<td></td>
</tr>
<tr>
<td>Define the objectives for the study</td>
<td>To develop and evaluate partnership that provide quality nurse education in the clinical learning environment focusing on work practices and improving policy</td>
<td></td>
</tr>
<tr>
<td>Select the approach and type of benchmarking</td>
<td>Functional benchmarks that improve work processes</td>
<td></td>
</tr>
<tr>
<td>Identify potential partners</td>
<td>Three universities and varied clinical learning environments within three major public metropolitan teaching hospitals</td>
<td></td>
</tr>
<tr>
<td>Produce a project plan</td>
<td>Using the PAR process to isolate elements and attributes of partnerships and identify aspects that can be considered best practice and those requiring reorientation</td>
<td></td>
</tr>
<tr>
<td>Develop a communications strategy</td>
<td>The PAR process was presented to senior managers and staff of partner organisations after ethical approval was received, to gain commitment and support from senior nurse managers</td>
<td></td>
</tr>
</tbody>
</table>
### Step 2 Collecting data & information

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compile information and data on performance</td>
<td>Using PAR groups and reference group in three states</td>
</tr>
<tr>
<td>Select and contact partners</td>
<td>Hospital partners provide several CLEs</td>
</tr>
<tr>
<td>Develop with partners, mutual understanding</td>
<td>All partners given information sheets re process and anticipated outcomes</td>
</tr>
<tr>
<td>of research procedures</td>
<td></td>
</tr>
<tr>
<td>Prepare and distribute questions and</td>
<td>Commenced with Oxford audit tool and 10 focus areas to explore</td>
</tr>
<tr>
<td>information</td>
<td></td>
</tr>
<tr>
<td>Data collection</td>
<td>Workshops and interviews with reference and PAR groups</td>
</tr>
<tr>
<td>Collate the findings to enable analysis</td>
<td>Data transcribed and thematically coded and three context specific CLE evaluation instruments developed, piloted and refined</td>
</tr>
</tbody>
</table>

### Step 3 Analysing the findings

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review the findings and produce tables,</td>
<td>Development of CLE evaluation instruments and benchmarks</td>
</tr>
<tr>
<td>charts and graphs to support the analysis</td>
<td></td>
</tr>
<tr>
<td>Note factors that can be established as the</td>
<td>Development of good practice criteria for each benchmark</td>
</tr>
<tr>
<td>baseline for good practice</td>
<td></td>
</tr>
<tr>
<td>Ensure that criteria are meaningful and</td>
<td>Discussions in several varied CLEs and reference groups</td>
</tr>
<tr>
<td>credible across the partner organisations</td>
<td></td>
</tr>
<tr>
<td>Communicate the findings</td>
<td>Instruments returned to PAR groups</td>
</tr>
<tr>
<td>Identify realistic universal baselines for</td>
<td>Provide rationale for baseline benchmarks and criteria that may be considered good practice</td>
</tr>
<tr>
<td>benchmarks</td>
<td></td>
</tr>
</tbody>
</table>

### Step 4 Recommendations

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examine feasibility of benchmarks in the</td>
<td>Specific local knowledge, work practice, policies noted that impacts on</td>
</tr>
<tr>
<td>light of the conditions within partner</td>
<td>benchmark development</td>
</tr>
<tr>
<td>organisations</td>
<td></td>
</tr>
<tr>
<td>Agree on feasible benchmark statements</td>
<td>Mutual and agreed on benchmarks decided</td>
</tr>
<tr>
<td>Produce a report on the ‘Benchmarking Project’ including recommendations</td>
<td>Final report articulates these as a beginning point for future development (especially scoring systems for the defined criteria)</td>
</tr>
</tbody>
</table>

### 5. Monitoring and reviewing

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluate benchmarking process</td>
<td>Note in final report results of partnerships and identification of success criteria</td>
</tr>
<tr>
<td>Document lessons and make available</td>
<td>In final report</td>
</tr>
<tr>
<td>Re-consider benchmarks in light of changed</td>
<td>Recommend regular yearly audit using evaluation instruments</td>
</tr>
<tr>
<td>conditions that impact on performance</td>
<td></td>
</tr>
<tr>
<td>relative to good practice</td>
<td></td>
</tr>
</tbody>
</table>
Summary

This chapter has discussed the site specific research processes used to develop the three contextually appropriate evaluation instruments. It has also outlined mechanisms used to elicit the information required to develop benchmarks for successful partnerships that will optimise clinical learning. There are no such best practice benchmarks documented, so this project used a benchmarking process that was modified to dovetail into the participatory action research process. Only half of the traditional benchmarking process was possible as Figure 3.2 illustrates due to financial and time constraints rendering the scoring aspects of the benchmarking process beyond the scope of this study. The project gained consensus on specific best practice benchmarks and what might be considered good practice criteria for each benchmark. However, future research should focus on developing scoring ranks using the good practice criteria as a measure moving toward each best practice benchmark.

Figure 3.2 The benchmarking process to advance best practice partnerships that optimise clinical learning
(Adapted from Ellis 2000a, pp.33-37)
Chapter 4
Discussion, benchmarks and recommendations

The research process aimed to have practical application by developing successful partnerships that facilitated quality clinical learning for nursing students. In this process two discrete but compatible outcomes resulted. Namely, the development of three context and partner specific clinical learning environment evaluation instruments and the advancement of a set of national best practice benchmarks for successful partnerships between universities and health service providers. This chapter discusses the key project findings relating them back to the literature on partnerships to make recommendations for practice. It continues to discuss the development and use of the evaluation instruments and discusses the benchmarks for best practice partnerships and their good practice criteria that which will enhance clinical teaching and learning for nursing students. Finally, recommendations for implementation of the research findings and details of gaps requiring future development are provided.

Linking the research findings back to the literature

An overview of issues uncovered in this research is provided in Table 4.1 and suggestions are made to address these considerations to facilitate more successful partnerships between universities and health services. The findings have been documented under the seven requirements for thriving partnerships noted in the literature in Chapter 2.

Table 4.1   Research findings and suggestions for achieving successful partnerships that facilitate teaching and learning for nursing students

<table>
<thead>
<tr>
<th>Recommendations for developing successful partnerships informed by the research and literature</th>
<th>Research findings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Right reasons</strong></td>
<td></td>
</tr>
<tr>
<td>Universities and health services entering partnerships have different purposes, goals and service drivers, therefore:</td>
<td>It is easy for people at the 'top level' of the partnership to be passionate about the alliance, but this enthusiasm needs to be conveyed to clinicians that increasingly view students as additional workload. Goals are more likely to be achieved when all partners recognise their joint responsibility in developing an effective and safe nursing graduate.</td>
</tr>
<tr>
<td>▪ be passionate and enthusiastic at every level about the partnership;</td>
<td></td>
</tr>
<tr>
<td>▪ promote the notion of joint professional responsibility for development of registered nurses;</td>
<td></td>
</tr>
<tr>
<td>▪ develop a shared vision for student education and a joint commitment to student learning; and</td>
<td></td>
</tr>
<tr>
<td>▪ keep the focus long term.</td>
<td></td>
</tr>
</tbody>
</table>
Increase the stakes

Stakes are already high for universities. There is a need to increase stakes for health services, specifically at the level of each Clinical Learning Environment. Suggestions include:

- lobby for increased funding for student placements with money going to health service, with significant portion to the unit level CLE;
- link student funding to quality placements;
- evaluate the Clinical Learning Environment and provide rapid feedback to the facility and unit;
- offer use of university resources, facilities, courses, lectures, continuing education to facility staff; and
- stress the fact students are their potential colleagues and future employees.

The enthusiasm to be involved in student education is likely to increase when structures and processes such as those outlined in the benchmarks and their criteria are implemented appropriately. Then CLEs will have a greater stake in ensuring clinical education as well as having a future recruitment solution to staffing shortages.

Involve the right people

Choose your ‘best people’ and collaborative leaders who are dedicated to making the partnership work and:

- empower frontline staff to make decisions, manage student matters, progress, communication and conflict;
- provide adequate resources and support commensurate with nursing workloads;
- include and involve stakeholders, students, CLE nurses, academics and consumers in the partnership; and
- encourage open and transparent communication and clearly defined rights, responsibilities and role clarification for participants at every level of the partnership.

While academic staffs operating at the CLE level are usually the best and right people, the best clinicians are not always the best teachers. Additionally, over-worked clinicians that are unable to perform their job to their own satisfaction, become stressed and this diminishes motivation to take on teaching of students.

Create a strong, balanced relationship

Both partners should manage the relationship by:

- troubleshooting quickly, cooperatively and with fairness;
- listening and responding to partners at every partnership level;
- recognising and accepting that the goals and service drivers of both partners are different, therefore remain flexible;
- collecting reciprocal feedback and acting on it rapidly;
- developing integrated connections at many levels: look at developing partnerships in other areas e.g. research, management, training, sporting, social, political, media and lobbying for improved health care outcomes etc.;
- ensuring that power relationships remain equal;
- considering partnerships with fewer facilities to concentrate resources on improving a limited number of relationships, thus increasing the chances of success;
- using responsible and accountable financial management;
- ensuring sufficient financial and human resources are provided to sustain and support clinical education; and
- promoting the shared use of human resources.

Partners need to encourage nurses in their joint responsibility to participate in planning, development and evaluation of clinical learning environments and education of future colleagues. This is a problem in some areas where nurses in some CLEs did not view themselves as clinical education partners.

There is a perceived lack of balance in the education partnership that favours the university and this needs to be addressed.

Balanced and reciprocal partnerships are being achieved in smaller States but universities such as UTS have partnerships with 150 health facilities. Partnerships with so many facilities are difficult to establish, manage and maintain.
Trust and respect your partner and your staff

Mutual trust, reciprocity and respect are developed by:
- allowing continuity of personnel so trust can develop;
- behaving with integrity and respect;
- recognising and rewarding your and your partner’s staff;
- respecting and maintaining your partner’s confidential information; and
- understanding the pressures and workloads of your partner at every level of the partnership. Look for ways to minimise work, and maximise results within the time and resource constraints of both systems.

Ensure good communication

Partners at all levels must be accessible and informed by:
- developing ways to better communicate understanding of priorities;
- sharing ideas and exchanging information, while avoiding the establishment of new bureaucracies;
- managing communication structures and processes;
- facilitating and encouraging information exchange e.g. share contact details at all levels - e-mail, phone, fax…
- educating regarding each partner’s desired outcomes; and
- ensuring accessible documentation that is clear, succinct and available for all partners.

Formalise the relationship

Commit to honour and build the trust of registered nurses throughout the profession by:
- supporting shared decision making;
- developing responsible reporting and monitoring mechanisms;
- committing to openness and transparency in all dealings;
- ensuring partnership and relationships can continue beyond tenure of individual staff;
- developing formal agreements and/or ‘Memoranda of Understanding’;
- understanding partners’ responsibilities regarding OHW&S legislation, curriculum accreditation, and other industrial, safety, and accreditation standards;
- identifying and responding to issues impeding partnerships that promote clinical learning in formal manner;
- developing policies and best practice benchmarks and guidelines that get reviewed annually; and
- involving partners in strategic planning for the clinical education component of curriculum review.

Gaps in understanding between academic and clinical partners of the service drivers, pressures and workload each is under. Clinical staff feel under appreciated and unrewarded, academics feel stretched and misunderstood. Improved communication and quality processes and structures that distribute equitable workloads will promote greater understanding and respect for all partners.

Clinicians can feel powerless when unaware of who to contact re student matters. These contact details are readily available but may not always get communicated. Timely notice of student arrival in the CLE is mandatory. Systems for CLE staff to reduce or refuse students when they feel unable to accommodate them should be considered.

Agreements should share philosophies and responsibilities using joint decision-making processes, instead of just focusing on legal, financial and contractual obligations.

Relationships are under less strain when there is continuity of facilitators / academics working with students in the CLE.

Appropriate agreements that are well executed in practice will diminish (perhaps even eliminate) the glitches regarding communication that divide and strain the educational partnerships within a CLE.
The shared principles for partnerships that optimise clinical learning

To put the suggestions noted in Table 4.1 in place requires the development of a partnership that is built on a platform of shared principles, mutually desired outcomes, and a commitment to specific values. The benchmarks and evaluation tools were developed on a platform of trust, respect and reciprocity. The good practice criteria for each benchmark may be scaffolded on this platform to create a framework for best practice. The shared principles for each partnership include:

**Desirable outcomes of partnerships that facilitate clinical learning include:**

- advancing clinical learning for nurses via partnerships between the university and health services that build, develop and reinforce complementary systems;
- redressing the pragmatic problems that impede such partnerships;
- developing quality communication protocols that clarify, facilitate and nurture future partnerships; and
- development of appropriate benchmarks that detail policies and practices that support clinical learning partnerships.

**There should be a shared commitment to the following values:**

- open and transparent dealings by all partners;
- trust, mutual respect and reciprocity should be evident in all interactions and actions;
- equality in participation and responsibility by both partners;
- recognition of diverse product drivers for both partners;
- tolerance and goodwill for a level of ambiguity as the partnership develops;
- sustainable practices by both partners so costs are managed appropriately; and
- connections built between people at every level of the partnership.

**The following principles should be shared by both partners:**

- *The importance of partnership* as a shared responsibility and commitment to creating a ‘new value’ that facilitates the educational future of the nursing profession.
- *Cooperation, consultation and support:* partners will operate in an open and cooperative manner to share information, with meaningful consultation, networking, collaboration and support as the basis for the partnership.
- *Independence:* each partner has different structures of accountability and each partner has the right as a separate entity to express their views independently.
- *Interdependence:* the partnership acknowledges the human aspect of partnerships rely on common vision and commitment from partners at every level to achieve the collective aims. In doing so, partners recognise decisions made within one organisation indirectly affect the other, and neither can accomplish the combined purpose alone.
- *Leadership and action:* all organisations need to consider their partners in long-term strategic planning for solutions and actions.
- *Accountability:* sound and viable management processes will be used that monitor quality and report regularly to all partners regarding the outcomes of the partnerships. Stakeholders will have a voice and concomitant responsibility and accountability for

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8 See Appendix E for copy of *The European Benchmarking Code of Conduct* that informed the principles derived in the research process.
their actions and outcomes. High standards of conduct will be utilised when managing the partnerships.

- **Investment:** partners will demonstrate their commitment to each other and their mutual vision by adequately resourcing the partnership (e.g. finances and the right people).

### Significant findings regarding the ‘Clinical Learning Environment Evaluation Tools’

Using the shared principles as the basis for working together, three site specific evaluation instruments were developed in partnership using the Participatory Action Research process. These tools had the specific aim of reviewing clinical learning environments to measure the quality of the partnership relationships and their influence on the CLE. Each evaluation instrument was developed using processes described in Chapter 3 of this document. What follows is a brief discussion regarding how each team proposes their instrument should be used. The three instruments are provided in the appendices of this document in the hope that universities will utilise and develop further these researched tools, which can become part of the benchmarking process that improves the quality of clinical teaching and learning between partner organisations.

### The FUAA/FMC instrument

The FUAA/FMC instrument focuses on evaluating the partnership by assessing the clinical learning environment. The university will make contact with the health service to negotiate dates of administration of the evaluation tool by an independent member of FUAA and a nominated clinician from the health service. Part A of the tool supplies baseline data from the CLE and should be completed by the clinical nurse consultant/manager. Part B will be administered by either paper or electronically, to a random selection of students (of various levels), nurses acting as preceptors, the clinical nurse consultant/manager, the principal academic/clinical facilitator, and clinical personnel the auditors believe should evaluate the quality of clinical education in that CLE.

Part B of the tool has two sections for each of 126 items identified in the research process as significant factors that contribute to student learning. The tool aims to find the perspective of various partners regarding the importance of each factor to effective clinical learning for nursing students, and to rate the performance of that particular clinical learning environment for each item. It is envisaged differences between participating partner’s responses, and comparisons over time will demonstrate areas of the partnership that are working well, so these can be acknowledged and rewarded. Should aspects of the evaluation demonstrate areas that require attention, a meeting will be set up by the administering team to include nominated clinicians, the university academic and/or clinical facilitator, and the Clinical Nurse Consultant/Manager of the clinical unit involved. The purpose of this meeting will be to identify strategies for remedial assistance/action and support to any/all staff, should these be required. Action plans will be reviewed at a date specified by both partners.

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9 The FUAA/FMC tool is in Appendix B; The UTS/RNSH tool is in Appendix C; The QUT/RBH tool is in Appendix D
10 See Appendix B
The UTS/RNSH instrument

The UTS/RNSH instrument\textsuperscript{11} is focused on assessing the partnership by evaluating staff and student perspectives of clinical learning and the CLE. The tool is developed for use in a variety of health care environments and locations thus the terminology used is generic and non specific to individual settings. Questions for students relate to specific placements and are designed to be answered following every clinical placement while staff questions are more general and are designed to be administered on an annual basis. The instrument is intended to be self-administered and is divided into sections applicable to different members of staff involved in student learning and to students.

The QUT/RBH instrument

Participants in the QUT/RBH PAR process felt strongly from the outset that the evaluation instrument\textsuperscript{12} should itself contribute to increasing collegiality and collaboration among members of the partnership. To that end, the instrument was designed to focus on the broader aspects of the university health service partnership. It is designed to be administered by a review team comprising a number of individuals representing both sectors in the partnership. Participants felt that such a process, whereby representatives of each of the partnering organisations would conduct the review, would contribute to enhancing collaborative relationships in their joint identification of areas of optimum performance and those requiring attention and remedial actions.

Significant findings regarding benchmarking

The research process to develop the evaluation instruments was modified to include development of best practice benchmarks. The process used is detailed in Chapter 3 of this document. The procedure highlighted six best practice benchmarks for collaborative partnerships that facilitate quality clinical learning for undergraduate nurses. These benchmarks and their related good practice criteria can be measured, but scoring regimes are yet to be developed, as this was beyond the scope of this project.

The best practice benchmarks are listed as follows:
1. Partners will develop a shared formal agreement between a university and a health service regarding clinical education of undergraduate nurses.
2. There is effective and timely communication between partners.
3. The rights, roles and responsibilities of persons at every level of the clinical learning partnership are clearly defined.
4. Scholarly teaching by both partners occurs in the clinical learning environment.
5. The partnership elements that promote high quality clinical learning for students are provided within the clinical learning environment.
6. There is regular monitoring of agreed partnership elements that affect learning, teaching and progress of students.

\textsuperscript{11} See Appendix C
\textsuperscript{12} See Appendix D
How the benchmarks could be used

The benchmarks were developed in partnerships between universities and health services. They have been deliberately linked to the work of the Australian Vice Chancellors’ Committee’s (McKinnon et al. 1999) learning and teaching benchmarks for Australian universities, so they can form the basis of internal university auditing of quality teaching and learning in nursing. Benchmarks were modified to speak to the unique aspects of clinical learning and good practice criteria were derived from participatory work undertaken during this study.

It is confirmed by State and Territory nursing regulatory bodies that students must be able to meet the ANCI competencies upon graduation, therefore it is imperative that all CLEs provide learning experiences and opportunities for undergraduates to progress toward these competencies. Partners may choose to apply these competencies into more specific and tangible evaluation criteria tailored to their unique CLE contexts, but such specificity is beyond the scope of this project.

The six benchmarks developed in the research process fit comfortably with the seven requirements for effective collaboration that were identified in the literature discussed in Chapter 2 as Table 4.2 indicates.

<table>
<thead>
<tr>
<th>Requirements for Effective Collaborations</th>
<th>Benchmark for Quality Clinical Learning Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good reasons</td>
<td>5, 6</td>
</tr>
<tr>
<td>High stakes</td>
<td>5, 6</td>
</tr>
<tr>
<td>Right people</td>
<td>4, 5, 6</td>
</tr>
<tr>
<td>Strong, balanced relationships</td>
<td>1, 2, 3, 4, 5, 6</td>
</tr>
<tr>
<td>Trust and respect</td>
<td>1, 2, 3, 4, 5, 6</td>
</tr>
<tr>
<td>Good communication</td>
<td>2, 4, 5, 6</td>
</tr>
<tr>
<td>Formalisation</td>
<td>1</td>
</tr>
</tbody>
</table>

The research teams resolved that the implementation process should be agreed by both partner organisations, especially at the CLE level of the partnership. The following suggestions were made:

- use mutually agreed language to describe the rights, roles and responsibilities of your partners;13
- compare practice within the CLE to each of the six agreed best practice benchmarks;
- provide training in use of benchmarks (this is the responsibility of both partners);
- devise simple (not too time consuming) scoring systems, preferably worked out nationally, but across the institution would be the minimum requisite;
- when a CLE scores highly they should be recognised and rewarded;

13 The language used to describe partners in the clinical learning relationship differs across Australia, so to facilitate common understanding each term used in the benchmarks in this project is described in a brief glossary in the preliminary pages of this document.
there should be clear demonstration that ‘the best is attainable’ to other CLEs and/or individuals within a CLE that is not performing as well as hoped;
- to network and share ideas that improve quality with other best practice CLEs;
- benchmarks and their criteria and scores should be fluid documents open to annual review in the light of changing circumstances that influence performance relative to good practice such as, curricula, research, regulation, policies, processes etc.;
- identify areas where education, training and remediation should occur; and
- identify CLEs that are leading edge environments that can assist others within the partnership in the process of quality improvement.

There will no doubt be others as the benchmarking process is rolled out between partner organisations. But these points present the basis for how the following benchmarks can work. Whatever the case, participants agreed benchmarking should not be a punitive process that promotes a ‘big brother is watching you’ approach to quality improvement, nor should it be a piece of ‘administrative paperwork’ that has no discernable impact in improving the situation for both partners.
Benchmarks for learning and teaching partnerships in the clinical learning environment

Benchmark 1

Partners will develop a shared formal agreement between a university and a health service regarding clinical education of undergraduate nurses.

Benchmark rationale:

A written agreement between the university and the health service/s that includes a commitment to share the responsibility for student learning and clearly defines each partner’s responsibilities and accountability regarding the quality of student learning. This will ensure members at every level of the partnership negotiate, agree and understand their rights, roles and responsibilities, and will provide a clear and agreed framework on which the partnership will be established. These may take the form of Memoranda of Agreement, Service Agreements, or Affiliation Agreements.

Source of data:

- Philosophical statements of all partnership organisations
- Written agreements

Good practice criteria:

- The agreement is built on reciprocity and understanding of what each partner has to offer the partnership and what each partner needs from the alliance.
- Professional respect is demonstrated by recognising, accepting and prioritising each partner’s core business needs and organisational constraints, thus mitigating the current ‘silo mentality’.
- A 360 degree-feedback cycle is developed in evaluating the clinical learning environment so participants at every level of the partnership can continue to improve their contribution.
- Systems and processes within each partner organisation reinforce and build the partnership, and the products of that partnership.
- Health service staff and university staff are jointly committed to maintaining continuing collegial working relationships and open communication networks.
- This memorandum of agreement will:
  - elucidate a joint commitment to share the responsibility for student learning,
  - recognise that students are integral to the core business of both partners,
  - share a congruent philosophy of nursing and nurse education between partners,
  - meet the needs of both partner organisations’ core business requirements,
  - recognises there are different system drivers for each partner,
  - be flexible, responsive and open to regular review,
  - be developed using shared values and principles between partners,
- allow for equal and reciprocal involvement at all levels of the partnership,
- outline steps to make the partnership happen by providing a clear understanding of each group of participants’ roles and responsibilities (e.g. students, nurse academics, clinical facilitators, clinicians etc.),
- ensure all significant changes are communicated between partners and forwarded to their membership in a timely and open manner, and
- ensure new incumbents are informed and time reinvested into new staffing complements, so all participants in the partnership understand the philosophical and practical application of the alliance.
Benchmark 2

**There is effective and timely communication between partners.**

*Benchmark rationale:*

The success of the partnership will depend on open, transparent and effective communication and information sharing between people at all levels of the partnership, both within and between partner organisations.

**Source of data:**

- Documents pertaining to roles and responsibilities of partners
- CLEET and other evaluation instruments
- Communication and information process and policy documents

**Good practice criteria:**

- Accurate and applicable information is communicated effectively to students regarding their clinical placements for example: expectations, clinical learning objectives, expected outcomes, pragmatic information such as transport and parking arrangements, occupational health and safety requirements, uniform policies, special considerations etc.
- There is accurate and timely communication regarding placement of students (dates, numbers, year students are in, and any changes to existing arrangements) to the health service, and to the staff in the specific clinical learning environment.
- There is accurate and timely communication regarding changes that might influence the quality of clinical education for students (staffing levels, patient profile etc.) to the university, and to the allocated academic/clinical facilitator responsible for particular student placement at the CLE level.
- The CLE staff receive accurate information regarding the expected outcomes before each clinical placement. These include: clinical learning objectives, general competency/skill profiles that can be expected from each cohort of students placed, specific competency and skill expectations, and identified areas of specific learning need/s for individual students coming to a CLE.
- There are clear, accessible and timely communication processes negotiated between partners, for clinicians to communicate with students and the academic/clinical facilitator regarding student progress and student related matters.
- There is regular and ongoing communication between the nurses in the CLE, clinical facilitators and nurse academics (and health service liaison staff if appropriate) throughout each placement that ensures effective liaison and/or trouble-shooting takes place.
Benchmark 3

The rights, roles and responsibilities of persons at every level of the clinical learning partnerships are clearly defined.

Benchmark rationale:

Effective partnerships require the negotiation, articulation and documentation of clearly defined rights, roles and responsibilities for persons at all levels of the partnership. When such clarification is present at the academic/clinician interface each person readily understands for what and whom they are responsible, thus facilitating the processes that support student learning.

Source of data:

- Philosophical statements of partnership organisations
- Policy documents detailing rights roles and responsibilities of partners
- Position description documents
- Negotiated protocol documents between partners at every level of the partnership

Good practice criteria:

- There is joint planning of all clinical placements and implementation of the clinical education program, by appointed staff from the university and the health service.
- There are appropriate policies, processes and structures established that support those who provide clinical facilitation and preceptorship.
- All individuals involved in clinical learning and teaching have a clear understanding of their respective rights, roles and responsibilities that were developed in partnership.
- All partners receive written guidelines and/or protocols of their position description, roles and responsibilities regarding student learning written in accessible language\(^\text{14}\).

\(^{14}\) An exemplar of how one PAR group commenced that process of defining roles and responsibilities is provided in Appendix F. The exemplar provides one model of how each partners’ responsibilities may be clarified but the information provided is neither exhaustive, nor prescriptive, and is a work in progress.
Benchmark 4

Scholarly teaching by both partners occurs in the clinical learning environment.

Benchmark rationale:

Nurse academics and/or clinical facilitators, and preceptors working within a clinical learning environment as clinical teachers must be adequately prepared to provide clinical teaching and learning experiences. To do this effectively necessitates: current clinical knowledge and the capacity to access and apply research evidence to practice, current knowledge of the CLE; an appropriate attitude that enjoys teaching and views students as learners; and the willingness and ability to facilitate and supervise clinical education experiences that expedite the transfer of knowledge into practice.

Source of data:

- Student feedback data
- Clinical Learning Environment evaluation instrument/s
- Scholarly portfolio of evidence provided by clinical teachers/academics
- Organisational unit data

Good practice criteria:

- The university checks the academic's and/or clinical facilitator's suitability to teach in the stated clinical learning environment, noting contemporary clinical engagement and up-to-date knowledge and experience in the focus area of that CLE.
- The university links academics and/or clinical facilitators to a clinical learning environment in which they have current knowledge, expertise and interest.
- Academics and/or clinical facilitators working in clinical areas are provided with time and workload arrangements that allow them to maintain knowledge of current practice and research issues, to ensure up-to-date and enhanced clinical knowledge and skills.
- Academics working in clinical areas have workloads that facilitate regular contact with CLEs and the ability to remain in contact with all students where required.
- The university uses clinical facilitators as partners to deliver the curriculum in the CLE and on campus.
- The university facilitates cross-institutional teaching by both partner organisations. For example, clinicians can play a greater teaching role on campus and academics provide more in-service education within the CLE.
Benchmark 5

The partnership elements that promote high quality clinical learning for students are provided within the clinical learning environment.

**Benchmark rationale:**

Effective partnerships promote high quality clinical learning environments that enhance student learning, link theory and practice and allow for the professional socialisation that facilitates work readiness. The best learning occurs when nurses and academics/facilitators involved in supporting student learning are accomplished in their area of clinical practice, prepared for the role of teacher, knowledgeable, enthusiastic, able, well supported and adequately resourced. Quality is facilitated by a social and professional milieu that embraces, supports and encourages learning. These environments are carefully and deliberately created, nurtured and developed by both partners.

**Sources of data:**

- Documents that indicate support for clinical teaching and learning e.g. orientation manuals, induction packages, staff development programs
- Clinical learning environment evaluation instruments
- Student feedback and evaluation data
- Organisational quality audits and performance appraisal documents of all partners

**Good practice criteria:**

**Induction and orientation**

- The university provides a practical system of education and training, supervision, mentoring, appraisal of clinical teaching effectiveness, and opportunities for development of these skills, to all persons working as nurse academics, clinical facilitators and preceptors that support students in the CLE.
- An effective orientation and induction system for clinical facilitators and preceptors that presents appropriate curriculum content, guidelines, expectations, and the processes of assessment for clinical education of nursing students in the CLE.
- An effective orientation and induction system for nurse academics, clinical facilitators and students to the policy, procedures, geographic layout and unique work practices of each specific CLE.
- Explicit guidelines are in place, where required, to determine circumstances when certain students should not attend e.g. male midwifery students in delivery units when Muslim women are being attended.

**Resourcing learning**

- Work conditions in the CLE are appropriate and conducive to learning. For example, space to move aside with a student for practical teaching, counselling or debriefing.
- Both partners resource student learning so reasonable and fair workloads are managed optimising teaching and learning for all members of the partnership.
- The number of students allocated to each CLE at any given time, considers the level of care of the unit’s patients, the skill mix within the unit, and the level of experience of the students.
A resource person or designated liaison person (usually an experienced clinician) is nominated to handle student queries on every unit that students attend.

Each student has an identified preceptor each day of his or her clinical placement.

There are regular and extensive opportunities for staff development, including mentoring and continuing education provided by both partners, for the membership of all organisational partners.

The student will have access to resources such as: audiovisuals, policy and procedure manuals, internet/intranet, up-to-date nursing journals and books, independent study packages pertinent to the specific focus of the CLE.

Quality of nursing care in the CLE

- Clinicians demonstrate high standards of evidence-based nursing practice.
- Clinicians demonstrate practical application of the organisation’s philosophy of care, policies, procedures and protocols in their clinical environment.
- There is congruence between what the university teaches and what is practised as safe, effective professional nursing care.
- Students are actively involved in the assessment, planning, provision, evaluation, documentation and reporting of nursing care.
- Students are provided with opportunities to take on increasing responsibility for patient care once they have demonstrated appropriate, safe practice.

Climate of the CLE

- Relationships between the students and academic/facilitator, between nurses and students, and between nurses and the academic/facilitator are based on mutual trust and reciprocity.
- There is a climate of positive peer support and mentoring for students, where student presence is valued and their contribution recognised.
- Clinicians in the CLE demonstrate a positive attitude toward the university program.
- There is a cooperative and collegial team spirit evident between nurses in the CLE.
- Clinicians in the CLE demonstrate respect and work collaboratively with non-nursing colleagues.
- Students demonstrate respect for their clinical colleagues.
- Clinicians in the CLE are invited to take part in decision making regarding the model of student education/supervision used within their CLE.
- Clinicians in the CLE role model appropriate professional attitude in all aspects of their nursing practice.

Recognition and acknowledgement

- Preceptors working with students are recognised, acknowledged and if possible rewarded for the resulting increase in their workload. Suggested methods may include those listed below as incentives and or rewards for exemplary clinical teaching.
- Some suggestions put forward by clinicians in the PAR groups include:
  - provision of academic status and academic privileges such as access to library, resources, lectures and continuing education;
  - letters of acknowledgement / certificates of appreciation;
  - incentives such as, books, coffee and massage vouchers, gym memberships, time in lieu, financial, supernumerary education days etc.;
  - linking promotion, tenure and performance standards to demonstrated excellence in clinical teaching;
  - rewarding and banking of continuing education points that can be cashed in for course fees and conference registration costs.
Benchmark 6

There is regular monitoring of agreed partnership elements that affect learning, teaching and progress of students.

Benchmark rationale:

Regular monitoring of the quality of teaching and learning within CLEs enhances partnerships between universities and health care facilities and enables the early detection of problems, facilitating joint, negotiated action and intervention, if and when it is required.

Sources of data:

- ANCI competencies, codes and ethics related documents
- The university curriculum document
- Subject outlines for specific learning objectives
- Student data collection regarding clinical learning contracts
- Data collections within each organisation regarding student progress

Good practice criteria:

Monitoring progress toward learning objectives

- Clinical learning objectives are accessible, having clearly expressed goals, processes and desired outcomes, with descriptions that are intelligible and reliable explanations of the expected standards.
- Clinical learning objectives are directly linked to assessment tasks.
- Students are provided with information linking their clinical learning objectives with educational opportunities in the clinical area.
- Students are encouraged to ask questions, evaluate learning experiences, identify their learning needs, and adjust personal learning objectives accordingly.
- Facilitators prepare staff regarding expected student competencies and learning objectives, clearly specifying the amount and type of clinical experiences necessary to achieve the desired outcomes.
- Each individual in the partnership is aware of their defined responsibilities regarding the successful implementation and assessment of student clinical learning objectives.

Monitoring student progress

- Partners agree on processes that provide uniform monitoring and assessment of student progress and strategies such as clinical contracts designed to address problems, if and when they arise.
- The nurse academic and/or clinical facilitator monitors the clinical learning environment and student progress at regular intervals, negotiated with staff in the CLE.
- Students are assured of uniformity, fairness and equity in assessment of their progress.
- Student assessment is transparent and individual feedback is constructive.
Students understand their right to access available coaching to address identified learning needs and meet clinical learning objectives.

Mechanisms are in place that ensure students not meeting expected standards/levels of competency have their learning issues identified during the placement, and strategies designed to overcome these problems are implemented expeditiously.

Students attend post-placement debriefing sessions.

Clinical facilitators/ nurse academics attend a meeting with staff of the CLE (at least annually) with the CLE nursing representatives to debrief, evaluate the clinical learning environment, discuss student matters, review expectations, policies and processes etc.

The university monitors the number of, and reasons for, students being placed on clinical learning contracts.

The university monitors the numbers of equity groups e.g. culturally diverse, Indigenous, Mature, former Enrolled Nurses, to get specific information regarding the learning and support needs for such specific student groups.

Evaluation of the Clinical Learning Environment

- Annual evaluation processes involve rigorous and independent implementation by the university in collaboration and concert with the partner organisation/s.
- The regular evaluation processes are uniform, objective and provide a 360-degree feedback cycle to all partners.
- Appropriate follow-up counselling and support toward growth and development of teaching and learning is negotiated and actioned as requested/required, by both partners.
The potential problem areas of benchmarking

The research process identified several areas that may be problematic when rolling out benchmarks for clinical learning partnerships. These include:

*Lack of perceived benefit at the clinical interface of the partnership*

The main issue is the perceived lack of relevance of benchmarks to the daily practice at the clinician level of the partnership. There are definite advantages for the organisational partners, but these need translation to tangible outcomes for clinicians, so their support can be enlisted, otherwise benchmarking is in danger of being viewed as another piece of administrative paperwork that achieves nothing for clinicians, yet it increases their workload.

*Dependence on the culture and climate within the CLE*

The attitude of clinicians influences the culture of the clinical unit as an optimal learning and teaching environment, thus it will affect how benchmarking is received and embraced. Phase One discussed several models that enhance teaching and learning, and South Australian PAR group participants were keen to share how a cultural shift regarding teaching and learning had occurred when one such model (the Dedicated Education Unit model) was introduced in their clinical learning environment. Participants noted positive changes in the learning and teaching culture, evidenced by:

- clinicians demonstrating an increased acceptance and ownership of their responsibility in creating nurses and providing clinical care;
- nurses developing a vested interest in students, thus providing teaching input;
- a growing pool of people actively engaged in advancing nursing;
- excellent continuity with continual exposure to the same cohort of students over a fourteen week semester, so clinical nursing staff stayed attuned to student needs;
- students who are learning the finer nuances of professional socialisation, communication and practice which takes time to inculcate and assimilate; and
- a developing culture of learning as nurses take active roles in clinical teaching and supervision, which stimulates their interest, resulting in many wanting to increase their knowledge base by undertaking further study.

Additionally, findings evidenced by participants using the ‘Clinical Education Unit’ model in Queensland noted increases or improvements in:

- use of clinical buddies/practice partners to ensure quality experiences;
- development of mechanisms that foster collaboration between partners;
- collaborative implementation of strategies to bridge the gap between the students’ supernumerary status and their experience of being ‘part of a clinical nursing team’;
- cooperation in the development of cost effective clinical facilitation models; and
- consistency of learning outcomes provided by continuity of long-term clinical placements over one academic year within the same CEU.

Such models of organising clinical education are likely to embrace benchmarking but environments which do not have an ethos that embraces teaching and learning may be
less likely to accept such evaluation benchmarks. Participants note when staff are ‘anti-
student’, ‘anti-university’, or just generally apathetic toward teaching students, they are
likely to be dispassionate, possibly even antagonistic toward any notion of benchmarking,
fearing possible punitive consequences.

**Unwillingness to disseminate innovation and best practice benchmarks**

Industry notes problems associated with accessing best practice information due to the
competitive climate (especially when purchaser contracts are involved) between
organisations, making them reluctant to share what gives them the leading edge (Ellis
1995). Even when information is not shared, competitors can and do catch up, and even
overtake. It is sharing of information that keeps them progressing rapidly. If best practice
is to grow and develop, benchmarking results have to be shared within institutions at the
very least. Many participants stated that they want these results widely disseminated and
available, so real changes are affected, otherwise the task would be a waste of resource,
time and effort.

**Recommendations**

Phase One of this study gave overwhelming support for the development of collaborative
partnerships between universities and health services to improve the quality of clinical
learning and teaching for undergraduate nurses. This is a serious issue for a profession
experiencing increased demand for its services, decreased recruitment and retention of
nurses, and increased attrition rates from the profession. The solutions to our
professional problems cannot be tackled by single institutions and hence the formation of
collaborative partnerships in Phase Two of the study is proposed as one opportunity to
create the synergy required to tackle these issues.

This research has developed three clinical learning environment evaluation tools
(CLEET) which may be used to measure various aspects of the benchmarks that were
elicited from the research data. Many of the benchmark and their related criteria might be
considered recommendations, as are the suggestions in Table 4.1. To summarise this
study recommends:

**Develop strong partnerships between universities and health services**

Formalise these partnerships, make them a high priority, resource them and staff them
with committed, capable people who are enthusiastic about the partnership. Look to the
partnership as a long-term investment. Encourage links at all levels. Manage the
relationships carefully, be trusting and act with integrity. Ensure all partners know their
roles and for what they are responsible as well as their rights within the partnership.
Facilitate a positive learning climate in the clinical learning environment

There needs to be recognition that positive work environments and the relationships therein, contribute both to the effective learning experiences of students and the provision of quality patient care.

Recognise and acknowledge clinicians working with students

Resentment of participants will adversely effect student learning, therefore consider a consultation processes to find ways of recognising the clinicians’ contribution. Possibilities include: offering access to university facilities; courses and continuing education programs; the redirecting of funding previously delivered at health service level to the clinical unit level; joint appointment of clinical staff; rewards and incentives; and measures to reduce workloads or recognise clinicians involved in clinical teaching. No doubt such schemes will require an increase, or at the very least a shift in funding to support such endeavours, but this should not stop partnerships from trying to effect these suggestions.

Practise open and transparent communication between partners at every level

Empower clinicians in the CLE to communicate with designated university representatives. Ensure health service clinicians feel supported at all times to enhance troubleshooting and provide early conflict resolution. Consider the establishment of direct and fluid communication structures and processes between partners, so responses are rapid and effective. Have clear, well documented divisions of responsibilities to maximise performance, but avoid developing an inflexible bureaucracy that hinders rapid responses to problems and issues.

Ensure flawless preparation of students and clinicians for clinical placements

Send students to units that are prepared to receive them and try to place them with skilled and knowledgeable clinicians that enjoy working with students. Prepare facilities and staff to provide quality teaching and learning; making sure they understand how to supervise and assess practice, and monitor student progress. Confer and give timely notice of student arrival. Ensure clinicians and students know the students’ learning objectives and how to structure learning to meet these objectives in accessible and achievable ways. Maintain these skills.

Ensure the administrative structures in place work as planned

Don’t be complacent about established patterns of behaviour or structures. Seek regular feedback from students and clinicians at the CLE level and act responsibly to the issues that are raised. Test the administrative systems regularly to ensure they are working as planned. Track students’ clinical placements and their performances, monitoring trends and developments over time so quality improvements can be instituted.
Ensure manageable workloads for clinicians and academics involved at clinical education

Clinicians, preceptors, academics and clinical facilitators are the vital links in the provision of clinical education so the organisation and management of their workloads impacts the core business of both partners. Put in place policies, processes and structural frameworks that allow them to do their jobs well, with the opportunity of achieving successful outcomes.

Accept differing needs, aspirations, processes, and keep responses flexible

Universities and health services have different service drivers and thus varying goals and agendas. Academics and clinicians have different priorities and skills, and use fundamentally different work patterns. Both sides bring special, invaluable attributes to the partnership. Approach each other with mutual respect, trust and tolerance, appreciating each partner’s differences. Be flexible and make allowances for some ambiguity in the processes without damaging the partnership. Instead, work together to create something new and viable for nursing and consequently the health care of all Australians.

Conclusion

Much has been written about partnerships in the business and management literature and most of this information is equally applicable to university/practice partnerships. This material has been covered in Chapter 2 of this document. However, there were significant factors evident across all sites in relation to clinical learning partnerships.

There was resounding agreement across all research sites that strong collegial partnerships between tertiary education providers and health service providers are vital to the quality of clinical education and the outcome of that process: effective beginning registered nurses. All participants felt that it was important to focus on what they viewed as being best practice based on their experiences of what constituted an effective partnership. They felt that best practice was evident when key stakeholders, including clinicians, academics, clinical educators and students demonstrated awareness of their mutual responsibility in the educational preparation of registered nurses, in which quality clinical practice was a critical element. The challenge lies in the clinical learning environment, which has many variables that can be difficult to manage.

It was found that successful partnerships that developed positive learning cultures displayed the following elements, which were pivotal to their success:

- communication of information, including objectives/expectations for the clinical placement to clinicians before student commencement;
- thorough student orientation to the health service and the clinical learning environment;
- selection of suitable preceptors/clinical partners for individual students;
- organisation of specific learning experiences that ensure course and individual learning objectives are met;
- one to one clinical support for each student;
organised clinical teaching on an individual and/or group basis;
pre-briefing and debriefing sessions for students and nursing staff in the CLE;
timely and accurate provision of formative feedback and summative assessment to
students regarding their performance (including relevant performance appraisal tools);
continuing and open liaison between university and health service partners; and the
contribution by university personnel to in-service education and support of staff
working with students.

The most essential element to impact on every aspect of successful partnerships is
effective, timely and accurate communication processes between stakeholders. Research
participants highlighted aspects that require excellent communication. These included
assuring that students’ learning objectives are appropriately communicated, logistics of
placements are advised in a timely manner, effective and appropriate communication
between students and facilitators occurs at the patient care interface, and appropriate
debriefing opportunities are conducted.

A second key element of a quality clinical learning environment is the recognition that
positive working environments may contribute to the maintenance of high quality nursing
care. Inherent in this environment is a clear understanding of the respective roles and
responsibilities of all key stakeholders. The importance of mutual trust and respect
between members of the partnership at all levels is highlighted as being a positive and
necessary characteristic of an effective partnership. All participants also recognise the
need for students to be valued and to have their learning nurtured by both the university
representatives and clinicians within the clinical unit, for quality learning to occur. The
presence of such elements contributes to the development of positive role modeling for
students.

Such a climate is assisted when appropriate preparation and supervision of students is
completed by the university, and when universities educate and develop clinicians within
the CLE in the art of clinical teaching. However, it needs to be backed up by effective
communication and agreed strategies for dealing with student progress difficulty if/when
they arise.

One issue of concern to clinicians was the limited acknowledgment and recognition (or
compensation) they receive for the increased workload of facilitating student learning.
Even when hospitals and universities have agreements and payments in place for the
allocation of students, staff at the interface of CLEs are seldom acknowledged or
rewarded for their efforts with students. Some CLE staff are concerned by their lack of
control over student placements. Participants at the Sydney site were troubled by the fact
they were unable to decline or defer student placements. Needless to say when a student
arrives at such a workplace, their learning is likely to be adversely affected by the climate
of tension in the CLE. Militating factors such as staff sick leave, chronic under supply of
experienced staff, higher patient numbers and acuity, and increasing administrative loads
impact on the quality of student learning. Clinicians want to be able to renegotiate their
workload regarding students because at times they can find their personal resources are
insufficient to cope with student teaching and the concomitant increased workload.
However, most participants perceive the presence of students as helpful in the provision
of patient care, viewing student teaching as part of their registered nurse role and an
agreed function of the teaching hospital.
A second area of concern was the lack of, or untimely communication to the clinicians in the CLE regarding student placements. Administrative structures of communication between and within universities and health services may be in place formally, but breakdowns are common place, with communication channels not working as one might hope or anticipate. Consequently, while nursing executive units work on the premise that they support student clinical placements, at the clinical unit the situation may be anything but supportive for some students. There were examples cited of students arriving on units at short notice, or without warning, and of clinicians with no information about who to call regarding student matters. It was not uncommon for both partners to believe details had been dispatched in a timely manner, yet communication glitches in the flow of information were evident. This indicates the need for clearly designated responsibilities and communication channels in large health services, so roles are clarified and understood by all participants.

A third area of concern for some of the research sites was the apparent lack of clearly articulated, easily interpreted student learning objectives. Clinicians and students want learning objectives that are easy to translate into practical assistance. Clinicians want clear student guidelines for practice and well-defined practice boundaries pertaining to each cohort of students. Additionally, some are concerned about their qualification to assess students and to give fair, open and honest feedback. Again, the university staff believe these issues have been discussed and strategies developed such as the provision of educational programs on educational facilitation for clinicians. It is hoped that benchmarking will illuminate just where the problems are in communication and education for clinicians so these issues can be rectified.

In conclusion, this project, funded by the Australian University Teaching Committee, aimed to improve teaching and learning partnership between universities and their clinical partners. It used a modified Participatory Action Research process to identify the elements of such alliances that would optimise clinical learning, specifically identifying work practices that require reorientation and better management. In this process six benchmarks were identified as standards against which the quality of partnerships may be measured. Additionally, three site-specific evaluation instruments were developed to evaluate the clinical learning environment and the partnerships that influence teaching and learning within that environment. These tools may be used and adapted by other education – practice partnerships throughout Australia, with the aim of assuring the quality of clinical education for undergraduate nurses across this nation, facilitating their ability to commence quality practice on graduation, and refining and improving patient care in this country.
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