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The Clinical Instructor of Nursing and the Learning Environment: A Qualitative Study

by

Ardene Louise Robinson Vollman

Thesis presented to the

School of Graduate Studies and Research

of the

University of Ottawa

in partial fulfillment of the requirements

for the degree of Doctor of Philosophy

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"With you I can fly higher than an eagle,
You are the wind beneath my wings."
Bette Midler, 1988
(written by L. Henley & J. Silbar)

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Abstract

Clinical experience is central to the preparation of professional nurses because nursing is a practice profession, a discipline whose nature is an interactive process with patients and their families. The importance of clinical experience can be illustrated by the fact that student nurses spend twice as much time in clinical as in the classroom. Despite recent changes which have profoundly affected the profession (technological advances, feminist movement, aging population, increased health care spending), there exists little research regarding the effectiveness of the clinical learning experience.

The purpose of this research was to investigate and describe the clinical learning environment, specifically how the clinical instructor in nursing education interacts with that environment to foster learning. Three supplemental questions were asked: what are the elements which comprise the clinical learning environment, what are the characteristics of these elements, and how does the clinical instructor cope with, adapt to, influence, and manipulate the environment?

Symbolic interaction formed the philosophic foundation for the research approach used in the study. The investigation used a qualitative methodology to collect data. Three clinical instructors were observed on three wards, in two hospitals, over a seven week period. Key participants (clinical instructors, students, staff nurses, and head nurses) were invited to explain their experiences in their own words. These insights were coupled with participant observation and document analysis to provide a rich source of data; some 300,000 words were electronically transcribed to form the research database. During the course of the study, 112 people signed consent forms and participated in some manner: 92 in the study proper, and an additional 20 in a pilot study.

The analysis of transcript units was facilitated by the use of a microcomputer and database software. All fields in the data base were identified by name of informant, date, site, and type of data (transcript, field note, memo), and further categorized as the data

were analysed. As the data were unitized, key words and phrases were used to code the idea contained in the unit. As the number of units increased, themes and patterns began to emerge, and the units were constantly reevaluated and compared in light of these themes.

Instructors were observed to be carrying out five major functions: personal orientation activities, preparation of the nursing unit to receive students, preparation of students for their clinical experiences on the unit, instructional activities, and monitoring and evaluation exercises. Four roles characterized her practice: coach, consultant, colleague, and counsellor.

The clinical learning environment was conceived as being comprised of seven dimensions: personal, physical, social, curricular, contextual, political, and economic. A model was proposed to illustrate the environmental dimensions. No attempt was made to determine which dimensions of the clinical learning environment were most important. The intent of the study was to determine which elements existed and to describe them. In any given clinical learning situation all dimensions were more or less present. The teacher based her responses to any situation on the prominence or salience of each dimension.

The clinical learning environment was characterized by a set of four common characteristics, or properties. These properties were complexity, structure, stability, and opportunity. In attempting to manage the environment, the instructor viewed the clinical milieu in relation to her connection to the students and their learning needs. She wanted to be able to intervene directly in the milieu without her actions or decisions being mediated, compromised or thwarted by others. She viewed each clinical situation as a potential learning opportunity for her student, and worked to alter conditions where student learning might be hindered. Instructors acted to integrate college curricular requirements with clinical experiences, creating circumstances from which students could learn what they needed and prepare themselves for their future roles and responsibilities in the profession.

The author suggests that clinical instructors must begin to practice their craft with theoretical rationale for their strategies. There is a need for more planned educational and experiential preparation of clinical instructors.

Further investigation of the proposed model to reveal interactions among dimensions, and the relative importance of each dimension to the teacher and the student, is required.

Investigation of practical curriculum theory which addresses interaction of the teachers, students, subject matter and milieu may serve as a fruitful undertaking for further research development. If clinical teaching activities and clinical learning environments are systematically studied in conjunction with research on nursing students and nursing theory, propositions can be developed that can be tested and applied to improving the effectiveness of teaching and the efficiency of learning.

The model of the clinical learning environment proposed in this study needs to be applied in a wider variety of settings and with a broader range of teaching programs (baccalaureate, continuing education, graduate studies) in order to determine its general utility.

Curriculum Studiorum

Ardene Louise Robinson Vollman received her diploma in nursing in 1970 from the University of Saskatchewan, Saskatoon, Saskatchewan, and her Bachelor of Science in Nursing degree from the same university in 1978.

A Master of Arts in Education was conferred by the University of Ottawa in 1985. The topic of her thesis was: Student task relevant maturity level and instructor leadership style as factors of effectiveness of clinical instruction in nursing education: A test of Situational Leadership Theory.

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Chapter 1
Introduction and Review of the Literature

Every year nearly 7,000 nurses graduate from schools of nursing in Canada. Nursing education serves to ensure that qualified and competent nurses are available to health care agencies to meet a continuing growth in demand. The manner in which this mandate is fulfilled reflects a complex mix of beliefs and traditions about professional education, nursing theory, and the nature of the professional nurse in the workplace. The following overview of the history of nursing education in Canada provides a synthesis of the social and political factors which have affected the development of professional education for nurses, and the manner in which such influence remains prevalent.

Substantial change has taken place in nursing education since Florence Nightingale instituted the first training school in England in 1860, the concept of which was imported to Canada in 1874. Initially, nurses in Canada were trained in hospitals where standards varied enormously from school to school and students worked long arduous hours on the wards under difficult circumstances. If offered at all, classroom theory was fit in after ward duties were complete. Following release of the Canadian Nurses' Association commissioned Weir Report (1932), calls were made for fundamental reforms, specifically that the responsibility for nursing education be transferred from hospital to educational institutions. The objective was to have educational needs of the profession take priority over hospital service requirements.

Despite these recommendations, until the 1960s over 95% of Canadian nurses received their basic nursing education in hospital programmes. However, a great deal of experimentation and planning was occurring in an effort to improve the quality of nursing preparation. Professional associations spearheaded many of these innovations and were assisted by changes in the funding structures to health care agencies and the demands of increasing technology in health care (Baumgart & Larsen, 1988).

Over the past three decades, the percentage of the Gross National Product allocated to education and health care has more than doubled, promoting a dramatic growth in services.

The twenty years between 1960 and 1980 saw a tremendous change in general post-secondary education which in turn had an enormous impact on nursing education. A network of community colleges and vocational/technical institutes was developed. Universities flourished. Adult continuing education enrolments increased. Basic, graduate, and continuing education programmes for nurses expanded in scope, size, and resources, causing major changes to the pattern of education for nurses. The curriculum and content of nursing programmes shifted in response to improved technology, advances in nursing knowledge, and the advent of nursing theory to govern practice.

Hospital schools of nursing were closed and diploma programmes transferred to community colleges (with the exception of 21 schools out of 186) across Canada. There are currently 110 diploma programmes offered in Canada (89 in community colleges) and 21 baccalaureate (university-based) programmes. The percentage of baccalaureate-prepared graduates has increased to 20% from 6% (C.N.A., 1982).

Willman (1986) asserts that increases in nursing enrolment are a result of societal changes related to demographics (lower birth rate coupled with improvements in medical care), changing health needs (aging population), the feminist movement, changing perceptions of nursing as a career, affirmative action, equal opportunity and pay equity programmes, and the community college movement which has increased the availability of post-secondary education to a greater numbers of students.

The nature of the student body is more heterogeneous than in the past with an increasing proportion of males, mature students, and minorities enrolled in nursing education programmes. Lifestyles of students are also changing. No longer do students live in dormitories; many commute long distances. Financially, many students are dependent upon part-time employment to maintain their lifestyles while studying. As well,

students differ in academic background, intellectual ability, and motivation (Willman, 1986).

The many changes that have occurred in basic nursing education in Canada have profoundly affected the relationship between nursing service and education. A new partnership is being forged and many questions about the congruence between knowledge and competencies required by today's employers and what nurse educators feel is important to the future diversity of roles within the profession need to be addressed (Miller, 1985, p. 418). Consideration of the student, the subject matter and the nursing environment is paramount. The context within which nursing takes place has a significant impact on the way nursing is practised.

Chater (1982) pictures the conceptual framework of nursing studies as three interlocking circles: setting, student, and subject. The setting includes variables such as the type, mission, location, and characteristics of the institution. The student circle calls attention to the characteristics of the learner: age, personality, ethnicity, level of education, background, and goals. The subject represents the discipline of nursing. Schubert (1986) adds one aspect to Chater's (1982) interlocking circles to form what he calls the four curricular commonplaces: teacher, student, subject matter and milieu.

According to Schein (1972), professional knowledge consists of basic sciences, applied sciences, and the skills and attitudes that comprise the performance of service to clients. The essence of nursing is the clinical act (Chater, 1982). The clinical act happens between the nurse and the patient. The Canadian Nurses' Association defines it as

> *a dynamic, caring, helping relationship in which the nurse assists the client to achieve and maintain optimal health. The nurse fulfils this purpose by applying knowledge and skills from nursing and related fields using the nursing process.*
>
> C.N.A.1980 p.vi.

The clinical setting is a broad term encompassing any milieu where a nurse interacts with a patient. Obvious settings include hospital wards, clinics, and nursing homes.

Theory and practice are viewed as two related components of nursing practice yet, for the most part, have been taught as separate entities. The clinical component is integral to and in fact constitutes the major part of any programme of nursing studies. An understanding and description of how the clinical environment affects learning is central to the improvement of nursing education programmes.

The remainder of this chapter comprises a review of the literature and is arranged in four major sections. The review of the literature will focus on that which is relevant to the milieu which, in this instance, refers to the clinical setting where the practical component of nursing education takes place. In the first section, the literature respecting clinical instruction in nursing is surveyed. In section two, research relevant to environments in schools and organizations is reviewed to determine its applicability to the nursing setting. In the third section, literature on the practical component of professional education is briefly outlined to seek concepts applicable to nursing education. The research question and implications for the investigation are outlined in section four, followed by a brief summary to conclude the chapter.

1.1 The Clinical Component of Nursing Education

Clinical learning experiences refer to the totality of directed activity in which a student engages with patients. Clinical nursing practice is central to the preparation of professional nurses (Redman, 1965; Allerman & Britten, 1978; Carr, 1983) because nursing is a practice profession, a discipline whose nature is demonstrated through an interactive process with patients and their families. The importance of the clinical component in a nursing education programme can be illustrated by the relative number of hours devoted to teaching nursing theory compared to the number of hours in the clinical setting. Twice as much time is spent in clinical as in the classroom. It is in the clinical setting that patient contact is made, nursing skills are practised, and the nursing process is

integrated with patient care. Students view clinical experience as crucial to their education because it most closely resembles the performance of a graduate nurse (Carr, 1983).

Because of the continued existence of three models for the preparation of nurses (hospital, community college, and university) and the resulting duplication, cost, confusion, and division between nursing education and service, it is imperative that nurse educators maintain frequent and informed dialogue concerning teaching and learning in the clinical area. However, this has not been the case; clinical teaching seems to have a status secondary to classroom work. Commonly, senior faculty teach in the classroom, while less experienced faculty supervise clinical experiences (Smith, 1988).

The place of clinical practice as a necessary component of the professional preparation of the practitioner of nursing is undisputed. However, because of the complex nature of clinical practice and the long-standing, and essentially unchallenged, traditions and patterns for providing clinical experiences, there is a need for careful scrutiny of how and under what conditions clinical practice is conducted, and how clinical learning takes place. In the next section, research relevant to the clinical instructional process in nursing education is presented.

1.1.1 Clinical Instruction

The education of nurses is the responsibility of community colleges and universities. Clinical sites are chosen and contractual arrangements are made for student field placement in health care agencies for the purpose of clinical experiences. The nurse educator and the students are guests in the agency and accountability for patient care rests with the health care agency, not the educational institution (College of Nurses of Ontario, 1985; Infante, 1985). The nursing programme utilizes the unit as a laboratory for the purposes of teaching and learning, not provision of care (Infante, 1985), although the latter takes place as a part of the learning process.

The primary responsibility of the clinical instructor is to facilitate the transfer of learning from the theoretical to the practical with respect to the specified goals and objectives of the course being taught. The student nurse also learns to apply theories of action to real clinical situations, learns how to learn, develops skills in handling ambiguity, and becomes socialized into the profession (Reilly & Oermann, 1985, p. 77). The process of clinical teaching is complex because it is influenced by many variables. These variables include multiple programme objectives, a wide range of practice settings, diverse abilities of the learners, skill and experience of the instructor as a nurse and as a teacher, and interpersonal and group dynamics operative in the clinical field (Vollman, 1985).

The purpose of the clinical experience is to provide systematic learning experiences for student nurses during their assignment to the clinical area. The focus is on the learner (Quinn, 1980). Clinical experiences are selected by faculty on the basis of the nature of nursing as a profession, the health care needs of the population, and the nature of the educational environment (Haukenes & Mundt, 1983). The educational environment includes the curriculum model, the nature of the faculty, the nature of the community, and the nature of the student. According to Roman (1986) the essentials of the instructional process, as generated from documented actual practice, are the participants, their goals, the environment, the instructional means, and their effects.

The impact of the clinical instructor on student learning is considerable (Vollman, 1985), but the process of clinical teaching has been neither well documented nor well communicated (Pugh, 1980). O'Shea and Parsons (1979) pointed out that this appeared to be an area in need of further investigation. A search of literature pertaining to clinical instruction leads to the conclusion that little research has been directed toward a basic analysis of clinical teaching behaviour (Daggett, Cassie, & Collins, 1979). Previous nursing research which has focused on faculty behaviours has centred primarily on the identification of effective or ineffective instruction (Jacobson, 1966; Karns & Schwab, 1982; O'Shea & Parsons, 1979; Rauen, 1974). Effective teacher characteristics and the

importance of the nature of the teacher-student relationship have been drawn from clinical incident reports, literature reviews, and general education theorists. Results are categorized into six major areas: availability to students, professional competence, interpersonal relations, teacher practices, personal characteristics, and evaluation practices (Theis, 1988; Zimmerman & Waltman, 1986).

In a comparative study Pugh (1976) found that the ideal teacher-student relationship "involves good or excellent communication in a peer relationship." This relationship is formed primarily for the purpose of teaching and learning. The teacher role is that of facilitator, counsellor, and colleague, assisting the student to seek answers to various questions in their quest for knowledge.

The nature of the relationship between instructor and student has been characterized as intense and transient. Wang and Blumberg (1983) observed 44 nurse faculty over two-hour periods as they interacted with students, and found that the majority of interactions were on a 1:1 basis, with one third lasting one minute or less, and another one third lasting one to six minutes.

Guinée (1978) characterizes the relationship which exists between a teacher and a student as a partnership. It is the learner's responsibility to achieve the learning objectives and the teacher's responsibility to help them be attained through guidance and the provision of appropriate learning experiences. Communication skills which include empathy, respect, and a response to the whole message make outcomes between teacher and learner more meaningful and productive.

Carr (1983) characterizes the student-teacher relationship as a partnership which is essentially political in nature. The teacher maintains a position of power and control with the authority to purposefully manipulate situations and resources for students. Teachers select and organize learning experiences and determine the nature of the evolving partnership between themselves and their students. Four social-emotional qualities characterize the partnership: dynamic, reciprocal, cumulative, and humanistic. The

constant exchange of energy and information make it a dynamic partnership. The reciprocal nature is illustrated by teachers linking their perceived effectiveness to student performance outcomes. Successive responses in the partnership are built upon those preceding and serve to shape the relationship. The humanistic quality is indicated by the mutual need to be accepted and respected as individuals and by communication which is open, honest, and caring.

The role of the clinical instructor and her working relationship with the service (health care) agency personnel vary in different programs. The divergent practices and relationships which are developed reflect the beliefs of faculty, the educational administration, and the health care agency about what the role of the clinical instructor should be (Smith, 1977, p. 203). Quinn (1980) suggests that the clinical instructor acts as counsellor for learners, assessor for the school, liaison officer between the school and the hospital ward, and as a nurse during busy periods. The hospital ward is directed toward many goals and purposes (administrative, professional, service) and involves many professional disciplines. This creates the potential for competition and conflicting sources of activity at any given time (Reilly & Oermann, 1985, p. 79). The differences stem from different cultures and value systems and the clinical instructor must negotiate among competing interests to find a role for herself and create a positive environment for the students.

Instructors are advised to establish constructive professional relationships with hospital personnel by clarifying their respective roles, evaluating student performance, frankly discussing problems, jointly planning student learning experiences, and developing mutual respect (Smith, 1977, p. 217).

The selection and creation of the learning environment that will be suited to the student is the responsibility of the teacher (Guinée, 1978). A milieu that is conducive to learning is one in which there is pleasant student-teacher interaction and opportunity for concept formation. To develop generalizations about nursing and transfer them to other

situations a student must understand the concept, have a positive attitude toward new situations, and possess a sense of security so that the self-image is not assaulted.

Dodd (1973; cited in Lewin and Leach, 1982) explored two hospitals as learning environments for student nurses and found that neither constituted a learning environment because learners experienced difficulties in knowledge application. The ideal description of skills as practised in nursing school did not correspond with the reality of the ward.

Several subsequent studies investigated the appropriateness of selected wards for learning (Schröck, 1973; Strohmann, 1977; Fretwell, 1980; Skeath, Deadman, Gousy, Harvey, Tyrrel, & Yorston, 1979; Lewin & Leach, 1982). A common finding was that the head nurse was a key person in the clinical setting. The ideal head nurse was democratic, patient-oriented, and fulfilled an active teaching role. Her leadership style set the tone or climate for student experiences in the clinical setting.

1.1.2 Ward Climate

Carr (1983) stated that the clinical milieu displayed the features characteristic of a social setting which exhibited three salient qualities: multidimensionality, simultaneity, and relative uncertainty. Multidimensionality and simultaneity refer not only to the fact that a multitude of human events occur simultaneously, but also to the multiple goals and objectives of the organization. Relative uncertainty relates to the unpredictability of events in the clinical field. As an institutional structure, each ward exemplified four dimensions: physical, political, social, and emotional. Subtle and complex relationships between behaviour and the milieu create a general atmosphere or climate on the ward.

Ogier (1983) investigated the relationship of the head nurse to student learning and found that the ward climate, that is, the atmosphere of the work environment whether friendly or hostile, was directly influenced by the head nurse. Students preferred wards whose head nurses had a style which was open and inclusive of the learner.

According to Schweer and Gebbie (1976) the development of a favourable climate for learning is dependent in part on the establishment of working relationships between the teacher of clinical nursing and others concerned with the education of nurses (p. 45). The authors suggest that the following activities are important strategies: soliciting the cooperation of the head nurse, working together cooperatively with the staff, fostering reciprocal communications, and coordinating learning activities.

The relationship between the educational institution and the health care agency is a critical variable in setting the tone or climate in which student learning is to take place. Every clinical site has its own culture (norms, values, and expected behaviours). New entrants, i.e., teachers and students, need to understand the culture in order to work successfully in the clinical setting (Reilly & Oermann, 1985, p. 79).

Climate is multidimensional, with two aspects related to the impact of the organization itself (individual autonomy, degree of structure imposed on the job, reward orientation, consideration, warmth, and support) and leadership (work versus relationship orientation). Ward atmosphere reflects the quality of human relationships. Orton (1983) found student response to climate to be most notable in terms of satisfaction with clinical experience. There was no attempt in this study to correlate student response to ward climate with academic achievement, however, Griffith and Bakanauskas (1983) cite empirical and experimental evidence to show a direct relationship between an individual's self-concept and manifest behaviour, perceptions, academic performance, and intellectual efficiency (p. 105).

The teacher and the students, according to Heidgerken (1965), constitute a group. This group may be considered as a small social system consisting of persons influencing and being influenced by one another and drawn together because of common concerns, goals, and values. All groups have certain characteristics in common; goals to achieve, members who are joined together in common purpose, activities designed for goal achievement, and some sort of leadership or control. Group climate forms the emotional

environment for members. Climate is very important in the clinical group because it has an influence on the type of learning which takes place. Climate is not a simple entity, but is the sum total or composite of a variety of factors such as administrative structure, nature of the curriculum, aims of education, methods of instruction and discipline, the teacher, and the student. The teacher is viewed as the central factor affecting group climate because all other factors are, to at least some degree, subject to her control. The teacher brings herself to personal relationships with students and gives meaning to the learning experience.

Peer group attitudes cannot be ignored. They are important in that they are readily transferred and become powerful climate determiners. As adolescents, students seek conformity and acceptance (Heidgerkin, 1952). The peer group is important in the development of professional identity (Chaska, 1983). The stage of late adolescence is characterized by Erickson (1968) as a potential crisis period as professional role identity is defined and synthesized. As nursing students move into the clinical setting, they interact with other nurses and experience the role of nurse through practising nursing behaviours, thus identifying with the group to which they hope to belong. Self-concept develops through interpersonal relationships with significant others. This is the essence of professional socialization (Griffith & Bakanauskas, 1983).

The reference groups for the student in the clinical setting are the faculty and staff nurses. Peers are also important in providing feedback with regard to the appropriateness of behaviour, support, potential solutions to problems, and reinforcement for behaviours and emotions experienced. Less advanced students look to upper classes for cues (Merton, Reader, & Kendall, 1957). Student biases about faculty rest largely upon the teacher's reputation among fellow students.

Ogier (1983) examined the self-identification of student nurses as learners and workers. She found that students feel like learners most of the time, but also identify themselves as workers. Interestingly, the least discrepancy between identification as worker or learner was at the end of their first clinical experience, indicating that at this point

in their academic career they are most likely to suffer role ambiguity and conflict. Ambiguity is considered to be a source of stress in the workplace and was reported to be alleviated in this study by consideration (a climate of good rapport, warmth, and two-way communication) and structure (active direction in planning goal attainment).

Pugh (1980) describes the literature on clinical teaching and learning over the past three decades to be sparse and limited in scope. There appears to be much difficulty, she asserts, in defining what clinical instruction is and identifying what makes it effective. Despite a slowly growing body of literature that describes the clinical teaching process, there are few studies which elaborate the particular practices, procedures, roles, and relationships the instructor experiences in her efforts to facilitate student learning. The knowledge about clinical teaching that does exist tends to be framed as common sense guidelines or propositions. Rarely is such knowledge grounded in studies of what the clinical instructor actually does. From such perspectives one is led to believe that there is a good deal of information about what transpires between students and teachers in the clinical setting when, in fact, there is very little actually documented on this topic.

Until Carr (1983), no comprehensive direct look had been taken at the clinical instructor. Carr studied how two clinical instructors processed information during clinical instruction and presented a beginning framework for investigating the process of clinical instruction. She calls for a more thorough investigation of the setting to describe the environment for learning and how the clinical instructor works within it to facilitate student acquisition of knowledge, skill, and professional values.

1.1.3 The Ward as a Learning Environment

Quinn (1980) considers the environment on the ward the most important factor in clinical learning. She states that the crucial factor in a positive clinical learning environment is psychological safety for the student nurse.

The learning environment is all-encompassing and links the teaching – learning process with learner development (Roberts, 1984). The learning environment is a set of perceived attributes or properties that refers to an individual's cognitive description of the milieu. It involves processing perceptions into more abstract meaningful depictions. It relates to characteristics in the immediate situation that have direct and immediate ties to individual experience. The learning environment is depicted by nurse educators and researchers as multidimensional, with a core set of elements that apply across a variety of situations.

Environmental variables in education are those factors which deal with the mutual relationship and interaction between the person and the environment (Huckabay, 1980). Educational theorists are charged with stressing perceptual and cognitive abilities and excluding what to Huckabay is the most important environmental variable in learning, the environment. Environment influences learning on two levels, early and immediate. The learner's early environment influences the development of genetic potential in terms of perception, language, and cognitive development. The immediate environment influences attention, perception, motivation, and efficiency. Certain variables such as age, maturation level, socioeconomic status, and sensory function require consideration although they are generally not manipulable. The immediate environment is described by Huckabay as being comprised of four components. They are physical, conceptual, classroom management, and discipline.

The relationships established between clinical instructor and agency personnel and between students and staff are important to establish a supportive learning milieu. The type of relationship which exists between the instructor and staff was characterized as a "shared relationship" (Carr, 1983, p. 210). Nurses are co-assigned with students to a patient, the instructor participates in nursing service activities, and nurses and instructors share themselves personally and professionally. A reciprocity exists between the instructor and the clinical setting. The clinical instructor is responsible for clarifying the role and

expectations of staff in relation to student learning and clinical supervision. The instructor helps to establish lines of communication between all parties. These task statements illuminate the important negotiating/mediating role the clinical instructor must play (Reilly & Oermann, 1985, p. 85).

How the clinical instructor facilitates learning in such a diverse and dynamic milieu is not fully explicated in the present literature on clinical instruction.

In the next section, relevant literature pertaining to school learning environments and organizational climate will be reviewed to seek principles relevant to nursing education. For the student nurse, the ward encompasses both learning and work environments and therefore links the two bodies of literature in a unique manner. Hospitals, of course, differ from both schools and business organizations and caution must be exercised in relating existing studies to the clinical situation.

1.2 Learning Environments

Lewin (1935) characterizes human behaviour as a function of the the person and the environment. Sheahan (1983) reviewed the educational literature and analyzed Lewin's framework in the context of the teaching process. The behaviour desired by a teacher is student learning. Learning has several domains; cognitive, affective, psychomotor, social, moral, and experiential. In order for learning to occur, account must be taken of the person involved in the learning activity. The person has many characteristics which must be considered; biological, intellectual, memory, motivation, perception, personality, self-concept, and style of thinking. These characteristics relate to how well the person learns, but the context within which the learning takes place cannot be ignored. The environment consists of attitudes, expectations, groups, roles, social climate, teachers, and relationships between teachers and learners. Sheahan's modification of Lewin's approach provides a useful model for examining the teaching and learning process.

The school environment has for some time been acknowledged as a powerful influence on the organization and operation of a school, and there is no shortage of literature on school climate, learning environments, school ecology, and organizational culture and context. However, much of the research which has been conducted has utilized traditional research models and approaches to inquiry into the phenomenon (Barker, 1968; Brookover et al., 1978; Hall & Griffin, 1982; Halpin & Croft, 1963; James & Jones, 1974, 1979; Lam, 1985), linking environment to academic outcomes to predict achievement and describe school effectiveness.

Theoretical work has moved beyond the conception of schools as closed, isolated systems run according to professional standards and judgments to a more open-system perspective of the institution subject to both internal and external environments (Weick, 1976). Empirical researchers, however, have failed to take environment seriously (Schubert, 1986). Not only are the effects of environmental variations on school organizations and student learning unclear, there is a lack of definition of the concept and the attendant variables which comprise it, evidenced by the number of synonymous terms used to describe it.

The physical conditions of the school, its organizational structure, norms, expectations, and other persons in the educational environment influence and place boundaries on what an individual teacher does (Hall & Griffin, 1982). The learning environment is defined by Brookover (1982) as

> *a composite of variables as defined and perceived by the members of the group. These factors may be broadly conceived as the norms of the social system and expectations held for various members as perceived by the members of the group and communicated to the members of the group.*

The focus of the Brookover research is on the composition of the student group, school climate, and academic achievement. The school was characterized as a total learning environment, with the learning environment in any particular classroom not isolated from

the total milieu. Three clusters of school characteristics were identified; ideology, organizational structure, and instructional practices (Brookover, 1982).

A comprehensive review of the literature on organizational climate, context, environment, ecology and their related measures was conducted by James and Jones (1974, 1979) with the subsequent development of a model which describes the relationship of climate to a situation and a person. The model was arranged to represent psychological climate (the individual's perception of the organization) as a function of the situation (context, structure, process, physical environment, and systems values and norms), the person (personality, demographic, and experiential variables) and the reciprocal interaction that occurs when the individual's perception of the climate influences the situation, the person, or the person-situation interaction. What an individual can or cannot do to affect the overall climate is unclear.

Little of the present literature on school learning environment or organizational climate addresses the unique situation of the clinical experience component of a programme of nursing studies. Most of the information available was generated from organizational research, or research on schools with the classroom as the unit of analysis. Clinical learning takes place in a practice setting, not within the confines of a classroom in an educational institution. It is questionable then, to what extent the existing literature can be transferred to the clinical education context in nursing.

It is important to distinguish how clinical teaching is different from classroom teaching and why the literature on classroom climate and environments is not necessarily generalizable to the clinical context. Firstly, the student teacher ratio is much smaller in the clinical setting. A classroom teacher could be faced with a very large group. In the clinical setting, however, the instructor rarely supervises more than eight students, depending on collective agreements and institutional practice. On the ward, the instructor does not exert the degree of control over what happens in the learning situation as the teacher does in the classroom. The clinical instructor must remain adaptable and flexible because unusual and

unpredictable events can occur. Because of the presence of patients, there is added stress due to an increased element of risk. Patients are in the hospital because they are in need of nursing care, and they may not have the patience or stamina to deal with a learner. As well, the risk of error can be quite devastating to teachers and students, so the stress levels of all parties may be unduly elevated in this milieu. The content of learning differs from the classroom; psychomotor and communication skills dominate in clinical, while cognitive skills dominate the classroom (Quinn, 1980).

Nursing is not unique in its use of the practice setting as a component of professional studies. Other professional programmes have incorporated various models of practical experience into the preparation of their graduates. A brief review of the relevant literature respecting education in the professions follows.

1.3 Professional Education

Professional education is a significant component of post-secondary education. While curricula in professional programmes vary both within the profession and in comparison to other professions, Dinham & Stritter (1986) outline the three sorts of experiences that are typically offered; courses in basic arts and/or sciences, courses which address the professional body of knowledge, and a practical component which initiates the student to the profession and links theory to professional practice.

Professions vary widely in their use of practical experiences for students. Characteristics learners bring to the setting also vary. McGlothlin (1964) cites differences in entrance requirements to the professions which range from from high school diploma (engineering, nursing, pharmacy, architecture), several years of basic arts or science courses (law, medicine, dentistry, veterinary medicine), and baccalaureate degree (social work, theology, clinical psychology).

Irby (1986) describes clinical education in medicine as having three distinguishing

characteristics; a problem-centred approach, an experienced-based learning model, and a combination of team and individual learning. The focus is on the patient and the richness of the learning experience depends largely upon faculty members' instructional skills and the patient mix available.

Several problems with clinical experiences in medicine are described by Irby (1986). He found persistent complaints about overwhelming work demands placed upon students allowing them little time to reflect on their experience and make connections to theoretical knowledge. Clear expectations for performance were lacking. As well, role models and clinical settings to which students were exposed were not always appropriate.

Typically, professional education research focuses on the analysis of student performance outcomes, measuring acquisition of skills, knowledge, and attitudes. Foley (1983) suggests "research must be concerned with assessing the behavioural outcomes that result from educational intervention." Pearsol (1987) disagrees. He suggests that by placing greater emphasis on education than on the profession itself, researchers who undertake field-based practical inquiry will generate insights which are more educationally valid than those investigators who focus on prescriptive research. He calls for research which embraces the complexity of the professional environment, not that which seeks to artificially simplify it.

Daggett, Cassie, and Collins (1979), making general observations about clinical teaching in their comprehensive overview of medical education research on the topic, state that research efforts in medical education are neither particularly extensive or revealing. They searched the other health professions for pertinent information and found the largest body of knowledge on the subject to be from the nursing profession, but little relative to teaching skills per se. They found a good number of research reports from other professions (education, counselling, administration) which concerned themselves with general observations on teaching in the professional setting, but the results were rarely reported in a comprehensive fashion which would articulate appropriate teaching roles.

Nor were these research studies based upon systematic observation of actual teaching. Clearly, much still needs to be accomplished in this area of research across the professions.

It is evident that other professions have little to offer to the understanding of the clinical component of nursing education. What knowledge does exist is often not applied in any systematic fashion. Becker (1961) provided a student view of medical education, and demonstrated the use of ethnographic methods. Daggett et al. (1970) provided a Canadian perspective on clinical teaching in medical school and presented an overview of the literature on clinical teaching in the helping professions, supervisors' training roles, important components in clinical teaching, and alternative teaching methods. In their literature review, which spanned several different health disciplines, they stated:

> *there is a great congruence in the studies reported of what constitutes effective and ineffective clinical teaching. As a result, one would expect to find evidence of well-thought out approaches to clinical teaching, as well as appropriate training programs for clinical instructors. Sadly, this is not the case (p. 161).*

The model for medical education differs widely from the model for nursing education (Morgan, 1986). Dental schools also provide a clinical component for their students, but again this differs in context. Law, education, and social work use practical experiences as well, but literature on clinical supervision in these professions is not readily transferable to the general nursing setting. Since the contexts differ widely with respect to teacher-student relationships and ratios, organised bodies of knowledge, types of skills required, and the clinical practice sites, the environments experienced by educators and students of nursing are very different from other professional groups.

Across the professions, clinical teaching relates to the overall preservice education in different ways, with differing levels of importance, and is placed in the programs differently (concurrent, as in medicine, dentistry, and nursing; in blocks, as in teacher education; terminally as in medical internships and articling placements for lawyers and architects). The focus also differs (acquisition of psychomotor skills, application of

different models of practice, socialization into the profession), the practice of the professions takes place in different settings and is based on different bodies of knowledge.

Furthermore, clinical instructors vary across the professions. They have different backgrounds of experiences and qualifications as professionals, relationships to their employer (college or university), and respective departments. They are bound by differing rules and regulations of their professions, have different responsibilities, and are accountable to the institutions and clientele in different ways. Instructors are accorded different status relative to the hierarchy of their profession and interprofessional tensions.

Few comparative studies exist where different professions and their clinical apprenticeships are examined and the model from one profession is applied to another. There is an unwieldy set of studies spanning more than 20 years, and which is difficult to synthesize because of the lack of consistent focus and instrumentation within the literature relating to a single profession, much less across professions. In the absence of a cohesive body of empirical literature, it is difficult to guide, inform, or compare the clinical experiences or characterize the learning environments across the professions.

1.4 Implications for Research

Nurse educators cannot assert causal relationships between teacher behaviour and student learning without preliminary investigation into the elements of clinical instruction. There is a need to understand why teachers do what they do in the context of the clinical setting. Clearly, the profession knows little about clinical instruction and the environment in which it is conducted. It is evident that this is an area in need of inquiry, especially to discover what contextual information is deemed relevant by clinical instructors and what teaching decisions they make to cope with, adapt to, or transform the milieu.

Further, it has been pointed out (Clissold, 1962) that there is little or no guidance given to new teachers in nursing. Clinical instructors work from a basis of common sense,

rely on their intuitive understanding of teaching and learning, and have little empirical evidence to inform their approaches, and there is no framework to guide their actions. There are certainly limitations to this professional over-reliance on experiential bases for teacher development in the absence of empirical data and a theoretical framework for action. Beck, Youngblood, and Stritter (1988) concur with Clissold's analysis of the lack preparation for teaching in the professions. Little practical knowledge can be gleaned from present studies, and in the absence of data from systematic studies of the clinical instructor in the practice setting, few guidelines are available to those concerned with improving the quality of clinical experiences in professional education. Such guidance is necessary because most clinical instructors have the majority of their formal education in the theoretical and technical aspects of their discipline and little training in education.

Little is gained by looking to other professions, schools, or organizations for assistance. An investigation into the clinical context where teaching and learning take place and inquiry into the relevant dimensions and characteristics of this environment is clearly essential. As the profession grows and changes to accommodate new knowledge and advancing technology, more effective use must be made of the clinical experiences provided for students. A necessary first step is to determine what constitutes the clinical environment, and how instructors act within this milieu to facilitate student learning.

In the next section, the research problem, question, and implications for investigation are presented and discussed.

1.4.1 Research Question

In view of the lack of information relating to clinical instruction in nursing education, this study focuses on a description of the learning environment and the practices, roles, and relationships of the clinical instructor as she or he attempts to transform what is essentially a practice environment within a health care agency into a

learning environment for the students assigned to the ward for the purpose of learning nursing theory and practice.

> *Social scientists are dramatically impotent in their ability to characterize environments. Generally, they do not even try. ... The language of education and the behavioral science is in great need of a set of terms for describing environments that is as articulated, specific and functional as those already posed for characterizing individuals."*
> Shulman, 1970; p. 374

The clinical setting has been described as a dynamic and complex environment. The clinical instructor not only strives to make sense of this environment but also attempts to work within it in ways which support the development of the students.

The general research problem was translated into the following central question:

How does the clinical instructor interact with the environment during clinical experience?

Given the limitations of the present knowledge about clinical learning environments and clinical instruction in nursing education, the following activities were undertaken to respond to the research question:

1. Description of what the instructor does and how these activities relate to student learning,
2. Portrayal of the clinical setting, as viewed by key participants, focusing particularly on those aspects which link directly to the learning experience of student nurses, and
3. Examination of the connection between the clinical instructor, students, and the clinical setting.

The environment is not only central to the educative process, it is considered to be the major component over which the individual teacher has some control. While the importance of the physical milieu cannot be denied, the elements in the immediately present interpersonal environment are considered to be the most educationally relevant (Hunt & Sullivan, 1974).

There are several reasons for the study of the educational environment. Environments are described in order to communicate with others about methods, to

determine important factors influencing development and behaviour, to decide how and where to influence implementation of innovations in educational practices, and to characterize differences in educational approaches. Since much of the research on environments is linked to student achievement variables (Brookover, 1982), one assumes that understanding environments will allow educators and administrators to manipulate them to improve student learning.

1.4.2 Methodological Considerations

Much depends upon the environment in which students learn. So little is known. Researchers are confronted with three problems when investigating learning environments: how much of the environment to describe, which units of study (variables) to employ, and whose perceptions of the environment to use. In addition, time can become an important factor when the researcher wishes to go beyond a single moment in time, which may be neither typical nor representative.

How much of the environment should be described? Inasmuch as the behaviour of a teacher provides the most immediate environmental effect on a learner (Hunt & Sullivan, 1974), the teacher's actions must be considered paramount when investigating an educational environment. But the student nurse is not separated from the broader context which might include the culture and characteristics of the community, nursing school, health care agency, the organization of the course, hospital unit, and the personal characteristics of the teacher and the student. In order to focus the study, the researcher must make a decision with respect to how many of these variables to include in the investigation. Some aspects or elements which comprise the environment are general (culture) while others are specific (teacher characteristics), some are remote to individual experience (organizational size) and others are more immediate (teacher behaviour). Teacher behaviours and instructional activities are more heavily represented in research on

the environment than structural or macro-organizational characteristics, because teacher-related variables are of lesser magnitude and more immediate to the experiences of the individual.

The decision about which units of the educational environment to study becomes problematic to the researcher when the literature is reviewed and the number of potential variables for study become evident (Chavez, 1984; Ellett, 1986). This is a critical decision because it relates to the context and purpose of the study. What becomes important to the researcher is not only which variables are chosen for investigation, but how they are described. Since much of the research on education environments is linked (directly or implicitly) to student achievement, it is important that the researcher who wishes to describe the environment use value-free language. Terminology can set up distinctions of good or bad, desirable or undesirable.

Whose perceptions should be used in describing the environment? An environment is felt more than it is seen or heard. It is perceived in light of individual knowledge and experience. An individual then organizes information about the environment into a cognitive map that guides future actions. Perceptions about the environment will therefore reflect individual characteristics in the processes of perception, concept and attitude formation as well as in the situation itself. Diversity of perception, because of the roles of the participants, their ages and experiences, is certainly to be expected. Insight into differing perceptions of the same context will serve to illuminate ambiguous and poorly defined elements of the environment. By describing events, roles, relationships, and meanings in the context of the situation, the researcher will more clearly understand the elements which comprise the learning environment, their properties, and how they are manipulated.

The major aspects of the educational environment that were included in this study are the patterns of the interactions of the instructor with students and hospital staff and how these interactions relate to subject matter and teaching processes. The clinical site was the

primary unit of analysis but was not separated from the total milieu, the structures of the institutions (both educational institution and health care agency), the overall atmosphere, and the academic and intellectual norms, emphases, and expectations. The perceptions sought were those of key participants in the clinical learning situation; clinical instructors, students, and hospital staff. Description, not evaluation, was the intent of the investigation.

When researching the complex world of clinical experiences in nursing education, it quickly becomes apparent that the more traditional techniques of research which emphasize preordinate theories and methods are often inappropriate due to the special nature of the clinical experience and the lack of empirical knowledge about the process. Since an attempt to link the instructional process in the clinical component of nursing studies to leadership theory did not yield relevant results, it became evident that this research route was not fruitful (Vollman, 1985). Additional research of a more exploratory nature was required to examine the complexity of the teaching-learning process in the discipline. In the absence of guiding theory and known variables research to generate understanding is necessary.

No preordinate theory existed to direct this study, to define testable hypotheses, or to determine methodologies for data collection and statistical analysis. The question itself is generative, implying an inquiry to discover the environment through the actions and interpretations of clinical instructors. The emphasis is on an in depth exploration of what exists in reality and what actually happens. Hence, the need for an insider's view of the environment is obvious.

These concerns are better served by a qualitative study, open to the variables and interpretations which emerge. This mode of research has a philosophical foundation which is compatible with both the intent of the question and the present state of knowledge about the environment of clinical instruction in the health care field. In chapter two, the research approach is discussed in detail.

1.5 Summary

The clinical component is integral to and in fact constitutes the major part of any program of nursing studies. An understanding and description of how the clinical environment affects learning is central to the improvement of nursing education programs. Currently there is a dearth of studies drawn from actual clinical nursing instructional practice and no agreed upon concept of the process among nurse educators. Nurse educators are becoming increasingly aware of the need for more attention to the impact of the clinical setting on the education of the nursing student and of what can be done to make it a more effective and favourable learning environment.

The intent of this study was to describe the clinical learning environment and the actions instructors take to influence that environment. It is hoped that this study elaborates the contextual realities of clinical instruction in nursing education, describes the circumstances and actions of instructors in their efforts to facilitate learning, and builds a framework for understanding the dynamic forces of instruction in the clinical field.

In order to study the complex world of clinical experiences in nursing education, it is apparent that the more traditional techniques of research which emphasize preordinate theories and methods were inappropriate due to the unique nature of the learning experience. Traditional methods imply that variables are not only measurable and quantifiable, but also identical for all participants. These assumptions, when dealing with a situation as personal as a clinical learning experience in nursing, create a distance which minimizes the understanding of the dynamic context and which limits the presentation of multiple perspectives of the phenomenon. Therefore, a different approach to inquiry, based on the philosophical foundation of symbolic interaction, was used.

In the next chapter symbolic interaction is presented and discussed in light of the research question and qualitative research methods. As well, the research approach used for the investigation is presented and outlined in detail.

Chapter 2
Research Approach

In this chapter the research approach is presented in conjunction with the theoretical foundation for the methods utilized. The sites, settings, and sample are described. Research methods used, participant observation and intensive interviewing, are discussed. The data analysis process is presented in detail, and issues of reliability, validity and ethical inquiry are explored in the context of qualitative research.

For this study an adaptive and flexible approach was employed which minimized preconceived notions and encouraged natural responses from the participants. It was important to understand the complexity of the meaning given to the phenomenon of the clinical learning environment and the actions engaged in by the actors (clinical instructors, students, and nurses) within this context.

I wished to enter transactions with the participants in the field as neutrally as possible so that any a priori frameworks did not unduly bias the data collection and analysis. I was aware of the existing literature, theories, and frameworks, and had examined my own assumptions about clinical teaching and learning. I was determined to be open to the worlds of the instructors in the study. To get close, to understand their perspective, and to feel what it was like in their context was vital to the description of the clinical learning environment as experienced in action.

2.1 Conceptual Framework for the Methodology

Symbolic interaction (Blumer, 1969) forms the philosophic foundation upon which the research approach used in this study is grounded. This theoretical perspective is based upon three major premises dealing with human behaviour in society. People act toward things on the basis of the meaning that the things have for them. This meaning is derived

from or arises out of the social interaction that people have with others. An interpretive process is used by a person to deal with the things encountered. Meanings are handled and modified by this interpretive process.

Central concepts of symbolic interaction are that the mind, self, and society are most usefully viewed as processes of human conduct. Language is the primary mechanism to consciously convey meaning to others. Human conduct is determined by how one defines situations within which one must operate, and behaviour is constructed in the course of execution based upon the definition and meaning of the situation. One does not merely respond mechanically to external stimuli. People are socialized into society but are not merely passive actors; they can choose to act in accordance with convention (arbitrary laws), manners (mutually agreed upon behaviours), or to deviate from social group norms (Manis & Meltzer, 1967). Symbolic interaction refers to the manner in which people interact:

> *Human beings interpret or "define" each other's actions instead of merely reacting to each other's actions. Their response is ... based on the meaning which they attach to such actions. Thus, human interaction is mediated by the use of symbols, by interpretation, or by ascertaining the meaning of one another's actions.*
>
> (Blumer, 1962, p. 180).

People, therefore, make indications to others about what to do and they interpret others' signals to themselves. Conflict can be created if these signals are misunderstood. Intrapersonal conversation and conflict can also be created if one views the self as two parts: "I" and "me". The "I" responds to the environment and to others and the "me" is the organized set of attitudes one has developed over time. The "me" can empathize with and take the role of others, whereas the "I" provides a sense of freedom and initiative. Individuals, by viewing themselves self-consciously, are able to control their reactions to situations. Social control is thus explained as individuals cooperatively exchange roles and monitor behaviours toward each other. Communication is central to this process.

Symbolic interactionists view modern culture as essentially dynamic, emphasizing

the reality of genuine creative change and evolution.

Blumer (1962) expresses the doubt that human society can be

> *analyzed by schemes which do not take into account persons constructing individual and collective action through an interpretation of the situations which confront them* (p. 192).

Rose (1962) summarized interactionist research methodology by emphasizing three key points: (a) subjects are studied in their natural environment and the research technique tends to be some form of observation, (b) the conceptual framework of the research is based on the assumption that human behaviour and social life are in continuous process, and (c) people are perceived as living in a symbolic environment which mediates the relation of the physical environment toward which he is responding.

Blumer (1969) explains that human groups live in different situations (cultures) which create different sets of meaning but

> *Whether one is dealing with a family, a boy's gang, an industrial corporation, or a political party, one must see the activities of the collectivity as being formed through a process of designation and interpretation* (p. 21).

He goes on to assert that the researcher must have first hand acquaintance with the sphere of social life under investigation. The concepts of symbolic interaction are congruent with the values of qualitative research approaches such as phenomenology, ethnomethodology, and naturalistic inquiry. These approaches use methods of participant observation, intensive interviewing, and inductive reasoning, placing emphasis upon personal perception. Observers are required to suspend personal biases to view behaviour from the actor's point of view. Qualitative approaches are particularly useful in the study of social processes which are dynamic and bounded in time.

Naturalistic inquiry (Lincoln & Guba, 1985) is a qualitative approach to doing social science research, examining meaning as it is generated in the context of human interaction. Its congruence with the framework and criteria for research of symbolic interaction is evident in their description of the method.

> *In doing research from a naturalistic perspective, [the researcher] is forced into the natural setting because he or she cannot specify, without an a priori theory or hypothesis, what is important to control or even to study. Until [the researcher] has spent some time in the setting he or she cannot specify the focus (problem, evaluand, or policy option) in more than rudimentary form, or place boundaries on it. [The researcher] could not design a contrived study (an experiment, say) because he or she would not know what to contrive. If theory is to be grounded in data, those data must first be located and analyzed inductively. Since [the researcher] cannot specify the precise form of the data to be sought, he or she must fall back on an open-ended adaptive instrument: the human being, who, like the 'smart bomb', can identify and wend its way to (purposefully sample) the target without having been precisely programmed to strike it. Humans find certain data collection means more congenial than others; they tend toward the use of qualitative methods that 'extend' human senses: seeing, hearing, and tacit 'sixth-sensing' that lead one to observation, interview, documentary analysis and the like. These methods result in insights and information about the sending context so that the extent of transferability and applicability in some other receiving context may be judged. No aggregations, no generalizations, no cause-effect statements can emerge, but only idiographic interpretations negotiated with knowledgeable respondents; hence an air of tentativeness surrounds any proposed application. Finally, the case study mode lends itself well to the full description that will be required to encompass all of these facets and make possible understanding on the part of the reader (building on his or her own tacit knowledge and making 'naturalistic generalizations' possible). Judgments about the trustworthiness of such a process cannot be made with conventional criteria; criteria devised especially for and demonstrably appropriate to naturalistic inquiry are required.* (p. 43-44).

Since humans act toward events based on the meanings things have for them, they are not simply responding or reacting to stimuli. They are deriving meaning from the interactions they have with others in the milieu. Individuals, then, act within a larger network of other individuals and society; the organization of this society frames the social action, but does not determine it. Symbolic interactionists recognize a degree of choice in human behaviour, and as this choice is exercised the resulting actions generate new experiences, new meanings, and new lines of action. Thinking is involved in interpreting events and making choices, and a dialectical process is used to identify tentative meanings which may be revised as instruments for informing and guiding future behaviours. To

describe and understand the clinical instructor's "world", the researcher must capture the process of interpretation and must observe the person at a time when events are encountered and interpreted.

When little is known about a phenomenon, one must begin an investigation by observing and analyzing it in an effort to understand and describe it. These efforts assist future researchers in identification, prediction, and determination of causal relationships. Qualitative methods are chosen because they are logically consistent with the theoretical framework of symbolic interaction and with the research questions being investigated. The operations of field study assume reality is infinitely complex; in order to reveal the phenomenon, a discovery (rather than verification) form of research approach best presents the world from the participant's point of view. The methodology of an investigation, therefore, emphasizes subjective interpretations of phenomena by utilizing observations and conversations, inductive strategies, situational content, and observation of performance in the actual setting. This approach demands flexibility and a vital sensitivity to process. Qualitative methods are sufficient to prove the existence of phenomena, to describe elements of them and processes relating to them, but are inadequate to specifying causal connections.

Clearly, this methodology suits the intent of this study. As stated earlier, the intent of this investigation is to describe, not evaluate. To obtain a more comprehensive understanding of the actual processes that constitute the daily life of the people involved in a clinical learning experience, a naturalistic approach was employed to provide qualitative (as opposed to quantitative) information (Lincoln & Guba, 1985). The emphasis was on observation in the natural setting with responses made to new issues as they emerged. Natural (that is, not contrived) responses to actual events were the data collected. The orientation was to activities, interpretations, and intents of the participants. This approach is particularly useful when there is uncertainty as to what issues would arise and when an understanding of a process is desired. The aim of the research was to describe and

understand the learning environment, the practices, roles, and relationships of the individuals involved. I considered existing theory in comparison to the emerging data.

The research approach is described as a case-like portrayal of the researcher in action. In the next section, the steps toward entry into the field and access to participants are presented, including a discussion of the selection process for the clinical settings and instructors. Pseudonyms are used throughout this report to protect the identities of the agencies and people who took part in the study.

2.2 Selection, Access, and Entry

Strategies for gaining access to and entry into a site can be unpredictably difficult for qualitative researchers (Bogdan & Biklen, 1982; Carr, 1983; Pugh, 1984). Trust, communication skills, and interpersonal competence are necessary attributes for the researcher; yet, a dilemma exists when the researcher is not known to the community involved. A further obstacle is created by the preponderance of quantitative and emprical studies conducted in the health care setting and the resulting lack of familiarity with the qualitative research approach.

The original criteria for selection of the health care agencies for this study were that the site (hospital and ward) be utilized by at least two clinical instructors and their students, that the site be in an accredited teaching hospital, and that instructors be from a undergraduate university-based programme. Given that the prevailing emphasis in nursing education favours baccalaureate preparation as minimum education for entry to the profession, it seemed ideal to select participants from this population.

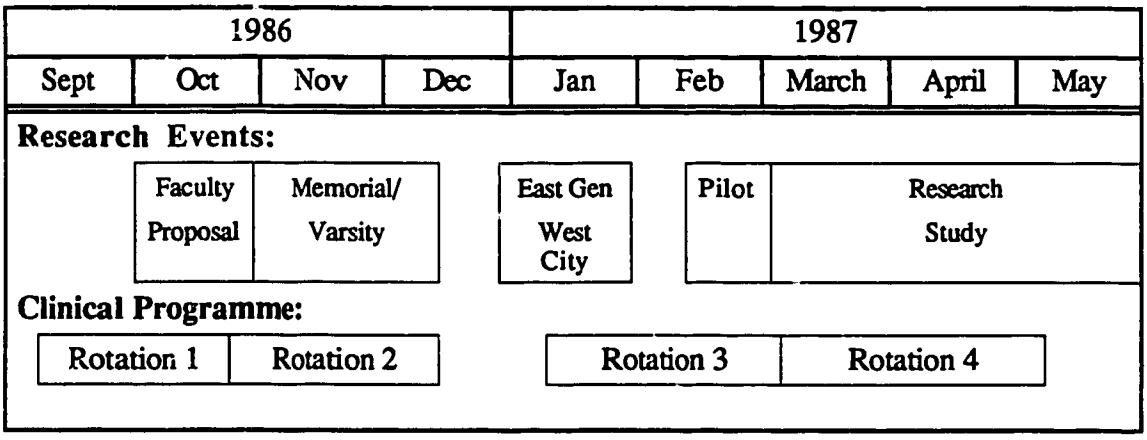
Two clinical instructors and their students, using the same site, were interacting in the same structure and with the same people. Any differences, therefore, were probed in terms of differing perceptions and decisions in response to essentially the same structural milieu. This strategy minimized confounding factors.

Accredited teaching hospitals are required to meet certain minimum standards of quality and provide certain services to students. Accredited teaching hospitals see their mission as not only patient care but also education and research. It was assumed that this milieu provided a more welcoming atmosphere for educators, and that staff would espouse values conducive to education. In conducting a study of this nature, working with staff who held negative attitudes toward education and research would have been potentially disruptive.

In addition, I wished to select a site and a clinical setting with which I was moderately familiar. To be required to develop an understanding of the intricacies of nursing practice in an unfamiliar subject area was a discomforting thought. Since my clinical practice background included medicine, surgery, pediatrics, and obstetrics, the potential choices for settings within the selected site were reasonably broad in nature. Ruled out were specialty areas of critical care, operating room, and psychiatry.

The selection process, obtaining access to hospitals, and gaining entry to the wards took place over the academic year. As well, the schools of nursing were operating their courses and students were rotating through the clinical sites over the course of the term. In Table 2.1, the two agendas are illustrated.

Table 2.1
Timing of Academic and Research Events, 1987 Academic Year



2.2.1 Obtaining Access to Hospital Sites

Gaining permission to use nursing units in health care agencies where student learning experiences took place proved to be a difficult and time-consuming process. Initial requests for access went out early in the proposal stage to Varsity (a pseudonym) nursing faculty and Memorial Hospital (a pseudonym) which met the criteria for the study. Informal acceptance was given by representatives of the hospital, pending approval by the University of Ottawa Faculty of Education and the Memorial Hospital Nursing Research Committee. Application to the Memorial Hospital Review and Ethics Committee, which had the final approval in matters of research access within the hospital, would follow only after the first two levels of approval were granted. When the research proposal went through official channels it was accepted at the Faculty of Education, but rejected at the level of Memorial Hospital's Nursing Research Committee. The rationale for rejection was based on four concerns: (a) the apparent lack of framework for conducting interviews, (b) the difficulty assuring objectivity and anonymity, (c) informed consent for all participants (concern that patient data may inadvertently be recorded), and (d) the degree to which any published conclusions would invade privacy of the hospital and its personnel. Given the nature of the professional confidence at that time with the Grange Inquiry (1984) having a major impact on scrutinizing and sensationalizing the conduct of nurses in Ontario, the points were considered valid. Although an attempt was made to resolve these concerns by sending a letter of clarification to the Director of Nursing, access was denied. The proposal never reached the final review stage at Memorial Hospital.

At the same time as the proposal was submitted to Memorial Hospital, it was also submitted to the Varsity School of Nursing Research Committee. This committee approved the proposal. Prior to meeting with faculty to seek volunteers to participate in the research, a host site needed to be found. Application was made to two teaching hospitals, East General and West City Hospitals (pseudonyms). After presenting the proposal and

researcher credentials, access was granted by East General Hospital. This process did not require a committee review since a reciprocal arrangement with the Varsity committee was in place. Permission for access was approved by the West City Hospital Research Review and Ethics Committee, on condition that conversations with patients and physicians not be tape-recorded.

2.2.2 Selecting Research Participants

The Director of Varsity School of Nursing granted permission to approach teaching faculty with requests for volunteers. Knowing that two sites were available for the study, Varsity clinical instructors needed to be solicited to take part in the study. Volunteers who had come forward as a result of the proposal review at the Varsity School of Nursing were ineligible because they were assigned to the hospital that had rejected the research or were assigned to specialty units. The coordinator of the section assigned to medical-surgical settings was approached for referral to potential volunteers. Three candidates were named. All refused. One instructor was part-time and considered the research burden excessive. Another was concerned that since her application for tenure was under review, it was too risky for her to engage in additional activities. A third was concerned that the student group to which she was assigned included some borderline students and she felt under too much pressure because of these demands. Presentations of the research were made individually, and although initial interest was expressed, all requested additional time to think the matter over. The ultimate result was refusal, and other options had to be considered: drop the study, change the selection criteria, or reconceptualize the entire project.

I elected to modify the selection criteria. The decision was made to present the proposal to the two local community colleges, North College and South College (pseudonyms) which had nursing students assigned to East General and West City

Hospitals and seek volunteers from their faculties. This decision was justified by reflecting on three points; both programmes are mandated by the same governing bodies of the profession (College of Nurses and Ministry of Colleges and Universities), they use the same clinical units for practical experiences, students graduate with the same professional designation (Registered Nurse) and legally are held accountable for having equivalent minimal nursing knowledge. Although educators are seeking to identify and measure distinguishing characteristics, current evidence to support the idea that baccalaureate degree graduates practise nursing any differently than diploma (community college) graduates is inadequate (Watson, 1981; Dennis & Janken, 1979). Indeed, Chamings and Treevan (1979) conducted a study in which university and college nursing programme heads rated their graduates on expected competencies and concluded that the expectations for graduates of the baccalaureate degree programmes were higher, but not clearly different. Although programme components are not comparable in terms of length, there are enough generic similarities between the programmes, the nursing theoretical frameworks used, and the clinical context, that the argument to proceed with this modification in selection seemed reasonable.

University baccalaureate preparation for nursing differs from community college preparation in several ways. University applicants are screened much more critically in terms of high school marks, although both programmes demand essentially the same high school academic credits. The ratio of clinical to classroom hours are essentially equal in both programmes. University programmes provide more basic science, nursing administration, community health, teaching, and research courses which are only superficially introduced in community college programmes. In addition, Varsity's programme followed a pluralistic approach to nursing theory, unlike the North and South Colleges' programmes which concentrated on a single theoretical framework for nursing. It was apparent that the differences between the programmes were most notable in terms of the classroom (theoretical) component rather than in the clinical experiences.

The chairperson of each of the two local English-speaking Colleges were very interested in the study and invited me to make presentations to their staff. Several volunteers were forthcoming as a result, allowing me to make a purposeful selection of the respondents for the study. A few were ineligible because they were assigned to agencies where I had not been granted access. Of the eligible instructors, selection was made based on the area assigned for clinical experience, years of teaching experience, and initial rapport with the researcher. Two instructors (pseudonyms Sara and Errin) were assigned to the obstetrical unit at West City, on different days of the week, with different levels of students. A third instructor (pseudonym Peggy) was selected who was in the same teaching team as Errin, instructing in the same year of the programme, but assigned to a different clinical site (East General) for different days of the week. The selection of Peggy was considered desirable because the time was becoming short and three instructors made it possible to collect data seven days a week. In addition, it provided an opportunity for comparison across sites as well as across participants. Since she was in the same educational situation (first year students in an obstetrical setting) as Errin, differences in findings could be examined in relation to the students' different levels of preparation and experience. Interestingly enough, the three instructors represented a variety of experience levels themselves, which could provide contrasts in perceptions and actions. In a later section, a profile of the three participants is presented which illustrates the contrasts.

Once the clinical instructors had agreed to take part in the study, meetings were set to inform the students and to elicit their support and participation. The instructors introduced me, set the research in the context of professionalism for nurses, and left it to me to outline the study and what student participation would mean. The students' questions were almost exclusively related to time and evaluation. Would this take more of their precious time? Would I be carrying tales of their performance or conversations back to the instructor? I took this opportunity to point out the appropriate clauses in the consent forms (Appendix A) which addressed their concerns and assured them the research would

be conducted in an ethical fashion. All students signed consent forms.

It was important to the intent of the study that reasonably typical nursing units in active treatment teaching hospitals be selected. Since all nursing students spend a portion of their clinical experience time in maternal-child nursing areas, the selection of obstetrical nursing units for the research setting makes sense in terms of the nursing curricular demands.

2.2.3 Gaining Entry to the Hospital Ward Research Settings

The next step was to obtain entry to the hospital wards. At West City Hospital, the research proposal which had received review committee approval, was presented to the director of nursing responsible for the obstetrical programme. She gave permission to approach the staff, through the programme coordinator. A meeting was arranged by telephone for two days hence. We met in the coordinator's office, which was situated adjacent to the wards (called MAT1 and MAT2 for the purposes of this thesis) I wanted to use for the research. During some preliminary small talk prior to presenting the research proposal, we discovered an old acquaintanceship. The coordinator had worked as a nurse in a remote northern area where I had grown up, and she had known my father, a bush pilot. This made entry to the area very much smoother than anticipated, as the coordinator reported being initially cool in her reception of the research.

It was now the appropriate time to speak to the head nurses on the two wards in question. Both were away at a conference that day, so I telephoned the next day to set up a meeting. I was unable to arrange a convenient time to meet them both, so two separate meetings were set. When we met, the proposal was discussed, and what it meant to the head nurse and staff in terms of consent and potential work disruption was outlined. The acceptance of the study was enthusiastic and gracious. Both Lil and Michelle (pseudonyms) readily supported the research, volunteering to solicit participants from

among their staff and coordinate the signing of consent forms. I declined this offer, wishing to ensure that volunteers understood the nature of the research and the commitment they were assuming when they agreed to participate. Proposal and sample consent forms were left in the staff report rooms, and meetings were set to meet the staff prior to the beginning of the field study.

It was interesting to note that night staff on MAT1 read the proposal and signed consent forms prior to the staff meeting. They left notes for me that they wanted to be involved when their shift changed and they were back on the day shift to which the students were assigned. There seemed to be a feeling of pride in being selected for research. On the other hand, some Registered Nursing Assistant (RNA) staff on MAT2 showed a certain reluctance to participate. One refused outright, flinging the consent form back at me after the information meeting. While I did not seek to change her mind, I did attempt to uncover reasons for refusal. In this case, the policy the hospital had adopted with respect to phasing out RNA staff in favour of all-RN staffing appeared to be the reason for reluctance on the part of the RNAs. This policy was identified as the source of some conflict which is discussed in the latter part of this report. All but one RNA eventually agreed to participate in the study. It was arranged that no students would be assigned to her patients for the duration of the study. This was not a difficult task as she soon went on an evening and night shift schedule and the problem resolved itself.

A similar scenario took place at East General Hospital. The proposal for research was presented simultaneously to a group of staff nurses, the programme director, and head nurses (Claire and Helen) of the obstetrics service. The response was overwhelmingly supportive. Some nine years previously I had taught students in the case room (labour and delivery) and several people recalled that experience.

The difficult search for a research site and volunteers was now complete. The process had taken in excess of five months. I had planned to conduct the study over one complete semester (15 weeks); little over half that time remained in the academic year.

Decisions about how to most effectively utilize the remaining weeks in the semester were now critical. During the course of the study, 112 people would sign consent forms and participate in some manner: 92 in the study proper, and an additional 20 in a pilot study. In the next section the pilot study is presented.

2.3 Pilot Study

With permission for access to two research sites, and three clinical instructors available for the study, time was now becoming a major concern. There was one student rotation left in the academic year before college broke for the summer. I did not have the luxury of a full semester (fifteen weeks) remaining in the academic year in which to conduct the study (see Table 2.1). In one week it would be winter study break, and then a new group of students would be assigned to each clinical area for the final clinical placement of the year. It was mandatory that I make use of this one complete student rotation for data collection purposes. I could not afford to take time to familiarize myself with technical equipment or field research procedures during the course of the project. It was essential that a pilot study be conducted to assess the adequacy of the data collection and analysis techniques and remedy any unanticipated problems.

Nathalie, a nurse educator from North College, had originally volunteered for the research and was not selected. She would be an ideal candidate to participate instead in this pilot study. Nathalie was assigned to East General Hospital at that particular point in time with a group of third year students on an active treatment orthopedic surgical unit. Nathalie and her six students were informed about the study and all signed consents to participate. As well, the head nurse and staff met with the researcher and agreed to take part in the pilot study.

The selection of Nathalie was problematic in that she and I had known each other for several years and had worked together four years ago. I was sensitive to how the data

might be influenced by our relationship. Glesne (1988) outlined three concerns when the researcher becomes friends with informants: (a) danger of data bias because of an unconscious subjective selection process, (b) denial of access to other data sources because of this friendship, and (c) overidentification of the friend with the researcher, causing the participant to become more observer or to act to impress, not inform, the researcher. These problems never emerged. Throughout the pilot, I was very conscious of this relationship with Nathalie, although, upon reflection, we related more as colleagues than friends. Since the pilot study was intended to focus on research methods and strategies it was not difficult to avoid problems of overidentification.

The pilot study spanned four days; the day prior to clinical experiences when the instructor selected patients with whom the students would work, three clinical days of 6.5 hours each, plus three one-hour post-conferences.

The pilot study began with major interviews with the clinical instructor, Nathalie, and the head nurse, Mae. The interview with Nathalie focused on what she actually did while in the clinical area and what relationships she found important. We discussed the clinical teaching and learning environment from Nathalie's point of view as a clinical instructor. Mae directed the conversation in her interview toward her role as head nurse and to what extent she perceived it as being central to the climate of the unit. As well, the roles and responsibilities of the various staff on the ward were examined, and how staff interacted with the students and clinical instructor was discussed. Considerable latitude was offered to explore a wide range of clinical topics related to the education of nurses. By probing what instructor actions and values Mae felt were important, areas for future elaboration were generated.

By encouraging Nathalie and Mae to talk about their experiences, probing more deeply about the subjects which were raised, I obtained an idea of how people actively engaged in the clinical setting structured their work with students and ordered their thoughts about the learning in the clinical milieu. The interviews were open and quite free-

flowing, allowing an exploration of the perspectives of the participants and a general understanding of the range of concerns related to the phenomenon of the clinical learning environment. Transcripts and my summary comments were given to both participants for review within two weeks. Transcripts were returned with only minor editing corrections as well as a small number of thoughts or elaborations the participants had added, clarifying their perspectives.

Once the field portion of the pilot study began, information about the phenomenon of the learning environment was secondary to method-oriented issues. I sought to resolve questions or concerns about ease of observation, technical aspects of tape recording versus note-taking, disruption of work if I spoke with people on the ward, and ease of maintaining more of an observer than participant stance in the clinical milieu. During the pilot study I, in effect, trained myself as a field researcher. In order to provide a focus for the pilot study, I took note of the functions of the instructor as she interacted with the students and staff, elaborating, corroborating, or questioning her actions in comparison with our initial interview. I spent some time selecting interactions and writing notes to characterize them. I engaged in spontaneous but method-oriented conversations with staff and students that gave me information about the degree to which people noted differences in the instructor or their own practice when they were under scrutiny.

A memorandum written during the pilot study indicates the lessons I was learning, primarily about myself, about actual field study and its methodological, personal, and ethical challenges.

> *The purpose of the pilot is to assure myself that what I planned to do was "do-able" and that the data collection procedures, taping, etc. went smoothly.*
>
> ***Interviews:** Went smoothly overall - I need to be more specific in terms of searching for examples of elements in the clinical milieu without directing the flow too much. Sometimes the interviewee rambles and I don't think I probe deeply enough or assert enough direction. On the other hand, I don't want to cut them off too soon and lose valuable data.*

Interviews must take place in a quiet place with few possibilities of interruptions if I want to tape record. The air conditioning fans and intercom provide much background noise. Also, I must be careful of interrupting and/or speaking over the interviewee - makes it difficult for transcribing. I didn't do too much taping of spontaneous chats - people were quite intimidated by the recorder but were more willing to speak to me if I was just taking notes. It will be a good idea to carry the recorder around and not use it for the first week of the study - just to get people used to seeing it.

Consents: *Getting consents from staff in the a.m. was problematic. It is very busy at that time and (a) it's an extra burden for staff and (b) they tended to sign without reading which made me concerned from an ethical standpoint. They did, however, take their own copy so maybe they would read it later in more detail.*

Participant - Observation: *I attempted to maintain a passive observer stance which was, for the most part, successful. At times the clinical instructor (and occasionally the students) would include me in interactions. The staff was welcoming and friendly, asking questions about the research and my background. It seemed important to them that I was a nurse; I must remember to make people aware of that as I do the study. While there was limited opportunity for any conflict re my role, I can see that it may cause problems in the study because of its extended duration: I am a nurse, educator, colleague, clinical instructor, researcher. I was an "outsider" in that I was not privy to relationships on a personal level, but socially I felt accepted. People called me by name, asked if I'd had a break, and chatted to me, including me in conversations, etc. The Team Leader introduced me to doctors that came onto the ward. It's hard to say how my presence affected the people involved. Students said the clinical instructor was "different" at first, more questioning and demonstrating behaviours in particular, but that she returned to "normal" in a couple of hours. Students expressed some nervousness at first, but settled down when they realized I was, as I said, just observing. They all felt the staff acted quite naturally.*

Personal Concerns: *This sort of research is very intensive and demanding. In order to reduce fatigue and capture as much as possible I must remember to take rest and coffee breaks and take "writing" breaks occasionally. If I can't capture enough by writing - which I hate doing - I should use my verbal abilities to tape record my reflections. Debriefing will become important. Who and by what means can I facilitate this process? Perhaps I should get someone to interview me? Am I missing important data because of what my professor calls "headnodding reflex"? Am I accepting certain practices without question? Am I being critical enough? Am I making the best use of the data which presents itself?*

Memo 14.02.87

In addition to evaluation of the data collection and analysis procedures a secondary purpose of conducting a pilot study was to examine two substantive bases for the study, derived from the literature review, which offered potentially useful frameworks for investigating the learning environment (Lam, 1985; James and Jones, 1974). It became apparent after analyzing the data from the pilot study that reliance on these frameworks would hinder the conceptualization of the environment because they set artificial guidelines and limits to the scope of the investigation. Methodologically, a great deal of insight and practical knowledge was gained during the conduct of the pilot study. The lessons learned, when taken in context of Bogdan and Biklen's suggestions for novice researchers (1982, p. 127), proved to be prophetic in the coming weeks when the primary investigation took place. They advise the researcher to find someone who will make introductions to people in the field, to be friendly, and to remain relatively passive. They caution against taking what happens in the field too personally and admonish the researcher to set realistic goals and not to attempt to accomplish too much in the first days.

As illustrated by the above memorandum, I was learning about myself as a researcher and about some of the hazards of field research. Discussion of the pilot study has been included for its methodological utility to the early stages of the investigation. It was valuable in testing, adjusting, and framing my research approach.

The remainder of the discussion will focus on the main body of the study and the research approach used to investigate the clinical learning environment. In the next section, the participants and the clinical sites are described.

2.4 Sample and Site Description

Three instructors were selected from South College for the main body of the study. They varied in experience as teachers, but were all considered to be satisfactory performers according to their chairperson. All were articulate about their practice and enthusiastic

about my research. In Table 2.2 their clinical teaching assignments (to the obstetrical service at the respective hospitals) during the study are presented. The hospital, the wards, and the days of the week they were in the setting are also outlined.

Table 2.2
Description of Clinical Teacher Placement

Name	Programme Year	Hospital	Ward	Days (2 weeks)
Sara	2	West City	Obstetric MAT1, MAT2, Case Room	M-T-W T-W
Errin	1	West City	Obstetric MAT1, MAT2	Th-F S-S
Peggy	1	East General	Obstetric MAT3	Th-F S-S

The first instructor selected, Sara, was a very experienced nurse educator who had in the past been director of a nursing education programme in a hospital setting. She was assigned to teach eight second year nursing students on an obstetrical service, wards MAT1 and MAT2 (pseudonyms) at West City Hospital. Her clinical days were Monday, Tuesday, and Wednesday. Interestingly, Sara had, at one time many years previously, been head nurse on one of the units to which she was now assigned as a clinical instructor. As well, because of her extensive experience in education, several of her former students were nurses working on the wards.

The second instructor, Errin, was assigned to the same obstetrical wards at West City Hospital as Sara (MAT1 and MAT2), with eight first year students from South College, on Thursdays and Fridays alternating every two weeks with Saturday and Sunday. Errin had several years of experience teaching nursing in a community college in another province. She was new to South College, new to West City Hospital, and expressed a great deal of interest in being a part of the study.

Peggy, who also taught in first year, was assigned to obstetrical ward MAT3 at East General Hospital with eight first year students. Peggy was a new instructor; this was her first teaching position. Her clinical hours were the same as Errin's.

Each ward, regardless of the hospital in which it was situated, provided a basis for comparison (corroboration or repudiation of what was discovered) and the selection of an instructor who taught in a different hospital setting provided the basis for additional environmental comparisons based on a different organizational structure which is described below. The descriptions of the nursing units selected for the study are presented in a brief format in Table 2.3.

Table 2.3
Description of the Major Characteristics of the Research Settings

Hospital	Ward	Size	Service	Structure	Delivery	Staffing
West City	MAT1	28 beds 28 cots	Obstetric High Risk Pregnancy	Traditional (central-ized)	Combined Care	All R.N.
West City	MAT2	32 beds 32 cots	Obstetric	Traditional (central-ized)	Combined Care	Mixed R.N. R.N.A.
East General	MAT3	34 beds 26 cots	Obstetric High Risk Pregnancy	Friesen (decentral-ized)	Separate Mother & Baby	Mixed R.N. R.N.A.

The two wards selected at West City Hospital used a method of combined care to deliver nursing services to mothers and babies. In combined care, one nurse is assigned to the mother and her baby. In a traditional delivery setting, a nurse from the nursery cares for the baby, and another nurse from the postpartum floor cares for the mother. The structure of West City's wards was traditional; that is with a central nursing station and supply areas.

The larger of the two wards, MAT2 (32 beds), was geographically widespread and also contained a 32-bassinette Nursery, which categorized it as a 64-bed ward. The patient content was primarily postpartum. It was staffed with 23 registered nurses (RN) and 12 registered nursing assistants (RNA). MAT2 was an older ward which was scheduled for renovation in the near future.

MAT1 was a smaller ward (28 beds, 28 bassinettes), recently renovated. An all-RN staff (17) provides care to postpartum patients as well as high-risk antepartum women. In general, the antepartum and postpartum patients are geographically separated.

The third ward setting utilized in the study was at East General. MAT3 was a 34-bed combination antepartum and postpartum ward with a 26-bassinette nursery adjacent to it. This hospital was planning the implementation of combined care, but was delivering care in the traditional mode for the duration of the study. East General was a relatively new hospital, constructed less than ten years prior to the study, and was structured in a Friesen concept, which is decentralized. There was no central nursing station and supplies were kept in alcoves, called nurse servers, adjacent to the patient rooms. The staff was mixed RN and RNA, some of whom had moved from the previous site (the Old Hospital) to this building when it opened. East General was a bilingual institution, serving both francophone and anglophone clientele.

The three wards were similar in several ways, but different in others. MAT3 and MAT1 both served a mixed antepartum and postpartum clientele. MAT2 was different in that it served primarily postpartum women, only accepting antepartum cases if MAT1 was full. MAT3 and MAT2 had nurseries adjacent to their units, but in the case of MAT2 both areas were the responsibility of one head nurse. At East General, the nursery and floor areas had separate head nurses. In terms of organization and delivery of care, two main differences were notable. East General organized their nursing units according to the decentralized Friesen concept. West City was structured in the more traditional centralized fashion. West City used a combined care delivery system, whereas East General utilized a

traditional (separate) approach to care of the mother and baby.

It is apparent that there was a range of both variation and commonality in the settings selected for the study. This allowed opportunities for comparison of the ways in which instructors interacted with different models of organization and delivery of nursing care.

In this section, the sites, settings, and participants were discussed. In the following section, the methodology of data collection in the clinical field is presented.

2.5 Data Collection

Data collection took place over one semester from February to May 1987. The field portion of the study was conducted for seven weeks over a period of one student clinical rotation at the college, beginning in March (see Table 2.1). In total, 27 clinical days (out of a possible 31) were spent in the field with the three instructors.

Data collection was comprised of three phases. The first phase, orientation and overview, commanded the majority of the time in the pilot study previously described. In this phase, technical aspects of the study were rehearsed and some of the prominent aspects of the research problem were identified. Early in the main body of the study, I was still seeking sufficient relevant information to determine what was important to pursue and develop further. In the second phase the exploration became more focused. Interview and observation protocols became more structured as I probed in depth to solicit more information about the salient elements of the phenomenon of the clinical learning environment. The third phase represented the stage where interpretations were shared with the research participants to ascertain the validity of the analysis. By subjecting the written study to the scrutiny of those who provided the information, its credibility is established and the investigation is allowed to reach closure. There are of course significant overlaps among the phases of the data collection process, and time is an important factor. Time is

required between phases to synthesize interpretations, to determine key areas for further reflection and investigation, and to set the foundation for links and transitions to the other phases.

Data sources were of two types; human and nonhuman. The primary methods tapped human sources by interviews and field observation. Secondary methods included written reports, records, drawings and official documents. The core data were comprised of field notes, transcripts of conversations, document analysis, and journal entries. In all, a cohesive strategy of participant observation in conjunction with conversational strategies and supplementary techniques was utilized to collect descriptive data to develop insight into the world of the clinical instructor and her interpretation of interactions with the learning environment.

Three issues critical to data collection guided the inquiry process: (a) identification of the full range of variation in the modes of organization and nursing practice and learning situations, the roles and relationships of the members, and their perspectives on events, (b) collection of recurrent instances of a wide range of events so that their characteristics are able to be established, and (c) examination of discrete events in a holistic manner, linking them to the wider context. By remaining cognizant of these issues throughout the study, I was able to ensure that an adequate amount and variety of observational evidence was gathered. The essence of establishing a reliable and credible portrayal of events lay in capturing different kinds of data from different people in different positions in the milieu over time.

In Table 2.4, the data requirements are matched to the questions of the investigation to illustrate how the data collection methods related to the central questions of the research. In the following sections the methods of data collection, participant observation, and interview strategies are presented in detail.

Table 2.4
The Relationship of the Data Requirements to the Research Questions

Central Question	Research Questions	Data Requirements
How does the clinical instructor interact with the environment during clinical experience?	What are the elements which comprise the clinical learning environment?	**Observation** of activities of key participants to describe the nature of the milieu. **Interview** of key participants to obtain verbal statements about how they perceive the milieu. **Examination** of documents (manuals, reports) to determine their impact on activities and behaviours.
	What are the characteristics of these elements?	**Observation** of situations to describe the context where clinical instructor activity occurs and who is involved. **Interview** of key participants to determine the processing of information concerning the nature of specific situations as well as decision making rationale for activities. Verbal discussion with participants about situations to examine perceptions of the learning potential, enabling or constraining properties inherent in the situation.
	What does the instructor do in relating to the elements and properties of the clinical learning environment?	**Observation** of the clinical instructor, focused on actions and combined with conversation to explain rationale and intent of activities, roles, and functions. **Interview** of key participants, focused on how the instructor relates to others and for what purpose, how she copes with, adapts to, influences and manipulates the milieu.

2.5.1 Participant Observation

Participant observation was the principal method used in the field portion of this study. The task of the participant observer is to gather data by becoming involved in the daily life of the group under scrutiny. By watching the people, the researcher may determine the types of situations that ordinarily present themselves and how the people behave in them. By entering into conversations, the researcher is able to discover interpretations of events which have occurred.

Participant observation is a methodological technique grounded in the tradition of sociology and anthropology. It is a process of deliberate investigation founded upon a long and well established tradition of inquiry into the social and cultural worlds of the group a researcher seeks to understand. If one wishes to truly understand a group, one must become a part of its structure and processes.

In participant observation the investigator establishes and sustains a many-sided and relatively long-term relationship with a human association in its natural setting for the purpose of developing a scientific understanding (Lofland & Lofland, 1984).

It is important to stress that it is key to the operation of participant observation that any preconceptions in the form of theories or hypotheses must not be allowed to dictate data collection and analysis. It must be understood, however, that the field researcher cannot help but enter the research with a background of culture and beliefs. I was interested in the people on the ward as they were, not as I considered they should be. I concentrated on what the instructors did, how and why they did it, and any variables considered in advance because of literature review or experience were used as organisers for the study. The process of the research was open and flexible.

I followed the clinical instructors through the daily round of clinical experiences, seeing what they did, when, with whom, and under what circumstances, and questioned them as to the rationale for their actions. People with whom the instructors interacted were included in observations, and their perceptions of events were also obtained. In this way I built up a body of field notes and conversation transcripts that captured the activities and patterns of interactions as they occurred.

Initially I used a very comprehensive survey of the setting to get an overall sense of the milieu, identifying the events, their frequency, and times of occurrence during the day. The important activities suggested by Schweer and Gebbie (1976) served as initial organizing foci for observation of the functions of the clinical instructor. I observed and probed how the instructor solicited the cooperation of the head nurse, worked together

cooperatively with the staff, fostered reciprocal communication, and coordinated learning activities. Other factors, functions, roles and relationships emerged as the research process evolved and were probed in depth and detail to determine their meaning to the participants.

From repeated observation I began to focus on events of central interest to the study, restricting the range of times and places where observation occurred. I periodically stepped back into the survey mode in order to restore the broad perspective and confirm the holistic view of clinical practice. With a systematic and rigourous approach to the inquiry, vast amounts of information became available as the research progressed. By gaining the confidence of the people in the field and by maintaining a presence which neither disrupted nor interfered with the course of events, a wealth of impressions was generated.

The development and maintenance of relationships with research participants is of utmost concern. In order to understand, I sought out individuals who were willing to interpret the activities of the ward to me. I viewed these people as "colleagues" rather than research subjects under investigation. It was important that I develop the confidence and support of these colleagues to complete the research and gain as much understanding as possible of the phenomenon of the learning environment and the roles, relationships, and practices of the clinical instructor as she attempted to capitalize on the learning opportunities presented in the practice milieu. While I felt accepted as a nurse and nursing education colleague by staff and teachers respectively, I do not believe that the informants viewed me as a colleague in research. They were, however, able to develop the trust and confidence necessary to give me complete and honest information and insight. In view of the fact that most staff nurses do not conduct independent research and what research is conducted in hospitals fits the traditional positivistic research paradigm, an understanding of qualitative research methods did not exist in this milieu. While I viewed participants as collaborators in the investigation and analysis, true reciprocal collegiality was an impossible task.

Trust and rapport are not simply a matter of social pleasantness and proper etiquette. If I wanted to gain valid insight, which is critical to the success of the research,

trust was mandatory. The issue of evaluation was a continuing source of concern among participants. They were given repeated assurances about the purpose of the study and reminded that they could request that certain information be "off the record" or used indirectly. This alleviated immediate concerns, but the idea of evaluation persisted despite my disclaimers. However, I believe a genuine partnership evolved over time, allowing the researcher and teachers to jointly frame questions and plan data collection strategies.

> *One of the things I enjoyed about having you present was that you, in a way, provided me with a sounding board and tossed out ideas and helped give a different perspective. And that to me makes it a little more exciting.*
>
> Errin, L1500

The choice of settings proved fortuitous in that I had never taught in either of these hospitals, and while I had some clinical expertise in obstetrics, it was in the case room (labour and delivery) at the Old Hospital prior to the move to East General. The study itself utilized only the floor and the nursery, although the second year clinical instructor (Sara) sent her students to the case room for observational experiences on a rotational basis. Because I was not expert in postpartum or newborn nursery areas, I was open to the subtleties of interactions, and could ask genuinely naive questions as I probed for meaning. My experience as a nurse and as an educator were invaluable in recognising and separating the roles of the participants in the field. Hence, as I was neither a member of the setting nor the nursing specialty, I was considered an "outsider". But since I was a nurse, I was also an "insider".

> *It's been pleasant having you around. I must say in the very beginning the reception wasn't very good. The staff thought "Oh No!" In fact, I don't really know what they thought, whether they were going to be evaluated or interrogated or dear knows what! It took a couple of weeks to warm some people up, then after that, my goodness, it was lovely having you around. We knew what you were here for.*
>
> Lil, L735

Since I was acknowledged as an experienced nurse educator, it was not difficult to establish credibility and rapport with the clinical instructors. It was important, however,

that I not accept events at face value, but exhibit a certain naivete so that others would explain what they had done and why. This dual role of being both "insider" and "outsider" was deliberately fostered. It allowed greater opportunity to step in and out of the settings under study, to participate and also to reflect on the data. It also prevented problems of over-identification with any one group of participants. It did at times present some ethical dilemmas when I was privy to information from several different groups and could not share perceptions without revealing confidences. This was handled by asking probing questions such as "What do you think [the other person] was trying to do when she said [did] that?" to facilitate examining situations from an alternative point of view. This strategy also fostered revelation of tacit knowledge of the participants, making the implicit more explicit, and understanding those events or activities that were taken for granted.

> *You would say "Well, why did you do it?" I don't know why I do it, I just do! You helped me look at things with the students. I mean, not just being another pair of eyes and ears, but the probing kinds of questions that you'd ask me or ask the students. You made us really think about what we're doing and why we're doing it and try to grapple with the reasons.*
>
> Errin, L1601

In a qualitative inquiry the researcher is viewed as the data collection instrument and, of necessity, must become very familiar with the phenomenon and context under investigation. I immersed myself in the environment by actively participating, observing, and extensively questioning others. Becoming a visible part of the milieu affected my gradual acceptance into the culture. This was an interesting procedure. Staff nurses were very interested in my nursing background. Several questioned my credentials; where I trained and where I had worked. The following exemplar illustrates the importance that nurses attached to my nursing credibility.

> *This morning, as I was walking down the ward, a woman called out to me "Nurse!" She appeared agitated, and her baby was wailing loudly, obviously hungry. The woman was scrunched on the bed, the baby held awkwardly. I went into the room. "Can I help you?" Apparently when the nurse came in to help her put the baby to breast, the woman was not*

ready. The nurse had left, intending to return, but had not yet done so. The mother decided she would take care of matters herself, but with the discomfort of the episiotomy and the lack of experience with breast-feeding, was having a difficult time of it. She was nearly in tears. I could not in good conscience leave her to find a staff nurse, so I did what came naturally. I put my notebook and tape recorder on the overbed table, slipped the baby into the bassinette, and proceeded to arrange the woman comfortably on the bed with pillows and blankets. I bundled up the baby, then gave her to the mom. With a little assistance, the baby took to the breast, the mother relaxed and beamed at me "Thank you so much." As I left the room, I realized a staff nurse had been watching the whole episode. Later, she was heard to tell another nurse: "You should have seen Ardene. She put that baby on the breast and had that mom relaxed - just like a pro." After that, I was invited to coffee with the staff. It was as if my actions proved I was <u>really</u> a nurse. I began to feel accepted. The nurses seemed to be more open.

Field Note

I was concerned that my presence in the setting did not change the daily events or actions of the participants. Initially, a flurry of activity and interest was produced which quickly settled as people got into the routine of their tasks and roles. At several points I would stop and inquire if events as they were occurring were indeed typical, and, if not, how they differed when I was not present. I believe by clearly identifying my role and purpose and by developing relationships in the field, my presence was accepted and a normal state of affairs generally prevailed as illustrated in the following excerpts.

Have you noticed my observing you from time to time?

Student: *Not really. No. When I get busy I just don't notice. In fact, I was expecting to see more of you.*

T.E., L540

I thought it would be a little different than normal but I hardly even noticed you were around. And some times I wished you were there, like if I was doing something: "Where's Ardene?" No, the research hasn't influenced my work at all. Maybe the first day I might have felt nervous when you were walking around but, it kind of just fit in. Because you've been here since the beginning of our rotation. Every day our buddy nurse is new to us. You're not. So you fit right in. If you had come in the middle of the rotation, like say today or our last day, and you had just arrived and followed us around, then I'd be nervous! Plus, you know, you're not always behind our back in everything we do. I'm also used to other people around because it's our second year and whenever a dressing change or another skill comes up, the teacher says "How many students want to come and watch?" So people would be

watching while you were taking staples out or whatever. So I'm kind of used to someone being there.

I.O., L321

While I was in the clinical area for the entire day the student and teachers were there, not all of the time was spent in observation. After determining the temporal aspects of nursing practice and teaching strategies through my survey technique, I was able to select and plan observations in a more scheduled fashion. In most instances, observations were in half-hour blocks. Memory and the need to write up the event precluded much longer observation periods. On occasion, I would station myself unobtrusively and write notes as I observed. This strategy made people a little self-conscious at first, but in time they took it as a matter of course. I developed abbreviations and shortcuts in order to prevent the curious from discovering what I was writing when it was controversial or could affect their behaviours. It was easier to write notes when others in the area were also writing, during report or conferences, for example. While I always carried my pad, pen and tape recorder, I did so to make them familiar to the participants, so that when they were used, it was not viewed as unusual or special. Field work is very demanding physically and intellectually. I took care to ensure that I was prepared and alert, fitting breaks to eat and relax into the schedule. I was concerned that fatigue, stress, or illness might prevent the adequate collection of data. While it was more fun to conduct the field work than do the notes, I disciplined myself to complete them before leaving the hospital for the day. Once I became involved with the demands of life at home, I had a natural tendency to set aside my research obligations.

Each field visit had at least one focus, often generated from previous insights or questions. There was ample time to follow up on ongoing situations since students were on the ward for at least two days in a row with the same assignments and, as well, to get involved with new activities and developments.

As a participant observer I was not confined but was free to wander around the units and the nursery areas. A strict observation schedule was not used. I moved to

whichever locale was deemed appropriate for the data being sought to gain access to the broadest possible kinds and amounts of information. I was able to observe anywhere in the setting at any time and able to interview most members in the setting since few had not agreed to participate.

The role position I attempted to pursue throughout the course of the study was that of participant observer. I participated in activities, but clearly as researcher. Bogdan and Biklen (1982) state that "becoming a researcher means internalizing the research goal while collecting data in the field." I behaved socially and even assisted in performing some of the duties of the nurse or the instructor, but always with the reason of promoting the goals of my research. Going for coffee with the nurses may not have generated a great deal of usable data, but it was an invaluable aid to acceptance and rapport-building. The choice of activities to observe on the ward was determined by my research interest and objectives. Formal and informal conversations and methods were used to supplement the field data. Subsidiary techniques were also employed with the open cooperation of the participants. In one instance, for example, I asked the students to draw a picture of the clinical environment, the people in it, and how they were linked to each other. This strategy, along with the verbal explanation by the student, was an incredibly rich data source.

I assumed several different roles during the course of the study. While changing roles seemed to be natural, I wondered whether it would affect the data collection process. At times I felt compelled to intervene as a teacher or as a nurse if I had information or advice which could benefit the student or prevent harm to a patient. Inasmuch, however, that these roles appeared to assist in establishing credibility and rapport with the participants, it is my view that these roles, rather than impeding collection of data, enhanced the data collected.

I was readily allowed, indeed invited, into clinical situations where I had opportunity to observe interactions and collect data. As nurses and students became sensitized to my research goals, they gave me advance notice of when events of potential

interest to my study were planned to occur. In addition, participants knew that I wanted to talk to them about incidents after they happened and built this into their schedule. In fact, on one occasion an instructor said

> *I know you want to discuss what just happened in detail, but I just have to leave for an appointment. I jotted down a couple of points on this scrap of paper. You can read it now, then let's follow up after conference, O.K?*
>
> [Sara] Field Note

My intuitive knowledge and previous experiences in nursing education were used to gain an appreciation of the nuances of the realities and actions of the participants. Such tacit knowledge reflected my personal value patterns, allowing any apparent biases to be identified and taken into account. My task was to become aware of the frames of interpretation that I brought to the investigation and to the frames of those I observed. This process was fostered by debriefing strategies which challenged my interpretations of events, and fostered the development of alternative viewpoints from which an understanding of the key aspects of complex actions and meaning could be discerned.

During the course of a day in the field, I would stop hourly to write notes, descriptions of incidents, and conversations. When possible, I asked individuals and/or groups to comment on events giving their perceptions and feelings about incidents that occurred. These activities were carried out as soon as possible after events happened in order to limit any time-related distortions. At first I felt bombarded by information, tried to capture everything, and attempted to document every detail in the field notes. Later, as I became more immersed in the culture, understood the patterns of work and activities better, and felt more accepted by the participants, my nervousness abated and the field notes indicate much more focused inquiry.

In retrospect, I see this as taking a panoramic view of the setting, taking it all in to get a sense of what was happening. Over time, key areas of practice, potential areas of conflict, and particular trends emerged from the setting, and I returned to these areas to

purposefully observe and focus on particular activities or phenomena. My activity could be characterized as an ebb and flow, some days active and intense, and other days quite detached. In this way I was able to spiral my observation and conversation to greater depths, while still retaining a broad sense of the whole.

2.5.2 Interviews

As well as participant observation and the conversational strategies that formed a part of the method and were reported in field notes, formal intensive interviews were conducted with focal participants (clinical instructors, head nurses) and other major informants (students, staff nurses). An interview is a purposeful conversation that is guided by one person in order to get information. In this instance I wanted to elicit rich, detailed explanations of clinical learning and teaching experiences in the informants' own words. I sought to discover the clinical learning environment as experienced by the people in the milieu, what aspects were deemed important as impediments or facilitants, and how the participants in the investigation related to them. Interviews took place during all facets of the study.

No prior interview agenda could be definitively specified because not enough was known to predict possible interactions and outcomes. Therefore, I utilized an emergent and adaptive agenda, not one which controlled the substance of what the participants expressed. What was said and how it was said were chosen by the participants. I wanted to understand the complexity of the meaning given to the phenomenon of the learning environment and the actions in which the participants engaged. This did not mean I ignored past research conducted on the concept of learning environments. While certain conceptions of the environment were held from past teaching experience and literature review, and guiding questions were present, I did not know specifically where these initial questions and conceptions would next lead the inquiry. In a sense, I "tested" what I had

read and experienced as I engaged in observations and conversations.

Interviews were conducted with instructors, head nurses, some staff nurses, and most students. At the beginning, they were relatively open-ended, focused by the research interest and guided by some very general questions. I encouraged considerable freedom to pursue a range of topics and offered the participant a chance to shape the content and tell her story. As the study proceeded, interviews became progressively more focused. Since a relationship had been built between myself and the participant and specific information was being sought, less time was spent on amenities and exploration and more on the focus and intent of the question.

In all, participants seemed at ease after some initial self-consciousness about being tape-recorded. They spoke freely about their points of view, giving examples and offering rationales for their actions. Beyond asking for specifics, all that was required of me was my attention and encouragement. One topic usually flowed naturally into another with little guidance. On occasion, debate ensued with regard to competing interpretations of events, and this lead to healthy clarifications of various points of view. Participants were asked to reflect back on specific events and "relive" the event, explaining what they were doing, why, and what they hoped to accomplish. This was a very fruitful avenue of exploration.

The formal interviews with the instructors evolved into free-wheeling discussions of the milieu, the subject matter and nursing model, the people involved with the instructor (students, staff, other teachers), and how and why the clinical instructor taught the way she did. These opportunities served to enlighten the rationales and pedagogical plans of the instructor.

Head nurses kept closely to their roles and relationships with students and instructors, outlining functions that were important to them in the administration of the ward and the assurance of quality nursing care. Staff nurses were much more practical in their view of the clinical learning experience, focusing on what they did for and with the student and why it was important. Since time was short, interviews were of short

duration, making them of necessity more focused. Interviews with staff nurses were initiated by me, by a nurse wanting to say something "on the record", or in response to a clinical situation or event. In order to foster this spontaneous communication, I announced at report in the morning what my "topic of the day" was. It was apparent that there was usually a "slow period" between 1100 and 1200 each day, and I made myself available during that time to communicate with the nurses. In no way did I constrain them to any specific topic. My "topic of the day" (examples: the student and I, the teacher and I, how this research is affecting me) and my time frame was a strategy to show that I was available and wanted to hear from them. It was a successful strategy, since I could count on at least two nurses each day coming to talk to me about clinical teaching and learning issues.

Similar questions or topics were given to the students, who replied either in writing (as letters to me) or on tape, whichever they chose. Interviews with students were interesting. For the most part they were quite intimidated about talking with me when the tape recorder was running. I discovered that if I had explicit questions or was seeking specific information, they were more articulate. In an attempt to generate more data, I tried interviewing students in pairs if they had shared particular experiences. This was more fruitful. An exciting strategy was the "round table" discussions. In these cases, the tape recorder was placed in the centre of a table and we talked, primarily, about reasonably public topics which would not be of potential embarrassment to anyone. This strategy presented multiple perspectives on issues, open discussions, debates, and fostered more open interpretations and peer questioning. It allowed students time to reflect and recall, quiet moments in which to listen and not speak, opportunity to rethink, clarify, or amend statements. One person's comments stimulated another to state an opinion, seek clarification, contradict, or qualify. In this manner, contrasting perspectives were brought into prominent relief. Control was an issue that I handled by acting as moderator, encouraging reticent participants to speak, and preventing the more dominant from taking over the discussion. Transcription was an impossibly difficult task, so notes served as

records of these discussions. In each group there was at least one person who was talkative, and I used them to reveal issues of importance to students and to frame questions for further conversations with individual students.

Questions relating to impressions of the clinical area, interpersonal relationships with their peers, instructors, staff nurses, and researcher formed the general substance of interviews with students. I carried a card with me to serve as a reminder or a guide. This guide was not a structured series of questions to be asked verbatim as written. Rather it was a list of topics to investigate when talking to students. I wanted them to speak freely in their own terms, yet provide them with a set of concerns and also encourage them to introduce their own issues. Some students were "chattier" than others and the guide served merely as a checklist that reassured me that I had not overlooked anything. With the more reticent, less verbal student, I needed to ask the questions more specifically, probing and seeking more detail and explicit examples, remembering to avoid posing questions in a leading manner.

In all cases, tapes were transcribed and given to the participants for review with a summary of the main points raised. At a later date we discussed the summaries, and further questions and insights were explored. In this way the interviewee was able to clarify, correct, and extend what was said, ensuring credibility and clarity of the ultimate product. While I transcribed some tapes myself, the bulk were given to a secretary to type. My role was to review them for accuracy and provide the contextual detail and summary. This working arrangement was very efficient and time-saving, allowing quick turnaround of transcripts and effective analysis. Since students in the study were in either first or second year of a three year programme, I was able to contact them easily for this follow up procedure. At this time, all students gave permission to use quotes from their transcripts in the research report. Transcripts were sent to the home address of staff nurses with potential quotes highlighted with a marker, telephone conversations were employed to receive feedback, and verbal permission to quote from the transcript was solicited.

2.5.3 Related Data Collection Techniques

I employed several supplementary techniques during the course of the inquiry. Hospitals produce many documents including procedure and policy manuals to guide the practice of employees. These were reviewed for their clarification of rules and roles as they pertained to the clinical experiences for students. The clinical instructors' records and students' anecdotal recordings were reviewed and analysed for insight and understanding. In addition, students were often requested to do small written or visual assignments for me, to help me to understand their unique perspectives on the clinical milieu. Photocopies of selected students' anecdotal records were obtained with their permission.

Because of the intensity of the field portion of the study, notes were not typed daily, but were reviewed, clarified, extended, and superficially interpreted prior to returning to the field each day. I reviewed planned activities early in the day with the key participants, shared insights and ongoing questions over lunch, and discussed the events of the day over coffee with the instructor after students had left for the day. In the evening I would conduct a provisional and partial analysis, determining the current status of the study compared with the overall goals and plans and project the next day's data collection activities. On weekends, more rigourous review of the data was conducted. Weekly meetings were held with my professor to share my experiences and concerns, to debrief, and to receive support and encouragement. In these sessions, we discussed how to adapt to unforeseen circumstances or unexpected opportunities. My professor shared articles, files, and perspectives to enlighten possible avenues of approach and analysis.

Problems of data collection and recording posed difficulties throughout the study. Recorders failed to work, batteries ran down, tapes got mangled. Handwritten notes and abbreviations were illegible. Travelling on winter roads and finding parking were troublesome. Administrative details like scheduling meetings, seminars, finding rooms in

which to interview people, and locating lockers in which to store clothing and equipment took time and effort. In addition, a family accident removed a major source of emotional support and placed additional personal responsibilities on me. The isolation of field work, the loneliness and anxiety, fatigue, and feelings of inadequacy became real concerns. Debriefing strategies with an experienced qualitative researcher allowed personal catharsis and yielded important practical advice and necessary encouragement and support to continue the study and maintain its quality.

Concerns of special interest arose in the course of the investigation, not only between wards and hospitals, but also within and across levels in the organizations. For example, the interests of the nurses and the head nurses were not always the same, nor were the special interests of teachers and nurses, or teachers and students. This caused certain conflicts and raised ethical dilemmas for me. Discretion became the key watchword as I probed the issues for key aspects.

When ethical issues arose, the basic principle I followed was to protect the interests of the particularly vulnerable people in the setting. The focal participants (clinical instructors) are especially at risk, the students to a lesser degree. In anticipation, I made it clear that data confidentiality would be respected (See consent forms, Appendix A). School administrators had been informed that I would not disclose any evaluative information about the research participants. Clinical instructors were requested not to ask me to evaluate student performances. These precautions did not totally eliminate risk, but it minimized informal verbal coercion throughout the course of the study. As it happened, no requests were forthcoming from administration.

The methodological challenge of the data collection process was to record, in some permanent form, the observations and conversations. Taped interviews were transcribed. A research diary (in the form of small notebooks) was kept which noted day to day events, quotes, impressions, and information. A second journal was kept which chronicled my reflections on the data, plans for future directions in observation and questioning, the

process of the study, the development of relationships, and the logical analysis of events, as well as ethical dilemmas faced in the course of the study. These memoranda regarding interpretations and insights into the data collected were used in the audit procedures to illuminate the analytical process and ensure trustworthiness, which is discussed later in this chapter.

In this section the methods of data collection were presented. The processes of focusing the inquiry, building relationships and becoming a part of the milieu, developing routines to establish the rhythm of the research process, and interrelating the formal and informal procedures of the method were discussed. In the next section, the process of ensuring reliability and validity is outlined.

2.6 Special Criteria for Trustworthiness

Conventional criteria (internal and external validity, reliability, and objectivity) are not consistent with the axioms and procedures of naturalistic inquiry. New (analogous) criteria have been defined and operational procedures have been devised to ensure trustworthiness (Lincoln and Guba, 1985). These criteria are: credibility, transferability, dependability, and confirmability. Research strategies to establish a trustworthy research study are outlined in Table 2.5 and discussed below.

Credibility, adequate representation of the multiple realities and perspectives, was ensured by prolonged engagement in the clinical sites. Sufficient time was spent in the clinical area (27 days) to achieve the purposes of the research, develop trust, and provide a wide scope of multiple perspectives. Persistent observation provided the depth and detail necessary to determine the most salient characteristics and elements in the situation. Triangulation, the use of different sources, methods, and theories, as well as member checks further ensured that credible findings and interpretations were produced. Debriefing strategies such as conversations with my professors and peer researchers and a reflexive

journal were used to expose my tacit knowledge, implicit interpretations, possible biases, apparent contradictions and gaps in data. These external checks served to "keep the researcher honest". Data, analytic categories, interpretations, and conclusions were checked with members of the group from whom data were originally collected, providing a direct test of the findings.

Table 2.5
Summary of Techniques Used to Establish Trustworthiness

Trustworthy Criterion	Technique
Credibility	1. prolonged time in the field 2. persistent observation 3. triangulation of sources and methods 4. debriefing 5. discrepant case analysis 6. member checks
Transferability	7. thick and rich descriptions
Dependability	8. audit procedures
Confirmability	9. audit procedures
All criteria	10. reflexive journal

Transferability was fostered by using thick descriptions and purposeful selection that allow the reader to determine the extent to which the research report can be generalized to another setting. To this end as much relevant data as reasonably possible is included in the written document, with charts and tables available to make quick reference possible.

Dependability (reliability) means taking into account factors of instability in the situation or design/phenomena-induced changes. An audit procedure conducted by a person external to the study, along with overlap methods, replication, triangulation, and reflexivity (Halpern, in Lincoln & Guba, 1985, pp. 382-392) were utilized to ensure dependability. In this way flaws in the process or product can be identified to ensure that

the study falls within acceptable professional, legal, academic, and ethical limits. In this investigation, the auditor, a peer doctoral candidate, selected and investigated a single theme. It was determined by consultation with research advisers that this would constitute an adequate test since the research process was closely monitored throughout by the research committee. For example, members of the research committee visited me in the field to acquire a deeper understanding of the context and better advise me.

Confirmability (objectivity) is ensured when the researcher shows that a concept or category has been experienced or reported by more than one informant. The neutrality of the researcher's data collection, analysis, and interpretation was tested by a confirmability audit procedure (Halpern, in Lincoln & Guba, 1985, pp. 382-392) conducted by a person external to the study, the above-mentioned peer doctoral candidate, using a process similar to that described above in the discussion on dependability and elaborated below.

For the audit procedure it was decided that rather than conducting a time-consuming audit of the total study, the auditor would select a particular theme, and follow the audit trail relating only to that theme. After reviewing the research proposal, the thesis, and all documents pertaining to the pilot study, the auditor selected a theme for investigation. She listened to relevant tape recordings to make certain they were accurately transcribed, read the raw data (field notes, journal, memoranda, supplementary documents), computer printouts, and process notes, and ensured that the interpretations were valid and that the theme was adequately portrayed in the report. Following a discussion with me relative to her findings, a letter of attestation was written and is included in Appendix B.

Activities to ensure trustworthiness were planned at the outset of the investigation and kept in mind as data were collected and analysed. Although it was a time-consuming process, it kept materials organized, reflexive notes purposeful, and defended the rigour of the method. In the next section, the process of analysing the data generated from the data collection procedures is presented.

2.7 Data Analysis

Analysis of the data represented an interactive process between myself as the researcher and the research experience. Exploring the clinical learning environment was viewed as an experience to be lived and understood. Perspectives and perceptions are influenced, if not governed, by the researcher's and participants' experiences, interests, and knowledge. I searched not only for the elements and properties of the learning environment, but also for a framework to describe them. In addition I sought to learn the significance these elements had for the clinical instructor and the meanings attached to her actions as they related to the environment - manipulating it, adapting to it, coping with it, or transforming it.

Participant observation is an ongoing process. It develops together with the explanation of events and interpretation of their meaning. With the knowledge that develops from understanding the world of the clinical instructor, it is possible to develop unifying themes and patterns. Incidents to further illuminate or illustrate these perspectives can be sought in the next observation or interview phase. Participant observation proceeds, then, through a tandem process of investigation and analysis, with one process informing the other.

As mentioned earlier, I entered into transactions with participants on the nursing units in ways that did not require them to view their situation through a particular framework or with a set of predetermined definitions or categories. I remained open to issues as they emerged and searched for alternative interpretations of events. For example, from some of the interactions which were observed taking place among staff nurse, student and instructor, it became evident that a socialization process was likely occurring. This was an aspect of the educative process to which I had not given a lot of attention, until seeing it in practice. This necessitated further literature review in order to identify and define the professional socialization process, in order to distinguish it from other basic

social processes which may also have been operant.

Inductive (rather than deductive) analysis was used with the interview and observational data gathered. The points of view of a variety of informants are more likely to be found using this technique, and the mutually shaping influences that interact in the clinical context are more likely to be identified. This approach is cyclical in nature and is not accomplished in distinct linear stages. Abstract thought processes such as introspection and intuition as well as reasoning were involved in the analytical process. Analysis is more then intuition, more than insight. It involves systematically combing the data, and going back to it time and time again as new ideas and patterns emerge. Analysis is looking for supportive evidence but also for cases, instances, or statements which are contradictory, in order to define what the phenomenon is and what it is not.

All the interview transcripts, field notes, and journal entries were reviewed in order to get a feeling for the data and to begin to make sense of them. The data were searched for themes and patterns which emerged using the method of analytic induction and constant comparison (Lincoln & Guba, 1985; Glaser & Strauss, 1979; Lofland & Lofland, 1984).

Major foci were identified and isolated by their recurrence in the data, or by the emotional intensity surrounding them. Emotional intensity was determined by nonverbal and verbal means such as increased voice volumes, more people speaking, gesticulations, body posture, and use of space in conversations. Analysis of this nature took place in the field as time permitted; most often insights came at odd moments, or when journals and notes were being reviewed. A crude classification scheme emerged, based on the research question and extended and was refined as more information became available.

The analysis proceeded, with some overlapping, in the following general stages derived from Lincoln and Guba (1985): unitizing, categorizing, pattern-filling, and member checking. This process proceeded manually in the early stages, but once a crude classification system emerged, a microcomputer and data base were used to facilitate the ordering and categorizing of the data.

Unitizing is the breaking down of information into singular chunks for analysis. A unit is determined by its ability to target some understanding or action that is required to illuminate the phenomenon. It must also be the smallest piece of information that can stand by itself in the absence of additional information except perhaps a broad contextual understanding. Some units were simple sentences, others were several paragraphs. These units were found within transcripts, field notes, documents, records, and research diaries. In order to prevent data loss, much data that later proved irrelevant were initially unitized. It seemed prudent to discard data very cautiously.

I did not unitize by cutting segments out of the transcripts and placing them onto index cards as traditional qualitative researchers describe. Transcripts were first created on my Macintosh 512Ke computer using Microsoft Word™, a standard word processing program. Features which were particularly useful to the researcher include automatic line numbering, global search and replace functions, and spell-checking.

The selection of a database program to store, organize, and synthesize the data was not so straight forward. Filemaker Plus™ was eventually selected because it provided variable length text fields to accommodate various sized transcript units, automatic indexing of field values which made data handling more efficient, ability to easily modify the database structure as my understanding of the relationships and meaning of the data evolved, and full compatibility with Microsoft Word™. Further, multiple layouts of the data could be maintained concurrently to facilitate data display and presentation.

For ease of access, both programs were used simultaneously to transfer word processed files into the data base. This was a relatively easy task (albeit time-consuming) since all data had been electronically captured and it was a simple "cut and paste" exercise. Units were selected from the word processed document and entered into the data base as a "text field". A complete unabridged file of raw transcript data was retained in both electronic format and hard copy. Categorization fields and a comments field were added to each record and modified throughout the study. A segment of raw transcript, the same

segment unitized, and the units as categorized in the final version of the data base can be found in Appendix C. The process of electronic unitizing is thus illustrated for the benefit of the reader.

All fields in the data base were identified by name of informant, date, site, and type of data (transcript, field note, memo), and further categorized as the data were analysed. As the data were unitized, key words and phrases were used to code the idea contained in the unit. These phrases were at times researcher-constructed; at other times, the codes were derived from the words of the participant. As the number of units increased, themes and patterns began to emerge, and the units were being constantly reevaluated and compared in light of these themes.

The second stage of data analysis, categorizing, then proceeded by applying the provisional categories or themes to each of the units. The unitized statements were individually reviewed, and judgments applied with respect to the provisional categories which had been roughly defined. For example, reflective notes were categorized according to Bogdan and Biklen (1982): reflections on analysis, method, ethical dilemmas and conflicts, observer frame of mind, and points of clarification (pp. 87-88).

Categories defined key elements of the environment and properties of these elements. Any unit could be categorized in more than one category. For instance, a unit might be described as a comment on the physical aspect of the ward. It would be categorized under that dimension. It may further relate to how the furniture is not movable, so it would also be categorized under the appropriate property. Further, the unit may illustrate how the instructor copes with this particular problem and adapts it to suit her needs, also allowing it to be catalogued under instructor activities. In a similar manner the roles of the instructor and her tasks during the clinical experience were catalogued. Since various sources were used to form the data base, statements could be compared from one source to another, from one informant to another, and from site to site. This triangulation strategy also served as a validity check.

At times, entire categories were examined to ensure internal consistency and avoid overlaps with other categories. The computer proved to be an invaluable tool at this stage, assisting with categorizing, searching, and ordering data. When the entire data base of some 300,000 words had to be manipulated simultaneously, arrangements were made to use a Mac SE 2.5 Ram with a 40 megabyte hard disk. Martin (1988) notes that the use of a microcomputer allows the social scientist to handle large volumes of ethnographic data efficiently, "allowing the researcher to focus on the phenomenon being studied rather than the mechanics of handling the data" (p. 14).

Statements were derived from the categories and then organized into a cluster of themes, which were referred back to the data for validation and searching for discrepancies and contradictions. At this point, two activities were required to move into the third stage of analysis; discrepant case analysis and pattern-filling.

Lincoln and Guba (1985) regard discrepant case analysis as a process of revising hypotheses with hindsight. The object is to refine the categories, their definitions and relationships until most known cases are accounted for in the analysis. When a unit did not "fit" a category, it was not coded immediately; but set aside. As the not-coded units grew, they were reviewed to determine if a category or pattern was emerging. Additionally, categories were continually being refined and redefined to make explicit what was and was not appropriate for inclusion in that category. Some categories were unwieldy in size and needed to be revised and subdivided. Others were sparse and could be subsumed under others. In this way, no data were lost and categories were inclusive of all the units.

In concert with this activity, the categories themselves were examined for overlap and drawn into a composite whole. Relationships among the categories were examined. At this point logic was used to determine gaps and missing pattern descriptions. The data were being reconstructed after being reduced to small units of analysis. Missing information to complete the emerging patterns could be pursued in subsequent data collection efforts.

At some point a decision to end the study is required. There are four criteria to inform a "stop" decision outlined by Guba (1978; in Lincoln and Guba, 1985): exhaustion of sources, saturation of categories, emergence of regularities (a sense of integration has emerged), and overextension (new information does not add to the understanding of the phenomenon). Fortunately, the above criteria were met within seven weeks, because the semester ended and the field portion of the data collection opportunity disappeared.

In the fourth stage of analysis (member checking) a description of the clinical learning environment was written. This description was given to the focal participants in the study (instructors) with a request for feedback about the adequacy of the interpretation and description of the phenomenon. In addition to the presentation of the dimensions and properties of the clinical learning environment, a discussion of how instructors dealt with the realities of the milieu was included. Final interviews with participants verified the description and interactions and provided an additional validity check.

2.8 Risks To Subjects

Ethical questions are of concern in all research. Anonymity remains problematic in ...y, even studies which include larger sample sizes. One has to determine whether ... onal anonymity or the anonymity of the informants is at risk. The institutions have not been directly identified. Participants were fully aware of the implications of their involvement from the beginning of the project. Pseudonyms and roles were used and informants had the option to negotiate which quotations and exemplars were included in the dissertation. To quote Simons (1984):

> *Where individuals are described, pseudonyms or roles are used in the report. While this does not assure anonymity from those in the immediate environment, it decreases the probability of identification over time and distance.* (p. 90)

All participants in the study had right of access to any information recorded (written

and audio) that they had provided; they shared and discussed interpretations developed en route and at the end. Participation was voluntary and any participant had the right to withdraw from the study at any time without prejudice. There were no drop-outs. The consent form made it clear that interviews would be tape-recorded. As well, participants could request certain data be kept confidential, rephrased, or used only indirectly. If a particular subject area was declared personal information or if the participant did not wish to discuss certain events, that wish was respected. I negotiated independent as well as collective concerns with each of the participants (e.g., timing, frequency, and venue of discussions and observation periods) to ensure the least amount of inconvenience to the research participants.

I followed the principles of ethical research, and paid particular attention to independence, impartiality, confidentiality, and ongoing consultation. Independence safeguards the investigation from the pressures of different interest groups. Impartiality requires the researcher to check accounts for bias and to secure fair and objective reporting. Confidentiality protects informants from inappropriate use of information private to them. Rules of access and consultation give individuals opportunities to decide what to share, to reflect on what has been shared, and to edit or comment on their information in context.

Since the informants collaborated in the analysis and interpretation processes, their perspectives could be included in the dissertation, thus reducing the risks of misunderstanding, misinterpretation, or researcher bias. Identifying characteristics were obscured or used only indirectly. The research is descriptive in nature, not evaluative; consequently no judgments of worth or merit of the informants or their practices were made.

It was not anticipated that any patient data or medical records would be required for the study. No patient information was transcribed when it arose in the course of interviews. Patient conversation data were included indirectly as they related to events under observation.

2.9 Limitations of the Study

This study is not without limitations. Because the group studied were from the community college system, it cannot be assumed that the ideas generated can be transferred to teachers and students in university-based programmes. It must also be noted that the clinical agencies in which the study was conducted were large urban teaching hospitals.

The environment as experienced by teachers and students is a learning environment. Whether the framework for describing the clinical learning environment can be transferred to the clinical environment itself, as experienced by staff nurses, was not the intent of the investigation and was therefore not examined.

Studies of this nature are often carried out by a team of researchers, thus allowing for much wider data collection, resulting in data which are greatly enriched. A team allows for validation of findings among researchers. As well, studies of this nature are often conducted over a much longer time frame, resulting in richer data.

2.10 Summary

In this chapter, the research approach was presented. Implementing a qualitative study is a complex and seemingly formidable task for this novice researcher. Before the inquiry could take place there were several necessary preliminary steps that proved time consuming and frustrating: making initial contacts and negotiating access and entry, building trust and rapport, and identifying and using key informants effectively and ethically.

As the study unfolded, the process seemed only nominally under my guidance. Ongoing reassessment and reiteration were required to ensure that the amount and variety of data necessary to inform the analytical process were retrieved and that all potential

sources were tapped. I used many techniques to collect data; participant observation, interviews and analysis of written records. Whatever the technique, I, the researcher was the primary instrument of data collection.

At all times the concern for trustworthiness (reliability and validity) remained uppermost in my mind. Field work, triangulation strategies and adequate notetaking safeguarded against major distortions in the data. Personal issues which arose cannot be discounted as trivial. Dealing with ambiguity, managing field problems, and handling the personal emotions and time constraints made the data collection process personally demanding.

During the analytical process, I examined the data and reconstructed it into a meaningful whole that lends understanding to the phenomenon of the clinical learning environment. To do this, I scanned the data for categories while simultaneously comparing all incidents documented. A continuous feedback loop was used to discover themes, patterns, and relationships. The four-part process outlined by Lincoln and Guba (1985) and assisted by a microcomputer and data base software was operationalized: unitizing, categorizing, pattern-filling, and member-checking.

In the following chapters the results of the data collection and analysis efforts are displayed and discussed.

Chapter 3
Teaching in the Clinical Setting

In this chapter, the observed functions, activities, and roles of the clinical instructor as she carries out her responsibilities in the hospital are described.

The work of the clinical instructor can be described as time bound and time dependent. Time is a critical element of clinical nursing practice, and time-related events provide a means for ordering thoughts, plans, and actions.

Time demarcates structures within which the events of clinical teaching take place. During a particular semester, certain courses are offered to students for a prescribed length of time. A specific number of hours are determined for class and lab activities; certain hours are allocated to clinical experiences. Within these hours, certain days of the week and certain shift hours are designated.

Each clinical day, the teachers divided time into blocks which served to decrease the complexity of decision tasks required at any given time. It allowed a degree of predictability to be imposed on the milieu, and provided set times during which specific goals could be accomplished. Particular events and behaviours were expected to occur at definite times, providing opportunities to monitor student progress. It was necessary for the clinical instructors to maintain a certain pace in order to accomplish the activities of the day.

> *In the morning I have 3 reports to take. What I usually do is set up the students in the case room and assign them to the buddy nurses. Then I will check in on the other two wards, depending on which students I want to work with. If it's medications, which is usually the high risk area with all the antepartum mothers, I'll start there. If I have a problem student, I'll start with that student, helping with the assignment. Then after I've done medications, I'll make appointments with the various students to to try to organize my day: who wants to see me and when so I can review teaching plans, supervise new procedures, meet people, ensure student-staff communication and report, help students with patient assessment if they are having trouble,*

help with charting, and give them assistance if they are having trouble with organizing their care. In the first 2 hours I hope to get around to see each student. Then from there, we'll progress throughout the day.

I usually want all the students to have their charting done by 11 o'clock, so between 10 and 11 I'll make rounds again. I see each of the patients and hopefully each of the students.

From 11 to 12, I either sit in on the teaching students are doing, or talk with individual students about any problems they're having.

Break for lunch. Then we do a tidying up of any special things that come up with the student again that she needs to be supervised for. It's more on new skills at this point at the moment than anything.

Then I usually try to have a post-conference for an hour. Some of these are open conferences where the students discuss some difficulty or exciting things that has happened. Sometimes it will be an educational program, like a tour of the special care nursery. We do have one research project and I ask that nurse to talk to them about it. We do several different things at conference.

Sara, L35

Although the concept of time was similar among instructors, the form in which it was applied differed. Each instructor ordered her day uniquely, placed emphasis on different activities, and dealt with inevitable time delays and interruptions in different manners. Part of the difference in time management could be attributed to the level of student. The second year students were able to act independently for many more nursing acts than the first year students. They carried more patients, however, and since the patients were generally more complex in terms of their nursing needs, the level of expertise required of the student was higher.

Not all instructor activities were teaching activities. I will mention them without elaborating in great detail, because the focus of this study is on teaching activities, although a certain amount of time was spent in non-engagement with students. For example, some teacher time was spent checking material and textbook references and consulting with staff and allied health personnel to improve her own knowledge and understanding of developments in the field of the clinical specialty. At times, instructors became involved in providing independent care-giving activities or interacting with patients and visitors.

Because of the distance created by the geography of the setting, much time was spent travelling among areas on the ward(s) as well as waiting for planned events to occur. Instructors required breaks from the ward for meals and often this non-engaged time was spent in working the informal network of contacts from both the hospital and the college.

3.1 Functions of the Clinical Instructor

Clinical instructors were observed to be carrying out five major functions: personal orientation activities, preparation of the ward to receive students, preparation of students for their clinical experiences on the ward, instructional activities, and monitoring and evaluation exercises (Table 3.1).

Table 3.1
The Instructor in the Clinical Setting

The Functions of the Clinical Instructor
Personal orientation.
Preparation of the ward.
Preparation of the students.
Instructional activities:
° Patient selection
° Communication
° Curriculum translation
Monitoring and evaluation:
° Student progress
° Self reflection
° Environment

3.1.1 Personal Orientation

Each of the instructors conducted personal orientation activities. The activities differed because the needs of each instructor were unique. The purposes of orientation

were uniform: to learn what was new and different about this ward and the people in it, to establish guidelines for her activities and the roles and responsibilities of others, to develop a sense of belonging, to feel secure in personal knowledge and practice base, to determine what kinds of information needed to be exchanged between the staff and the instructor, how this information is handled, and how conflict is managed.

> *I went in one day to the floor and buddied with a staff member to get into the routine, what's done. And then I spoke individually with the nurses and went with them to coffee. That's how they got used to me. I then spoke with the Head Nurses. That answered a lot of questions. If you go in and you are willing to go around and make the beds with them you can just sort of ease your way in. I also went into the Nursery for most of a morning and bathed some babies and answered questions and spoke to nurses individually. You see a fair number of the staff by doing it that way.*
>
> Peggy, L189

The disposition of these orientation activities set the tone for the remainder of the experience and affected the quality and degree of acceptance into the setting of the instructor by the ward staff.

> *The difference between ward orientation and going into the Case Room, where I was not comfortable and not known by the staff, you can't believe! I found that they were very unfriendly to me in the Case Room. They did not respond to me. They really checked me out. How much do I know? What can I do? When I got there with stude. they were really double checking my students on things. They were always asking "Where is that teacher coming from? She has this model and she talks to students in a language that we don't know." Once I went into a room and I didn't have a mask on, because I had seen a nurse in one of the Delivery Rooms without one. I was orienting students. They yelled at me. That frightened me; made me very nervous. So I felt very unsure there for the first 6 months.*
>
> Sara, L421

Errin was new to the health care system in the city, and she reflects on her first exposure to the ward:

> *I couldn't get into the swing of things. I hadn't gotten to know the staff well enough. I felt really out to lunch most of the time! First, the fact that I'd only, well, I hadn't even seen West City Hospital before the first week of work, so you can appreciate the trauma. It's a big hospital. It's got a lot of policies that are different than what other*

places have. And of course I don't know the doctors. I don't know the wards. I don't know the hospital policies. I didn't even know my way through the tunnels. I didn't know anything.

Errin, L1417

Some of it, of course, once I established credibility with them and the students, then things became more positive, more comfortable.

Errin, L683

Peggy and Errin, because they were new to the college, received orientation to the faculty as well.

This is a very formal orientation and we had five days out of town last year. All the new teachers in the region. This year we had three and a half days and next year we go again for a final session. So it's a two-year process. Every summer there's this orientation business where we get together. And in between it's writing personal objectives for yourself to work on throughout the year. Last fall I wrote a personal development plan, what I wanted to achieve and dates by when I hoped to achieve it. Now this fall, I will review last year's objectives and write new ones for the coming year.

Errin, L1364

Orientation activities served to inform the instructor about the important aspects of the ward and the nursing course. Without this preparation, she would have little credibility among staff or students. As she learned about the milieu, she discovered potential areas of conflict, and attempted to address these issues and negotiate a resolution prior to the arrival of the students.

3.1.2 Preparation of the Ward

The second function of the instructor was to prepare the ward to receive students. The head nurse was instrumental in this process. Her attitude toward education and students determined the complexion of the experience. Head nurses can be supportive and creative, or they can place obstacles in the way of student practice. The instructors viewed the head nurses' political influence as high, and their decisional jurisdiction over patient care as powerful. By initiating a cooperative relationship with the head nurse, instructors

hoped to positively influence the learning environment. If the students felt welcomed, instructors felt their anxieties would be reduced and they would learn more effectively.

> *I had a lot of discussions with Lil before I went to the obstetrics ward because she seemed to be more interested in talking with me then the other head nurse. I went to her ward (MAT1) in January. I had all kinds of questions and she took the time and talked with me, and encouraged me to ask questions. She was very helpful.*
>
> *They were just in the process of transition on the other ward (MAT 2) from the head nurse that was leaving to Michelle and consequently we never really formed that bond. I've never had a problem with when I've asked Michelle something, but she always seems so busy and it seems I hate to bother her. She often seems to be under more pressures than Lil.*
>
> Errin, L1269

A great deal of the instructor's time and effort during orientation was devoted to setting the stage for student activity, establishing her own credibility, determining who the power brokers and conflict generators are, and determining and establishing lines of communication.

> *Q: How do you establish credibility?*
>
> *A: Well, I don't know. It is just something you do. I try to be friendly with the staff and talk to them. I share what I would like to have happen with them and the students and find out what they want us to be doing. I try to include them, I guess, in what's going on. Certainly I offer them opportunities, on a fairly regular basis, to share any feelings, one way or the other, that they might have about students, learning, patient care, and what we are doing.*
>
> Errin, L687

> *We are just building our relationship up because I'm new, and I'm certain they know that I am not an obstetrics nurse. I haven't worked there in this hospital very much. I think sometimes that if you've been in a hospital a lot, been a staff nurse there, or been assigned to other floors, it is easier. But I was new, going into that hospital and had to make sure not to say "Well, at the City, or over at Memorial ..." You have to watch yourself. Everyone feels possessive about their own hospital and you can't say "well, there is a better way."*
>
> Peggy, L716

> *I think actually they were testing me. They were kind of watching to see. You go do the vitals in the Nursery and they think, "oh, okay." So you prove yourself, I think. But I always let them know what I can't*

do, or that what I expect my students to do I will be able to do. You have to lay some groundwork.

Peggy, L1365

I go in at 7:15 for orientation. I believe in that. I don't want to walk in at 1 o' clock to do my teacher orientation from 1 to 2 o' clock because right away I think their backs would be up. That's not nursing. I like to go for report in the morning. At least it shows I got out of bed and got there early, the way everybody else did. I think that helps a lot.

Peggy, L1371

The instructor needed to convey information about the students and their learning objectives to the head nurse so that the ward staff could prepare for their arrival. The instructor confirmed the dates and shifts with the ward, gave the head nurse a list of students with their home telephone numbers for security purposes, and determined time boundaries for patient selection, arrival on ward, and report activities. As well, head nurses were given folders which contained the course outline and clinical objectives for the experience. The instructor highlighted the types of opportunities she hoped to provide for the students, and what activities were excluded. She enlisted the support of the head nurse in carrying out her teaching functions in ways that would not impede the functioning of the ward or adversely affect quality of care.

At the beginning of the semester I bring objectives and talk to the head nurse about where my students are. I usually ask to meet with all three head nurses for an hour; sometimes I can do that, sometimes I can't. I also put up a list of skills that my students have accomplished and what they need. I give them a list of days and shifts we are on the ward. I find when I come back I need to go over it. The staff doesn't, I think with the number of students, always orient them according to where my students are. Now, at the present time, a new semester, it's really easy. My students are doing everything. So they just say "Sara, what are your students able to do?" And that is much easier than if my students are at levels where they were earlier in the year where they were just beginning their first injections, their first intravenous infusions, their first post-operative patients. Now, doing combined mother and baby, working with gestational diabetics, teaching; it is better.

Sara, L108

In preparing staff for their teaching role, she clarified practices already in place, and the degree of comfort the staff felt about teaching and supervising students. She negotiated

with them what sorts of things she would delegate, and what activities she would personally supervise.

> *I will supervise all first injections. After that, if a nurse wants to cover, that's fine with me. But I will pop in if I have time to make sure no steps are missed.*
>
> (Errin) Field Note

It was deemed essential by all instructors that ward staff understood the objectives of the learning experience. Teachers sought different sorts of learning situations depending upon student needs (e.g., admissions, discharges, caesarian sections, etc.). Frequent formal and informal means were used to communicate objectives.

> *Sara announces at report what she is looking for. Errin writes on the top of the assignment sheet ("prn meds only") in red ink. Peggy posts a list on the bulletin board. She phoned the nursery staff yesterday to confirm what babies she wanted for the students.*
>
> Memo

By the time the students arrived, the instructor had developed at least a beginning relationship with the ward staff which fostered communication and relationships among students, staff, and the instructor.

> *I know the staff will say to me "Oh Sara, did you know this rule has changed?" Whereas if it's a new teacher they don't feel they can approach them, they don't know how much to say to them, where they are coming from, or what or their facial expression means. I think I can kibbitz around with them but still keep my role. "How are your children doing?" "You're just back from a holiday?" I can say all those little things because I know about them and, as a result, they just treat me as one of the staff.*
>
> Sara, L412

The relationship between the instructor and the ward personnel can be characterized as guest and host. The clinical instructor is not employed by the hospital. Her employer is the educational institution. The instructors in this study felt especially vulnerable under these circumstances; they function alone, distant from their chairperson, director, and the rest of the teaching team. In contrast, the ward staff were a cohesive group with long-established patterns of interaction. They have "invited" the clinical instructor onto the

ward, but it remained for the instructors to "earn" their way into their lives. This takes time.

Prior to the students' arrival, all three instructors made advance arrangements for locker facilities, identification tags, and parking. In addition, conference rooms were booked well in advance (six months) and access to library facilities was ascertained. As guests, these accommodations could not be taken for granted. Pressures for space and equipment are very high because of the number of students and staff in the large teaching hospitals. Instructors have an elaborate advance plan and a large network of contacts to facilitate convenient and appropriate facilities for students.

> *We have some slide tapes and movies and things from the college that might help with combined care. I have some teaching things that they use at another hospital. I share them with the teachers here. They let me use the teaching room.*
>
> Sara, L610

Without sufficient advance work, the teacher can find herself conducting post-conferences in the cafeteria or locker room.

The purpose of ward preparation was to smooth the way for the acceptance of students into the milieu. The instructors felt it was critically important that the students feel welcomed and that there was as little anxiety in the clinical experience as possible under the circumstances. They felt their personal orientations and the ways in which they prepared the ward and solicited cooperation from the staff contributed significantly to positive student experiences. Next, the students were oriented to the ward.

3.1.3. Preparation of Students

Five activities characterize the preparation of the students for their clinical experience. The first, and of highest priority to the instructors, was the establishment of a personal relationship between the individual student and herself. The initial encounter was

in the absence of any prior history in most cases. Most students had not had previous contact with their instructor, although many had conducted a survey of other students who had been previously assigned.

> *I do it all the time; I go around knocking on doors to find out everything I can about the teacher before clinical starts. Are they fair, how do they mark, are they hard markers, what are they picky about?*
>
> A.W., L497

Nervousness was increased if they had received feedback from other students that the instructor was difficult to please or was a poor teacher. Instructors had no information other than names. The initial contact, then, was characterized by exploration and uncertainty. Teachers explored, through various means, the learning needs of the individual students, past experiences in clinical, and personal experiences in life and with the clinical specialty. She clarified her personal goals and expectations for the experience, and established her standards for performance.

> *I let them know the very first day what I expect. I have a manual all written out with the pages and the material that they need to know in this area. They must have a knowledge base and the hospital policy.*
>
> Sara, L523

By learning about their students, instructors were able to individualize their approaches and rationalize decisions.

> *The male student. Well, I suppose his major problem would be dealing with ladies in an obstetrical area, in a rather intimate manner. We addressed that issue right at the very beginning. I told him what I would do before we even got onto the floor. I told him I'd put him in the nursery first, so that he could develop some expertise, some knowledge about the system, and be more comfortable by dealing with the babies first. We could just show he was good student nurse, regardless of gender. The babies didn't care!*
>
> Peggy, L710

Relationship building was an ongoing activity, but one which was based on impressions gleaned at orientation.

> *First of all, I start on the first day of the students' orientation. It is in a small room. We sit in a circle. They know my name and I know their faces. We start off in sort of a warm-up thing and a little " tell me*

something about yourself." I give them my background and I let them know how I work as a instructor. I tell them I like to roll up my sleeves and work along with them. I stress that clinical is like learning to ride a bicycle - some of us take 5 times before we're balanced, and others can ride the first time. I also try and sit down, in the first two weeks, with the student and have a little chat. Maybe just a few minutes after conference, saying "How are you doing? How are things going?" I also make times when I have counselling hours and they can come see me. I usually keep an hour open in clinical when they can come and see me. I have two other hours during the week at the school."

Sara, L478

The second activity in preparation of the student for the ward was based on the curriculum. The instructor needed to establish the level of previous group achievement, what knowledge was expected in terms of entry to this course, and how this course linked to previous and next level courses. Performance criteria for pass/fail grades, and how these grades were determined were discussed.

I like to ask a lot of questions. I feel if I don't, I don't know where they're at. And I tell them at the beginning I ask lots of questions. But I tell them if they don't like it to please tell me.

They'll be pouring a medication and I'll come along and ask them what it is. I tell them at orientation to remind me later on, when this happens, to tell me "This is not the time to be questioning me on my drugs; I'm trying to concentrate on what I'm doing."

Peggy, L1745

I know where these students are coming from, what their level is, and I know where to begin clinically. I now know that when they come from Psychiatry that they've been out of physical skills and organization and I set up a totally different orientation for them.

Sara, L1716

Thirdly, the instructors engaged in many activities related to the establishment of group cohesion and morale. Ice breakers were used to introduce students to their peers, and anecdotes shared to foster the 'getting to know you' phase.

Usually I do some ice breakers: tell me how big a family you come from; have you ever had any children? Some of them have had babies and some of them haven't ... or I will start this particular session with "What did you do on Spring break that was fun?" They just laugh and tell me a little bit about themselves, and that usually starts them off. They will sort of have their head down, not looking at each other. Maybe one or two will know each other, but they've never worked

together as a group and they have difficulties that way, breaking the ice and getting together.

Sara, L643

Information about travel arrangements and other potential sources of difficulty was sought in order to solve problems before they happened and to avoid disruption to the ward:

I go right back on our first day to pointing our bus routes, etc. Just can they get there, and what arrangements do they need to get there. I like to know where they live, because some will have unavoidable problems being late. So if I know they are going to be late, then I can cope with it. As long as I know. If they get the one and only bus on Sunday, then whenever they show up is fine with me.

Peggy, L41

Attention was paid to how the students interacted and with whom they were most closely associated. Potentially negative cliques were identified and plans made to separate the students when patient assignments were made.

A tour constituted the fourth activity in orienting the student to the ward. Students were taken on a tour of the facilities to assist them in relating the line map to the actual geography of the ward. At this time the instructor pointed out the relevant rules governing behaviours in specific territories of the ward.

I also prepare them actually for the hospital. We tour the whole hospital on the first day, very briefly. The main floor, where things are, their locker room, the cafeteria. I also show them the connection of the hospital with the other hospitals, as we are in a big complex. I think it is nice to know that. They are not in isolation because once you get to the ward you're kind of lost on that particular floor. I try to help them that way. But not too much, because they forget it. If we walk it they remember it.

Peggy, L49

Last, but not least, the instructors attempted to prepare students for the interpersonal relationship and communication demands, and in recognition of the transient nature of the experience, instructions were given with respect to the norms and expectations for student behaviour.

I try to make the students aware that they have two people to keep informed, and I encourage them to report to both of us. At this point I

don't think students really know what the pertinent data is. I suggest to them that they go a couple of times in their hours here and just tell the staff nurse about the patient. I reassure them that the nurse will not bite off their heads. They will appreciate the effort, and will ask any questions if the student misses some point of information.

Errin, L1013

In many cases anecdotes and humour were used to illustrate famous 'boners' pulled by former students in this and other settings. This was effectively balanced by showing the possibilities for learning that were available in this rotation.

I told them how I arranged to buddy a student with a male staff nurse in the intensive care unit. This nurse has a lot of knowledge and skill. He works permanent nights. My student went in early to meet with this staff nurse, to identify with another male and to see if he had any problems and if so, how he dealt with them.

Peggy, L719

The instructors paraded a litany of past successes of students to motivate them and challenge their creativity. For the two new instructors, these examples were gleaned from information learned from others, or generated from their own experiences.

Orientation to the hospital not only benefitted faculty and students, instructors felt that it protected staff and patients from confusion and error. Exchange of knowledge shields people, staff in particular, from unnecessary delay and demands on their time from students' questions.

All three clinical instructors evaluated the orientation activity in terms of its perceived helpfulness to students. They were aware that increased time was needed because the students may never have been previously assigned to that hospital. The first year instructors, Peggy and Errin, were also cognizant of curricular gaps between what the student had been taught and what they needed to know to function safely on the wards. Three areas of conflicting demands characterized orientation activities: time in orientation versus time in practice, amount of information which would be ideal for the student to know versus what was feasible in light of the time available, and student knowledge needs versus patient safety needs.

The above five activities which were used to prepare students for clinical practice focused primarily on expectations for performance and relationship building. These activities set the foundation for the instructional strategies the instructor would implement in the subsequent weeks of the clinical rotation.

3.1.4 Instructional Activities

In implementing instructional activities in a clinical patient care setting, the instructors faced three major ethical dilemmas: patient consent for teaching, maintenance of professional standards of care, and time spent learning versus time spent caring for patients.

For the most part, none of the instructors asked patient permission to assign students. Upon admission, patients in both hospitals signed general consents allowing students to care for them.

> *I do not ask the patients if they mind if they had a male student nurse because I think they might have doubts and think that maybe they shouldn't. And if they were assigned one, without me asking, then it would just be a nurse.*
>
> Peggy, L724

> *I don't ask the patient's permission to assign a student unless it's perhaps a doctor's wife or somebody that the student might know, then I see if they mind. I base my selection on the student's learning needs and the patient's situation: what the patient offers in the way of procedures, skills, teaching, whatever. And I try to give the students a varied kind of assignment.*
>
> Errin, L931

Patient safety was uppermost in the instructors' minds at all times. They attempted to match patient needs with student ability, and monitored student activities and progress closely when there was any doubt in their minds. As well, checks were in place to ensure that potential errors were minimized. For example, medications were supervised through all steps of preparation and administration.

The dilemma of working and learning was more difficult to resolve. Giving patient care is a part of learning, but learning is the primary focus of the clinical experience. Sometimes this distinction is lost on ward staff.

> *Students who have patients assigned end up with two or three mothers and their babies. That's fairly heavy. Then the head nurse asks "A patient is coming out from the case room, can your student admit them to the floor?" And I've had to say "I'm sorry but if they get involved in that then there's other jobs that they are responsible for that they won't be able to get done before they leave for the day." I know sometimes I'm probably not too popular because I do those kinds of things.*
>
> Errin, L1207

On the other hand, as the students advanced in their course and were able to better organize their care activities, Sara felt they could begin to help out around the ward. These activities, she felt, fostered student role identification as a nurse and prepared them for the eventual reality of work life.

> *They have to learn to get along with people. They are now well into their second year, so I say "I think you should have a little bit of time that you can help out. If you help out, your buddy nurse will then have a little more time and perhaps she'll take you along and teach you. Sometime when you're doing other activities you might learn something." Secondly, we are guests, so we must respect all the things that are going on. Sometimes there are things we are not going to like, and we must realize that we can't change everything. But if there are crucial problems, I tell the student to come to me before going to the nurses.*
>
> Sara, L390

If questions were raised about standards of care, the instructors dealt with them in ways that clarified perspectives, gave advice, and explained decisions.

> *One nurse was a little burnt out so I just warned the students that she's an excellent nurse but seems to be a little burnt out and not her usual self. "Just be polite, be courteous, and don't bother her with questions when she is organizing her own care. Give her time to organize her care and then present your questions to her."*
>
> Peggy, L463

The reality of ward life occasionally fell short of the ideal as portrayed in nursing classes.

> *We had a situation on the ward last week where a patient was on isolation technique. Some of the things that were happening weren't by the book and there was dialogue going on about "how come you can do this thing and you can't do that?"*
>
> Errin, L342

Wards were understaffed at times, requiring the use of relief nurses who were not as able as regular staff to assist students.

> *I had to call this morning to get a relief nurse I had requested three weeks ago. I was not about to change the assignment then, so it resulted in the student having a different nurse than yesterday. It wasn't great for continuity, but the student had been here yesterday and knew the patients. The patients were fine, not critical, and the nurse had worked here before, but not on a regular basis.*
>
> Lil, L295

These concerns, along with her own personality, her educational preparation and teaching experience, her expertise in the clinical specialty she was teaching, and the demands on her as a representative of the college putting the curriculum into practice, determined the decisions the instructor made with respect to teaching tactics and strategies.

In addition to the initial impressions of each student formed during the orientation period, the instructor could go to the teaching team leader for a report on the academic status of each student. In most cases this was not necessary because instructors had put mechanisms in place whereby students came to them with a summary of their past achievements and present learning needs.

> *I have an introduction sheet the very first day that I give them on their learning needs. "How do I best learn? What are my objectives for the clinical area? Is there anything in my personal life right now that might interfere with my learning?" They don't have to elaborate on the questions unless they want to. I like to know how they best learn from the teacher. For example, if they are shy, whether they like the teacher around a lot, or do they prefer to work independently. It gives me quite a bit of information, and then I try to sit down, in the first two weeks, with the student to have a little chat.*
>
> Sara, L486

The contradictory nature of the student role in terms of combining nursing and learning functions on the ward was a continuing problem for the instructors about which they remained mindful as they assigned patients to students for their clinical experiences.

Once the students were oriented to the ward, they were co-assigned to a patient with a buddy nurse who retained responsibility for patient care. The nurse delegated certain aspects of that care to the student in consultation with the clinical instructor.

Patient Selection

Patient selection was a complex activity in which the instructor attempted to match the student with a patient to perform nursing skills at a level which was challenging but at the same time not overwhelming. At the beginning of the rotation this was a very time-consuming exercise.

> *Selecting patients to meet all of the conditions is a real skill. That's the hardest area in clinical teaching.*
>
> *Q: How did you learn to do it?*
>
> *It just takes time. And trial and error, I suppose. It helps to have a good handle on what is happening on the floor and how well you're supported in clinical. Where I'm going now to this area, they see me as being knowledgeable, they feel comfortable to say "No, that patient is too sick. Take your student off that assignment." They might say it abruptly but that doesn't upset me because I know they're busy. I'm not upset by that. I'll say "That's great, thanks. What other patients can I have?" So it's positive. It just takes a lot of time, I've found. Knowing the level of the student, the course content, what they are expected to learn, is critical, so you have to know your curriculum well. Very, very well.*
>
> Peggy, L1816

The three instructors fulfilled this function in slightly different ways. Peggy and Sara selected patients the morning of the first clinical day. Errin preferred to do patient selection the day before:

> *I go the day ahead to select patients. Like today I'll go to the ward and pick the patients I need. Then tonight I will phone each of the students and tell them what they'll be handling tomorrow. I will also give them any direction that they might need; for instance, perhaps the patient has a particular kind of problem. I'll advise the student to read up on it in the textbook. That way she is prepared to deal with that problem in*

the morning, after having given some thought and done some research about what they are going to do for the clinical day. I don't like them in the clinical area unless they have had adequate preparation. I don't feel that at this level they can think on their feet.

Errin, L225

Peggy made arrangements the day before by telephoning the ward and asking them to name patients that met her criteria.

I don't do the assignment until the actual morning of clinical. Then I post on the assignment sheet what skills the students are able do and what year they are. When we switch from the nursery to the floor, just before report I remind the staff "OK, this is the first time these students have been on the floor. These are new students."

Peggy, L200

Sara does all of her patient assignments first thing in the morning. She comes in at 5:30 or 6:00 o'clock so I don't have any input as to which patients she would choose. I am on the floor by 20 to seven in the morning, and Sara will say hello but she doesn't usually ask for my input. Why should she? She is as capable as I am of reading the sheets. She sees that patients are delivered every day. Maybe I'm coming back from a weekend off and I know as little as she does.

Michelle, L28

Peggy negotiated with her group about when they wanted to receive their assignments. Her first year group felt the morning was adequate because the focus was on healthy mothers and babies. The second year students were not consulted. Few of them, however, were unhappy with Sara's procedure:

It doesn't really matter to me. As long as Sara realizes that I won't know everything there is to know first thing in the morning. Personally, I prefer my patient assignment the night before. At least then I can relax the night before because I know what to expect and I can prepare myself. I don't spend all night worrying, wondering what is facing me in the morning.

A.W., L522

Input from students is solicited by teachers:

In preconference we discuss the areas they want to work on this week. When I am picking out patient assignments they don't get their assignment ahead of time but they will have told me what they want to work at and I try to find that sort of experience for them. I respect their needs. They know themselves best. Sometimes I have to encourage them.

Sara, L880

Students advanced weekly in terms of the numbers of patients assigned and the complexity of their cases. As instructors became better acquainted with the individual students, the task of patient selection took less time, and the determination of which patients to assign to which students was clearer.

> *They start with one and then they get two patients. Then we just add on another. Just keep moving on. As much as I can cope with in one day.*
>
> Peggy, L179

The instructors communicated with head nurses about the selection of patients to be assigned to students.

> *I use the kardexes. I prefer to look through them myself and select the kinds of experiences that I think the students need. I like the head nurse's input after the fact. Just as a yes, no, they shouldn't have a student because of whatever. There might be something she knew about the patient that I didn't know. I need to rely on her knowledge of the situation.*
>
> Errin, L956

The instructors were faced with a dilemma when ward needs (efficiency of care delivery) and student learning needs were in conflict.

> *I don't approve of assigning students based on convenience. I prefer to select patients to meet student learning needs. Sometimes students have to run a little distance but I account for that. They are students. They should not be expected to carry the same load as a graduate nurse. I don't think assigning both patients just because they are in the same room is the right reason.*
>
> Errin, L962

Head nurses often had preferences with respect to how they wished students assigned.

> *If you assign two patients in two different rooms you might run into a situation where a student is reporting to two different staff nurses. I don't think that is a problem but some staff think it's problem. The head nurse thinks it is a problem. If I assign according to student need, perhaps one nurse would have no patients because the students would have them all. That meant that another nurse didn't have any students and therefore had all her own work to do.*
>
> Errin, L982

In terms of patient selection, head nurses generally deferred to the instructor. Although students were supernumary, their presence was taken into account by one head nurse:

> *I like to have students down the centre corridor with moms and babes if at all possible. It means that I won't have to request extra staff if the workload is too heavy.*
>
> Lil, L53

Communication was the basis of successful patient selection for students that also met, or at least did not interfere with, ward needs.

Communication

Teachers spent a great deal of their time in different forms of communication with students. They conveyed information. They gave students advice, instruction, and direction. They gave them feedback on performance. They questioned them constantly about knowledge, nursing process, analysis of assessment data, and personal feelings about the experience. They helped the student link practice and theory. Nonverbally, through the use of personal space, touch, tone of voice, and gestures, they personalized their communication and gave affective messages. Written methods were also used to develop a more permanent record: assignments, anecdotal records, work plans, and charting exercises. In all, the primary mode of instruction was through one-on-one communication which took place face-to-face.

Following the introductory mutual exploration stage which took place during orientation activities, instructors and students settled into a working phase where they knew what to expect of each other. This phase was characterized by more certainty and trust in the relationship between student and clinical instructor.

> *We will have coffee together, and then I get to know the group. If the group needs discipline, then I hold back and I usually will read the previous records and I kind of will get a feeling of the group, and I'll*

pick up how they are, if they are attentive, if the questions they are asking are knowledge based, and their age group. It's quite interesting, an older student, I find, you can relax a little bit more. Some of our younger students might be partying or not just applying themselves, and I feel I keep a more strict teacher relationship at that time.

Sara, L554

I think I can control where I need to be strict. You have that power and students know it. At the end if they are not functioning you have that right to pass or fail them. So I don't think it's a problem getting close to the students or giving them some warmth. You certainly can be annoyed with them, and you can raise your voice a little bit, but only in private. You can let the student know they are just not functioning at a proper level, they are not working, and I won't tolerate it. But the next day you can go back to your relationship. I am firm but I will make a point of giving the student a few positive strokes, too, to try and build her up.

Sara, L1158

Communication among all parties attending to the care of the patient is necessary to ensure the patient's health is not jeopardized and to promote efficient use of time and resources.

Occasionally one of my nurses will realize something wasn't done and the student's gone. They have to disturb the patient to do it over again. Maybe it is something that can wait until the following day and be rectified. If they are on duty the next day. I think when they establish and maintain good working habits early, the students learn exactly what's expected of them. For instance if the nurse doesn't say, "Look, I want report from you before you go off" and give them a little direction, you can't expect the student to think of it as importantly as the nurse might. I think working with the nurse, using the proper channels, and communicating with her regularly, it works best that way. Safer practice, sure, because if the grad doesn't tell the student initially what's expected, that's when the trouble starts.

Lil, L523

Without thinking, I mentioned a problem with a student to Sara and she said "Oh yes, but it was the students who were on over the weekend. Not mine." And this is one area where the head nurse can intervene because the staff who were on the weekend won't necessarily be on when the students return, but I will be here to pass on the word.

Michelle, L109

The first person the student contacted in the morning was her teacher, who gave out the daily assignment. In addition, the student was expected to let the teacher know approximately when and for what reason the teacher should make herself available to the

student. For example, if a student knew she had medications to give at a particular time, she noted it to the teacher. The teacher then agreed to be there, or arranged with a staff nurse to take over.

Secondly, the student was introduced to her staff nurse, usually by the head nurse before report, and spent some time in conversation with her to organize patient care.

> *It's something I've always done. I do it as much for my own convenience as for the students' edification. I say to them "Look, I want, apart from what your instructor wants, by the end of the shift, I want the blood pressure done twice. I want to know the lochia, fundus, etc. I expect you to report it to me before you leave." Those few minutes meant that I didn't get a student stammering in front of me saying "No I didn't take the blood pressure twice; I didn't know I had to."*
>
> Michelle, L559

Communication also fostered efficient and safe delivery of care. Students were urged to coordinate their breaks with staff, so that in the event a patient needed a nurse, one would be available.

> *"When do we go to break?" I usually say "I don't mind as long as you don't all go together. Try to cover for each other while you're gone." I think that is good for them to learn. We work as a team here.*
>
> Michelle, L637

There are several people to whom the student could turn in the event she needed assistance: instructor, staff nurse, head nurse, ward secretary, and student colleagues. The instructors encouraged students to communicate regularly with staff nurses. Students were often shy and intimidated.

> *I interact on a need basis. I don't intervene unless I see there's a problem with the students. For example if their messages are not getting sent or staff are feeling that they're not getting informed, I'll step in. I only intervene when I have to. Students have to learn that there are going to be people that they work with more easily than others and they need to learn how to deal with that.*
>
> Errin, L1098

Communication was not always without conflict.

> *I don't encourage them to be confrontational at all. I try to work around it. We look at the variables that might be influencing the nurses. We*

discussed that topic in conference one day. There are so many causes for them to be abrupt with students. Something might be going on at home, and so on, that students have no idea of. So they have to accept that some people will react differently than others. Perhaps once they get to know them better, they may find them much easier to deal with.
Errin, L1104

The instructors occasionally ran interference for students.

It is easier for me to say no to a request than it is for the student. They feel they are not in a position to refuse. They will always take on extra work. But I guess I'm there to also protect the patients that the students have been assigned to, as far as making sure patients get their needs met.
Errin, L1217

Sometimes the staff can be abrupt. I tell the students that it can happen. I certainly cannot change the staff member. We must deal with the situation, though. I tell them always to be polite because we are guests. You can't start screaming back because that doesn't make it any better. Just be polite, but be assertive, and, if need be, call me at any moment and I will come and help you. But if it were a hindrance to their learning, I just wouldn't assign that nurse's patients to my students. I go to the hospital early in the morning to make the student assignments and I see where that nurse is assigned, then I keep my students at the other end of the ward.
Peggy, L566

Instructors also maintained frequent contact with nurses, usually in an informal manner. Specific information about patient care or student performance were dealt with more formally.

If there were some sort of problem I was concerned about, I would approach the nurse that the patient and the student are with. She is the nurse in the room and is responsible for everything.
Peggy, L551

Instructors used many techniques for direct instruction. Peggy liked the Friesen concept ward where all charts were readily available near the patient's room.

I can nip around the ward and say "Let's look at your chart. There's your patient, she just went into the showers." We have a moment to look at the notes and to check the orders. Everything is so handy, and we can look at the chart together. Otherwise I see the student in the room and then have to run and find the chart. I like this system. And the students really like it. They find it quite reasonable, to be able to sit right there in the patient's room and do their charting.
Peggy, L271

Another technique that Peggy used was to have the student role model the teaching she was planning to do by pretending the instructor was the patient. In this way, Peggy ensured the student knew the correct information, and that he or she could transmit it effectively. Peggy assisted in the process of communicating with the patient by making suggestions and providing examples for the student.

Humour was used effectively:

> *I tell them that they aren't supposed to know how to bath a baby. It is my job to teach them. I tell them I love babies, and if they don't watch it, I'll be teaching them every day! Grab your babies, I say, or I will!*
>
> Peggy, L700

All teachers quizzed the students unremittingly. The primary topics were pharmacology and nursing assessment.

> *I have had question-askers in the past so I try to be as prepared as I can be. Sometimes, of course, I'm not, but that's because of the situation. I might have been doing something else the night before and I didn't have time to look it up. I had a teacher who always asked me everything about a medication. For that teacher, I adapted. I learned my meds thoroughly. Another teacher might want to know more about different things, procedures or diseases. So I guess you adapt. It doesn't bother me. It is her job. She doesn't ask trick questions, and if I don't know, she will tell me, and then ask me to write it out for tomorrow to help remember. No big deal.*
>
> A.R., L185

The student, the instructor, and the staff nurse formed a partnership that had two purposes, student learning and patient care. The student interacted closely and communicated constantly with all parties, while the instructor focused on the student and the staff nurse on the patient. Instructors and staff nurses needed to be in reasonably frequent contact to ensure the student had the knowledge and ability to carry out the required nursing acts, and that the patient's condition had not changed.

Communication facilitated the development of interpersonal relationships and fostered group cohesion. The atmosphere of the ward and the climate within the group were considered important to learning and socialization into the professional role.

Curriculum Translation

The instructors were responsible for animating the curriculum and assisting the student to develop the ethic and skills of the profession. They demonstrated the behaviours of a nurse and translated the practical knowledge students were acquiring on the ward into the more theoretical language and constructs of nursing theory.

> *The nursing theory model we use has special terminology and staff are looking at you like: I can't talk to a student. I can't help her out because I don't know what she wants! Of course they are more oriented to health problems, the medical model. You have to be very careful about this. So what I do is I have my students, I say, we are going to do a combination of both. You are actually thinking the model but you talk in ward terminology. You have to put it over into their terms.*
>
> Sara, L829

For ease of organization and presentation of subject matter to the students the college faculty had selected one nursing theory upon which the entire curriculum was based. In the hospital, however, nursing was practised following the traditional medical model. The nursing model used very different terminology than was usually employed. Students had been taught in class using one concept and were expected to practise using the other.

Thinking in terms of the nursing model and charting in traditional terms was a formidable task for students. They were at times confused about what to say to whom and what to write in the charts. A lack of understanding among the nursing and medical staff about nursing theory development had also caused problems for teachers.

> *Students are trying to use the vocabulary but they are not quite sure what to do with it. Another snag we ran into was that we were putting certain things in charting, and we happened to put in that the patient had an adaptation problem of potential infection. One of the doctors was upset because he felt we were out of line making a medical diagnosis. We got our hands slapped for that. So we do not use model terminology on charts now.*
>
> Sara, L844

Sara and Errin were very resourceful, however. They were committed to the use of nursing theory and attempted to find a way to allow students to implement the model without causing undue conflict on the ward.

> *We have started using the kardexes now, putting adaptation problems on the back where no one ever reads them. But the students are involved, and maybe a staff nurse will look at them some day.*
>
> Sara, L851

Sara helped the students by presenting case studies during conference time. By discussing a ward-relevant topic in terms of the model of nursing, she helped the students make the links between practice and theory.

> *There was a little study on organization of care and it brought out aspects such as what a nurse would do if a woman came into the Case Room bleeding. Those sorts of issues are on the registration exams.*
>
> Sara, L1261

With first year students, Erin and Peggy used practice assignments to help their students transfer their level of assessment into a postpartum check and put it all back into the terminology of the model. This activity was confusing to the students, especially since some faculty were also novices in applying the model.

> *You know, it's starting to come automatic now but there's some things that I just, I just don't know. And it's difficult because all teachers interpret the model slightly different. Especially when it comes to the nursing care plan. And I don't know if there's one perfect way to do a nursing care plan or if it's just what your teacher likes. Whatever your teacher interprets it to be. And it's, you know, it's really hard. I find it really hard because if you only do one nursing care plan how can you know what is right, for that particular teacher, especially since you did another one for another teacher and it was fine. You did everything the way the first teacher wanted. But this one doesn't like your interventions, but yet they were fine for the last teacher. So it's all that lack of consistency.*
>
> A.R., L290

Instructors spent time working with the model and reading articles about it as part of their personal orientation to the college. As well, they were involved in curriculum development and revision which gave them a forum for learning and discussion. Nursing theory development is a relatively new area, with educators embracing the concept more

rapidly than clinicians. This gap between theory and practice did not go unnoticed by students.

> *I find it difficult in the sense, it's not hard to deal with the hospital work, it's the model itself on the assignments that we have to do. I sometimes wonder why we even bother. I think it's a waste of time. I might know everything there is to know the day I graduate and then turn around and never use it. The hospital will be using another model and I'll have to change.*
>
> A.R., L275

The use of the model to organize the curriculum was a fact of working and learning life with which the students and instructors had to deal. The hospital ward, however, did not use this model. A great deal of time was spent in translation. The instructors recognized this as an important task because of the critical need for students to communicate patient assessment data to nurses in terms that could not be misunderstood.

Instructional activities were designed to result in student learning. Patients were carefully selected according to the needs of the learner. Teachers instructed students using many different methods. Teaching strategies were selected based on teacher understanding of the individual learning styles of students. To ensure safety and foster communication, the curriculum was translated so that all parties used the same terminology. To determine the effectiveness of their interventions, instructors carefully monitored the environment, student progress, and their own teaching activities.

3.1.5 Monitoring and Evaluation

Monitoring and evaluation activities continued from the beginning of the experience to the last day. The primary focus was student progress, but in order to take advantage of opportunities which might arise in the course of the day or to intervene if obstacles to learning were in place, the instructors developed a keen sensitivity to the milieu. An excerpt from field notes provides an illustration:

0800 Sara in the medication room with student (A.R.) preparing an analgesic. She was called to the telephone; H.C. calling to report a sore throat and that she would be absent. Sara advised her seek medical attention for throat swab and antibiotics to rule out strep throat. She returned to the med room to resume her supervision of A.R. In the background, a staff nurse was on the telephone, requesting supplies to remove surgical staples. Sara wheeled around and returned to the desk and requested the nurse save this experience for a student. She called a student over and gave directions to the operating room to pick up the equipment, then went down the hall to supervise the medication administration with A.R. She interacted briefly with the patient; she had asked the student about her assessment of the level of pain and her analysis on the patient condition on the way to the room. They returned to the nursing station to chart; on the way Sara complimented the student on how well she did in a test at school last week, and a student from MAT1 came down the hall to interrupt them with a question. "Are we allowed to give meds with our grad?" Sara: "Yes, what drug is it?" Student: "Colace. I have already checked everything, I am just waiting for breakfast to arrive." Sara: "OK, go ahead." At the nursing station she went over the procedure for staple removal with the student, then went to the patient's room to assess the situation with the student. Sara introduced herself and the student and explained what they would do. Doctor was with the patient. Student went to gather the necessary equipment and Sara used this time to quiz another student who was in the same room about blood sugar levels and assessment of diabetic patients. The student returned with the dressing tray and cleansing solution, and I left the room. It was not yet 0830.

Field Note

The instructors knew which students needed what sorts of experiences. Tuning into the interchanges and conversations around them helped them take advantage of opportunities which arose. Quick decisions were often necessary. The pace of the ward was fast; many things were happening at the same time. For students to meet their learning objectives, they needed exposure to different nursing situations. Instructors assessed students and monitored their progress on a regular basis, using many different means.

Student Progress

Student needs and achievement of objectives were assessed and monitored regularly by the student herself (in anecdotal notes) and by the instructor (more formally on

evaluation forms). The instructors kept track of what patient assignments the student had been given, what learning opportunities they had, and what skills they had mastered.

> *I do look at their previous evaluations. From my point of view, I want to know where they are academically so that I can zero in right away. If I know someone is a D student I will start with more knowledge questions on the student right away. If they are having trouble with the model in areas of stimulus or nursing intervention, I'll say, okay, we are going to zero in on that. Then I keep a flowsheet that reminds me who needs what and who has been assigned to antepartum and case room and when. That sort of thing.*
>
> Sara, L687

A major area of concern for the instructors was knowledge base. All instructors quizzed the students a great deal, assessing their level of knowledge relevant to anatomy, physiology, and understanding of the obstetrical patient. In particular, they focused on understanding why certain medications were given, what the potential side effects were, and what teaching could be done to prevent the side effects. No student was allowed to give a drug if he or she did not know and understand these concepts. All instructors linked this knowledge to safe nursing practice. The need for medication was united with patient assessment data. It was expected that the student would transfer theoretical knowledge into practical application.

> *I will have them write me out anecdotal records about their experiences that day. I will write comments on these, as well, so they will know what I think about their positive areas and their negative areas. What they need to concentrate on.*
>
> Sara, L531

A second area of concern was the ability to carry out psychomotor skills in a safe manner. This meant knowing the steps to a procedure, understanding relevant scientific concepts, understanding the risks to the nurse and the patient, and taking proper precautions to prevent harm. Instructors did not expect perfection, but they were concerned that progress be made and that the same mistake not occur over and over. Students had laboratory classes at the college where they were taught relevant skills and were able to practice them on mannequins in a simulated ward setting. Instructors

recognized the difference between lab and ward experiences and made allowances for student practice by reviewing the procedure in advance and pointing out potential areas of concern before they went to the patient room.

> *If they have not had the experience then I let them do it a couple of times before I evaluate. I talk the procedure over with them before they do it. I will also talk with them as they do it and guide them through the procedure. Then I'll give them an evaluation as soon as the procedure is done.*
>
> Sara, L526

Instructors also expected that students would progress in terms of setting priorities, organizing their time, and exercising clinical judgment.

> *The student really could not organize and whether you are on obstetrics or any area, you can organize. Whether it's handling your baby or whatever.*
>
> Sara, L119

Ward staff often gave feedback to the instructors.

> *The staff nurse will come back to me and say, "Your student is really doing well." or "Sara, this student is really the pits, and you've got to do something about her, I had to recheck everything she did." Sometimes they are very annoyed. They have every reason to be. They usually come to me very early in the situation. Several times I have had them document for me that I could use them as a reference in a student evaluation.*
>
> Sara, L463

Organizational concerns were handled by instructors in several ways; any incomplete procedures could be handed back to the staff to complete, the student could be given assistance by other students or the teacher, or the student could be required to stay late on the ward to complete her care. In any case, such incidents were often documented in some form since they were evidence that certain objectives were not being met.

> *Whenever I have an incident that I think is significant, I document the whole incident right away that day or even immediately so that the facts are straight, and the times are right and so on. Normally I also discuss the incident with the student. Why it is important and what it means.*
>
> Errin, L196

Ethical practice was stressed by all instructors. Honesty was valued above all else. If an error was made, the student was expected to "own up" so that remedial action could take place.

> *I tell them if they lie to me, they fail. Period. I have to trust them. If you screw up, admit it so the patient is not harmed. Sure you will be embarrassed, you may even be disciplined. So what. Everyone has made a mistake at one time or another. You will learn from it. Just don't let the patient die from it.*
>
> (Errin) Field Note

Through the orientation process and the time spent on the ward, instructors learned about the students; the ways in which they learned best, instructional techniques that helped and hindered them, and personality attributes that affected relationships with others. All instructors operated on the dictum of "No surprises". Students were informed regularly about their progress toward meeting the objectives. This wasn't always easy to do. If the instructor was not very direct, the students might not get the message that they were in difficulty. An illustration follows. In this case, the student was identified as a borderline student and had suffered health problems in the previous year which had resulted in lost clinical time. At orientation, she was not able to answer questions accurately, a fact that was noted by her instructor at the time. Additionally, she was handing her assignments in late.

> *She dropped this bomb on me last week that I need more time. And that I had done poorly on my assignment.*
> *Q: It came as a surprise to you?*
> *A: Yes.*
> *Q: You'd had no indication up until then that you were struggling?*
> *A: No. Nobody had told me anything. They just said my anxiety level was up.*
> *Q: Do you feel it was?*
> *A: The first week it was, yes. Because the, I was in a new setting, the teacher I didn't know, place that I didn't know either. So everybody's anxiety level was up. And I didn't know what to expect. I didn't know what to expect from Sara. Cause, you know, I just didn't know what she was going to do. She started telling me I had a weak knowledge base. That first day we had orientation and she went around asking everybody questions. Now I answered every question that I remember. I really screwed up my assignment. I don't think it was very fair for her*

to just mark it and tell me I am going up for evaluation committee. I think she should have let me do it over again.

E.A., L21

On the other hand, the student could be emotionally devastated by a perceived reprimand.

They' ll tell me "I went home and cried all night." And I' ll feel badly.

Sara, L1768

Head nurses deferred to instructors in matters of teaching and learning, but monitored events closely to ensure patient safety.

In one instance Sara was spending most of the day with this one particular student. I felt the load was just too heavy for this student. One patient, post-section, first day, a diabetic. Other students could handle it, but not this one. But I think Sara knew what she was doing. She was trying to prove something, which I think she proved. The student was just not capable of caring for a patient at the proper level.

That student did not come back to clinical as far as I know.

Michelle, L68

If students happen to be in the rooms when I am making rounds, or whatever, I see them. It is not a total evaluation but I try to assess them if I can. See what they are doing and if the patient's needs are being met. I spend a lot of time at the desk as well, so I have occasion then to talk with students.

Lil, L193

The instructor made it known to ward staff that student evaluation was her responsibility but that she also recognized that she was not able to observe all students in all activities. She welcomed feedback from staff. Indeed, many times the instructors sought feedback, particularly regarding weak students. Occasionally the instructor sought verification of her own assessment. They reported a dilemma with respect to involving staff in the process. If she asked a staff nurse for feedback, it was possible that she was causing bias against the student on the part of the staff nurse. On the other hand, the staff needed to be aware that a certain student might need assistance.

Responses to staff input varied. The instructor indicated her appreciation for the feedback and said she would address the particular issue with the student involved. They

usually attempted to present a perspective of explanation or clarification to ensure she understood the exact nature of the incident.

> *Sometimes they'll come and say to me "Well, that student isn't too well organized." I'll say, "Remember when you were learning?" Then they seem to be more supportive!*
>
> Sara, L162

> *I'd hear "Well, I just did this and the student didn't understand." I would say "Well, geez, they haven't had that yet. That's coming up in two weeks." I help them put the programme in perspective. Students felt that they had been thrown in the deep end. Really deep end!*
>
> Errin, L1495

When a student was clearly not meeting objectives, instructors felt a personal loss. It was as if they and their teaching were being judged ineffective because the student was not learning.

Student progress was being constantly monitored by instructors. They used methods of questioning, observation, return demonstrations, student self-evaluation, ward staff input, as well as their own perceptions. Instructors linked student evaluation with the assessment of their own teaching. If a student was experiencing difficulty, the instructor changed her approach to the student or used different teaching strategies to facilitate skill acquisition.

Self-Reflection

Self-reflection formed part of the evaluation and monitoring activity. Perhaps this activity was more a result of the research than a usual conscious instructor practice. The relationships with students, the goals of the clinical course, and the feedback from staff were all consolidated at the end of the day in terms of "what went well?" and "what do I need to do differently tomorrow?" In addition, they reflected on aspects of their work that gave them satisfaction, and aspects that did not.

Instructors wanted to be treated with warmth and respect.

I like to be treated as a human being. I know I feel bad if people don't support each other. Or give positive strokes.

Sara, L1172

I like to be where people treat me nicely or are more open to my presence or friendly. It's only natural. I think I tend to be a bit more independent and not as open in asking questions when there's an atmosphere that's not receptive. I tend to try to not interfere or interrupt staff for things if I can manage on my own, unless I feel it's important.

Errin, L1113

They liked people around with whom they could consult and share experiences.

We did a lot of talking at coffee in the fall semester. There were many teachers at City in the fall. We tried to get to coffee and lunch together. And we just went at it tooth and nail. Doing this exact kind of "Well, you'll never guess what so and so just did, now what and I going to do about that?" or "Can you believe it, they didn't know this or that." I felt that helped me tremendously because they were experienced teachers, most of them. Many years of experience.

Errin, L1486

They responded to students who receive their comments with grace and friendliness. Criticism from students was taken very seriously.

She said I was a perfectionist. And too strict. She had never had a teacher that strict. In the area of medications particularly I was very thorough. They had to go through everything and ask me before doing procedures. She hadn't kind of had that experience before. It made me think.

Sara, L777

Peggy reflects on evaluation:

I've just based how I evaluate on my experience as a nurse; not as a teacher, as a nurse. I've been in many new situations and knowing how I felt, what was helpful to me, how I learned best, is what I then try to apply to my students. I don't have to be a nice person. I don't feel threatened as a teacher now if they don't like me. I want them to learn, they are here to learn. I really don't care, well I do care if they like me or not, but that's not the issue. I don't try to be a nice person, I try to be a good teacher.

Peggy, L1785

They reflected on their work as it pertained to the college, their job assignment, and the people with whom they taught. Often they felt isolated in the clinical setting, far from

the administrative support they wanted.

> *I felt very ill-prepared to go into the City to do the job I was there to do. I'd never done that before in a totally foreign environment, not knowing the programme very well, that kind of thing. And of course not being in the classroom in the fall also kept me out of touch with what students are learning and when and the depth to which they're learning it. I found after Christmas when I had a partial theory load that I was much more in tune with what students should know at any given time.*
>
> Errin, L1501

> *Now I have found that sometimes she withdraws with me because I asked her outright how she felt about community college students. I know the hospital supports baccalaureate. She does not know where we are coming from nor is she aware of what our programme is. I had to speak out.*
>
> Sara, L635

> *I am a high energy person and I open my mouth sometimes too often. I've learned now that I choose one or two things to work on and if I can't do it with the teaching team then I do it clinically. I can work within this faculty very happily by rechannelling my energies in different ways. I rechannelled with people that I feel positive with.*
>
> Sara, L1483

Occasionally during research debriefing periods the instructors would state that they should have spent more time in a certain area or with a particular student. They would look ahead and reveal their feelings that because some students were not able to exceed the minimal standard for the learning objective, that somehow they had failed to give the student adequate instruction.

As part of the research study, the instructors discussed the advantages and disadvantages of certain teaching strategies as they applied to particular students or situations. Their concern was to develop a rapport with a student that would foster learning.

All instructors expressed a wish for specific instruction about how to teach in the clinical area. Their agreement to participate in the study was a result of this quest for information and feedback.

Monitoring the Environment

The instructor monitored the environment in sophisticated and often intuitive ways, adapting her activities to the task at hand and the salient elements of the clinical situation and the characteristics of the milieu.

Through orientation activities, the instructor met and developed working relationships with the staff. They learned about the nurses on a personal as well as a professional level, often asking about a child, inquiring about a holiday, or the health of a parent.

They used information to assist the students. As they learned the roles of the various people on the ward and the rules for working in the area, they transferred this information to students in order to make their transition easier. As well, they used their relationships with staff to foster acceptance of the student.

> *There are some idiosyncrasies as far as staff. For example, one or two like their beds certain ways. I might as well tell the student and avoid a problem.*
>
> Peggy, L459

The instructors received a report on the condition of the patients and their particular needs during patient selection activities. Ongoing feedback from students and the co-assigned staff assisted them in monitoring changes in patient condition. In this way they were able to anticipate student learning needs. For example, Sara noted one morning that a patient was reported to have a low hemoglobin. Since she understood the routine of the ward, she suggested that the student read the procedure for blood transfusion. Within two hours, the student was requested to assist the staff nurse with the transfusion. The student was prepared. The nurse was not delayed while the student received instruction. Patient care was not compromised.

Over time, instructors became aware of how individual students learned and responded to certain teaching techniques. They would alter their method of instruction

depending on the student. In one case, Errin stayed in the patient's room during a procedure, instructing the student step by step. In another instance, she gave a student an instruction sheet on the same procedure, answered questions, and allowed the student to proceed independently.

Student activities were monitored very closely. Instructors carried a paper with them which indicated what each student was doing during the day. Errin organized her sheet by student name, Peggy by patient name. Sara organized hers by time. As they conducted their activities, they were in contact with students to ensure that assessments were done, medications and treatments given on time, and reporting activities carried out. In addition, they arranged that students were assigned to coffee and lunch breaks and noted who was having difficulty getting off the ward on time.

The student formed two major partnerships; one with the teacher and one with the staff nurse. The instructor monitored the relationship between staff and student to ensure the staff were kept informed of changes in patient condition and that the student was learning appropriately. Occasionally, the instructor had to step in to negotiate activities, resolve conflicts, or mediate disagreements.

The complexity of teaching in the clinical environment was noted by all instructors. Multiple relationships were maintained, many nursing procedures were supervised, different instructional activities were implemented, and a watchful eye was kept on the progress of students. Instructors were constantly seeking opportunities for teaching and learning.

In this section, the functions of the clinical instructor were presented in an attempt to portray her activities and develop a deeper understanding of the process of clinical instruction as it pertains to the clinical learning environment. Each individual teacher activity served several purposes, was bound by time constraints, and focused on the student and his or her response to the experience. The instructor tried to tailor the environment, the learning opportunities, and her relationships with others to the needs of

the student and to facilitation of learning. In the next section an overview of the four major roles the instructor enacted as she worked within the clinical learning environment is presented.

3.2 Roles of the Clinical Instructor

In performing her functions as clinical instructor, the teacher assumed four major roles: coach, consultant, colleague, and counsellor. She enacted these roles with her students and with hospital staff, depending on the circumstances and the context of the situation.

3.2.1 Coach

As coach, she instructed, interpreted events observed by the student, and demonstrated techniques for nursing interventions. The instructor modelled the role of nurse and provided encouragement and feedback on performance.

First, the instructor set the stage for the clinical experience. Orientation activities conveyed the roles of the people on the ward, the expectations for student activities, and the rules to be followed. In particular, her role as teacher was addressed. All three instructors told the students about themselves and their particular teaching styles and philosophies.

> *As far as student-teacher relationships, I tell the students that I am their teacher and they don't have to like me. I am the teacher and that's my role, my job. If you don't like me or what I'm doing, I tell them, "Please tell me now and not later." I have my style of teaching but it might not be their way of learning, so let me know at the beginning, and I'll change my way of teaching. I sometimes hear about students and teachers "She did not like me" and I won't validate that. I let the students know that. I am the teacher and let's get through this rotation in a civilized manner.*
>
> Peggy, L1186

They are all going to make mistakes. I tell them that but they never remember. "You only look at my mistakes." I say, "You're not supposed to be perfect right now. Just wait. You could be in third year or you could be the teacher, and you will make mistakes". I tell them "I don't want life-threatening ones and we won't have any mistakes if you follow my little rules for some things." I expect errors, I wouldn't have anything to do if it weren't for students' charting errors, poor organizational skills, or weak knowledge bases!

Peggy, L785

As coach, the instructors wished to learn about the relative strengths and learning needs of the individual students in order to give them appropriate assignments and advice.

H.C. had a chronic lateness problem, she had a self-image problem, but very bright. I had to find an area that could twig her, motivate her to work. She had something to work with and she challenged me. She didn't realize how flippant she could be. Staff were complaining. When she said something I didn't like, cynical or flippant, I just would put my finger up. It was our message for "I want you to word that differently."

Sara, L276

She stood out because of her hair. She seemed rather vocal at the school and had a loud voice. I told her that that might be a problem and that she certainly should be watching that because her voice does carry. She did very well; she kept that for coffee or whenever, but when she was with patients and staff in report it was not a problem at all. She was a very direct, positive person and related well.

Peggy, L544

I put her on the floor first because she could talk with patients. She'd worked as a waitress and could deal with others on a social level, and not be shy.

Peggy, L1411

The group was also an important consideration for the instructors. They wanted to foster group spirit to encourage cooperation among the students.

They don't have the same group dynamics that my previous group had. They formed good relationships and were a very close group; they supported and helped one another. This group I find tend to be little pockets of individuals, pairs. Because they come from different teaching groups, theory groups, they're not necessarily together, except in my clinical group. So there's not a lot of time to form relationships. I have to work pretty hard to get good group dynamics going.

Errin, L599

At the beginning, I remember being on MAT1 for report and when I came out in the hallway there were four students from MAT2,

wondering what they should do next. They were practically arm in arm in the hallway. They didn't seem to fit in with the staff well, and they seemed to not have the direction. My other group were just out there doing whatever they could.

Errin, L650

In post-conference they tend to be terribly giddy at the hospital. That's why usually we close the door and go away. And I always have a post-conference regardless of whether it's in the timetable or not. They need time to sound off; not in the elevator, in the locker room, or on the bus. I allow them that time to talk and vocalize.

Peggy, L524

To coach staff nurses, the instructors encouraged their role with students, gave them feedback, and guided them in interactions with students.

I asked the nurse "Can you take my student under your wing?" I told her she's shy and her knowledge is a little weak. "You might ask her some questions as you're going along, and take her in and show her how you do an assessment on the mom. She can make beds with you. She is not comfortable talking to nursing staff yet."

Sara, L458

Instructors encouraged students to develop related personal skills and positive attitudes toward learning.

Her communication, her verbal communication, was a real concern. We talked about it. Afterwards she registered herself for an assertiveness course. I felt that she knew very well that communication skills are very important and that next fall she probably wouldn't be successful unless she had made some gains in that area.

Errin, L340

I like to check with them as far as interpersonal relationships between student and patient. If they really don't like obstetrics and don't want to practice nursing there I say, "You do have to get through it. I don't expect you to jump up and down and be terribly enthusiastic, but you have to meet the mandatory behaviours, so I'll try and help you deal with it."

Peggy, L1197

In her role as coach, the clinical instructor focused on developing skills and teamwork. She intervened directly with the students, singly or as a group. She determined their needs and enacted strategies to meet these needs. She encouraged, motivated, and evaluated.

3.2.2 Consultant

As consultant, the relationship with students was like novices consulting experts. The instructor had acknowledged expertise in the area of theory and practice, but the student knew the individual patient more intimately.

> *My patient was in pain, but didn't want medication which would make her constipated. She had two pain killers ordered, and also a laxative. I figured I would offer the least analgesic I could, and a laxative. Sara thought it was a good idea after she listened to my rationale and my assessment.*
>
> U.O., L537

The student sought advice, brainstormed options with the instructor, and discussed suggestions offered in light of personal knowledge about the patient.

> *I think Sara tries to get my point of view, my perspective, as to why I am asking questions. She tends to ask a few more questions in return, and she does go into a little more depth in explanation. She doesn't just answer what I have asked. "What do you think?" "Well yes, plus this, this, and this." She helps me to learn.*
>
> H.C., L274

> *For something like an injection I have to be there. We always do a baby first. I hold the leg. I tell them that I will select the site for them, but they will give the injection. They tell me if they like the site, because if not, we will stop, start over. They're giving it, they have to be accountable.*
>
> Peggy, L1007

> *I explain the rationale to them. The principles are observed. There are a few variations from what they learned in lab. Sometimes they don't know how to apply what they know to a new situation, so I help them with that. They learn where the policy and procedure manuals are and know where to look things up.*
>
> Errin, L329

The instructor acted as consultant to staff nurses as well. She was the academic with the time and the mandate to remain up to date in the field. She brought new information to the attention of staff as it became pertinent.

Because of her job, she was often assigned to other hospitals and clinical

specialities and thus brought a wider knowledge base to the area which was of benefit to the delivery or quality of patient services.

3.2.3 Colleague

As colleague, the instructors shared responsibility in the learning partnership with the student and in the caring partnership with the staff nurse. They negotiated teaching and learning activities with the student, determining through this partnership how and when she would enact her instructional activities. Through shared personal knowledge and experience, the partners had developed trust and mutual respect, and acted on an essentially equal footing within their relationship.

> *If I said "You will check the arm band of the mom and read it against the card" or if they had identified those steps, I knew that they would. I would just stand at the door, but where the patient really couldn't see me. I would be pretending to do something else. I would tell the students that I was supervising them but so that it didn't make it awkward, the patient didn't have to know. After one or two like that, I didn't really have to see them any more.*
>
> Peggy, L1024

With staff nurses she shared experiences and knowledge as a nurse, and collaborated with staff in the delivery and quality of care. The instructor knew that without the collegiality that existed among nurses the student would not develop his or her professional identity. Additionally, since the instructors were socialized initially as nurses, not as teachers, they had strong bonds and professional identification with nursing.

3.2.4 Counsellor

As counsellor, the instructor focused on the student as a person, facilitating self-growth, exploring feelings of anxiety, and monitoring the development of professional identity, role conflict, or confusion.

She came into my office and started to tell me about some things that had occurred in her relationship with her mother; her mother was a nurse. The student had left home because of these problems and had to work. She worked in a nursing home. She has worked there four years. The residents love her. She had personal problems, but she was working on them. They were spilling over into her school life.

Sara, L345

I referred her to a counsellor for her home problems. She was staying up and doing nursing care for an ill relative. Twenty-four hours a day practically. Her shoolwork was falling behind. Through the counsellor her relative got onto some community care which relieved the student. She had a tremendous responsiblity at home. She needed a lot of personal support.

Errin, L400

Similarly, the instructor acted as educational counsellor to staff who were exploring ideas of returning to school (as RNAs updating or RNs going back for a degree) or assessing entry requirements and school demands of a nursing programme for a relative.

The roles of coach, consultant, colleague, and counsellor were enacted as the instructor carried out her duties as clinical instructor and manager of the clinical learning environment. Relationships with students evolved over time, and the instructors played roles within these relationships, depending on the level of knowledge the student had developed and the degree of rapport and trust in each relationship.

3.3 Summary

The focus of this chapter was on teaching in the clinical environment. First the major teaching functions of the clinical instructor were discussed, then the roles she assumed were presented. This discussion addresses the first research question, a description of what the clinical instructor does in the clinical setting and how these activities relate to student learning.

The creative use of the clinical setting depends on how readily the instructor can seize opportunities which present themselves and tailor the environment to suit learning needs of students.

As the instructor carries out her roles and functions, she constantly monitors the environment and adapts her tactics and strategies to benefit student learning. Many examples from the data were quoted to support these assertions.

The first task of the clinical instructor was to familiarize herself with the ward. Through the personal orientation process she initiated relationships and gained knowledge to facilitate student learning. Additional instructor functions were the preparation of the ward and students for the clinical experience, instructional activities that were time limited and relationship focused, and implementation of strategies for monitoring and evaluation of the environment, student achievement, and her own practice. Roles of the instructor related to her professional relationships with others, particularly the students, as coach, consultant, colleague, and counsellor.

The next chapter is focused on the second point of the research question: a portrayal of the clinical setting as a learning environment.

Chapter 4
Understanding the Clinical Learning Environment

Nurse educators are being challenged to take a new look at the way nurses are educated to enter the profession. In light of proposed changes to the structures and procedures of health care delivery and nursing education, changing patterns of health and illness, increasing information and technology, and diminished resources, there is a greater need than ever to understand the environmental influences on nursing education. Since the clinical component represents such an important part of the professional education of nurses, it serves as an excellent point of departure for scrutiny.

The learning environment in this study refers to the clinical practice setting which is utilized by schools of nursing in order that their students can learn their profession. This thesis presents the clinical setting from the point of view of the key participants, the clinical instructors and student nurses. Since they are in the hospital for teaching and learning purposes, the description of the environment is focused on this aim. The intent of the study, while not unconcerned with organizational, professional, or teacher effectiveness, is clearly focused upon the environment as it is experienced and as it affects learning activities. This thesis presents a conceptualization of a learning environment that portrays the complexities and adaptability of people within the organization and the turbulence caused by external forces to which people are forced to react. This research presents a framework which represents the dynamic and holistic nature of the learning milieu.

As the data were analysed, it became apparent to the researcher that the clinical learning environment was indeed multidimensional as stated in the literature review. As data units were analysed, categories, themes, and patterns emerged by which the dimensions of the environment could be described. These emergent categories were named, renamed, and compared throughout the analytical process. The final structure which emerged represents this researcher's interpretation of the data.

A framework to describe and discuss the dimensions of the clinical learning environment is presented in this chapter. A model is proposed which represents the clinical learning environment as comprised of seven dimensions. This chapter begins with an overview of the model, then follows with a breakdown of each dimension, which includes detailed descriptions and representative exemplars from the data. To facilitate the reader, parameters which define each dimension are presented at the beginning of each section.

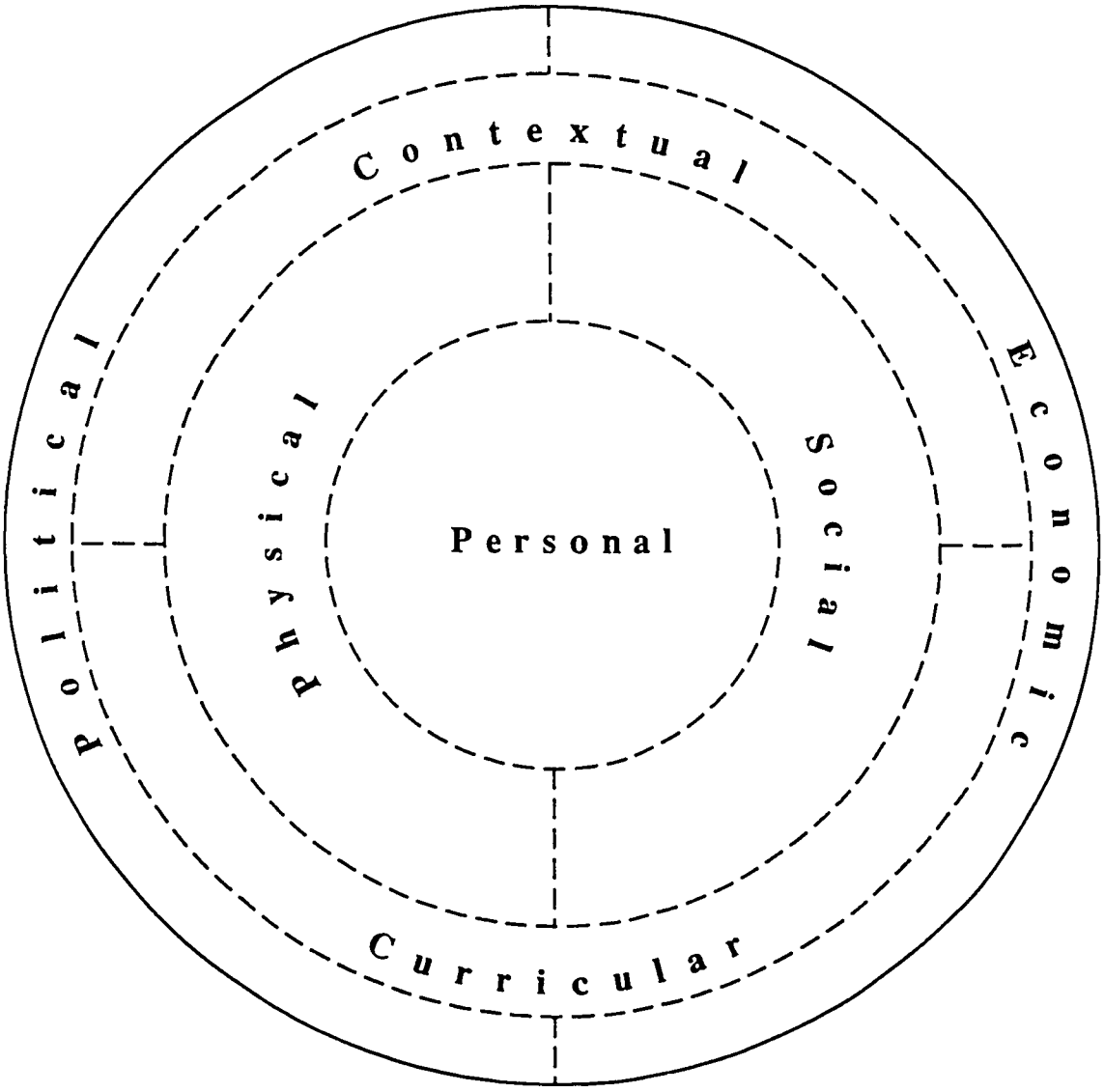
4.1 The Framework

Seven dimensions of the learning environment in the clinical setting emerged from the study: personal, physical, social, curricular, contextual, political, and economic. In any given clinical teaching situation, these dimensions were found to be present to varying degrees. Each participant brought a unique perspective, but there were commonalities which can be defined and described. A model of the clinical learning environment is presented in Figure 4.1.

Since no situation or event is unidimensional, it may appear that the elements of the environment are interactive. I have chosen to represent the dimensions as being more or less present, exerting varying degrees of influence in a given situation, rather than as interactive in nature. Further research would need to be conducted to move beyond a description of the learning environment to an understanding of the processes of interaction among the dimensions.

The environment is conceived by the researcher as a series of concentric circles, the central circle representing the hub of the model, the personal dimension, through which all experiences are filtered and by which personal reality is created.

Figure 4.1
Seven Dimensions of the Clinical Learning Environment



The second circle represents the two dimensions which are most direct and immediate to the person experiencing the environment, the physical setting and the people who populate it.

The third and fourth circles represent an ever-widening movement away from direct and immediate influence on the individual's experience of the clinical learning environment. The lines separating all circles are broken, indicating a semipermeable membrane allowing the free flow of information and a dynamic interchange among the circles and the dimensions of the environment.

In the next section, the dimensions of the clinical learning environment are presented.

4.2 The Dimensions of the Clinical Learning Environment

As each individual notes what is around him or her, a perception of that environment evolves in light of a background of experience and knowledge. Each person's view is sifted through a sieve of emotions, ideas, biases, needs, interests, and aims that are uniquely his or hers.

An interpretation-free reality cannot be contacted directly. It is experienced and filtered and construed as individual reality. It can be determined that a truthful account of the experienced phenomenon has been discovered when several individuals' realities converge. Plausible conceptualizations of the phenomenon under investigation can be constructed if we can logically explain inconsistencies and/or contradictions by examining them in light of the data, a holistic understanding of the situation, and a general broad knowledge of the world.

This section is organized by presenting the personal dimension first. This will be followed by the physical, allowing the reader to develop a visual image of the design and layout of the wards used for the study.

Third, the social dimension is presented and discussed. As people begin to act within the milieu, they interact with others and learn to respond to the values and beliefs operant in the setting, and also with the course demands and subject matter presented. The curricular and contextual dimensions therefore follow the presentation of the social dimension, and the two dimensions found to be most remote to individual experience, the political and economic, conclude the discussion. While no dimension is more important than any other, some are more immediate in a given situation. None can be ignored.

The following discussion of the clinical learning environment distills and synthesizes the perceptions generated from the respondents in the study, clinical instructors, nursing students, head nurses, and ward staff.

4.2.1 Personal Dimension

At one level of analysis, the persons in the milieu can be separated from the conceptualization of the learning environment. At another level, however, generic and over-riding concepts unify their perceptions into perspectives, attitudes, and behaviours.

The personal dimension is oriented toward the individual and personal development and growth. In this dimension the way students and instructors construct and organize their unique reality is emphasized. The emotional life of the participants is one focus of this dimension.

That a person receives information about the environment, interprets it, and acts on the basis of this information processing cannot be denied. As one lives in our world, one experiences it and defines it, reflecting both an individual and an environmental perspective. This cognitively-based description of a situation tends to be most closely related to characteristics in the setting which have the most direct and immediate ties to the individual experience. The personal dimension of the environment is closely linked to the physical and social dimensions, and is at the centre of the model. One notes the physical

setting (both the building and the people in it), evaluate how it makes one feel, and one plans how to modify what one doesn't like about it. This internal process is intrapersonal and forms the foundation for the concepts whichwere included in delimiting the definition and description of this dimension of the clinical learning environment.

The parameters for inclusion in the definition of the personal dimension of the model are illustrated in Table 4.1 and refer primarily to the formation of concepts and attitudes which lead to personal development necessary to success as a nursing student.

Throughout the study, the student was reported to be the major determinant of instructor behaviour. Since student learning is the aim of clinical experience, and because learning is an individual and intrapersonal activity, this section is presented largely from the student perspective.

Table 4.1
The Personal Dimension of the Clinical Learning Environment

Parameters for Inclusion in the Personal Dimension of the Model
Environment is personally experienced. There is a reciprocal relationship between a person and the environment. The environment is perceived and also created. Attitudes are formed from perceptions: ° satisfaction ° fear/safety Personal development evolves from attitudes and attendant behaviours: ° autonomy ° independence

Representative exemplars from the data base have been chosen, triangulated by using different sources (students, instructors, and staff nurses) and different methods (observation and interview) to illustrate how the clinical learning environment is personally experienced, perceived, and created by the student. In addition, certain literature is cited to substantiate the findings.

The Environment as Personally Experienced, Perceived, and Created

The presence of a personal psychological dimension is implicitly understood in the following definition which had been composed from the literature and accepted for the purposes of this investigation. The learning environment is a set of perceptually based attributes or properties that refers to an individual's cognitively based description. It involves processing specific perceptions into more abstract meaningful depictions. It relates to characteristics in the situation that have direct and immediate ties to individual experience. The educational environment is multidimensional, with a core set of elements that apply across a variety of situations.

I turned to Moos (1974) for an ecological perspective of the environment and its relationship to the person. The relevance of this literature had not been appreciated until the study was under way. Since it was not reviewed until data analysis had begun, it was not presented in the literature review chapter. It is presented here to illustrate the cyclical nature of the methodology.

Social ecology is the multidisciplinary study of the impacts on human beings of physical and social environments (Moos, 1974). Since the physical and social dimensions are central to the model of the clinical learning environment as proposed in this study, an understanding of this perspective seemed a logical first step. Social ecology is concerned with the assessment and optimization of the human milieu. The view of the environment is from the perspective of the individual; therefore, similar environments have differential impacts on people, and people impact on the environment in ways that mutually shape both the milieu and the individual.

Both the characteristics of settings and the interaction between persons and settings consistently account for substantial proportions of variance in a wide range of individual behaviours. That is, people vary their behaviour extensively in different social and physical environments (James & Jones, 1974). As well, a great deal of a person's

environment is individually engendered by his/her own behaviour, creating certain social milieux which then "reciprocate" by fostering certain behaviours and forming attitudes.

> *The individual transforms perceptions of relatively specific events and conditions into psychologically meaningful descriptions of contingencies and situational influences (e.g. ambiguity, warmth, progressiveness) and further, these descriptions are used to apprehend order, predict outcomes, and gauge appropriateness of behaviours.*
>
> (James and Jones, 1979, p. 204)

This representation of the environment is viewed as perceptual/cognitive and affective/evaluative, showing the close relationship between concept formation and attitude formation. This relationship is illustrated in the section on the physical dimension of the learning environment. Students and instructors described the setting in terms of how it made them feel. In addition, instructors looked for ways to use the environment to foster learning. They noted obstacles and planned how to overcome them. They noted opportunities and arranged ways to make the best use of them. The following excerpt from a field note illustrates the concept of mutual shaping between an individual and the environment:

> *One day a few students were complaining because they felt the nursery staff was so unfriendly. "No one even says hello." Since I had spent two days observing there, I had noted that the students themselves just came in, did their work and left. Not one student initiated any conversation with the staff. I suggested that they go in there in the next morning, say a cheery "Good morning" and see what happened. At the end of the day, the students reported to me that they had had a wonderful time in the nursery, that the staff was friendly and helpful. The nurses assigned to the nursery were the same as the day before.*
>
> Field Note

Attitude Formation

Satisfaction and functioning in an environment depend as much on the person's expectations as they do on the characteristics of the setting. Moos (1974) terms satisfaction a "negotiated settlement" between what an individual wants and expects and what an environment has to offer. Morale and performance can change because individual

expectations or perceptions change. That is, the information changes or the individual changes his/her behaviours because the setting itself changes. Moos (1974) asserts, therefore, that human behaviour cannot be understood apart from the environmental context within which it occurs. Understanding of the environment can be derived, then, from observing behaviours and discerning perceptions of people experiencing it. Hence, the researcher believes the literature lends credibility to the data and supports the inclusion of a personal dimension as an appropriate and defensible dimension of the clinical learning environment.

It was a widely held belief among the instructors in the study that whether or not students liked their course work and/or the clinical area could affect their learning. If students disliked the clinical subject, found themselves in conflict with an instructor or their classmates, or found the physical setting too complex or stressful, it could be expected to adversely affect their learning and result in less than optimal performance. If students understood the objectives and the reasons for their clinical assignments, instructors believed they would more likely be satisfied. If they were satisfied, they were more likely to perform better. None of the instructors liked how teaching and evaluation were linked. They expressed the opinion that anxiety about evaluation placed stress on students that impeded their learning. Teachers accepted that student mistakes were part of learning, and in this respect they were in conflict with the implicit values of the hospital and staff nurses. Hospitals wanted all mistakes to be avoided, prevented at all costs. This belief is prevalent among nurses and is a common theme in published standards of nursing care (Murphy, 1988). This axiom applied equally to events that were incidental as to events that were potentially life-threatening. This quest for perfection in practice caused much anxiety for students.

Q: Do you have to be perfect?

A: Pretty well, in nursing. They get pretty upset if you're not. If you miss something they let you know about it. Medication errors are the

worst. Charting isn't as bad.

A.W., L95

Students brought many fears to the clinical learning process. Several, particularly the older students, reported fears relating to the consequences of the course; that there would not be enough time to learn all there was to learn.

> *We're here for such a short time. We don't come back before we graduate, and we have to remember all this for the RN exams. I'm positive I'll forget. I keep all my notes. Maybe that will help when I study. A.R. is lucky. She's had children and has something to relate to.*
>
> (U.A.) Field Note

Anxiety about instructor presence and performance evaluation was also reported. Students were afraid of receiving a negative evaluation if they did not perform perfectly and of punishment for errors. Fears of an interpersonal nature were also reported. These related to being too embarrassed to speak up in front of others, fear of being called upon by nurses, doctors, or patients for information and advice, and fear of criticism by instructor and peers.

> *A doctor yelled at me once, now I stay out of their way. It really stuck in my mind.*
>
> A.W., L220

After a staff nurse had pointed out to a student that she had neglected to chart three important things the day before, I asked the student how she felt.

> *I was upset that everyone knew about it, not just her, but 10 different people knew about it, including my instructor, the substitute instructor. You probably knew about it too. It's embarrassing when you miss something. You sound like a real screw-up.*
>
> A.W., L54

In addition, threats to self-concept added to the anxiety experienced in the setting. Students reported fears of the additional responsibilities they carried in the clinical area and consequent feelings of incompetence and inadequacy.

Anxiety and fear are pervasive in the clinical learning environment. According to Maslow (1968) safety must be assured for growth to take place. Growth toward self-actualization proceeds as prepotent needs are met. Learning results from a sense of inner

emotional safety. These needs are physiological needs, safety needs, acceptance, friendship, recognition of achievement, and self-actualization. True safety is achieved, according to Maslow (1968), when one's self-worth is assured and the delights of learning and personal growth outweigh the anxieties surrounding the learning process.

The clinical instructors in the study felt that their role was to create environments that were emotionally secure yet still stimulating and motivating for the students.

The following verbatim account from a student's anecdotal record starkly illustrates the concept of psychological safety in the clinical learning environment.

> *0705. Came onto the floor and Sara gave us out the patient(s) we would have for the day. I was only given one patient and she was scheduled for a caesarian section at 0800. Sara told me to rush down to the case room and change into my greens.*
>
> *I walked down the hall and into the case room to change. When I walked out, I had no idea where to go or who to talk to. I walked down to the board and checked the list of women, but my patient's name was not up. Now what? I saw U.A. and I went to see what she was up to. The nurses were getting ready for report and so I stayed there with her.*
>
> *Then Sara walked in and we found my patient. I'm very glad Sara showed up. I introduced myself to the patient and she seemed so nice. I felt very comfortable talking with her and her husband and gave her any info she wanted to prepare her for O.R.*
>
> *A grad came to us and just cut in on the conversation. She was extremely unfriendly and made me feel very uncomfortable.*
>
> *I wanted to help out in any way I could but no one really seemed to want me there. A nurse told me to take a break for ten minutes and return later to the recovery room. I went quietly to the changing room and closed the door. I sat in a chair, stared out the window, and cried. I felt so useless.*
>
> U.O., Notes

With the human events taking place on an obstetrical ward, the students often felt personally emotionally charged. They expressed emotions such as joy and happiness at witnessing the birth of a child, pleasure at helping a new mother and baby, gratitude that the family allowed them to participate, and, sometimes, fear, frustration, and anger.

Development of Autonomy and Independence

Students wanted to be themselves, to act freely and with integrity. Under these conditions, they felt they could be most constructive and creative. They wanted to feel good about themselves and needed the respect of others. It was important to them that their past experiences be legitimized as the foundation for dealing with what was to come. They needed to see the order in events and wanted to achieve some sort of freedom to practise "their way". Students wanted to be treated as adults and as "becoming" nurses.

> *One thing that happens is that the staff nurse will criticize something. But she says it indirectly like "you should be doing it this way" when that's not the way we were taught. It isn't a better way, either. It's just different. Why do they bother?*
>
> H.C., L97

> *I do not feel like a colleague at all with my buddy nurse. Actually, what was going on in the back of my mind was "My God, I'm 25 years old. I'm not a child." She made me feel useless. I have been a student for two years and I work in a nursing home on weekends. I do know something.*
>
> H.C., L209

In terms of trust, instructors recognized that ultimate control of learning was in the hands of the student. They accorded students the ability to make use of learning opportunities and clinical problems. They saw their role as manager of the opportunities. ("I get to know a little about each student's interests. This information gives me insight and helps me to find analogies that help her to understand a concept.") Further discussion on how instructors act to establish an emotionally safe environment is described in the next chapter. ("If students see I care, they are willing to work hard.")

Students know they are sometimes a burden to the ward and seek to feel welcomed in spite of it. Empathetic nurses who recall their student days can assist students by their warmth and caring attitudes and behaviours. The converse is also true. One student says: "She (buddy nurse) kept calling me Lee and my name is Lee-Ann. This bugged me since she continued to call me this even after I corrected her." Another student reported an

incident where, in the report room, a nurse came in when the student was the only other person in there. Instead of responding to the student's smile, she took a chair and deliberately turned her back to the student and ignored her. The student reported feeling uncomfortable that maybe she was not allowed to work in there, so she left. Although it was perfectly acceptable for students to use the conference room, this particular student could never bring herself to do so for the entire remainder of the rotation. The following excerpt from anecdotal records is illustrative:

> *I.O. and I got to the change room at 0700. No one was there to greet us or explain what procedure was to be followed for report or who we were going to be buddied with for the day. Anyway, we took off our clothes and tried to find a uniform that fit or didn't have a name on it. There was only a few small ones and I couldn't get it past my hips. I had to go over to the other side of the hall and get the green pants and top. A whole bunch of women had arrived by now and were sitting around the small room chattering. Then, all of a sudden, they all got up and headed out to the floor. So we just followed them out. I was feeling pretty nervous and a lot like an outsider. No one seemed to notice us at all. We stood near the wall close enough to hear one of the nurses go through each patient's case. Then a nurse started assigning patients to individual nurses and we were left standing there. A nurse finally approached us and told each one of us to go to a particular room and we parted from each other at that point.*
>
> (U.O.) Field Note

Nursing curricula traditionally have three main threads: knowledge acquisition relating to caring for patients, professionalism and ethics, and self-actualization of the student nurse. Caring and growth (change) are the central concepts in the education and practice of nursing. As the curriculum is implemented and students complete their courses and clinical requirements, they develop both personally and professionally, earning the right to practice the profession. Autonomy and independence are goals to be achieved. Independence in clinical experiences was granted by staff nurses who had satisfied themselves their patients were safe with this particular student. Once entrusted with the patient care tasks, the student was allowed to autonomously make decisions relating to that care.

My nurse went through her patients this morning with me, and she gave me some suggestions like "maybe you can get her up to a shower". Another buddy nurse I had would say "I want her up to the shower no later than 0830" and heaven help me if it was 0900 and she hadn't showered yet! This nurse asked me if I had any questions: I inquired about the dressing. Throughout the day she stood back and let me approach her if I needed help. If I did approach her she would answer my questions, but she didn't come in and take over. I learned a lot today. When I had this other nurse I was just a robot programmed to do her bidding. I wasn't learning, I was just doing what I was told.

H.C., L224

Trust appeared to be a critical factor that determined the staff nurse's decision to allow the student the freedom to act independently. Ultimately the staff nurse is accountable for the care given, and they stated emphatically that unless they were certain the student was capable, they monitored the situation very closely, asking for frequent reports and personally supervising care activities by students. They assumed the instructor would warn them of any difficulties a student was experiencing, and they were more reluctant to "back off" if the student was early in her academic career or the patient was potentially unstable. A staff nurse said:

I go over her whole assignment, beginning to end. Then I tell her exactly what has to be done, like reminding her not to give the patient breakfast until the fasting blood work is done. I find things get missed if I don't tell students specifically. I had to weigh a patient today because a student forgot. Then a student was late giving insulin because she was waiting for her instructor. That's not good. She should have grabbed me and I could have helped her. I ended up supervising her myself.

I find it easier to just jump in and get it done. I know I talk fast so I always ask if she understood me.

One student came to me to supervise a med. That's OK, but she didn't have everything ready, so it ended up taking half an hour when it should have taken only 5 minutes. I don't have the kind of time to stand around while she gets the ticket out, finds the medication, gets her syringe and needle, and then draws up the med. She could have done most of that ahead of time. So I told her not to ask in the future until she had assembled all her supplies. It will give her some self-confidence too if she can be organized.

This is a busy floor, the patients aren't always stable and sometimes you have to act fast. You need to know that you told the student what

to do. Not that they always remember, but you did what you were responsible for. The rest is up to them.

E.S., L13

It's almost as if it is the student's fault if something didn't get done. Maybe the student did the best she could, maybe the patient absolutely refused to get up and even if the head nurse had gone in there herself and tried to coax the patient up, she might not have been able to get him up. There are ways to say things to students so that learning can take place effectively. The student doesn't need a lecture at that time. I like a conscientious nurse, but I don't want them to be supercritical when things don't go exactly right.

Nathalie, L856

Teachers knew and understood the importance of the personal dimension in the facilitation of learning and in the next chapter a discussion of how they fostered positive personal learning experiences for students is presented.

Representative exemplars chosen from the data base, have provided an illustration of how the clinical learning environment is personally experienced, perceived, and created by the student.

Inasmuch as the environment that immediately and directly affects the individual is important in developing concepts and forming attitudes, the personally experienced physical and social aspects of the setting are inextricably linked and form the core of the model proposed in this study. The physical dimension is presented in the next section.

4.2.2 Physical Dimension

The first thing one notices about the environment are ones surroundings, the physical characteristics, what one sees, hears, smells, or feels. This section, therefore, begins with a walk-through of the two sites used for the investigation. Exemplars which represent teachers' and students' reactions will be used to illustrate the impressions created by the physical surroundings.

Table 4.2
The Physical Dimension of the Clinical Learning Environment

Sensations	Sights	Smells	Sounds
Size	Patients	Antiseptics	People talking
Geography	Personnel	Food	Paging system
Atmosphere	Colour	Cigarette Smoke	Telephones ringing
Temperature	Equipment		Call bells

West City Hospital

West City is a large red-brick sprawling building which dominates the better part of two city blocks. As the students arrived, they met at the front entrance of the education centre, and sat on chairs while they waited for the instructor to arrive. The entrance was small, but impressive; large windows provided a view to the outdoors, and there was a circular staircase leading to the second floor. The colours were subdued; pale beiges and grey. A small hall lead to conference rooms, and an alcove signified an auditorium beyond the doors. Near the elevators was an information desk, staffed by two women. Several students reported to be impressed by the size of the building.

> *As I got off the bus in front of the building I felt intimidated by the large building and the front entrance.*
>
> L.A., Notes

As students walked past the elevators and information area, they entered a hallway that was brightly-coloured with yellow and white tile, archways, and mirrors. To the right was a café, green in accessories with white tables and chairs. They went around a corner, down the stairs, and entered a tunnel. This tunnel was dark, no windows. Pipes traversed the ceiling. It was warm. After a few yards, they turned and entered their locker room. This room was only for the use of students assigned to the hospital. Students were told to use their own locks and remove their belongings at the end of their shifts. They shared at least two students to a locker. There was a small washroom area attached.

Our lockers are in the dungeons. To get to them you have to go underground and the passageway is narrow and not much room for tall people, because there are pipes all over the ceiling.

R.O., Notes

After they left the lockers, the students returned to the main level and ascended by elevator to fourth floor, where they were escorted to a small brightly lit conference room. Padded armchairs were arranged in rows. This room was decorated in blue and beige, with carpet on the floor and framed prints on the wall. There was a blackboard, a white board, and lighted panels for radiology films. A podium stood to the front, and audiovisual equipment was stored to the side. The room was warm although a noisy fan was in operation. The door remained shut because noise from the hallway was disturbing.

Ward MAT1

MAT1 was an L-shaped ward with west and south wings (See Figure 4.2). The nursing station was situated at the break in the L. Patient rooms were aligned to the sides of the central corridor. This ward had recently been renovated and students and instructor found it to be bright and cheerful. The walls were pale blue, and the tile floors were beige. A padded handrail ran the length of the hallway, on both sides. There was a sitting area across from the nursing station, furnished with blue padded couches, a chair and a wheelchair. A half-wall divided it from the hallway. The area was lit by lamps mounted on the wall. Seated here, one could see the people walking by, note the activity in the nursing station, hear the sounds of the ward, and see the entrance to the intensive care nursery. A sun room was situated at the southeast corner of the south wing; windows along the length of one wall and blooming geraniums on the sill made it a bright room. It was furnished with couches, tables, chairs, a television, VCR, and there were magazines and maternity-related pamphlets on the tables. Framed prints decorated the walls.

Figure 4.2
Location of Research Setting at West City Hospital Site

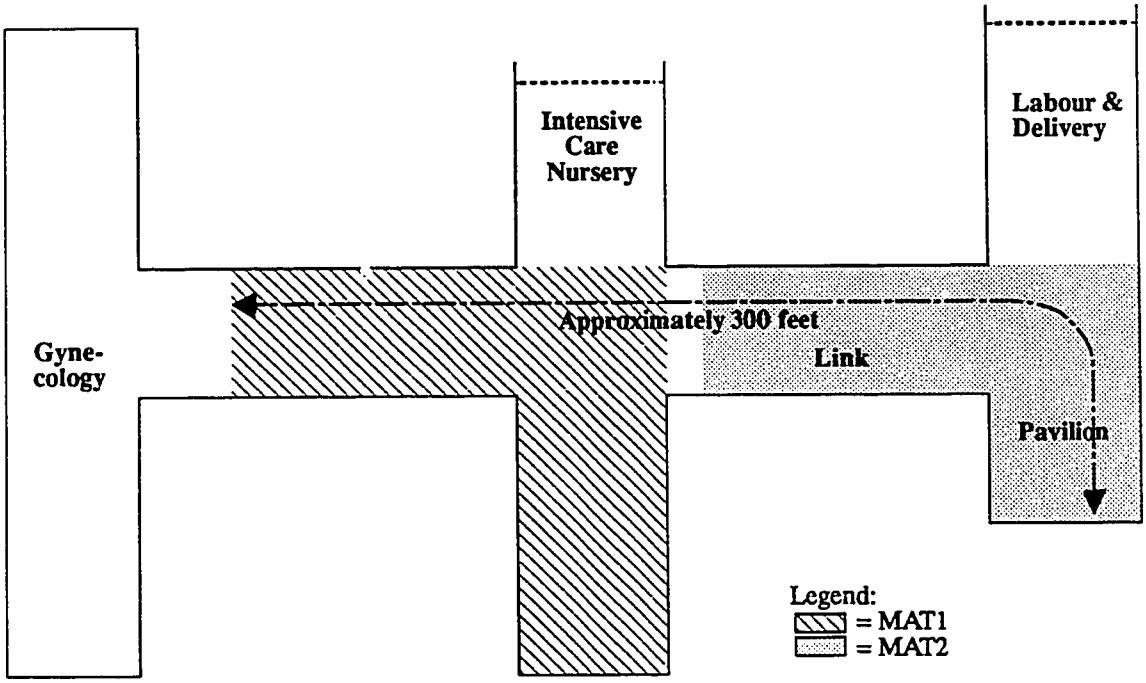
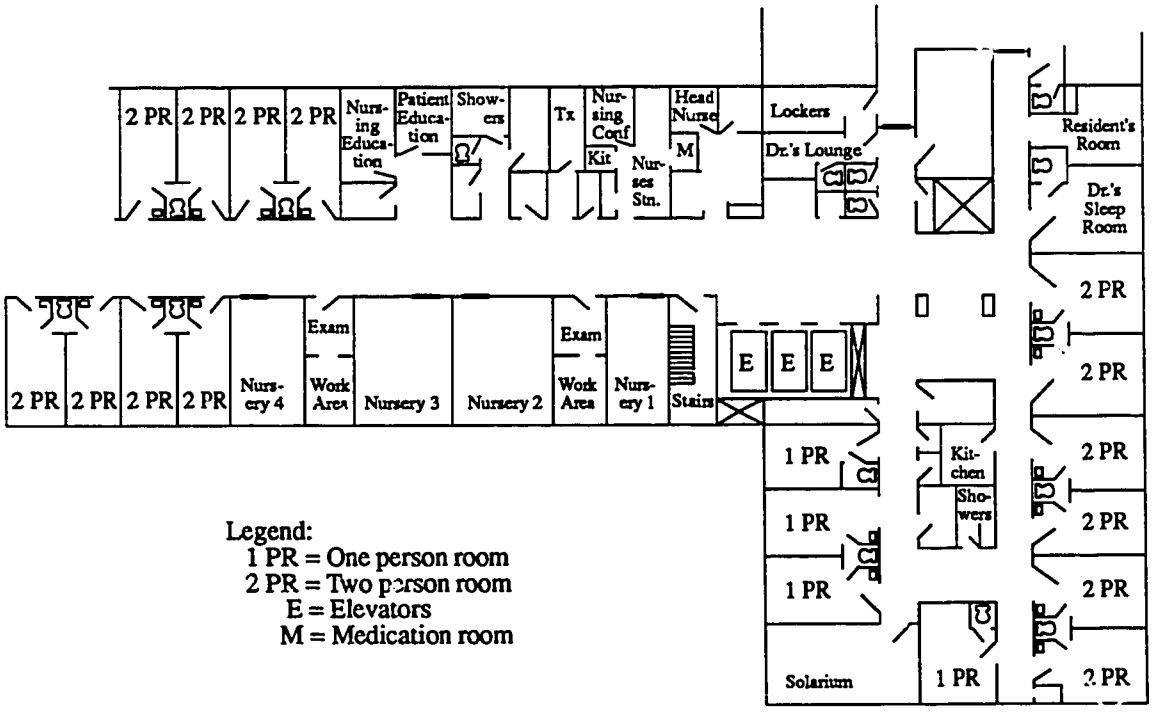


Figure 4.3
Detailed Floor Plan of a Traditional Ward at West City Hospital



The nursing station had a central charting desk with chairs placed around it. Charts were in ring binders and were accessible from this desk. The area was painted off-white and was carpeted. Counters and cupboards were light blue melamine. There was generous storage space and drawers. A white board with patient information is on the wall. A poster dominated the wall, pronouncing: "Nurses: speaking with their eyes, teaching with their hands, comforting with their presence." The area was neat and appeared orderly.

In one corner was a small windowless report room with a table, tape recorder, and four rolling armchairs. This room has two small bulletin boards, a white board, nurses' mail slots, and a wall hanging given to the ward by a patient. It asserted "MAT1 nurses are the best." Around the corner was the head nurse's office and some paper storage cupboards, one of which was locked. Adjacent to this were the medication and utility rooms. The medication room is large and had a window. The area near the window was messy. There was an off-white counter with a sink and drawers. Above, the cupboard had glass doors. There was a large refrigerator in the room. Ward medications were in a locked glass cupboard flanked by a second trolley containing assorted equipment. A bulletin board and medication card slots are mounted on the wall and an insulin reaction poster is mounted on the door.

A counter separated the nursing station from the hallway. At one side was the ward clerk's area. At another was the counter used by the lab technicians. It had the specimen holder and the lab order book on it.

Since there was no smoking allowed in patient rooms, a smoking room was provided. It was small and smelled of stale smoke. There were chairs and a television provided in this room. Prints decorated the walls.

> *The smoking room was a typical black cloud and the door was wide open to the hallway. An actual baby cart was wheeled in amongst the lounge where everyone was smoking. I think the babies should be forbidden to go there.*
>
> O.A., Notes

Patient rooms were small and seemed crowded with the baby bassinette and supplies, the mothers' personal effects and flowers, balloons, and gifts everywhere. It was a cheerfully busy place, especially the west wing area. The south wing primarily housed the antepartum patients. It is also where the single rooms are located. The atmosphere down this wing was quieter and more sedate.

> *The rooms are very crowded because they have all these gifts and flowers and stuff. The students have a little bit of trouble, I think, trying to keep the room tidy, in that kind of situation . The moms bring out the baby cots and the cots are there as well. Trying to get around, they have to be careful that they're not tripping over things and bumping into things. We are not really into too many skills apart from bedmaking, a few vital signs. Just the basic caring. Even to make a bed is awkward sometimes with the room cluttered.*
>
> Errin, L34

Ward MAT2

Once the students passed through the doors and over the short walkway, past the elevators, and onto the ward MAT2, the decor abruptly changed. On the right were the nurseries, on the left were patient rooms. This area had not yet been renovated. The walls in the hall were dull, painted dark blue on the bottom half and light blue on the top. The rooms on the east side were poorly lit and in shadow from other buildings on the site. On the west, rooms were brighter, and the view of green fields was pleasant although traffic noise was noticeable in rooms where the windows were open.

The nursing station was near the end of the long hallway known as "the link". The east section of MAT2 is known as "the pavilion". Elevators were located between the link and the pavilion. (See Figures 4.2 and 4.3) The nursing station had large wooden cupboards at one side where the ward clerk's desk was located. Steel charts were kept on shelves near the ward clerk. These shelves opened on two sides, the other side being a small alcove where physicians could be seated to review charts and dictate notes. A small

medication room with a counter, sink, and an upper cupboard was located next to the physician's room. The remainder of the nursing station was an open area with a small table next to the window and a counter and book shelf on the west. A small galley and a larger report room was off to the side. The beige-coloured report room contained a large table, several chairs, blackboard, and bulletin board.

> *How does the ward itself impact on the students? If it's easy to get around and comfortable to the students and the charts are accessible, and textbooks are accessible, I think those kinds of things are helpful to students. I think some of the things that are negative in the ward environment are things like very small medication room. We're in the way when people are trying to do their meds and I have to be there with students. These kinds of things I think are kind of awkward, whereas floors that have more room we are not in the way so much. I think the students get positive feelings when they know they are not in anyone's way. They get negative feelings sometimes if people are hurrying around them and so on.*
>
> Errin, L15

The pavilion area was slightly different in its organization. (See Figure 4.3) It had two halls with a central core which contains the service areas: utility, supplies, showers. It was dimly lit. Rooms were arranged on one side of the halls. A lounge area was placed at the southwest corner. It was large and spacious, but sparsely furnished, with two ancient prints on the wall. At the opposite end of the pavilion, the case room (labour and delivery area) was located.

The head nurse's office was located around a corner opposite the bank of elevators. There was a seating alcove across from the elevators with two vinyl benches facing each other.

The nurseries were located on the south side of the link area. Windows provided a view into the nursery during viewing hours. At other times, the curtains were drawn. The curtains were colourful with a balloon motif. Nurses enter the nursery through a small foyer which contained a sink, linen, and a small counter. Upon entry to the nursery proper, the students first encountered the nurses' desk and supply area. Turning left or right put them in the baby area. The nursery was warm, bright, and colourful. There were

murals and wallpaper on the wall. Windows overlooked a field. Depending on the time of day, the nurseries could be quiet or full of the sound of crying and nurses talking as they oversaw the care of the infants.

> *Area in front of the nursery seemed cluttered with carts and people. The nursery was warm. Really warm.*
>
> O.A., Notes

First impressions are important. I asked a student nurse what she thought about the hospital that first day.

> *It seems so huge. I don't think I'll ever learn my way around. The decor is really beautiful and it seems more like a luxury hotel than a hospital. We didn't really get to see too much of the hospital except our wards. I didn't like the underground tunnels leading to the change room. I felt claustrophobic and could imagine those pipes breaking over my head. The wards where we will be working seemed warm and comfortable. In the nursery the babies' cots were scattered about and I felt like putting them in neat rows. I like organization. I like the fact that the babies "room in" with the mothers. The patients' rooms seemed small. I also thought one of the med rooms was awfully small and preparing meds in there will probably be difficult.*
>
> O.N., Notes

One student group will spend seven 2-day clinical weeks on the two wards located on this floor (MAT1 AND MAT2) with Errin as their instructor. Sara will spend five days every two weeks on this floor with the eight students assigned to her group. The remaining group in the study will spend their time at East General Hospital with Peggy, two days each week for seven weeks. East General and the ward used by this group, MAT3, are described next.

East General Hospital

East General is a large grey concrete building situated in a health sciences complex comprising several hospitals and university buildings. It is surrounded with a large green park area. In close proximity, are several other low-rise health and related buildings.

Upon entering the hospital, the students found themselves in a large and spacious lobby. To the left, near the admitting area, were a bank of padded banquettes. Centrally located in the lobby was an escalator leading to the outpatient clinic area. At the foot of the escalator was a coffee shop with green plants acting as screens. Also in the lobby was a gift shop, a pharmacy, and an information booth. A bank of elevators was situated just past the coffee shop. The lobby was decorated in a modern style in colours of cream and blue. Hallways lead off in three directions. Hallways leading away from the lobby were painted yellow. Above one, colourful banners hung which directed the visitor to administration and the cafeteria. Large wall graphics indicated that the locker rooms were located in the second hallway, while a conservative sign near the third hallway announced the library location and exit to parking garage. A instructor recalled her first impression:

> *It is a welcoming atmosphere. The blue is very peaceful, I think; when you come in and you see the art on the wall, I think it sort of gives a nice look. And the escalators are very impressive.*
>
> Nathalie, L58

Comments from students:

> *Big, modern.*
> *Impersonal. So large. People are moving so quickly and there's so many people.*
> *Like a mall. A shopping mall.*
>
> Round Table

The first clinical days provided the richest descriptions of the hospital as the students experienced it for the first time. The first stop for the students and instructor was the locker rooms. They went past the elevators, turned right, and into the locker room area. Students were assigned lockers which they shared in pairs. They were reminded that lockers were also used by other programmes, so they must remove their belongings after each day. The locker area was dimly lit and benches were located between each bank of lockers. The students shared a common space down one aisle. The lockers were coloured bright yellow and the locker room itself had green as an accent colour. Attached to the locker room was a toilet and shower area with sinks and mirrors.

The students commented on the locker situation:

Crowded.
Really bad.
They just added a whole row or two, it was larger a few weeks ago.
Mine wouldn't open.

Round Table

The next stop was down the hallway to an office where students received their identification tags and personal information (address, telephone number, next of kin) was recorded for hospital records.

Then they took the elevator to the patient care area. As they stepped off the elevator they saw a large rectangular open area with a desk along the long wall (A.C.C.: Administration and Control Centre). A clerk at this desk answered all the patients call bells, called for the nurse when a patient needed one, directed the flow of patients and visitors, and assisted with the paper work.

Ward MAT3

To the left was a small seating area with two couches and a coffee table. Hallways left this central area in two directions, left and right. They headed left to MAT3. As they stood looking down the hallway, they seemed puzzled. The traditional nursing station did not exist, and room doors did not open directly onto the hallway. This was a Friesen concept hospital.

I think new students feel overwhelmed when they come here. They have to be here at least a week before they feel comfortable.

Mae, L315

In this concept, the ward is divided into a central support area, with patient rooms around the perimeter (See Figures 4.4 and 4.5). Adjacent to each patient room is an alcove called a nurse server, consisting of a counter, sink, and storage cupboards. Charts are kept in the drawers under the counter. Supplies and medications are kept in an upper cupboard

Figure 4.4
Location of Research Setting at East General Hospital Site

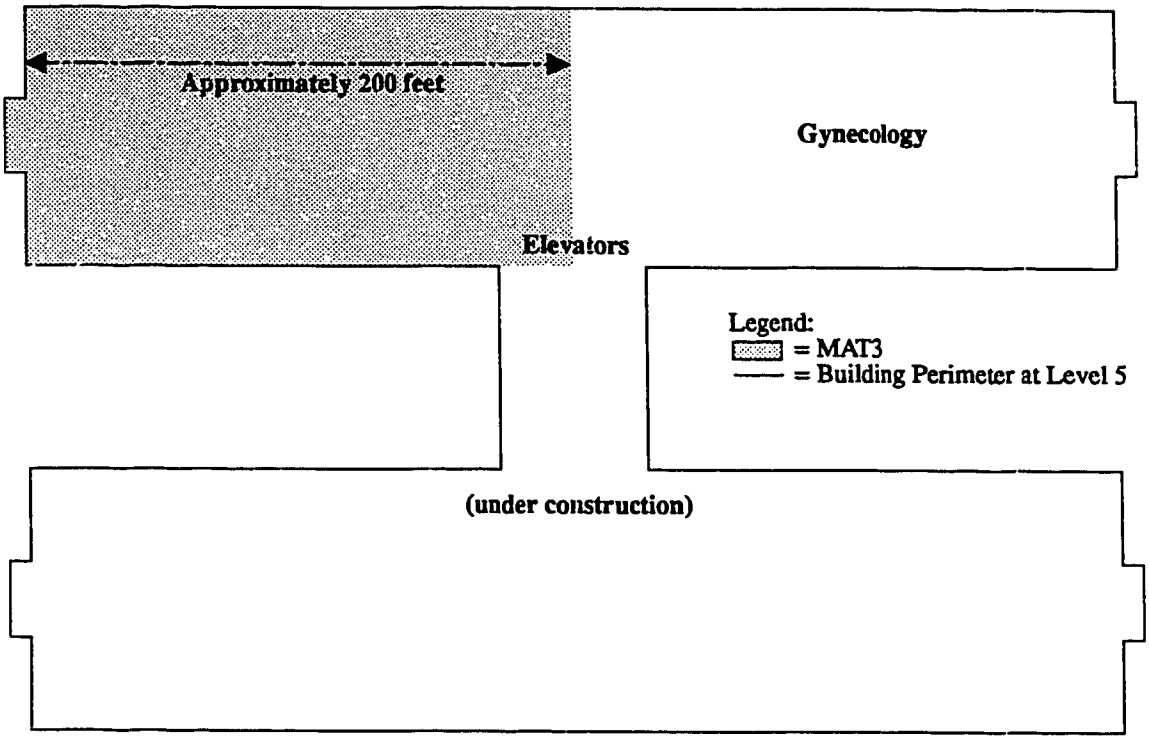
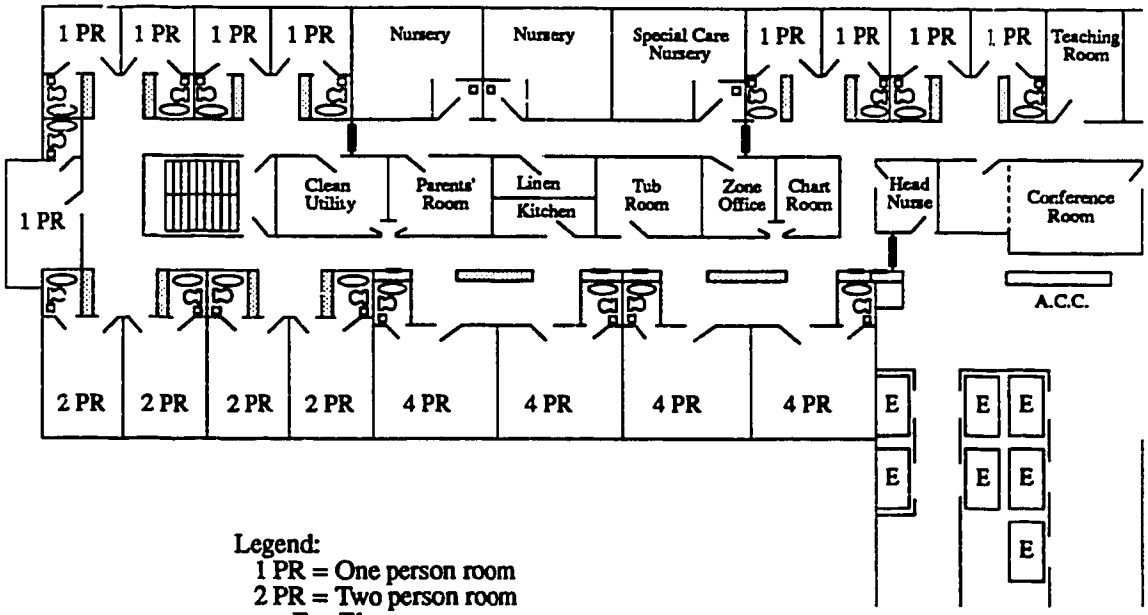


Figure 4.5
Detailed Floor Plan of a Friesen Concept Ward at East General Hospital



opposite the sink area, and dirty linen and equipment are housed in the bottom cupboard. The alcoves are clean and functional. Nurses are not visible in the hallways. Since all patient supplies and charts are at the nurse server, if an instructor wishes to locate a student she must go to the patient room. No central area is provided for nurses to congregate.

> *I find it difficult to see anybody. You have to look on the list to see where people are assigned and go to the room. If a nurse is in a room or in an alcove, you can't see her.*
>
> Mae, L323

> *I do look out into the hall to see if there is a student out. I figure if the student is looking for me they'll probably be in the hall. Or if I see that they are out of their ward area. I'll say "Are you looking for me?" Or they page me.*
>
> Nathalie, L1230

In the central area is found the chart room which physicians use for dictation and where textbooks and other information are housed. Next to that is the zone office. In this office, which contains a small round table, a few chairs, a counter and book shelf, a bulletin board for notices, and a blackboard with patient data, nursing staff congregate for report.

> *The only time you see anyone sitting in this little room is when they get report in the morning, when they are writing in their report book, or when they are signing out narcotics.*
>
> Nathalie, L1289

The galley, for preparation of patient snacks, and the clean supply room are located next as students moved east down the hallway. A small room, carpeted and with home-like furniture (couch, rocking chair, pictures), was also provided for breastfeeding mothers. As they turned the corner at the end of the hallway, they moved into the nursery area. There are three nurseries. The first is crowded with bassinettes. The curtains are open and the area is light and airy. There is a fair bit of noise, crying babies and nurses talking to the babies and to one another. The nurses were all wearing pink scrub dresses. Some mothers were in the nursery bathing their babies. A large sink as well as a counter area, linen storage cart, and charts lined the west wall. An open window provided a view into the

second nursery. Here there were fewer babies; most were in incubators or under the lights. This is where babies under observation (newborn, jaundiced) are kept. The area was quieter and there were only two staff nurses in the room. The blinds to the hall are open and a family was viewing a newborn baby. The outer hallway between the nurseries and the central core was crowded with supplies and people. The next nursery is the intensive care nursery. The blinds to the hall are shut; if one looked through the glass windows on the door, the incubators and equipment were visible.

Further down the hall was a large lounge area which also serves the gynaecology ward. It had windows to the outside and also to the hallway. There were vinyl couches and chairs, a television, and posters on the wall. Adjacent to the lounge was a teaching room for patient teaching and postpartum exercises. Blue exercise mats were stored leaning against the wall. A book shelf held several magazines, and there are a table and several chairs in the room. Across the hall from this room was a brightly lit teaching conference room with a blackboard, white board, overhead projector, and an examining table. A large table with yellow vinyl chairs encircling it dominated the room.

The foregoing description of the wards was presented primarily from the students' perspectives. Because students were unfamiliar with the wards they were able to provide a fresh look at what was familiar and commonplace to the instructor.

Commentary

In addition to painting a word picture of the wards, it is interesting to note that the physical spaces on the wards had certain characteristics which differentiated them from others. Not only did the spaces within the ward have designated purposes, the wards themselves were different from other hospital units. Clearly, babies are rarely seen on other units! Also, for the most part, the patients were healthy, not ill. The atmosphere was not one of illness and death, but of health and wellness. There were very few pieces of

high tech equipment that one would expect to see in more critical care areas. These characteristics were common to both hospitals in the study.

Clearly the patients' rooms formed one type of physical space. Curtains drawn around a bed in a shared room delineated the private space. Curtains were closed for feeding activities when the room-mate had visitors. If the patients were alone with their babies the curtains remained open. Nurses closed curtains when they did their assessments.

Patients were assigned to rooms based on their reason for admission. Only rarely were antepartum and postpartum women assigned to the same room. For that reason, the "tone" of the rooms differed depending on the type of patients housed there. Antepartum rooms were less crowded because they tended to have fewer flowers, and no bassinettes were in the room to take up additional space. Inasmuch as these women were in hospital for medical reasons related to the pregnancy, their ambulation was often restricted, so there was less activity and motion. These characteristics differentiated the space and determined the activities of the nursing personnel.

Lounge areas were also clearly differentiated by their characteristics. For example, the nonsmokers did not use the smoking lounge and smokers were rarely found in the nonsmoking lounge. Visitors and families often spent time in the lounges; as well, these areas were also used by health workers for teaching or meeting purposes in the mornings. For instance, the community health nurse conducted prenatal classes in the MAT1 lounge for the antepartum women.

Nursery areas were different in character and purpose than other patient care areas. The nurseries were kept quite warm in temperature and were also brightly lit. Supplies were close at hand, and there was always a nurse present when there was a baby in the nursery.

An interesting area of differentiation was the nursing station (e.g., division of space for staff). There were certain areas that "belonged" to the ward clerk and the only other

person who could use that area was the head nurse or her team leader, and then only when the ward clerk was on break. Supplies had to be requested; students in particular could not go into a drawer to get a stapler, for instance, without permission. The ward clerk area was a "command centre" for the administration of the ward, whether this area was on the ward (as at West City) or in an external site (as at East General).

At both hospitals the photographer had access to a small part of the desk area and a particular book to find out who had delivered in the past day. In terms of the kardexes and report books, there was a definite priority access roster. These materials were kept on a part of the desk to be accessible to the team leader and the ward clerk. Interestingly, the desk area was accessible to individual doctors, but they were not encouraged to conduct teaching rounds in its vicinity. They were subtly moved to a classroom or hallway.

The report rooms (chart rooms) were for the use of nursing staff primarily, but other workers who needed a private place to interview patients were able to use them at certain times of the day. The nursing station (zone office) and the report room were often the only places nurses would be seen sitting.

There was restricted access to the case room and intensive care nursery. Signs to this effect were posted on the closed doors to these areas. In addition, special garb was worn by personnel entering these areas, lending a "mystique" to the territory.

Students were restricted to the ward to which they were assigned and, except for trips to the nursery or when seeking their instructor, they did not go to the other areas.

Students and instructors had very little personal space on the units. In most cases a small part of a counter or cupboard was provided for books and purses, but all were advised to leave everything but the essentials in their lockers. For privacy, instructors had to negotiate for space to speak to students. In many instances, this was the head nurse's office.

> *You have to pre-book rooms. This is a problem. Rooms are at a premium and hard to get. We've had to take pot luck, whatever we*

> *could find free. I can usually find a place to talk to a student privately. We just go down to the clean utility room. We can at least be apart from the others.*
>
> Farin, L129

The temperature level in the nursery caused some problems at times. Students felt that they were sluggish and sleepy if they had been in there for some time.

Because of infectious diseases personal protection was always a concern for nurses. Universal precautions were in place and protective equipment (disposable gloves) were available for assessments. In addition, sinks and antiseptic soaps were available in the nursery, along with gowns to wear while caring for the babies.

It must be remembered that the physical space was also "peopled" with hospital staff, patients, visitors, physicians, and other students. These people were distinguished by their clothing and hospital staff were further identified by their security tags. The number and types of people in the physical space created an impression on the students. I.S. summed it up:

> *So many people. All seem so busy, with so much to do and so many places to go. Will I ever belong?*
>
> (I.S.) Field Note

The interactions with those in the milieu form the social dimension of the learning environment, which is presented in a later section.

In general, all spaces were in close physical proximity which allowed and, indeed, fostered communication and interaction among people. The geographical remoteness of the MAT2 pavilion should be noted, however. The design and arrangement of the pavilion may have inhibited social interaction. In addition, the distance of the nursery from MAT1 made communication difficult at times. This remoteness may have been a factor in some lack of cohesion among inter-ward staff. Friendships are formed when people work in close proximity. Teachers in both hospitals found the geographical arrangements difficult and reported that they did not feel as available to students as they would have liked to have been. The students often had to go looking for the instructors. On the other hand, the

instructors felt that some students, knowing instructors could not hear and see everything they did, developed more confidence and overcame their anxiety more quickly than otherwise. When instructors were in the immediate environment (nursery, for example), students expressed a great deal more anxiety and felt they were more "clumsy".

The arrangement of furniture and chairs within the physical space can promote feelings of warmth and welcome, or it can shut people out. All instructors would move chairs in the conference room into a circle for meetings with the student group. At report, however, it was not unusual to see nurses sitting on chairs while the students stood around the room.

The organization of space into open and closed areas also had a bearing on mood and behaviour. In the nursery, a closed space, the staff were more talkative, more socially interactive, and seemed to be having more fun than the nurses out on the floor.

In this section, the physical dimension of the environment was discussed. This dimension is experienced through the senses. While all dimensions are personally experienced, the environment is presented in this thesis as a collective synthesis of these perceptions. It is through the personal eyes and voices that we come to an understanding of the clinical learning milieu. How the instructor interacts with and attempts to influence the environment is discussed in Chapter 5. In the next section, the social dimension is presented.

4.2.3 Social Dimension

The social dimension is linked closely to, but is different from, the personal dimension. Whereas the personal dimension is internally experienced, the social dimension is dependent upon interpersonal relationships and the attendant communication these relationships engender. As the student and instructor practised in the clinical milieu they interacted with each other and the members of the ward. There were patterns and

characteristics to these activities which emerged during the participant observation and data analysis. Behaviours relating to the interchange among people on the ward were governed by norms (which define appropriate forms of behaviour) and expectations. Practices, positions, roles, unwritten policies, and personal preferences formed the implicit rules for conducting certain activities.

While some authors group the personal and social domains into a psychosocial dimension when they discuss situations and environments (Lam, 1985), it became clear during the analytic process that in this study that a distinction between the two domains was warranted. If one views the personal dimension of the learning environment as internal and psychopedagogical in nature and the social dimension as external and interpersonal in nature, the distinction between the dimensions becomes clearer.

Carr (1983) suggests the clinical teaching milieu displays features characteristic of a social setting. She describes it as "an organized collectivity of interacting people whose activities were centred around a set of common goals." Her view of the social dimension, however, was limited to the conversations and activities that indicated people were interested in the life of their co-workers beyond the work place. Further, she limited the social group to the personnel who consistently remained on the ward.

I have extended the definition of the social dimension of the learning environment to include norms and expectations of the instructor and her students as well as the people on the ward, the communication and relationship patterns of the student learning group, and the interaction among students, nurses, and the instructor in order to better reflect the data that emerged in this study (See Table 4.3).

The social dimension of the clinical learning environment, then, respects the communication patterns and the nature of interpersonal relationships in the clinical setting. The social dimension affects what students learn about learning to be a nurse; that is, the social norms and expectations of the nursing student role. The students have a learning role, the instructors have a teaching role, and the role of the staff nurse is nursing.

Groups have social characteristics that differentiate them from others. Students are part of the social group of students, which is practising and learning within the social group comprised of the ward staff. As suggested earlier (see Chapter 3, p. 84), the relationship of the student group to the ward group is that of guest and host. The student group, on the ward for the purpose of learning, are considered "outsiders" by the ward group. Within each group are cliques and nonconformists. How this diversity is handled is also a component of the social dimension.

In Table 4.3 the parameters for inclusion in the social dimension are presented, and refer primarily to interpersonal relationships, communication, and group norms.

Table 4.3
The Social Dimension of the Clinical Learning Environment

Parameters for Inclusion in the Social Dimension of the Model
Depends on communication and interpersonal relationships in the setting, among students, instructor, and hospital staff. Behaviour is governed by norms and expectations of members in the social setting. Groups have social characteristics relating to: ° demographics ° cooperation ° reputation ° morale ° presence of cliques

As discussed in the literature review, climate is a term that is frequently used in the literature to define the nature of a social setting. The composition of the student body in terms of racial mix and socioeconomic status (Brookover, 1978), or student personality and organizational characteristics (Anderson, 1970; O'Reilly 1975) have often been used as synonyms for social climate. Carr (1983) typifies the clinical climate as the atmosphere on the ward. Brookover, a recognized expert in the study of learning environments, proposed a social view of learning environments.

> *The school social climate encompasses a composite of variables as defined and perceived by the members of this group. These factors may be broadly conceived as the norms of the social system and expectations held for various members as perceived by members of the group, and communicated to members of the group.*
> (Brookover and Erickson, 1975, p. 364, cited in Brookover et al., 1978)

Norms are the common beliefs concerning appropriate forms of behaviour for the people in the setting. Expectations are the definitions or boundaries of the behaviours deemed acceptable by the group. Student nurses learn how to learn in the clinical ward setting. According to Brookover, academic achievement is the implied outcome of positive learning environments. While the goals of the clinical experience for student nurses are to acquire the knowledge, attitudes, and skills related to the profession of nursing, this study did not link the description of the environment to learning outcomes. Any opinion expressed in the exemplars are incidental to the study, and reflect the experiences of the respondents and perhaps their intentions as certain teaching activities are implemented.

Interpersonal Relationships

It could be said that the ward represents a microcosm of society. Each person has roles and responsibilities to ensure smooth functioning of the ward. Recurring patterns of behaviour were evident and well-established, based on role expectations and temporal elements of the daily nursing care demands. In the social dimension of the clinical learning environment, the emphasis is on the relationships of the individual to the society of the ward at large, the people in it, and the way people relate to each other and function as a group.

In Chapter 2, the clinical instructors were described in some detail, and the staffing mix of the settings for the study was presented (pp. 45-46). Since the demographics of the learners have not yet been discussed, a brief overview of the group composition is presented in Table 4.4. Their characteristics are compared with recent statistics from two

local community college first year student groups (Vollman, 1985). Although the comparison group is small, and includes second year students (33%), the exercise is illuminative. Based on the demographic data of the two groups, it is apparent that the social composition of the group that took part in the research was not strikingly different from the composition of a larger sample of similar students.

Table 4.4
Characteristics of Students in the Study in Relation to a 1985 Reference Group

Characteristic		Present Investigation	1985 Reference Study
Sample size		24	143
Percent distribution by:			
i) Age	16-20	62.5	55.2
	21-25	20.8	24.5
	26-30	12.5	9.8
	>30	4.2	10.5
ii) Gender	Female	91.6	93.0
	Male	8.3	7.0

Three members of the group were from non-Caucasian ethnic groups, four students were married, and three were parents. One student held a post-graduate university degree, and four others were Registered Nursing Assistants who were upgrading their professional status to Registered Nurse.

Communication patterns and interpersonal relationships were primarily of the following types: student-student, student-nurse, student-patient, student-instructor, instructor-nurse, and instructor-head nurse. They will be discussed in that order for clarity, not necessarily indicating order of importance.

Student-Student Relationships

Students are randomly assigned to clinical spaces. Some students would know one another from previous rotations, laboratory, or classroom groups. Others might, because of the nature of their programme (RNA upgrade, self-directed), have no previous acquaintance with any member of the clinical group. Seeing at least one familiar face the first day made them feel more comfortable. As they waited in the foyer for their instructor to arrive, their attempts to create a social order were noted. First, they wanted to reassure themselves they were indeed in the correct meeting place. Then, they made certain that they had the proper apparel ("We were supposed to bring uniforms, right?") and writing material ("Would you hold my bag? I have to go down to that shop and see if I can buy a pen. I forgot to bring one."). As newcomers arrived they were greeted by those already there. Nobody introduced them to the rest of the group. They related to the people with whom they were familiar. They waited quietly for the instructor to arrive. There was very little conversation.

As the orientation process proceeded, students got to know a little about one another through activities which the instructor had planned. These activities and their intents were discussed in detail in the previous chapter. After a few weeks on the ward, subgroups began to form. Those students assigned to the same floor spent more time together, going to coffee, helping each other with their care, comparing notes about patients and buddy nurses. Shared experiences solidified relationships, such as pairs of students rotating to the case room for their observation experiences. Events such as rotating out of the group for an operating room experience hindered the social processes. Distance also affected the process; the students assigned to the pavilion or the antepartum wing, for example, were often socially isolated from their peers. Proximity fostered social relationships. Those students assigned to the nursery at East General developed firm connections because of their close association within the physical setting.

As the students interacted for a period of time, a feeling of closeness developed. Instructors termed this "the group coming together". Evidence of this cohesiveness was that students did favours for one another, and the atmosphere at group meetings was cooperative in nature when administrative and assignment problems were discussed. A spokesperson, someone who would listen to the students' thoughts and ideas and not be afraid to raise them with the instructor, came to the fore in each group.

Cliques formed after students became better acquainted. Cliques can be positive, or they can be negative. There was no apparent tension or hostility among the subgroups which formed, but their behaviours, as they affected the group as a whole, were noted by the others.

One such clique that formed in each group included the top students in that group; the two or three who were exceeding academic and clinical objectives tended to spend time together. In this way, they were positive in orientation and the students involved challenged and assisted each other to greater achievement.

Another type of clique, which formed in only one of the three groups in the study, found the three weakest students banded together. In this instance, rather than assisting each other, they spent their time comparing how poorly they were doing and finding scapegoats to blame. This subgroup provided alternate norms from the group as a whole, and the instructor found their presence disruptive to the work of the group. The students involved, however, felt protected, that they were with people who were like themselves and in the same circumstances. Their conversations centred on the promotions committee of the college, contracts, and extensions. A student who was suffering no academic difficulty would not have had to experience these ordeals.

Student-Staff Nurse Relationships

Relationships with staff centred primarily on patient care needs and were temporal in nature. In the morning, students would gather information on their assigned patients and listen to report. Following the report of the nurses from the previous shift, students would gather with their buddy nurse (the staff nurse with whom they were co-assigned for patient care) to plan their day. At this time a process of social negotiation would occur. The student would be told what the care needs were and how to report what was happening with the patient to the staff nurse. The student would let the nurse know what she was able to do independently and for what skills she needed supervision. The instructor then entered the exchange and plans would be made to supervise the care. For the most part, once trust had been established, the student went off on her own to plan and implement her nursing care. In the following exemplar, the process is explained from the point of view of the staff nurse.

> *The instructor usually goes over their patients with them, but then, just as a reassurance, I guess, we go over again exactly what they should look for and what's to be done ... sometimes they are not always sure. Maybe they haven't listened maybe well enough, for whatever reason, but just so that you know at least you've told them what they're to do. [I tell them] exactly what they're supposed to do for that patient through the day. Vital signs, what signs to look for, what tests they are going for, what in fact [I] will be covering while they are looking after this patient. Their medications, what they can and cannot give. They cannot put medications into the intravenous. They give insulin. They cannot do nonstress test of course, so we do that.*
>
> L.E., L11

Trust was introduced in the previous section on the personal dimension as a need expressed by the students in the study. The establishment of trust between the student and the staff nurse was found to be a complex and student-directed activity. Arpin (1981) terms it "setting the stage". By the questions the students asked the staff nurse, and the confidence exuded by the student through nonverbal cues, the staff nurse developed a sense of whether the student "knew her way around". The staff nurse supplemented her

judgment by asking for feedback from other nurses or the instructor if she was uncertain of her assessment.

A student reflects on the development of trust:

> *My nurse was not around as much today. I worked with her yesterday too, with the same patients. I guess she trusts me a bit more since I did OK yesterday. You have to prove yourself to the grads.*
>
> (U.A.) Field Note

A staff nurse perspective follows:

> *These patients are in my care. They are my total responsibility. If I let the student take care of them, I want to know she is not going to do something stupid. If I think she is weak, or just doesn't care, I watch her like a hawk. Once I see she can do OK, I leave her alone more. That's why I like to have the same student two days in a row.*
>
> N.R., L153

The activities of the ward took place between discrete blocks of time throughout the day. The first block was from report to coffee break. By break, certain care activities should have taken place and the nurse wanted a report before the student left. It was the student's responsibility to find her nurse and give report. Nurses found it irresponsible for students to leave the floor without reporting, even if everything was within normal limits.

The second block of time was from coffee to lunch. Since this was a reasonably "slow" time in terms of patient care needs, less formal interaction was most likely to take place during this time frame. Most activities related to teaching (bathing, breast feeding, etc.) and nurses often gave hints and resources to students. Again they expected to be kept informed of progress before students left the ward for lunch. The nurses, on the other hand, did not accord students the courtesy of informing them when they left the ward. This lack of reciprocity was a recurring theme in the student-staff nurse relationship:

> *My patient was back from the case room. I did my check and then I went to tell my nurse. I looked all over until someone told me she had left early for lunch. So I told the head nurse.*
>
> (U.A.) Field Note

From lunch to the time they left the ward for post-conference, they continued their care activities. It was at this time the buddy nurse checked that the student had charted appropriately and that all necessary care activities had been done. If things were incomplete and left for the staff nurse to finish, she wanted to know so that she could plan the remainder of her shift. The staff nurses "picked up" the students' patients when they left the ward for the day because students took their leave before the shift was over for staff.

> *Students are supposed to give us report before they leave. Sometimes you have to run after them. Sometimes they forget to tell you something isn't going well or something they haven't done until they are leaving and then it sort of compounds my afternoon load.*
>
> L.E., L44

It was very rare that a student would socialize with the nurses off the ward. While the nurse would remind the student it was break time, it was not an invitation to join the nursing staff. Interestingly, it was well into the rotation before students realized how to confirm coffee and break times. On one ward it was written on a board, on another it was on the assignment sheet.

> *Sometimes I find the students a little "familiar", calling nurses by their first name, shouting down the hall, not letting the nurses sit at report.*
>
> (J.L.) Field Note

> *Students don't go for coffee with the grads. Occasionally a pushy one will be aggressive and sit down with us. I find it a bit out of line.*
>
> (J.L.) Field Note

At times students found it difficult to locate their buddy nurse because the assignment sheet would have only a first name, and often the nurses would neglect to wear their name tags.

> *You sometimes don't catch the name when it is said, and it's, I don't know, you feel kind of stupid. You don't want to go around saying "Hey you." It's embarrassing. It would help if they wore their name tags. We do.*
>
> H.C., L17

Students noted differences in the way each of the head nurses handled the introductions in the mornings.

On MAT2 we are just told who we are with, and you peer around trying to figure out who's who.

Round Table

The head nurse here (MAT1) introduces everybody face to face before report even starts, and says who our patients are. If anything special is going on, like maybe we are leaving early or are going to rounds, she reads it off the paper.

Round Table

Student-Patient Relationships

Patients were very important to the students and formed a part of their social environment.

The patient and I got acquainted very nicely, and she made me feel really good for helping her. She told Sara that she found me so helpful and pleasant. Actually it was the patient who was being so helpful and pleasant.

U.O., Notes

When a patient was critical of a student, or uncooperative, the situation was difficult for the student to deal with.

Student upset. Says patient does not like her and won't let her do the assessment. After some discussion, Errin went into the room to see what was happening. Apparently, the patient, a 38 year old woman who had delivered her fifth child late last night was not amused by the student waking her and wanting to do the assessment.

Field Note

For the most part, the relationship was positive. Students were grateful that the families allowed them to share in the birthing experience.

Patients received shamrocks on their trays this morning. Many of them gave them to their student nurse. Students are proudly wearing them pinned to their uniforms.

Field Note

In turn, patients were pleased to have students. One student received a thank you card, another had her name included in the birth announcement in the local paper, and a third received a gift-wrapped box of chocolates from her patient's husband.

I spoke to several of the patients to find out what they felt about having student nurses assigned to them. They reported appreciation for the little "extras" the student did for which the staff nurse did not have time. "It is like having a private nurse." The allegation that student care delivery was not as efficient as that delivered by the nurse was met with the reply "That's O.K., I'm not going anywhere!" Patients were not worried about student competence because they were aware the student was supervised. They preferred the student to be introduced to them by either the staff nurse or the instructor. They felt this would increase their confidence that the staff nurse and instructor were indeed present. None felt the student was an intrusion. In fact, one woman stated:

> *This is my third baby. Seeing the student experiencing her first delivery was like reliving my first. She made this so special for my husband and myself. Just think, she will probably remember this experience all her life. I was happy to give her something in exchange for all the help she gave me.*
>
> Field Note

Student-Instructor Relationships

Communication and relationships with their clinical instructor were central to the students' clinical experiences. Instructors viewed students as the key determinant of their teaching activities. The establishment of a relationship with each student as well as with the group was the focus of many of the instructors' interactions.

> *If I can find out what turns her on I can motivate her. Right now, she's cruising. She won't pass if she doesn't pick up.*
>
> (Errin) Field Note

Students and instructors had regular conversations relating to the daily assignment. Students were quizzed when medications were given and provided assistance by the instructor when new procedures were carried out. Much of the communication was pedagogical in nature. With eight students to supervise, the reader can appreciate the time factor involved in developing relationships with students. In addition, instructors felt that

friendship would interfere with the ability to teach and evaluate. On the other hand, a knowledge of the student as a person developed trust and an understanding of the external life the student lived and how it was impacting on the learning situation. Instructors expressed this as a delicate balancing act between the job and relationships. Whether they focused on the task at hand or the student herself depended on the situation and the student's need at the time.

Students communicated with their instructors through a system called anecdotal recording. In these records a student reflected on his/her day. These reflections could be specifically directed (for example if a student did not know the peak times of insulin, he or she could be requested to write it up in the anecdotes) or very free-flowing (like a diary). The style depended on the student. Students wrote these notes after clinical experiences and submitted them to the instructor later in the week. The instructor reviewed them, made written comments on them, and returned them prior to the next clinical day.

In addition to these records, instructors kept personal anecdotes of the students' performances, primarily for evaluation and planning purposes. Students who were doing poorly and who lacked insight into their performance deficits were occasionally given copies of these records during conference with the instructor.

Counselling sessions were planned into the student timetables. Whether or not they took advantage of instructor availability at these times was a function of their perception of need (academic help or personal matters requiring advice) or of instructor initiation ("Come and see me Thursday noon. We need to discuss this.") Although these sessions were outside of clinical hours, they were directly related to the clinical setting in terms of preparing for it, doing the clinical assignments, or dealt with issues that were affecting their ability to perform to their potential.

Teachers generally took their breaks with other instructors or the staff, not including students in this group. When students and instructors were together at break, it was usually a single instructor with a few of her students. When a student was alone and

an instructor entered the cafeteria by herself, she might join the student. If the instructor was at a table alone, the students felt free to ask to join her. They did express some wariness, however, if they felt they had been rebuffed by past instructors. If, on the other hand, the instructor was with staff, students did not feel free to accompany them. Teachers, too, had their preferences and rationale for whom they chose to accompany on breaks. ("To be quite honest, I prefer to sit with another instructor or with students than with staff." Nathalie.) Interestingly, if the instructor and researcher were alone together, students felt quite welcome to join them.

Instructor-Staff Nurse Relationships

Instructor relationships with staff were most intense during the orientation period when the instructor was becoming familiar with the ward and the care routines. During the time students were on the ward, patterns of communication revolved around discussing assignments and negotiating supervision of student caregiving activities. Most interactions were instructor-initiated. Staff rarely initiated interactions unless there were problems to be resolved, or opportunities that were coming up of which the student might be able to take advantage. Instructors occasionally asked for advice about which patients to assign to the students and at times requested information about how a student performed, but these interactions were not regular enough to form a pattern. Sara said that seeking advice about patients depended on which nurse was on duty. Some nurses gave advice freely, others reluctantly. Errin said she could read the kardex and decide for herself which patients were suitable. As Nathalie (from the pilot study) said: "The most dreaded phrase I hear from nurses is 'Have I got a patient for your students!'. This is often a difficult or complex patient who is just not suitable for this level of student."

The history an instructor has with the ward affects the character of communications with the staff nurses. For the two new instructors, they had not been assigned to the ward

prior to this rotation and were in the process of building relationships and establishing credibility. For Sara, who had a longstanding relationship with West City Hospital and who had many previous students working as staff nurses in the agency, was maintaining relationships that had endured many years and many roles. Nathalie had taught on the ward included in the pilot study for several semesters, had established her reputation, and related to staff based on this framework of shared history and mutual respect. She says:

> *You have to recognize each other's expertise. They know more than I do but I have to be comfortable and say, "Would you show me" because I will have to teach the students. You can't be a know-it-all. I can help, too. Like I teach on other floors, and when I come here and a patient has a medical condition I can help them understand the consequences of drugs they don't see so often, for example.*
>
> Nathalie, L1383

Instructor-Head Nurse Relationships

Head nurses relate to instructors primarily in an administrative sense, keeping the ward running smoothly. Since they are not often at the bedside they do not involve themselves as closely in caregiving activities. By conducting their rounds, however, they observe student practices that they bring to the attention of the instructor from time to time. Most often these conversations take place informally at coffee breaks. They see their main role as ensuring the instructor is given an adequate orientation to the practices and procedures on the ward so that students will be informed and will give quality care.

Head nurses rarely had occasion to relate to students. Their relationship was primarily with the instructor whom they viewed as a peer. Any interaction with students was incidental.

> *Occasionally the instructor will ask me which patients I think are suitable for students but I find this has happened less and less since I have been a head nurse. It happens more as a staff nurse. So I feel my opinion is rarely asked on which are the better patients for students.*
>
> Michelle, L4

Additionally, the head nurses felt that their administrative duties kept them from forming a relationship with students. As expert nurses in their fields, they expressed a desire to become more involved with educating students.

> *I find that I have very little interaction with the students during the day. Occasionally they will ask me something because I am the person at the desk at the time, but that's about as intense as it gets. I would like to have time to spend with the students but this ward is so busy. I am interested in teaching. I would like to be able to sit down and give short classes myself, but I just don't have the time.*
>
> Michelle, L22

Norms and Expectations

Implicit in the previous discussion about communication patterns and interpersonal relationships were norms and expectations of appropriate behaviour for the participants in the clinical setting. Utilizing the "topic of the day" strategy, as outlined in Chapter 2 (p. 61), participants were asked "What do you expect from the [staff nurse, instructor, student, head nurse]?" the following memo was written to outline the prevalent norms of the ward:

> *Instructors will prepare the student assignments.*
> *Head nurse will link student with staff nurse.*
> *Staff nurse will give information and direction to the student.*
> *Student will report frequently to the staff nurse.*
> *Staff nurse will inform instructor and student of interesting skills planned.*
> *Teacher will supervise as much of the student work as she possibly can.*
> *Staff nurse will help with supervision if necessary.*
> *Patient safety is the foremost concern of all.*
>
> Journal Note

The characteristics of the clinical setting affected the perception of the social dimension. For example, there was some tension between the nurses on the two wards at West City Hospital. By policy relating to the combined care system, all infants were to be out to the floor by 0900. Because of the proximity of MAT2 to the nursery, this was a

relatively easy task. Due to the greater distance between MAT1 and the nursery, ward staff did not get there "early enough" in the opinion of the nursery staff. Often they had to be paged to complete the baby assessments and get the infant out to the mother.

In addition, because West City was in the process of phasing out Registered Nursing Assistant (RNA) staff, certain tensions were created as students, staff nurses, and RNAs worked together. Students found the differences in levels of staffing confusing as it appeared to them, on the surface at least, that all staff were doing the same things. In actual fact, Registered Nurse staff provided primary care when the patient was immediately post-delivery, monitored intravenous therapy, dispensed medications, and initiated all teaching. RNA staff cared for the more stable patients and reinforced teaching activities. RN and RNA staff covered each other's patients during breaks. Students often did not know to whom they should be reporting, especially since the staff did not take the time to clarify roles.

Furthermore, the tendency not to wear name tags made it doubly difficult for the student. Many of the RNA staff had worked in the area for years and were very capable. They were sensitive to "only" being RNAs having to deal with RN nursing students. The relationship was made more complex because of the agency policy to phase out RNA staff. Few people were willing to discuss the issue openly, and it became a factor in the general morale of the ward.

How can I help with a student, Sara? I am only an RNA.

Your students aren't very bright. Even an RNA knows how to do that.
Sara, L140

At East General, patterns of social interaction were in the process of change since combined care was being implemented. Nursery staff were being oriented to the floor and vice versa. The stress of learning an additional role caused some tension which was noted by students and instructors alike.

As the instructors experienced the social dimension of the clinical learning

environment, they became aware of the patterns of communication and interpersonal relationships, and utilized this knowledge to ensure positive learning experiences for their students. How this dimension was influenced by instructor activities is discussed in the next chapter.

The social dimension is linked closely to, but is different from, the personal dimension. The social dimension is dependent upon interpersonal relationships and the communication activities these relationships require. As the students and instructors practised in the clinical milieu they interacted with each other and the ward staff. As the data were analyzed, patterns and characteristics of these activities became evident. Behaviours were governed by certain rules (norms which defined appropriate behaviour) and expectations. The implicit rules for conducting certain activities included common practice, job descriptions, roles, unwritten policies, and personal preferences of the participants.

In the next section the dimensions of the clinical learning environment that are further removed from the immediate experience of the student, yet pervade all of his or her activities in a less direct manner, are discussed. The curricular and contextual dimensions are most notable in terms of their impact on the instructor.

4.2.4 Curricular Dimension

According to Schein (1972), professional knowledge consists of three elements; basic sciences, applied science, and the skills and attitudes that distinguish members of the profession from others. Nursing borrows heavily from the natural and social sciences and applies principles and theories derived from nursing science to the clinical act, the skills and attitudes that characterize the performance of nursing service.

The curriculum indicates what it is the student must learn to be a nurse. Inherent in the determination of the content of the programme are the goals. Goals reflect what is

valued by the profession and the educational institution. In the instance of North College, the motto "More than an education" was indicative of their commitment to the broad nature of professional education. Not only were North College nursing students offered courses in their professional specialty, they studied mandatory courses in English and philosophy. In addition, the college prided itself on its small size and ability to monitor student progress and provide personal counselling when necessary. Goals determine why the subject matter is important to be learned. Instructional plans indicate how to facilitate learning. The teaching process itself results in student learning. The evaluation process monitors progress and achievement. The teaching process itself, in terms of what functions and roles the instructors performed was presented in the previous chapter. In this section, the definition and description of the curricular dimension of the clinical learning environment is presented.

Table 4.5
The Curricular Dimension of the Clinical Learning Environment

Parameters for Inclusion in the Curricular Dimension of the Model
The nursing model
The nursing course design
The clinical objectives
The implicit curriculum and professional socialization

The curriculum is commonly conceived as a guide to instructional planning. Curriculum development took place at committee level and individual instructors rarely saw more than the final product - the course outline and evaluation guide. The nursing programme was divided into several courses which have classroom, laboratory, and clinical components. Each component had specific learning objectives relating to the

cognitive, affective, and psychomotor domains of learning. This study focused on the clinical component and its curricular objectives.

Nursing curricula are organized around an explicit conceptual model of nursing. The professional practice of nursing is based on scientific knowledge. This knowledge is applied from other disciplines, and also developed from nursing research. This base of knowledge has substantially shaped the nursing perspective and has guided educational programmes, research, and professional practice. It is focused on the elaboration of the relationship between the person and the environment in relation to health. The time between Florence Nightingale's nineteenth century statement on nursing to the contemporary nursing theories has been characterized by many social changes. All theorists, however, address the same basic concepts; person, environment, health, and nursing.

For ease of organization and presentation of the subject matter to the students, colleges have, for the most part, chosen one specific theory on which to base their entire curriculum. Health care agencies, however, practice from a more pluralistic perspective, often without a specific espoused theoretical framework. MacFarlane (1971) described nursing practice as atheoretical and task oriented. The notion of using explicit nursing theory is recent and adoption in clinical settings is proceeding slowly.

The differences between nursing as it is practised in the absence of an espoused theory and the way in which nursing is learned in the presence of a specific model was noted by students and nursing staff alike. The concepts of the model were foreign to those nurses who had been educated in the traditional manner. Traditionally, assessment and physical examination of the patient progressed from the top of the body toward the bottom.

> *Students don't follow a head to toe system. I have to teach them that. They wander all over when they assess, and try to fit it into their own model It doesn't have to be so complicated.*
>
> (E.S.) Field Note

Traditionally, the analytical part of assessment was carried out through the scientific method, which has been revised and renamed the nursing process. Through this process the plan of care is written. Because students used a particular model, and the staff used a traditional method, often the students had difficulty writing in the chart in words the staff found acceptable.

> *The hardest thing is the care plan. Now I know what to do, but I have to figure out what it means. This model is driving me crazy. Thank goodness my buddy nurse helped me with my charting today. She made it seem so easy.*
>
> (A.R.) Field Note

Several staff nurses were South College graduates who were cognizant of the particular model in use by the students. When asked if she used this knowledge to enhance student learning, one staff nurse replied:

> *I try to work in a holistic framework. I don't use the type of assessment I was taught. I don't use the model terminology, at least not consciously.*
>
> N.S., L189

The curriculum seemed remote to the students. They more or less passively accepted the organization of the programme. Any discussion of curriculum with students focused on the nursing model and how difficult (or easy) it was to learn and put into practice. In order to learn the theory and the attendant nursing process (clinical decision making), students were required to produce written work in the form of nursing care plans. There were no end of complaints about these assignments! Students understood the requirements of the course and actively sought the experiences they need to meet the objectives.

> *E.A. looked a little down to me this morning. Sara had promised her a particular kind of patient but then she ended up with another. As she left for the day, the student said to Sara, "Tomorrow a patient with [diagnosis]. Promise?" Sara said "I'll try." "Not good enough" replied E.A., "Promise. If there is one, I get her." "OK" Sara agreed.*
>
> Field Note

The curricular dimension was more pertinent to the practice of the instructor than

the student. When questioned about motives or decisions relating to students and their activities, the objectives of the experience were always in mind. In addition, instructors were aware of the previous semester's objectives and at what level the students would be expected to perform in the next semester.

The curriculum, the way in which the course is taught, and the theoretical model of nursing used to organize nursing knowledge, all have an effect on the clinical learning environment.

In addition to the explicit curriculum mandated by the college and the governing professional bodies, there is an implicit curriculum. This implicit curriculum has been termed the "hidden curriculum" (Bell, 1984; Gordon, 1982; Partridge, 1983) and refers primarily to the professional socialization process.

Professional socialization is the complex process by which a person acquires the knowledge, skills, and sense of occupational identity that are characteristic of a member of that profession. It involves the internalization of the values and norms of the group into the person's behaviour and conception (Jacox, 1973). Nursing students reportedly learned to behave in the ways the people with whom they interacted and who were important to them expected them to behave. These people were the nursing faculty, their clinical instructor in particular, and the ward staff.

As students moved through their programme, the importance of their instructors and the nurses varied. The first year students in the study identified the clinical instructor as the most important person to their clinical learning.

Interestingly, the second year students in the study showed evidence of role conflict, experiencing difficulty in determining who was most important to their acquisition of clinical skill.

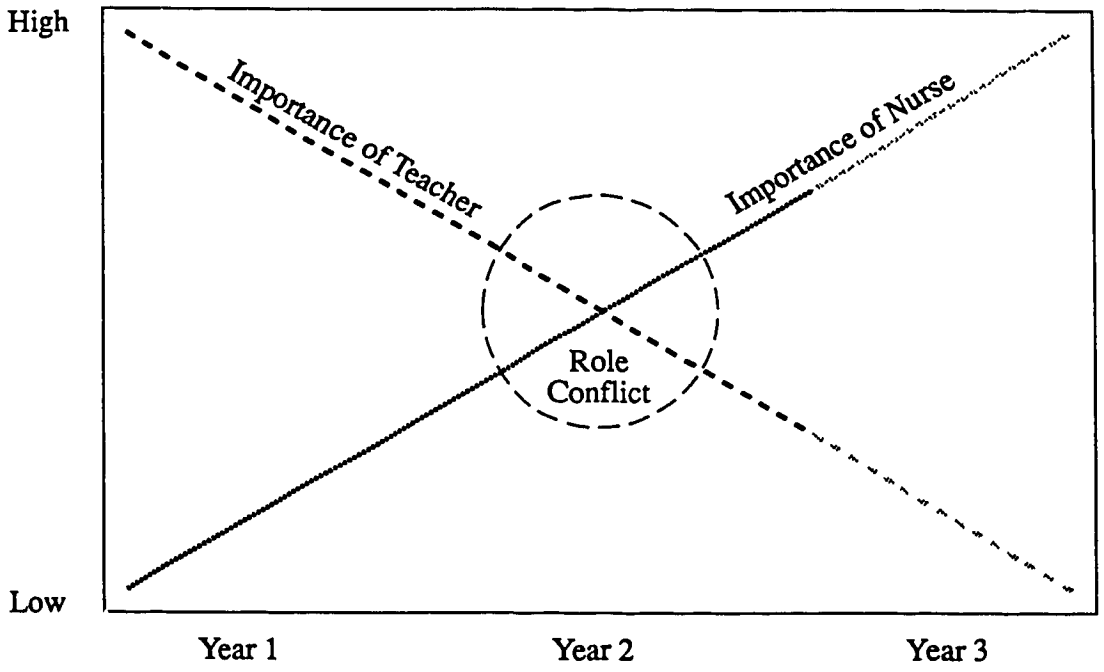
As data analysis proceeded, I speculated about how third year nurses would respond. I could infer from the literature on professional socialization that as the skills and independence of the student increased and the closer to graduation the student was, the

more he or she would begin to identify with the staff nurse, and the less the student would identify with the instructor.

I returned to the pilot study data and sought verification or disconfirmation of this speculative exercise. I was able to confirm that indeed this process seemed to be happening, but was not able to go beyond a superficial analysis because the questions asked and the nature of observations differed between the pilot and the primary study.

This process is illustrated in Figure 4.6 as one possible depiction of the role conflict that was apparent in the behaviour of the second year students who participated in the study.

Figure 4.6
An Illustration of a Process of Professional Socialization



When I ask a first year student whose advice she would take should she receive conflicting but equally correct instructions from her instructor and her buddy, without hesitation, she answers "My teacher." Her reason is that the instructor knows best what the student has been taught and how. The instructor is the expert. When I asked a similar question of a third year student (pilot) I heard "my staff nurse. She

knows the patient and she is the expert on this floor." The interesting answers came from second year students. They frequently reported a great deal of difficulty deciding whose advice to follow. In the end they would choose the instructor "because she evaluates me."

Memo

Professional socialization is undeniably a part of the educational process that is not made explicit in the curriculum. It represents a movement in the self-identification of the nursing student from learner to nurse, and indicates a readiness to accept the role and responsibility of a practitioner of the profession.

The curricular dimension affected the student less directly than the central dimensions (personal, physical, social) but provided the organizational structure for the presentation of the course subject matter and clinical learning objectives. Learning occurs as a result of the explicit as well as the implicit curriculum. Student nurses learned to nurse (perform the clinical acts) and to be a nurse (act and think like a professional nurse).

Because of the influence of the curriculum on what is learned in the clinical milieu, it is a dimension which cannot be disregarded. How the instructor implemented the curriculum and chose her instructional activities was discussed in the previous chapter.

4.2.5 Contextual Dimension

The contextual dimension of the clinical learning environment was defined, for the purposes of this study, as the ethnicity and language of the environment and to the organizational characteristics which form the cultures of the educational institution and the

Table 4.6
The Contextual Dimension of the Clinical Learning Environment

Parameters for Inclusion in the Contextual Dimension of the Model
Ethnicity
Language
Organizational culture
° Community College
° Health Care Agency

health care agency. In this city, there was not only a large francophone population, there was a substantial diplomatic and immigrant community. These factors were evident not only in the patient group but also in the student group and among the nursing staff. The context as a dimension of the clinical learning environment is discussed in this section.

Ethnicity

The ethnic composition of the patient population was an important factor to the instructor. Since textbooks are commonly standardized on the Caucasian population, the assignment of non-Caucasian patients or patients of other ethnic or religious groups to students provided an opportunity for nursing students to develop an appreciation for cultures and practices other than their own (e.g., diet, child care, family relationships) and to practice their techniques of physical assessment (e.g., cyanosis, jaundice, pallor) on patients not usually represented in textbooks.

The instructors reported a need for an understanding of the health practices and gender norms of various ethnic and religious groups. For example, certain religions forbid the care of women by male caregivers. Since some ten percent of the student group was male, this was an important factor in preparing student assignments. Occasionally, an error or misjudgment occurred which had ramification for all parties involved.

> *Only once did I not check the religion on the chart. Would you believe I assigned a male student! The woman's husband was horrified, the head nurse was furious, and the student embarrassed.*
>
> Errin, L943

> *I got burned once this term. A patient did not want a student. Period. The fact that the student was male was irrelevant. The patient was not cooperative, and on top of that the student would have had to work through a translator since she and the student did not speak the same language. Well, they both spoke a little French, but the woman kept saying she couldn't understand him. It just got too frustrating for everyone. I reassigned the student.*
>
> (Sara) Field Note

With respect to this particular incident the head nurse said:

> *It happens from time to time. Some patients don't want students. Very few patients compiain about anything, but the ones that do scream loud and clear!*
>
> Michelle, L429

There were positive learning experiences for students in other instances. The religious dietary restrictions of a particular patient needed to be considered when nutritional counselling was conducted by a student.

> *I did my teaching plan using the Food Guide and then Errin pointed out to me that the patient's religion did not allow her to eat some of the foods I wcs suggesting. When the dietician came to the ward, Errin asked her to talk to me and we changed my food suggestions. I am going to make a good copy so Errin can xerox it and give it to the other girls at conference tomorrow.*
>
> (T.K.) Field Note

Family patterns of care can differ among ethnic groups. In one family, the instructor cautioned a student to include the grandmother in the teaching session because she was the young mother's source of support in their particular culture.

> *The old grandma was always there. I was doing the bath demonstration and the mother wouldn't take part. She kept looking to the older lady. I finished up and then went to talk to Sara for suggestions an how to gei the old lady to leave. Her presence was obviously intimidating to the mother. It was her first baby and she had to learn to care for it. Was I wrong. Sara explained to me what might be going on. We checked it out with the interpreter. Sure enough. So I wrote it on the kardex because others felt the old woman was intruding. They didn't know she would be the mother's source of support at home.*
>
> (I.O.) Field Note

In addition to practices determined by their culture, people make life choices according to their religious, philosophical, or political beliefs that have an impact on their care (e.g., vegetarian, drug-free births). These choices were noted on the kardex and taken into consideration when the instructor assigned patients to students.

In the student group which participated in the research, three were non-Caucasian; one native Indian, one from the Philippines, and one black Canadian. Religious affiliation was not solicited.

Ethnicity is one parameter included in the definition and description of the contextual dimension. Language is another.

Language

Since East General was a bilingual (French-English) institution, charting and recording were carried out in either or both official languages. Students required a basic understanding of the second language in order to be able to function safely in this environment.

Additionally, the large diplomatic and ethnic community in the region served by the hospitals at times required knowledge of languages other than English or French. Few students had such a linguistic command and were required to work with translators to collect the data required for their assessments. It was interesting that students developed unique ways in which to foster the necessary communication and overcome the language obstacles:

> *E.E. got some index cards from her locker at break and drew pictures of care events (shower, pericare, baby feeding). She got the interpreter to write some words on them in Arabic. It worked great! The head nurse kept the cards when the patient was discharged. For a rainy day, she said.*
>
> (Errin) Field Note

There were two notable cases during the course of the investigation. One involved a deaf-mute antepartum patient, and the other a blind mother with her seeing-eye guide dog. This was "language" of a different sort. With the assistance of staff, students were able to communicate well enough to provide care to the patients.

> *I was scared at first, but then the nurse told me she could lip read and to always speak slowly and make sure she could see me before I said anything. The patient was really kind and helpful. She made it easy for me.*
>
> A.W., L15

Organizational Culture

Marsick (1987) states that "the culture of the organization can take on the character of a third partner because perception or misperception sets the tone for decisions, maintenance or breaking of norms, and ability to use the environment for learning."

Organizationally, there were two cultures; the hospital and the college. Both the college and the hospital had autonomous identities. Their purposes were different; their missions differed. Sources of funding were from different ministries.

These organizational differences worked against the instructor in that the goals of the two organizations varied. In fact, they were at times in conflict. It has been demonstrated in previous sections that staff nurses felt little "ownership" of students and were, therefore, minimally committed to their education. Staff nurses cared for the patients, students were there to learn.

> *I think one has to remember that the nursing instructors know the ability of their students better than the head nurse or staff nurse does. There's been some occasions when I wondered whether that patient should have been assigned to that student. But the instructor is in charge. They know whether their student is good whether she is ready to go ahead with something more difficult. Perhaps they are doing it because they feel the student needs a challenge. Would it be presumptuous to say something? Probably, but I'd say it if I felt strongly enough. If patient care was affected.*
>
> Michelle, L48

The climate or culture was assessed by the instructors in terms of morale and how amenable the staff were to students. Each ward was notably different in its "atmosphere" and its reception of students and instructors.

> *In the nursery the first day I was here I wasn't sure if we were supposed to chart in blue or black pen. I asked a nurse and she just looked at me and walked out of the room. It did not give me a good impression. I was thinking, "My goodness, the nurses here are not very friendly to students!"*
>
> T.E., L142

The changes in place with respect to organization of care caused a certain amount of

tension within the organization which in turn affected the instructor and students.

> *They just would ignore the students. When combined care was established in the fall, all staff were really upset. They were going through a crisis situation. "We are not interested in the students right now," they told me. "We're really upset about combined care. We cannot handle anything else."*
>
> Sara, L371

The head nurse denied any problem.

> *I don't think the students notice much about combined care. Students were actually the first ones who ever did combined care around here. Students were coming on the ward and on the first day they would look after the mother. On the second day they would look after the mother and the baby together. I don't think that this lot of students realize there is any other way to do maternity care.*
>
> Michelle, L169

In terms of the college culture, the characteristics of the teaching group and the amount of personal as well as professional support the instructors felt from their course leaders and programme administration determined their perception of the climate or "atmosphere".

> *Our chairman does things by paper messages all the time. Sometimes for example, I just had a notice on my annual leave, and I had 4 memos to deal with a simple request. Couldn't the chairman just stop me in the hall? Or pop into my office? If administration spoke to teachers they might learn something about them.*
>
> Sara, L1180

The reward orientation of the college affected the instructors:

> *There isn't anything at the college for which teachers get rewarded. After you get your maximum salary, which most of the teachers do, there's little reason.*
>
> Sara, L1398

In fact, there was little association with the college and other disciplines. Nursing was in a building by itself and, other than service courses, there was little reported interaction among faculties. The two new instructors attended college-wide orientation activities, but once the academic year began, retained little contact with people they had met during these activities.

This observation was made by the students as well:

> *We don't blend in with the other students at all. Very few of us go to college activities, we just stay with nurses.*
>
> Round table

Since teaching was done in teams, no instructor had complete autonomy over the course. Course work was divided among instructors, and each instructor had a finite amount of time to cover his or her content area. The same was true of clinical work. Certain assignments and subject matter, decided by the team, had to be covered in clinical. This restricted the creative use of time by instructors in the clinical agency.

In addition, working conditions affected their perception of the college milieu. Offices, provision of lounge areas, secretarial support, and determination of workload were concerns expressed by the instructors. The amount of freedom allowed to set their own schedules, work at home, or take days to do library work was important in feelings of autonomy at work.

I have definitionally separated the social and contextual dimensions of the clinical learning environment. The data in this study warrant the restriction of the definition of the social dimension to the work group, specifically the students, instructors, and their interactions with others which relate to learning on the ward. Since the group's work is learning, the definition is appropriate.

In contrast, the contextual dimension relates to organizational culture and its affect on the group, and also includes cultural matters (language and ethnic composition) related the people who populate the setting. In the next section, the political dimension of the clinical learning environment is presented.

4.2.6 Political Dimension

The political dimension of the clinical learning environment refers to the policies of

the educational institution and the health care agency which serve as guides to the instructors, students, and practitioners in the clinical field. Policies serve to provide predictability and stability and assist members of the setting to cope with complexity in the environment. A second aspect of this dimension is the type and nature of control of professional practice and learning that is exercised in the clinical field, that is, the process and jurisdiction of decision-making.

Table 4.7
The Political Dimension of the Clinical Learning Environment

Parameters for Inclusion in the Political Dimension of the Model
Policies and procedures which govern the implementation of the teaching programme in the clinical agency.
Process and jurisdiction of decision making in both college and hospital.

Colleges, universities, and continuing educational programmes compete with one other for clinical spaces in which students can be placed for actual practice experience. To ensure equitable access for all programmes, all aspects of the placement process are governed by policies and procedures.

To gain access to a health care agency in the city, programmes must request placement from the Clinical Resources Committee, a standing committee of the local Council of Nurse Executives. The mandate of this committee is to ensure the equitable placement of learners throughout the region. Members of the Clinical Resources Committee represent the nursing education programmes and together collaboratively allocate clinical placements based on a simple set of rules governing priority of access. This process is conducted in the spring for the following academic year (Mellon & Dunn, 1988).

Once access has been granted, contractual arrangements are negotiated between the

educational institution and the health care agency. I was unable to obtain a hard copy of this contract, but I was able to read one. In the main, the college agrees to send only qualified faculty and provide adequate insurance, and the hospital agrees to provide access to specific clinical areas, orientation for faculty, lockers, conference rooms, and cafeteria privileges. Much of this negotiation goes on at an organizational level above the clinical instructor and head nurse.

The remainder of the discussion of the political dimension of the clinical learning environment focuses on the ward level where students, instructors, and staff closely interact. I will discuss first the agency political dimension, and then the college policies and procedures.

Hospital Policies and Procedures

The nursing divisions of each of the hospitals used in this investigation had general policies relating to their educational function as it pertained to nursing students.

West City Policy Manual, Objectives for the Nursing Divisions read:

> *11. Provide a learning experience, clinical resources, and guidance for students in the health care system.*

East General Policy and Procedure Manual, Department of Nursing, Obstetrics Unit reads:

> *5. To provide an educational programme for graduate nurses, students and other appropriate health personnel.*

Clearly, the objectives of the Nursing Divisions of both hospitals stated their positions about nursing education. In addition, both hospital mission statements reflected a commitment to education.

Both hospitals had had a nursing school in years past, West City's being most recently moved to the community college system. Many of its RN and RNA faculty had

been absorbed directly by the college. As a result, many of the instructors teaching for the college were City graduates, educated under the former hospital system. Accordingly, West City's procedures were often seen as the norm, and alternative ways of doing things were not always readily received. One non-City graduate nurse termed it "the City way or the wrong way".

In both agencies, there were procedure manuals which outlined the steps to be taken in carrying out nursing acts. Few references were made to independent student action with respect to these acts. In one instance, I could find no basis in fact (policy of the hospital or school) for the comment from a staff nurse that "Students are not allowed to work with the machines." This "rule" was not stated in any official notice.

The West City Director of Nursing Education indicated that the staff nurse had a responsibility to teach students and foster their learning and that it was part of the job description. That being so, few staff nurses remembered being given information with respect to their roles with students, their responsibilities in terms of shared patient care, or their relationships with clinical instructors.

> *I don't recall ever being given information about working with students. I was told the patients are my responsibility, no matter what.*
>
> E.S., L96

Logan (1989) indicates the lack of recollection may be due in part to information overload at the time of staff orientation. At this time, involvement with students was the least of the concerns of new staff, and any discussion which took place was likely promptly forgotten.

Additionally, instructors wished for more and better information with respect to their roles and responsibilities while in the clinical setting with students.

> *I have been kind of annoyed at times that there haven't been more instructor guidelines from the hospital, or more interest in the instructors and what is being done with students on the wards.*
>
> Sara, L2156

Certain practices were governed by policies from either the professional body (College of Nurses of Ontario) or provincial and federal legislation (Health Disciplines Act, Narcotic Control Act). The Standards of Practice from the provincial College of Nurses governed the skills students were expected to acquire by graduation. The Narcotic Control Act determined policies with respect to the handling of narcotics. For example, instructors, because they were not employees of the hospital, were not allowed to carry narcotic keys. When it was busy, however, nurses would give the keys to the instructor saying "I didn't see you with the keys!" In normal circumstances, the staff nurse would assist the student in removing the narcotic from the cupboard, then the instructor would take over.

Administration of medications is a nursing act which is covered by many policies, one of which is the extent of supervision. East General specifies that all intravenous and injectable medications were to be supervised to the bedside. No such policy was stated for West City.

Charting was also covered by policy. At East General, it was specified that the student was to sign and indicate her/his level and affiliation. There was no specification that instructors needed to sign the chart, but Nathalie (pilot study) made it a point to cosign the sheet to indicate she had assigned and supervised the student. In addition, there was no policy requiring the instructor to cosign narrative charting.

It was assumed that the instructor knew her students, their strengths and weaknesses, and would assign patients accordingly. There was no policy requiring her to ask the permission of the staff to assign certain patients, although the head nurses felt they could indicate when a patient would be inappropriate for student experience.

Since the agencies were teaching hospitals, patients signed consent forms for treatment by students, so permission to assign a student was never requested of patients. In the event of a patient complaint, instructors would decide, in consultation with staff, whether or not to change a student assignment.

The policy with respect to student assignments was that it had to be prepared before

report. In the case of East General, it was supposed to be prepared the day prior to clinical experience. Both first year instructors prepared the student assignments the day before, but Sara went in at 0530 the first day of each clinical week to prepare the assignment.

Decisional Jurisdiction

Students were supernumary to the staffing of the ward, so they were not considered in the workload distribution. Patients were assigned by student needs, not on the basis of a staff nurse's assignment. This created certain problems at times. For example, a student may have two patients, each coassigned with a different nurse. If one of the nurses is an RNA, the situation is further complicated by RNA supervision by an RN. The director of nursing education at West City stipulated that RN students should not be assigned to RNAs because "they have nothing to offer the student", but there was no official policy governing assignments.

The assignment of students sometime caused a power play between head nurse and clinical instructor.

> *Lil said to Sara "How come so many students on High Risk? You never use these patients, do you?" Sara replied "Yes. They do antenatal care. Students study toxemia and gestational diabetes in class. I need to assign these patients." Lil countered, "Well I assumed you were doing postpartum so I staff around that." Sara let the conversation drop there. At break, Sara elaborated. She has always assigned two students to antepartum and two to postpartum on MAT1. Today's assignment was not out of the ordinary. Students are not to be considered for staffing reasons. She and Lil have apparently discussed this issue on several occasions. Lil continues to raise this issue at times.*
>
> Field Note

The power play continued over time and affected instructional activities. While there was a recognition that quality of patient care must not suffer, time frames and their implications for patients were open to interpretation. The competing concerns of the instructor (to ensure learning) and the ward staff (to ensure nursing care) occasionally

caused jurisdictional overlaps as illustrated in the following exemplar.

> *Sara took me aside and said Lil had instructed a staff nurse to give insulin and not wait for the student to do it. It was 10 minutes past the due time, and there is a 30 minute leeway for meds. Lil insists the insulin has to be given exactly on time or the physicians get upset. Physiologically it is important. Sara feels she cannot let students go ahead and give it if they do not have adequate knowledge of gestational diabetes, blood values, insulin, etc. Lil said, "Tell the students to come to work early then, if it takes them so long to get ready." Sara was visibly upset. She says she will have to clear this up with Lil.*
>
> Field Note

The actual instruction and supervision of students is the responsibility of the clinical instructor, but she does delegate to the staff nurse. This delegation is covered by the job description of the staff nurse, but the methods of delegation, the preparation and the evaluation of student performance are at the discretion of the instructor or the initiation of the staff nurse. Most of the instructors in the study made it a practice to supervise all students for the first time they did any particular skill. Afterward, future supervision would be delegated as necessary. Rarely were staff nurses asked for feedback. Carr (1983) characterized the relationship between the instructor and staff nurse as a "shared partnership". The reciprocity in the partnership as it related to the teaching function was not as evident as it was in the caregiving function.

The staff nurses and clinical instructor shared decision making responsibility. The staff nurse, in consultation with the head nurse, was ultimately responsible for decisions related to care of the patient. The clinical instructor was responsible for student learning. Their primary concern was for patient safety.

Students were governed by policies determined by the college, some written and some set by the instructor. For example, students were expected to be on time for report, or to notify the instructor in advance if they would be delayed. If they had advance warning, the instructors were quite flexible. Additionally, the ward and instructor were to be notified prior to report if the student was ill and unable to come to the clinical area.

Instructors set individual standards for student practice as well. The following exemplar will illustrate:

> *I prepare the assignments the day before. It takes me almost two hours. Then the students telephone me at home between six and eight in the evening to receive their assignment. This way they can read up what they need, and prepare teaching plans and drug cards. O.A. didn't call me last night, then she was late this morning. I reminded her of her responsibility, and allowed her to continue with her assignment even though she had not been able to read up on the drugs or anything. I said I would cover her for it one day, but never again. I said I would send her home if she ever came to the ward unprepared again. Today she arrived on the ward. She had not called for her assignment. I sent her home.*
>
> (Errin) Field Note

Standards of dress were prepared by the hospitals and supplemented by the college. Uniform dress codes were in place and students were required to display college shoulder flashes and wear identification tags. There was restricted access to medical records and library by students, by written policy. Unwritten norms were that students would not be in uniform in patient care areas to which they were not assigned.

> *Errin and I attended a meeting on another ward. There, in the nursing station, was a student. The student was in uniform, and was asking for information about a relative. Errin drew the student aside and suggested that this was not proper. At conference the next day, students were reminded that they were not to be in uniform on other wards, and the group discussed ethical dilemmas which could arise in such situations.*
>
> Field Note

Many policies determined by the college respect the rights and responsibilities of the parties when a student is not successfully meeting the objectives for the clinical experience and the instructor is planning to recommend a failing grade. The instructor must document the student's performance on the clinical objectives and inform the student that there is a problem. She must discuss the areas of concern with the student. The instructor then may confer with the leader of the teaching team for recommendations for action on her part or on the part of the student. The next step is to recommend failure and take the student formally to the promotion and probation committee. Students have the right to attend these meetings

and bring a spokesperson. The decision to fail or not, to extend the length of clinical experience, or put the student on a specific learning contract is at the discretion of the committee.

In this discussion the political dimension of the clinical learning environment has been defined as the policies and procedures governing the implementation of the teaching programme in the clinical agency. The process and jurisdiction of decision making has been presented as one element of this dimension.

4.2.7 Economic Dimension

The economic dimension of the clinical learning environment relates to the adequacy of funding for the human, technical, and curriculum resources that are required to meet student learning needs. In Table 4.8 the scope of the parameters included in the definition of the economic dimension is outlined.

Table 4.8
The Economic Dimension of the Clinical Learning Environment

Parameters for Inclusion in the Social Dimension of the Model
Adequacy of funding for human, technical and curriculum resources.
Cost-effectiveness and containment measures.
Student expenses and income generation.

This is a particularly important dimension as one considers the percentage of GNP allocated to education and health care and the very real concerns over rising costs in these sectors. Many educational institutions are experiencing difficulty juggling higher costs and declining enrolments.

We work with the number game. We have to make so much money and each student costs so much. Sometimes when you're asking students to leave the programme it is related to the time of year. If we are down in numbers students are encouraged to stay. If we're not its much easier to ask poor students to leave.

Administration assumes certain levels of attrition from year to year and the hiring policies and the clinical service areas that we are going to are all dependent upon having certain numbers of students.

We have a quota that determines the monies funded from the province. Our student ratio for instructors in the laboratory and clinical area is low. Nursing is a very expensive programme compared to others. The college is allowed 110 or 112 in nursing and we might admit sometimes 117 to 122. If numbers dropped, instructors may be laid off. Then next year when numbers increase and administration ask for the monies returned, the dollars have gone to other programmes. Monies are not going into traditional programmes as much. Non-traditional types of programmes are more and more inclined to be funded.

Sara, L141

It has long been recognized that professional education, nursing in particular, is very expensive (Gilchrist, 1982). Nursing education administrators are faced with the challenge of justifying expenses and creating cost-effective teaching structures.

These cost factors affect students and instructors. Students are finding the costs of tuition and related expenses escalating annually. In order to meet these costs, many are forced to find part-time employment. At times commitment to work interferes with requirements for learning, particularly if clinical experiences are scheduled for evenings and weekends.

Economic factors have a tremendous influence on students. In fact, I had one student in my group who was having some difficulties. This student worked 30 hours a week to earn the money to support himself. He worked on the weekends and when we are assigned to weekend clinical days it presents a real hardship for him. He can't afford not to work but it's really cutting into his school time, preparation time, and so on. Plus when he's at clinical or in class, he's very tired. Parking is expensive for clinical experiences as well. The bus is also a problem if a student does not own a car and depends on transit. It isn't all that expensive, really, but on Sunday the bus service is very poor. My students are late coming to clinical even though they take the earliest bus they can. They come tearing up the hallways about 5 minutes late every Sunday and they feel really bad and it upsets them.

Errin, L409

The usual student in a nursing programme is no longer the graduate straight from high school, living at home, and funded by parents (Vollman, 1985). Nursing educators have recruited the "nontraditional" student into their programmes, and are now faced with more mature students who have needs that exceed those of the "traditional" student: e.g., day care, advance notice of schedules, and flexible hours.

> *I had to give up my job. I find that, as a single mother, my expenses are out of this world, but I need time with my children. I am dependent on my family now, but I will be able to work during the summer months to build up a nest egg. I'm not sleeping properly. My sister, who baby sits for me, is pregnant and due any time now. I pray she holds on until the end of the semester. And my son scratched his eye and I had to take him to emergency. That caused me to miss a day.*
>
> A.R., L417

The cost factor also affects the clinical instructor. As the nursing laboratory at the college becomes a more important strategy in nursing education because of cost-effective higher student-instructor ratios, the demand for adequate numbers, types, and quality of supplies in the lab increases.

> *We do not have enough of the tools we need for our simulated lab experiences. We don't have enough supplies. I think that the college money goes into people and not into equipment. We are suffering in that department. We can't teach nursing skills unless we have the appropriate tools. The students are being short-changed there.*
>
> Errin, L462

Instructors also require access to certain technology and pedagogical supplies. Photocopy expenses need to be covered and an adequate selection of textbooks supplied for instructors.

> *The students are poor. I'm concerned about them sometimes. They have to buy books and meet their expenses. Just see what they are eating for lunch! I often make sure they've got enough on their tray. If I find an article I'll give it to them and they can read it. Maybe I'll get them a photocopy from the school. I pay the 5 cents a copy (instead of them paying 10 cents).*
>
> Peggy, L1166

Professional associations and collective bargaining have had an effect on hours of work and remuneration. In this context, the clinical instructor must balance the demands of

the job and the effects it has on the student. For example, the work day has been reduced so that students do not complete an entire shift on the ward each day. At other times, once an instructor has worked the total number of hours allowed by contract, another instructor must continue with the students.

> *I felt quite fragmented last fall. I didn't really have any loyalties to either group. I was just a fill-in. It's like a substitute teacher in a classroom. How effective is your teaching when you're doing that? Going across four wards with a total of, over the semester, thirty-two students. That's a lot of people to get to know. I had the students for one day a week. I didn't get to know them personally, what their learning needs were, or how they learn or anything. I did not feel the same commitment either. I found I really had to force myself to prepare. And I didn't get into the ward routines because I was switching wards so often. All of that and two different student groups. It was a very stressful semester. So I was very happy in January to have my own group and be on wards that I could get to know.*
>
> Errin, L1406

Implementation of the collective agreement and how teachers are assigned their workloads affects continuity, learning, and job satisfaction. These conditions affect the ward as well, as ward staff struggle to understand the changing schedules and personnel.

> *We have three different programmes coming to the ward; university, college RN, and college RNA. In the off-season we have continuing education. And the perinatal course. We see so many students it is hard to remember who can do what! It is further complicated when the college sends the same instructor with different groups.*
>
> Lil, L46

Hospitals accrue certain costs by allowing students in the agencies: lockers, conference room space, equipment, and uniforms for specialty areas.

> *The hospital provides uniforms in the Nursery. The uniforms and the laundry cost the hospital a great deal of money.*
>
> Peggy, L1153

Hospitals are no less affected by cost effectiveness measures, most often in terms of containment of costs of materials used in providing nursing care.

> *Oh no, economics are not a real concern. No. You know, students are not really using any more supplies than nurses. I don't think they make a big difference to the budget. Its bad enough without them. $4000.00*

> *on Proctosedyl cream. Cost containment for students is a short-sighted policy. I might scream and shout if she opened six or eight trays, but, you know, if she is going to be a decent nurse tomorrow, she's got to learn today, hasn't she?*
>
> Michelle, L486

The reality of nursing service is that wards are often understaffed, or are staffed by many relief nurses who are not familiar with the ward to which they are assigned. Since students are co-assigned with staff nurses for patient care, the instructors in the study expressed dismay over the extent to which this was happening.

> *I try to co-assign students with ward staff as much as possible, or with the regular part time nurses. It is becoming more difficult. So I try to keep a closer eye on those students who do not have a regular staff person. I also make certain I speak to the relief people to explain what the student can do. These people are sometimes short-tempered with the students, but I'm certain most of it is related to their own insecurity with the ward. I do have to help the student understand. They do not know the staff well enough to pick out the ones that are not regulars.*
>
> Errin, L473

When staff were under the stress such working conditions inevitably cause, they were neither as patient with the students nor as understanding of their needs for warmth, welcome, and support. Instructors were occasionally called upon to explain staff actions and concerns to students who reported anxiety and hurt feelings.

The economic dimension of the learning environment was found to be important to instructors, head nurses, staff nurses, and students although the impacts were felt in very different ways.

Funding arrangements depended on student numbers, which in turn affected the number of instructors which could be hired. Collective agreements determined the hours and conditions of work for the instructors. Hospitals were affected by nursing shortages, and wards were often staffed with relief nurses unfamiliar with the ward or remained understaffed. Such working conditions affected the quality of the learning experience for students. The students had financial concerns relating to cost of their education and demands of an independent lifestyle.

It was important be be cost effective and cost efficient, but it was recognized by the participants in the study that it is on the quality of the product, the nursing graduate, that the future credibility of the profession rests.

4.3 Summary

In this chapter, a model of the clinical learning environment has been presented. This model was derived from the data collected from key participants who lived and experienced the milieu. The discussion addressed the second research question: the portrayal of the clinical setting by key participants. The presentation of the model was focused upon aspects of the setting (clinical learning environment) which link directly to the learning experiences of student nurses.

The environment was perceived as a pervasive force in nursing education, and was found to be comprised of seven dimensions The central dimension was the personal dimension and provides the filter through which all other elements are perceived.

The clinical learning environment is personally experienced. There was a reciprocal relationship which mutually shapes the person and the environment. The environment was not only perceived, it was also created by the person, causing attitudes such as satisfaction and feelings of safety or fear to be formed. As attitudes are formed, and professional knowledge is acquired, students developed personally in terms of autonomy and independence.

The social dimension of the clinical learning environment depended on the interactions among people in the setting, specifically, their communication patterns and interpersonal relationships. Instructor, student, and nurse behaviours were governed by norms and expectations of members within the social setting of the ward. These expectations were explicitly and implicitly communicated. Groups have social characteristics which relate to such details as demographics, cooperation among parties, the

reputation of the programme, group morale, and the presence and character of cliques.

The nursing model, the nursing course design, and the clinical objectives defined the curricular dimension of the clinical learning environment. In addition, the implicit curriculum and professional socialization are included as aspects of the curricular dimension.

Ethnicity and language were viewed as part of the contextual dimension. They are elements of the prevailing culture of the society. Organizational culture (community college and hospital) formed the atmosphere or climate within which instructors and students functioned and was included as part of the context.

The political dimension of the clinical learning environment included the policies and procedures which governed the implementation of the teaching programme in the clinical agency. As well the process and jurisdiction of decision making in both college and hospital is included as a parameter within the political dimension, since decision-making relates closely to concepts of power and authority.

Economics is the study of how human and material resources are used to meet needs. Adequacy of funding for human, technical, and curriculum resources, cost-effectiveness and containment measures, and student expenses and income generation were included in the discussion of the economic dimension of the clinical learning environment.

In the next chapter, the properties of the learning environment and how the clinical instructor acts to influence it are presented.

Chapter 5
Managing the Clinical Learning Environment

In the previous chapter the definition and description of the clinical learning environment was presented in terms of the parameters which were included in each dimension. This presented a view of what a single dimension was comprised and what was excluded. In this chapter, the discussion will focus on how the instructors linked the environment to their activities. Fewer exemplars of the ways in which the instructor manages the clinical learning environment are presented, as the richness of the description in previous chapters served to set the stage for this more interpretive look at the environment.

This chapter represents the findings pertaining to the third research question: an examination of the connection between the clinical instructor, the nursing student, and the clinical setting. It is linked closely to the functions of the clinical instructor as described in Chapter 3 (what activities she carried out as she worked with students on the ward) and to the dimensions as described in Chapter 4.

5.1 Properties of the Clinical Learning Environment

As the data were analysed and the dimensions of the clinical learning environment became apparent, characteristic themes relating to the properties of the environment began to emerge. It became evident that the instructors did not delineate the dimensions of the environment as they explained their rationales for action; they responded more in terms of the characteristics of the setting. They spoke about how specific situations were complicated, how confined, constrained, or frustrated they felt as they attempted to cope with the milieu to benefit student learning. They rationalized their teaching strategies in words that encompassed several dimensions of the environment, and they determined what

strategies to use in addressing a particular issue based on what could be done easily and efficiently.

The clinical learning environment was found to exhibit the following characteristics or properties as determined by the themes discovered as the data were analyzed; complexity, structure, stability, and opportunity. To present and discuss the characteristics of the clinical learning environment, each property is first defined, then discussed in terms of how the instructors viewed it and strategies they used to manage it.

It is useful to view these properties, or characteristics, as dichotomous, having two poles. I do not assert that they are in fact bipolar, just that it is useful to think about them as if they were. For example, bipolarity is easily recognized where it is explicitly labelled as such (e.g., black and white). Even when no label is readily available to indicate contrast, it is accepted within a context. For example, "I feel sad" contrasts implicitly with "I feel happy". In this way we can envisage relationships between poles and also conceive a scalar view, such as 'shades of grey' in the black versus white analogy (Bannister & Fransella, 1982, p. 22).

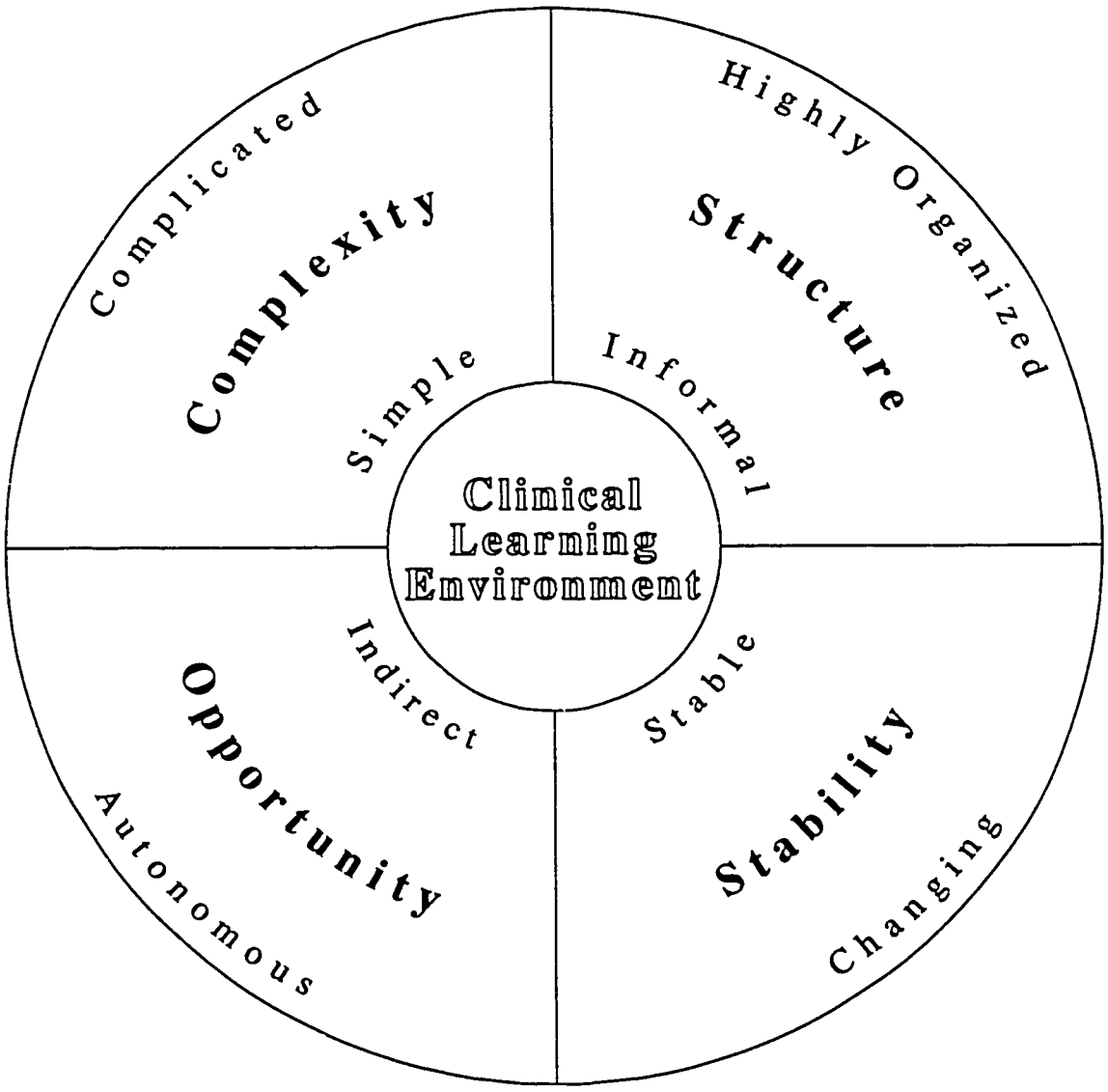
A visual depiction of the above properties is represented by a model proposed by the researcher following the analysis of data, illustrated in Figure 5.1.

The theme termed "complexity" referred to the number of differences, degree of variety, and the range of activity relevant to the ward (delivery of care) and the school (delivery of the course).

The label "structure" was used to represent the theme which related to the organization of participants in the settings, namely managerial structure, unions and associations, and lines of authority. Included in this theme were also the unwritten rules and policies determined by history or tradition.

The degree of change present within the organizations involved and how firmly fixed or established are the practices, roles and attitudes was represented by the third theme termed "stability".

Figure 5.1
Four Properties of the Clinical Learning Environment



The fourth theme found in the data was termed "opportunity" because it referred to how directly an instructor was able to act to resolve issues, influence the milieu, and take advantage of situations that presented themselves for student learning. Power was a recurring sub-theme found as the data were analyzed.

In the following sections, the properties of the clinical learning environment are presented. The clinical learning environment is viewed by instructors as more or less complex, providing opportunity for the instructor to creatively resolve issues or solve problems. It is structured so that incumbents in positions within the organizations have jobs to do and roles to play. It is seen as more or less directly amenable to impact by the instructor and is potentially in a state of change.

5.1.1 Complexity

There are many reasons a thing may be termed complex; it may be numerous in size or variety, it may have many parts, and its parts may be intricately interconnected in no apparent fashion rendering it incomprehensible. A complex thing may be poorly differentiated, partially obscured, or incompletely defined. Language may not be adequate to explain a phenomenon, technology may not be well enough advanced to study it, or knowledge too ill-defined to provide foundation for an investigation.

As noted in Chapter 4, each dimension is comprised of and defined by several parameters. In this manner, the dimensions themselves may be regarded as complex in nature. Many people were also involved in the clinical milieu, forming a "personed" environment, each person with his or her own background, history, ability, and role, constructing an intricate and interconnected group of ideas, feelings, attitudes, and expectations that influence behaviour and attitudes.

Few clinical situations experienced during the course of the investigation were unidimensional in nature, further complicating the conceptualization of the milieu and the

choice of strategies with which instructors could handle or manage the context for the benefit of teaching and learning.

The instructors viewed the clinical learning environment and its complexity as a challenge against which they could try their skill and wit. In the extreme, complexity was viewed as a frustrating condition that prevented achievement of clinical teaching goals.

The physical conditions of the school and the health care agency, its organizational framework, norms, expectations and other people in the milieu influence and place boundaries on what an individual clinical instructor does. She must be able to identify the quantity and quality of information available to her about the environment. The person who is unaware of an environmental option or of a characteristic of the clinical learning setting cannot consider this information when making a decision about tactics or strategies for teaching and learning activities. If the environment is complex, its detail needs to be examined by the instructor in order to determine which aspects of the milieu, when matched with the student and the subject matter of the nursing course, will result in improved learning. Teachers need to discover how the environment can be tailored to facilitate student growth.

From the description of the physical dimension of the clinical learning environment presented in the previous chapter, it is clear that the ward setting is indeed complex. Clinical instructors found the geography, size, and centralization of the wards at West City to be troublesome.

> *The physical layout is horrendous. I think it is the largest clinical area any of the instructors at the college have. The size is very detrimental to keeping track of all the students.*
>
> Sara, L18

On the other hand, Peggy liked the ward layout at East General.

> *I like the Friesen set-up because I feel we are more in charge. When I think of some areas I've to where one nurse used to sit and do all the orders and needs the chart, then they do rounds and have the charts; that made the students frustrated. Here the chart is with the patient and when I see the student I can do everything all at once; check orders,*

review lab results, and supervise the student's charting. It's wonderful.
Peggy, L256

Staff found that students add a degree of complexity by their very presence on the ward. This is an example of the concept of mutual shaping and reciprocity of people with the environment.

I think the staff get confused with the students because one day of the week we have one batch of students, then on the weekend we have another batch of students, so its not always plain who does what skills, what year of student does what sort of care.
Michelle, L87

The nurses get very mixed up; some days the students are on the ward until 12:30, sometimes they are here until 1:00, other times they are on duty until 3:00. Sometimes they've got conference at 12:00 and therefore are going to go to lunch at 11:30, or are they? You see, they have all their charting to finish! I think it would be great if we could all sort of get things a little more organized.
Michelle, L644

The lack of space and the number of people who populate the area at certain times of the day also made the area very complex. Although the following exemplar is from one hospital, the comment is representative of the three research sites.

It is so very busy. The set-up of the nursery is horrendous. There is only a small anteroom to the desk. There are always millions of people, there are new babies coming in, there are babies going out for feeding, there are doctors coming in to do circumcisions. There can be anywhere up to 6 or 8 paediatricians in there at 9 o'clock in the morning. There are 2 nursery nurses and 3 or 4 floor nurses and it is a very, very, very confusing place. On the other hand, the student who is looking after her baby should only have to think about her assigned baby. It bothers me that they are confused and intimidated. I wish I could make it easier for them.
Michelle, L272

Complexity is not necessarily a property or characteristic the instructor wishes to avoid. In fact, at the senior levels of the student experience instructors felt it was desirable to have a good deal of complexity in order to prepare students for the professional world to which they will need to adapt as graduates.

Students felt the complexity of the setting in terms of the number of people on the ward, the physical layout, and the demands made on the instructor, made it difficult for students to carry out their tasks. It seemed to the students that when they most needed the instructor, she was elsewhere, or was busy with another person.

> *So then the patient had to delay her breakfast for twenty minutes and she wasn't very happy. All because Sara was busy with the case room.*
> A.R., L355

At the novice level, however, instructors believed situations which were unnecessarily complex interfered with learning.

Expressions of fear were frequently voiced to the clinical instructors and it raised the necessity of increasing students' knowledge about unfamiliar hospital areas early in the rotation.

> *The students change around so many different hospitals for clinical over their three years in college. The group I have now, none of the students have ever been assigned to this institution. They're lost, they're afraid. They feel that they have some obstetrics knowledge from first year but they fear it has been too long ago. Add an unfamiliar ward to that and you have real fear.*
> Sara, L190

The student group is comprised of individual students, each of whom have different personal attributes through which they experience and view their environment. Laschinger (1987) points out that there are different ways of learning and knowing, and individual students may perceive the clinical situation in fundamentally unique ways. In addition, students come to the clinical experience with different background experiences because of their lifestyles, growth and development, and personal and family situations. This background influences the way they perceived and interpreted events in the clinical setting. Different students had different learning needs related to their relative academic strengths and weaknesses.

Clinical instructors felt the pressure to get to know each student in the group quickly in order to apprehend his or her individual personal needs in terms of clinical

learning. The intricate and complicated relationship of student personality, experience, and academic ability to the acquisition of knowledge, attitudes, and skills associated with the clinical component in nursing education provide an awesome task for the clinical instructor to manage. Central to the behaviour of the instructor was the development of a personal relationship with each student. Student needs were the major determinant of the actions of the instructors in the study.

No less complex were the social aspects of the clinical learning environment. If any term were to characterize this property, it would be "transiency". Student time on the ward is limited to specific days and times. In addition, they do not work a full shift. Since nurses work eight or twelve hour days and their shifts change from week to week, the student may never contact the same nurse two weeks in a row. The transient nature of the student rotation, the lack of time to develop relationships, and the number of people with whom the student must interact makes social relationships superficial at best.

Demographics further complicated the nature of communication and relationships. Students, in the main, were much younger than the nursing staff, and had much less life experience on which to draw for guidance. This lent the staff more control over relationships and communication patterns.

More complex than language and ethnicity was the apparent conflict in goals and cultures of the two organizations within which the student and instructor acted. Students characterized the goals very simply: work (hospital) and learn (college).

Learning was accomplished through instructional acts which implemented the curriculum. The apparent discrepancy between nursing theory used in the college and hospital environments added to the complexity for the student.

The political and economic dimensions of the clinical learning environment were relatively simple in terms of the impact on the instructor and student. Lines of authority and jurisdiction of decision-making were clear cut and a matter of written policy or contractual agreement.

The clinical learning environment, because of its multidimensional nature, is inherently complex. The interrelationship of dimensions in combination with the multiple purposes of instructor activities illustrates the true complexity with which the clinical instructor had to deal as she managed the clinical environment. Complexity was found to be a pervasive characteristic of the clinical learning environment.

Instructors felt they needed to be aware of the nature of these complexities in order to act to simplify situations when students require simplification, or to clarify issues when students were ready to deal with the complexities of the clinical learning environment.

Orientation, a pervasive process that prepared the instructor to teach in the setting and the student to learn on the ward, is the most obvious example of how the instructor coped with complexity. The main strategies were to clarify, simplify, and rehearse.

Through the activities of her personal orientation the instructor clarified the clinical setting, its geography, the people, the patients' diagnoses and acuity levels, as well as the policies and procedures governing how people worked on this ward. As she began to understand the milieu, she clarified the salient (most prominent) points in order to structure her teaching. Because of her experience, she had an understanding of where the students were in their course of studies and what sorts of things with which they would need to be familiar in order to carry out their dual learning and caring activities on the ward. Orientation of the student to the clinical area by the instructor addressed the elements of the clinical setting by presenting and structuring them in such a way that complexity was minimized, roles and responsibilities clarified, and important nursing skills rehearsed, and preparing students to enter into the field as safe learners.

Orientation activities for students typically lasted the first clinical week (in this case, two days for first year students, three days for second year students). Line drawings of the hospital were provided, indicating clinical and diagnostic areas of importance to the students' immediate experiences. In addition, directions to other areas of the hospital that the student needs were provided; library, audiovisual department, cafeteria, locker areas.

As well, students were taken on a tour, first of the hospital to orient them to the building, then to the ward.

> *I prepare them for the physical layout. We tour the whole hospital on the first day, very briefly. We do an in depth tour of the ward. Very detailed. Where to find things they need, what points need to be remembered. Then I give them a list of things to find, and a map. Their assignment is to locate on the map where the things are found. X marks the spot!*
>
> Peggy, L49

A supplementary activity consisted of "scavenger hunts" so students could more specifically and individually locate equipment and places where certain activities took place (e.g., treatment room, medication room).

As the clinical experience progressed and students interacted with patients who were required to be accompanied to other areas of the hospital, the student received directions and instructions about what to expect and how to act in these areas. For example, a mother may need to be accompanied to the special care nursery to spend some time with her infant. For this activity, a student needed only to be directed to the nursery. In another instance instructions were more intensive when, for example, a student was assigned to observe her client's caesarian section and provide immediate pre- and post-operative care. The instructor was required to provide the student with supplemental instruction such as an individual tour of the relevant areas of the case room, directions about where to change and what to wear, detailed instructions on what to expect during the course of surgery, and how to behave in the case room during surgery. In addition, she reviewed with the student the knowledge and skills required to complete the assessment and care of her patient. How the instructor decided on the activities for each student and the amount of preparation required, was determined by her knowledge of the student.

> *My student has been moving from MAT1 to MAT2, plus trying to take in the Nursery. She's been out on her OR experience, she's been in the Case Room. She just can't compile everything together.*
>
> Sara, L305

Relationships between and among students and the instructor were built over time and were, for the most part, initiated by the instructor and established at orientation. The form and structure of the relationships were primarily determined by the instructor. Activities used were termed "icebreakers" by one instructor, who noted their application to personalizing the clinical experience for students. She felt the experience needed to be personally meaningful in order for the students to learn.

> *I try to make the experience relate to something they already know. If I can link it to something personal it is more meaningful and will therefore be more likely remembered later. I try to show them how to empathize, put themselves in their patients' shoes.*
>
> Errin L643

The foundations for trust were set by the instructor. She told the students a little about herself, her educational background, and her nursing experience. Instructors then reflected on their philosophy about what they considered to be important for the rotation, clearly specifying the demands of the course and outlining the clinical objectives.

> *I tell the students exactly what I expect. Honesty above all. Integrity. Consideration for others. That means getting assignments in on time. If there are problems I want to find out from the student, not a third party. Perfection is not on the list of objectives.*
>
> (Errin) Field Note

Students were advised of the norms and expectations of their behaviour in a generic sense in order to apply these criteria to all future ward relationships and communications. Their clinical instructor assisted them at orientation by setting out general guidelines and, during the clinical rotation, helped by reminding individual students of the expectations and assisted them to adapt themselves to different situations and personnel.

Morale building was an important task for the instructor which began at orientation. Instructors wanted the group to develop a cohesiveness that would give the students a sense of belonging somewhere. Instructors felt that doing clinical in a large hospital, a large college, and a large city was depersonalizing for the student. The work of the group, they felt, could be best served if relationships within the group were harmonious. At

orientation, the instructors initiated many activities which served to develop peer relationships and foster group cohesiveness. Students were sent in pairs to conduct certain caregiving activities, assigned to cover each other's patients for breaks, and assigned to coffee and lunch break together. As well, they rotated in pairs through the case room.

Other activities of the instructor related to student development of the values and skills of the profession, not only as it is at present, but influencing the student to think of changes and trends which may influence the future practice of nursing. Instructors reported they believed that acquisition of basic knowledge is prerequisite to safe nursing practice by students. The complexity of the subject matter has been noted. The instructors dealt with the magnitude of facts and skills needed by the student by selecting the most prominent and important skills and information and focusing on them during the orientation period. They quizzed the students and provided review modules for the students to complete.

> *We will certainly continue with the one day orientation. That is the reality. Students have found it useful to have all that information, because they need it at the beginning of the rotation. Regardless of how boring it is, students need knowledge about obstetrics to function in the area. We showed two long movies together and we plan to change that order, to keep them more alert, and put the pleasant movie at the very end. We will address the issue of safety in greater detail. Safety aspects particular to newborns.*
>
> Peggy, L32

Psychomotor skills were rehearsed at orientation. For example, a postpartum assessment was demonstrated, practised, and the first one was supervised at the bedside by the clinical instructor. A baby bath was rehearsed using a doll and the hospital equipment, a demonstration bath with a real infant was done by the instructor, who then supervised each student individually as he or she bathed a baby. Other skills were similarly rehearsed e.g., peri-care, breast care, breast feeding, and bottle feeding. Much patient teaching is conducted on a maternity ward to prepare the new mother to care for her infant and herself following discharge from hospital. Students used role play to rehearse these skills.

Anxiety relating to knowledge of the clinical specialty and the physical setting was alleviated by rehearsal during the orientation period. By the process of clarifying and simplifying the milieu for the students, instructors taught individual students to circumscribe their immediate environments to minimize distractions and to distance themselves from activities and people with whom they had no need to interact.

In order to foster the important relationships between staff nurses and students, students were not given a patient assignment their first day on the ward. They were instead assigned directly to a buddy nurse. By assisting the buddy with her work, the student was able to discover the routines and temporal aspects of caring on this ward. As well, any knowledge deficits became apparent and inherent or acquired abilities were recognized. For the second year students, their buddy nurse, in consultation with the instructor and the student, delegated the care of one of her patients to the student the second day, allowing the student to put into practice the knowledge and skill he or she had managed to acquire through the process of orientation.

The use of an archetypical exemplar relating to a major function performed by the clinical instructors illustrated how the instructor coped with the complexity of the environment to foster student learning. Through orientation activities many dimensions of the environment were addressed, clarified, simplified, and rehearsed. In this way the instructors met the challenge presented by complexity and minimized the frustration to themselves and to the students that poor coping strategies would inevitably entail.

5.1.2 Structure

Structure relates to the organization and regulation of participants in the clinical setting (hospital) and the educational setting (college). The organizational framework, managerial structure, lines of authority, the role of unions and associations, and the

closeness of monitoring and supervision of work reflected the degree of structure placed on positions and people within the milieu. Included in this theme were also the unwritten rules and policies determined by history or tradition. Power is a pervasive force in this property.

The structure of the clinical learning environment can be described as either informal or highly organized. Organization in this sense refers to the degree that individual actions are externally controlled by contractual arrangements or collective agreements. These structures are in place to protect the employment rights of participants and to clearly delineate individual accountability and responsibility on the job.

The structure of the ward, the assignment of conference rooms, and the use of private spaces are all out of the instructor's span of control. She and her students are guests in the hospital and as such must abide by the policies and procedures in place. The size of the teaching hospitals and the location of the wards, locker rooms, and common spaces, and the comfort of seating and furniture arrangements are all a part of the learning environment with which the instructor and students must contend. Identification and determination of the roles and responsibilities of people in the setting were often not clearly articulated.

Structure is imposed on the student in terms of the responsibilities for reporting to her buddy nurse, charting pertinent information, and performing caregiving activities. The curriculum mandates the number of hours in the clinical area, the clinical learning objectives and the types of clinical situations in which the student is to be involved. In addition, the nursing theoretical model which is used to organize course content is specified. There are formal and highly organized rules and regulations (in some cases, learning contracts) which are to be followed with respect to assignments, marking, and evaluation.

> *Students have some choice as to what they want to do for marks. They must do one nursing care plan, but beyond that they could choose to do a teaching plan, a drug plan, they could present three-articles on obstetrical setting, they could do something on legal ethics, they could*

> *do a conference to the students, they could do some nursing research if they wanted. They negotiate that in a contract. The activities take place in the clinical area.*
>
> Sara, L826

Certain student clinical activities are monitored very closely, namely the administration of medications. In this case, the degree of structure imposed is highly formalized, and supervision is shared by staff nurses and instructor in the interests of patient safety. The assignment of patients, the division of supervision, and the evaluation of clinical performance and student learning are within the jurisdiction of the instructor. Accountability for care is under the jurisdiction of the staff nurse assigned to the patient. In this respect, a political partnership exists among instructor, student, and staff nurse.

The nature of collaboration between the student nurse and ward staff was dependent upon the climate of the ward, the interest of the staff nurse, and the degree to which the instructor had been able to promote a sense of commitment to the student on the part of the staff nurse. In effect, staff cooperated with learning activities as long as they did not interfere with their own caregiving responsibilities. Some staff nurses more willingly put up with inevitable work disruptions than others.

> *I would like the clinical instructor to tell me a little bit more about what the students are capable of doing and a little bit more about the structure of their day so that I can predict my work. I would like the instructor to be a little more available to do more supervising. If the staff are going to be taking over some of the teaching role, which is OK, I think this is part and parcel of what we accept in a teaching hospital, but there doesn't seem to be a lot of information going back and forth. I think it is pretty well nil and I don't like it.*
>
> Michelle, L742

The climate and the willingness on the part of the staff to collaborate is a function of the head nurse's leadership and the value the hospital placed on education.

> *The head nurse is very central to setting the climate or the tone of the unit, and I don't think that I've ever seen it quite as evident as it is here. I credit both the nurses in charge for the very positive attitude and atmosphere that's been created. I think Lil is a very positive person, particularly positive about the students, and friendly. That has really made this a nice situation for us. The other head nurse is an acting head nurses who took over the role just shortly after we came.*

> *She's not as outgoing, but very efficient and helpful whenever we have questions for her. So it has been a really good experience for the students. The head nurse is tremendously important!*
>
> Errin, L637

Structure had an effect on the economic dimension, but it was generally remote to the experience at the ward level. Certainly the staffing patterns which reflected the collective agreement had a bearing on learning. Relief staff, both on the ward and from the college, often were not expert in the clinical specialty and were, as a result, poorly prepared to give direction or information to the student.

The rules and regulations under which they must function caused the instructors to view the property of structure as constraining, prohibiting their creativity. The extreme in this case was termed liberating; fostering and supporting the creative use of the clinical field for student learning purposes.

The process of patient selection and student assignment is a classic illustration which characterizes the influence of structure on the management of the clinical learning environment. Once the clinical instructors negotiated their work assignments, they bargained with the other members of their teaching teams for a clinical assignment location and terms of work. This process was conducted primarily on the basis of seniority, with the least senior person getting the least desired placement. Sara was high on the seniority list, Peggy and Errin were low. Sara had the most choice and control over her assignment.

Once she had accepted her work assignment the instructor was bound by prearranged dates and shifts for clinical experiences. Students were randomly assigned to her group by the nursing school administration with some consultation with instructors and some deference to student preference (e.g., those who travelled together). Additionally, students were rotated out of the assigned groups in order to have operating room and community health experiences and the instructor had no say in what order the students were assigned to these experiences.

This process was highly organized and the instructor had very little power to influence any changes or adaptations to the assignment system. Once she arrived at the hospital, however, there was more room to manœuvre. Since, within the educational institution, the organization could be characterized as tightly coupled, the freedom of the loose coupling between the college and hospital proved advantageous for the instructor. The constraint was lessened and she was more free to pursue her teaching activities. The constraints at this time related more to the policies and procedures of the nursing division and the obstetrical programme. In order to work within the milieu, the instructors needed to apprise themselves of the rules and regulation that bound their practice. The clarified the constraints and attempted to adapt them to the level of student.

> *I asked questions at orientation about the relationship of who is responsible for whom. They said, "You should know that, being former director of a nursing programme and having been a instructor here." I replied, "Now I am not an employee of the hospital and I'm not a director. I'm a staff member from a community college. Am I responsible? Tell me the rules about narcotic keys, about double signatures for insulin. These are areas of concern to instructors."*
>
> Sara, L511

> *Errin and I phoned the education department at the hospital this September when chemstrips were taken off of the added skills list by the College of Nurses. This skill will now be going under the regular nursing acts. "Could our students do them? Will the policy now change?" They had not yet discussed and decided that. Students are not allowed to do them in first or second year. No rule for third. "But they were being taught diabetes and it seems strange that the patients are taught to do their own chemstrips and not the students!" Their rationale was that it is not doing the procedure as much as it is reading and interpreting the results. The student is responsible for the reading, why couldn't she do the whole procedure? No. She is not allowed. And that was as far as we got.*
>
> Sara, L591

The instructors considered themselves to be peers with the head nurse. Both were accountable for the overall performance of those under their management. Both set standards and evaluated performance in their own fields. On one occasion, Peggy was closely observing a borderline student while the head nurse was assessing a probationary

employee. They negotiated their strategy together, allowing the staff nurse and student nurse to nearly complete tasks before interrupting them with safety-related suggestions.

Once students were on the ward, the areas of jurisdiction became somewhat blurred. As students learned how to nurse, they provided nursing service in terms of actual care to patients. The instructor was accountable for learning, the head nurse was accountable for the quality and delivery of nursing care to patients, and the staff nurse was ultimately responsible for the care given since she had, in fact, delegated it to a student.

Instructors followed the very broad instructions for patient assignment to students which stated that the assignment should be complete and communicated to the head nurse before report. This was interpreted and implemented differently by all three instructors.

Advice, often as a matter of courtesy or to correct potential errors, was sought from the head nurse. Again, this was implemented differently by the three instructors in the study. Errin selected the patients and referred to the head nurse for approval. Peggy asked the head nurse to nominate appropriate patients based on the course requirements. Sara selected and assigned patients with little input from the head nurse except that which could occur immediately prior to report.

Patients were assigned to individual students based on the needs of the student. Although head nurses may have liked to see fewer students in one area, or more (or fewer) students buddied with a particular nurse, they were able to say very little. Where they could intervene was in questioning the instructor with respect to the propriety of a particular patient being assigned to a student. Matters of care were in her domain. Matters of instruction and learning were in the domain of the instructor. Much of the jurisdiction was mutually negotiated and rarely conflictual. In fact, the relationship between the instructor and the head nurse was relatively informal. That is, until or unless conflict arose. Jurisdictional conflict was managed by clarifying perspectives and purposes and reaching compromises with the head nurse. The instructors took a particularly accommodating stance in these situations, since they perceived themselves as guests on the ward, at the

mercy of the hospital, and subject to invitation and approval by the head nurse.

In some cases the charge nurse introduced the students to their co-assigned staff nurse at the morning report, in others the instructor took the initiative. These were not merely small social courtesies, but essential when you consider the student and staff nurse share responsibilities for the care of the patient.

Once the student was assigned to the patient, the relationship between the staff nurse and the student was key to the successful consummation of the caring and learning acts in which the student was engaged. Several issues of power emerged during the course of these activities. One related to the issue of name tags as identification was raised on several occasions. Students wore their tags, respecting the dress code. Staff nurses on the other hand, were identified on assignment sheets by first names (students were not on the sheets at all) and many did not wear name tags. Students were quick to generalize "RNAs don't wear name tags." While this was only partially true, it remained a problem. Since the head nurse in question had not taken initiative to correct this situation after repeated requests and reasoned arguments, the clinical instructor decided to take action herself. One morning she had used adhesive tape and a marker to create an ID tag for a student who had lost hers, then, using a humorous statement, she handed the material to a nurse and asked her to do the same. The staff nurse complied, and from then on the situation began to remedy itself.

A second issue relating to power and the regulations of the hospital is illustrated below:

> *A student was asked by a staff member to discontinue the IV and there was no doctor's order. I said the student couldn't do it under those circumstances, so the staff nurse discontinued it and told the student to document it on the chart. She then asked the staff member for her name and title. The staff nurse then got a little upset but I said "The student can't put on the nurses' notes that the IV was discontinued by a nurse without naming you. If you are going to ask the student to do your charting for you, she needs that information."*
>
> Sara, L80

Because staff nurses were older and more experienced as nurses, they were in a position of greater power than the student. In addition, since the student was a guest in the institution and was allowed to care for patients (and thereby learn) at the invitation of the ward staff, the issue of power became a major sub-theme for the property.

Vertical communication between staff nurse and student was essentially one-way. There was little reciprocity. Students were expected to give report to the staff nurse. Few staff nurses went over their expectations at the beginning of the shift. Students were expected to report to the staff nurse when they went off the ward. In contrast, staff rarely informed students of their comings and goings even though students were expected to cover their patients in their absence.

The clinical instructor made it clear that student evaluation was in her domain, but she sought input from staff nurses. How and if she used that input was at her discretion. In the area of teaching and evaluating, the instructor had the power.

> *There are certain mandatory behaviours, once they are met satisfactorily and the student is not unsafe in any way, he or she will pass.*
>
> Peggy, L1420

The primary decision of pass-fail was related to patient safety, an aspect of the caregiving activity.

> *Q: You speak frequently about students being unsafe as grounds for failure. Can you give me some examples of what unsafe means to you?*
>
> *A: Unsafe would be perhaps not putting a side rail up, for instance on a weak or confused patient. If you're with children, say a two-year old, putting him in his crib and forgetting to put the side up. In the nursery, unsafe to me is leaving a baby unattended on a surface where the baby could fall and have injury, brain damage. Even taking a rectal temperature, even though it sounds like a very simple procedure, students can be unsafe. They can cause damage if they don't have a secure hold of the baby and the thermometer. They can be unsafe with sterile technique as far as asepsis in general; not washing their hands, not wearing their lab coat over their uniform to go off the ward. One incident alone would not be enough to fail a student; there would have to be many things. I consider students unsafe if they don't do the things that have to be done prior to giving the medication. If they didn't check*

the patient's bracelet, especially. I have seen errors committed where wrong drugs were given, or drugs have been given to wrong patients. If students don't follow the rules of proper medication administration, then it is definitely unsafe practice.

Peggy, L1510

The role of the clinical instructor was to understand the structures imposed upon her practice and the practice of her students from the points of view of the two organizations and the provincial Standards of Practice for nurses, and to make decisions regarding teaching practices and learning activities within these constraints. The strategies used were clarification and adaptation.

Some of the procedures and policies forced her into a highly organized system, others allowed flexibility and were informal in nature.

During orientation the instructor learned the policies and procedures relating to nursing practice in the hospital. She clarified her roles and responsibilities with her peer, the head nurse, and negotiated an order to her instructional activities that respected student learning as well as patient care. Power was a recurring sub-theme in the archetypical situation described (ward assignments) to elucidate the property of structure.

5.1.3 Stability

The clinical learning environment has been characterized in the literature as dynamic. Dynamic, according to the Oxford dictionary, is defined as relating to energy or forces in motion, relating to or tending toward change, energetic, vigorous, forceful. In many cases, the antonym of dynamic is static, but I have chosen the term stable to indicate the opposite pole of the property.

In this investigation, I have defined the property of stability as the degree of change that is present within the two organizations, and how firmly established the work practices, roles, and relationships are.

Physically, the settings were undergoing little change. At one site, construction was taking place elsewhere in the hospital which caused some disruption in parking and access roads into the hospital, but had very little impact upon the students or instructors.

The patient acuity level and staff rotations were relatively predictable. All patients in the study were on the obstetrical service, so the nursing knowledge and skills were readily anticipated. While the group of nurses at the hospital changed weekly, sometimes daily, the practices and expectations of performance were relatively constant.

The curriculum was firmly established and the faculty were well versed in its application. The assignments were similar for all students, and the marking scheme was communicated in advance.

The staff and student groups and the patient population were characterized by different language abilities and different cultural and religious backgrounds, but were for the most part relatively homogeneous and stable. There were no major immigration patterns that changed the character of the milieu, such as that which happened when several thousand "boat people" were welcomed into the city.

Politically, however, major changes were being experienced. At West City combined care had been implemented and policies and procedures were being written and implemented on a daily basis. Communication of these policies didn't always proceed as quickly, so miscommunication was not uncommon. In addition, the hospital was moving to all-RN staffing and phasing out RNA staff. The RNA staff had a long history and tradition on MAT2 and there were many strong emotions surrounding this change.

At East General, combined care was in its early planning stages and staff from the various areas were being rotated in an endeavour to update their skills and practice. This made the political dimension of the clinical learning environment relatively unstable (certainly not static) and very dynamic in nature.

Economically, the funding for both the hospital and the college were stable, with enrolment quotas being reached at the college, and no programme cuts at the hospital.

While many of the students had work commitments, they held regular jobs, with predictable hours, which provided a relatively steady income.

The clinical learning environment can be characterized as dynamic or stable, depending on the changes which impact on it. The clinical instructor must be aware of the programme and personnel plans so that she can adapt her functions and activities, such as her personal orientation activities and teaching plans. Teachers viewed the organizational changes as sometimes confusing and conflict-ridden as players sorted out their respective roles and functions. For the most part, however, they viewed change as positive, presenting possibilities that they could use to the advantage of students. The role of the instructor during the process of change was to manipulate it for the benefit of the student.

> *Because their staff is undergoing this change, it actually makes it easier for us, I think. It is actually enhancing learning, I feel, because the staff who have been on the floor for x number of years, now have to look after the babies too. They have had to stop and think about baby care. The change is obviously threatening at first. They now appreciate the students more, understand their feelings; they see the students go back and forth from nursery to floor and now they know how hard it is.*
>
> Peggy, L1450

A pervasive issue relating to stability was related as much to the student group itself as to the hospital organization and ward setting. There was a lack of stability within the student group, and a number of changes impacted on it. At the time of admission, students with a wide variety of academic backgrounds are admitted to the nursing programme.

> *If applicants meet the admission requirements, selection only comes into play if we have an over-abundance of applications. I'm not sure that we do. I understand last year that we took everyone on that list, which of course means they're letting in applicants who are borderline academically, to start with. Some of these applicants are not strong academically. If applicants meet the criteria, then they can get into the programme if there's a spot available.*
>
> Errin, L164

Age differences, as well as academic differences, were a factor considered by instructors.

> *We are getting students from all different levels. When you get someone who is just out of high school and still in their adolescence and then you get another one who is a mother with three kids, and you get someone who has a university degree, you have to treat them differently on the ward.*
>
> Sara, L2290

Students were placed in hospitals for their clinical experiences, and complained of the lack of stability in their clinical assignments. Teachers recognised this as one of several changes with which the student had to deal.

> *This has come up more than once in my conversations with students. They never get to know one hospital. They are moved around so much. They could, with 4 rotations in the period of a year, be in 4 different hospitals. With 4 different groups of students, and four different instructors. And they often wouldn't have any of these teachers for classes or labs. This is disruptive for students.*
>
> Sara, L1889

Once students were assigned to wards, the only people they saw on a regular basis were their instructor, the head nurse, and the ward clerk. Staff changed weekly, even daily.

> *I have had at least, oh gosh, seven or eight different buddy nurses from the time that we've been here (5 weeks). And some weeks when we're here for three days, I ended up having one buddy nurse for the two days and then Wednesday I had a different one.*
>
> U.O., L203

In addition, staff had different roles and responsibilities. If a student was co-assigned with an RNA, an RN would also be involved in patient care because there were procedures the RNA was not allowed to perform; for example, medications, treatments, intravenous therapy, and patient teaching. Not all wards had RNA staff, causing further confusion among students. As well, the use of relief staff who were not familiar with the wards caused a lack of stability in the setting. The shift changes and the varied staffing patterns were another source of instability. The difficulty noted earlier (Chapter 3) in relationship formation between students and their staff nurses is more understandable when their lack of time together is taken into account.

Ward staff noted that the number of groups and the different levels of students rotating through the obstetrical service made it difficult for them to understand what nursing skills the students were able to do on the ward and assess what sort of assistance they would need from staff. Instructors used different techniques to inform staff, the most common being writing student information (e.g., first year students, no meds) in red at the top of the assignment sheet. Head nurses, recognizing the difficulties for both students and staff, clarified at report what the students were doing. As well, they coached relief staff regarding their role with students.

> *We've had a couple of new gals on the ward recently. I don't know how they handle students so it is something I draw to their attention.*
>
> Lil, L505

Instructors viewed the changes taking place on the wards as either possibilities for student learning or sources of confusion and conflict. The presence of a researcher and the students' involvement in the research project was seized as a possibility from which the students could learn. Sara used my presence to inform students about the role of research in the development of nursing knowledge and linked it to a completed nursery research project. She invited the principal investigator of this nursery research project to speak to the students, pointed out the different ways in which research could be conducted, and indicated how the results of research could be implemented in practice. While my research project was a change in their usual clinical experiences, my constant presence became a stabilizing factor in their clinical lives.

Staffing problems and the changing methods of care delivery were sources of confusion and conflict. Communication was the key method used by instructors to deal with instability and change in the clinical learning environment. They identified factors that were leading to confusion or conflict, and negotiated new ways of looking at or doing things. In this way, change and stability were seen to be in a state of dynamic tension, with changes in the ward setting affecting the instructors and the student group and vice

versa. Staff accommodated as best they could to the exigencies of student presence, and instructors took ward characteristics into consideration as they determined their teaching strategies. Instructors seized change as a chance to expedite student learning.

5.1.4 Opportunity

Opportunity refers to the degree of control the instructor has, or how directly she can impact the environment to resolve issues, influence the milieu, and take advantage of situations for student learning. When the number of intermediaries who are necessary for action increases, her effect is diminished. Opportunity is linked to organizational climate and relates to shared responsibility, rules orientation, and individual initiative.

From the complex and dynamic clinical environment came opportunities for learning and problems to be addressed. Structures mandated how the instructors acted in certain situations, but in others they had the opportunity to innovate. How she reacted to the environment in any given situation depended upon her personality, career experience, educational specialization, the demands and requirements of the instructional role, and the immediate task at hand. Her influence of the environment was viewed as either autonomous or indirect.

The instructors viewed all caregiving situations within the clinical setting as potential opportunities for student learning. Opportunity was viewed as either confining their activities or allowing a transformation of clinical situations from a work situation to a learning situation. The transformation (or confinement) was an outcome of the influence an instructor was able to exert. The instructor wished to have an autonomous, direct, and reasonably immediate effect in order to take advantage of situations which presented themselves and to capitalize on events thus enabling student participation and learning.

In order to address the personal learning needs of the students and ensure an assignment that challenged student abilities but rendered them safe to provide the necessary

patient care, the instructors prepared the student clinical assignments carefully. They requested information, as required, from head nurses and staff nurses about patient condition and needs, but the decision respecting to which student any patient was assigned was in her domain alone. The instructor was not able to determine staff assignments to ensure a student was either coassigned with a particular staff member or not. Staff assignment was the responsibility of the head nurse.

The strategies employed and the discretion allowed ' accommodate individual learning needs and styles of students was a reflection of the amount of teaching experience the instructor had. Academic preparation in the field of education as well as in the nursing profession promoted understanding of psychopedagogy and provided rationales for teaching decisions.

To what extent the instructor could directly impact the environment without going through several chains of command depended upon the level of decentralization of control within the setting. If the determination of access to space was controlled at the ward level, the instructor had a reasonably direct effect (e.g., ward teaching office). When control of access to physical space was held in a central office, she had to compete with other programmes and people to acquire what she needed (e.g., large conference room). Jurisdictionally, the decision rested quite distant from the individual instructor and it became difficult to gain priority over larger higher profile groups. While this may have been viewed as a constraining factor on their teaching, instructors, by booking rooms well in advance, avoided the problem.

The instructor monitored relationships and communication patterns between staff nurses and students. She anticipated what events might occur and intervened to mediate student entry and participation. She discussed issues and methods of social interaction with her students, fostering alternative explanations for behaviours, and empowering them to act independently to adapt their actions to changing situations.

Morale-building was a task the instructors took seriously. They noted "passages" like birthdays and celebrations and encouraged the students to do likewise. For example, one instructor brought chocolate bunnies to clinical during the Easter season. Another time students brought cards to a colleague who was celebrating a birthday and little baby gifts to one who had just announced her pregnancy.

The formation of cliques was a phenomenon of the social setting. The way in which the instructors acted with divergent groups was an illustration of the impact they were able to demonstrate. When an instructor managed the group as if it were a forum for presentation and discussion of alternative viewpoints, she increased the ability of her students to deal with nonconformist values.

One student had dyed her hair a rather odd colour, and the instructor dealt with it in the following manner:

> *I am not too concerned about her hair as long as it is neat and clean and tidy. I know it is certainly not traditional, but there is nothing in the dress code about hair style or colour. Green hair, I might have trouble with! If I were taking her to a different clinical area, I am thinking of the floor I'm assigned to next term, I would have told her that on this particular floor you can expect certain reactions because of your hair colour. I would advise her to tone it down a little bit unless she was prepared to deal with it. It doesn't upset me because it's just a colour. But I would give her a few clues, from my experience with that floor, how they would react to her. I would tell her that she will stand out and they might make fun of her or expect different things from her because of your hair. It would be her choice how to deal with it.*
>
> Peggy, L634

She had the power to alter the group through direct action but by using nonjudgmental responses, the instructors helped students within the clique feel validated, heard, and not personally rejected and those outside the group to develop awareness of divergent opinions and perceptions. By modelling behaviours, she used a parallel process whereby students learned how to effectively manage divergent opinions and behaviours in their own lives without feeling personally threatened or angry.

On the other hand, when a student showed up in lace-patterned white stockings and scuffed loafers, Peggy reminded her of the dress code and told her to wear proper attire when she returned. In this case, her effect was direct and immediate.

Social norms and expectations were communicated directly and indirectly to students and instructors alike. A student who deviated from expectations suffered consequences such as embarrassment in front of staff and peers. For example, lapses in charting are often on the report tape so that they are communicated to the head nurse and instructor a very public way for a student to find out she had neglected to chart something.

The clinical instructors had little direct effect on the course or clinical objectives. If there were experiences they were unable to provide because of the nature of the clinical setting, they informed the leader of their respective teaching teams and noted on the student evaluation form that there was no opportunity for the student to carry out the particular skill. Any more direct effect the instructor would like to exert on curriculum would necessitate her participation on the college curriculum committee.

Instructors, while constrained by the curriculum, were very isolated from the teaching team leaders. Very innovative ways were found by clinical instructors to interpret the assignments to suit their style and student needs. Statements like "What they don't know can't hurt" and "I tried to get the team to accept this method and they weren't interested. Said it was more work. It isn't. It's less work. So I just do it. If they find out I'll say I'm sorry."

> *I like the clinical area from the point of view that I can do whatever I like. Nobody really asks me what I'm doing or why. They know that I've got my credentials and they understand that what I do is for the students.*
>
> Sara, L727

Organizational issues were difficult for the instructor to impact directly because of the nature of the corporate culture.

> *No one has asked me for any feedback, as far as the administrative end of things, from the hospital or the college, about things that have been of*

> *concern to me. Teachers are really just turned loose out there. No news is good news, I guess that is how they see it. There is very little administrative input.*
>
> Errin, L1324

There were few opportunities for instructors to exert a direct impact on the economics of the college or hospital. They knew, however, if and where there were supplies hidden or stock hoarded for future use. They used this information to ensure students received the supplies necessary for quality care.

Instructors used clinical problems as opportunities to confer and consult with other professionals such as dieticians, social workers, and other nurses (community health nurses, nurse researchers, and neonatal intensive care nurses). These activities enriched the learning experiences for students. Occasionally there were conferences or seminars held at the hospital, and the instructors would excuse their students to attend all or part of the sessions.

Politically, the instructor needed to be very astute in knowing the rules and regulations and in being aware of possible loopholes and contradictory precedents. Much information to facilitate this activity was assembled in the informal intelligence-gathering that went on among her network at the hospital and college. Creativity was a gamble. In taking any action which did not accede to the power and governance structures of either institution, there were acknowledged risks. Instructors spent a good deal of time at what they called "public relations" to minimize the risk. They termed such activities as "back scratching": I scratch their back and they scratch mine.

> *The other thing I always set up was that my students will do some, what I call scut work. But if there are some beds to be made, or someone wants a glass of juice, or the grad needs someone to help move or turn, I'll say "Just grab one of my students and they'll help you." Or if we need to stay on an extra half hour because the ward is really busy, we will. Or we'll take patients just coming from the case room. I find that that has paid off. I think that if you don't have good PR on a ward it really reflects on your students."*
>
> Sara, L360

Much of this political activity took place at the ward level. Head nurses were active allies, feeling that the upper administration of both the hospital and the college sat in an ivory tower and did not understand the real world.

The ward environment offerred many clinical situations that could be used as learning situations for students. As students were assigned to patients for the purposes of learning, they also gave nursing care.

Sometimes locating opportunities for students was as simple as asking.

> *If I hear in the morning that a nurse is going down to a room to do something interesting, I'll say "Do you mind if my student comes along with you?" They are usually happy to have a student along.*
>
> Sara, L443

On other occasions, a great deal of intuition and negotiation is required to take advantage of unusual opportunities. One such example follows:

> *The ward had quite a few psychiatric patients, one in particular that they [physician, nurses, social worker] were afraid of injuring the baby. They thought Psychiatry should be responsible and that the mother should be down on the psychiatric ward. Finally, after the mother had a violent outburst, the mother was transferred. The problem which then arose was how to do the baby care and who was to supervise it. Everyone agreed the mother needed to be taught and encouraged to care for the infant, but the time it would take for a nurse from maternity to go to psychiatry to do this, was unreasonable. The maternity people thought the psychiatric nurse should be in there watching how the mother was reacting to feeding the baby and everything. There still remained a threat of potential injury to the baby. I listened to all this and thought I had an ideal solution. I had a really excellent student in my group and I said to the head nurse "She (the student) is going to be here for 3 days, I would like to assign her to this patient? She has met her objectives here, she is a mature woman, a mother herself; she has done an excellent home visit, and she's very interested in psychiatric nursing."*
>
> Sara, L890

The clinical instructor needed to be aware of the situations as they were happening, the decisions tasks to be carried out, and the abilities of her students so she could take immediate and direct action to take advantage of situations as learning opportunities for her students.

Because students were moving between areas, the instructors encouraged students to act as liaison whenever possible.

> *There is very little interaction between the ward and intensive care nursery. I really think those nurses should be out in the morning and telling those mothers how their babies are, and talking to the floor nurses. Often the floor nurse will not know how that baby is, and the mother might lie in bed all day, particularly if she's first day post-section. No one has really talked to her and the doctor doesn't come in until 3 or 4. I can't do anything about the staff, but I can send my student down to find out about the baby and report back to the mom regularly. I encourage them to do that.*
>
> Sara, L836

Certain ward practices, however, must be changed, and the instructor worked indirectly through the head nurse.

> *In the 3 years I've been there I have gone to the head nurse twice. We had a problem with narcotics being left out on the trays on evening shift. Of course it was improper, not only for the students, so I had to mention it to the head nurse. You can't ignore certain things when you are teaching. Other things you can ignore.*
>
> Sara, L406

Sometimes, however, the role of the student as learner and as worker caused a dilemma as the distinction between caregiving and learning activities was not always clear. Instructors occasionally had to intervene directly to ensure the situation in which the student was placed remained a learning situation.

> *I have to remind myself to go back to the nursery and make sure the students are not just folding laundry; that they are actually doing something to learn. I know it is quiet later on in the day, and they only look after well babies that mustn't be disrupted. You must let them sleep. So I allow one student (or 2) to leave the unit for maybe an hour, to go down to the library and do research. They all have a presentation to do, a very brief one, but I want the work done at the hospital.*
>
> Peggy, L315

> *I have a very set idea in that I think that the students are on the ward to learn specific kinds of things and I don't want other things interfering with their reason for being there. We have a limited period of time in which to achieve the goals that we have. I want them to have time to read charts, to read the textbooks, to communicate with their patients. I don't want them getting too task-oriented or hung up on tasks that they feel they've got to be helping the nurses out. There's lots of time*

in the future to be more assistive. I guess I'm trying to protect the students' reason for being here and I don't see bedmaking as a learning activity at this point.

Errin, L1160

Instructors viewed the clinical setting as offering potential opportunities for students to learn, and they managed to take advantage of as many situations as possible in order to capitalize on linking student ability with a challenging assignment to facilitate learning. They transformed what was essentially a clinical practice setting for the nurses into a clinical learning setting for students. They accomplished this by influencing people, situations, and decisions, based on their own experience and knowledge.

5.2 Learning to Teach

Because the opportunity to transform the milieu to a learning environment was linked with the instructors knowledge and experience, I decided to probe how these instructors had prepared themselves to assume their role as managers of the clinical learning environment. I posed the following question to each instructor that took part in the study: How did you learn to teach in the clinical area?

Once they had a job in nursing education, the clinical instructors learned by doing.

I thought I'd like a job teaching nurses. The place where they taught paediatrics was just a short distance from where I lived, so I walked up the hill to see if there was a job. I got a job, and I learned on the job, by doing. I didn't know anything about education and teaching. I had no courses on teaching. Other than patient teaching, I had no experience.

Nathalie, L702

I learned to teach in the clinical area by trial and error. Lots of errors, and many trials and tribulations! I read any clinical teaching books that are available, any books that I could get my hands on. I talked to other teachers and found out what they liked to do. I also asked students how they learned. I have asked the ward staff for feedback, too, because they see a variety of teachers and maybe they have different methods. I've tried various approaches and over time sort of developed a pattern of teaching.

Sara, L2189

There was no real way to learn to be a clinical instructor when I started. I read some things. There was the odd book that had something about clinical teaching. The odd article. I just got thrown into it, in the deep end, and I sank or swam and so did the students. I think most of us swam!

Errin, L1437

I had done some teaching, but not in a clinical area. In community health, where I had worked, there is a teaching role. I had a university student do some clinical with me, so I had a little bit of contact with a student that way, but really not very much teaching experience.

Errin, L1442

Teachers relied on their own knowledge and experience to guide them in their role.

I knew the nursing theory that students had to learn and in clinical, I showed them, demonstrated and they return demonstrated. I gave them principles for skills as we went along. Some of it I taught by role modelling. I interacted with the patient and observed the student. I interacted with staff to maintain good interpersonal relationships and I just assumed students picked it up from role modelling. I didn't go through lengthy explanations, "I did this because...."

Nathalie, L725

I've just based my teaching on my experience as a nurse. I've been in many new situations and knowing how I felt, what was helpful to me, how I learned best, is what I then try to apply to my students.

Peggy, L1785

I think I have learned more from staff nurses teaching me. If I go to a new clinical area I go in for an orientation and I'm usually buddied with a staff nurse. She shows me how the ward operates and I learn what to tell my students when we go there.

Peggy, L1930

The instructors had encountered "good" and "poor" teachers in their student careers.

It is very hard to be a teacher, a good teacher. Very hard. I've rarely come across a good teacher. When I was a student or when I was a nurse on the ward where students were assigned. I've learned from negative examples. I try to avoid those kinds of behaviours.

Peggy, L1872

Personal experiences from their student days had a profound effect on present practice.

I had an instructor that in second year; she was an older lady, an army

nurse. She was very nasty to me one day in the clinical area. I had come in early to get information from the chart for my nursing care plan. I had come in before day shift. When I got on the floor she was there, so I immediately went to get the information from the kardex. She left the nursing station and walked down the corridor. She noticed that the patient she was assigning to me that day needed to have a diaper change. The day staff were starting to arrive, and the interns were there early. Remember how inadequate you feel as a student nurse? I was very mildly trying to get this information and trying to make myself look as insignificant as possible. The instructor came into the nursing station and, at the top of her lungs it seemed to me, she said "What are you doing here? Don't you know your patient needs to be changed?" It was at least half an hour before the shift started. Report wasn't given. I was so embarrassed. I wanted to say "But I'm not on duty yet!" but I thought she knew that. I just dropped what I was doing and went down and changed the patient. I was really upset, tears were streaming down my face and I had go past the nursing station into the bathroom. I was so embarrassed because I was so emotional. I stayed in the washroom until I thought I looked OK again and then I came out. But I vowed if I ever became a nurse instructor I would never ever embarrass a student in front of others.

Nathalie, L745

Another instructor also stands out in my mind. I had worked on a nursing care plan very very hard. I remember staying up late and trying to do a really good job. It was very early in the critical care rotation. She corrected it and then she told me that I had done such a good job that I didn't have to do any more care plans. I think that gave me some insight into the importance of positive reinforcement and when a student does a really good job to tell them, and offer them some kind of reward for it. Recognition.

Nathalie, L781

Many instructors taught on the basis of mimicry without any undergirding rationale or theory. They sought to reincarnate the good teacher and avoid the behaviours of the poor one. By using common sense as a guide and their own feelings as barometers, the instructors selected ways of interacting with students.

Even if the information that I have to relate to the student is unpleasant I can't say it in a nasty tone. I'll try to minimize it and find something positive to explain the behaviour and you know so it won't come as too bad a blow to the student. I say to myself, if this were me how would I like to be told that I'm not making the grade. That's the way I try to tell the student.

Nathalie, L796

You have to be positive in your feedback and in your criticism. They

might not see it as such at the time because it's hard to be criticized, even in a positive way, to be told that what you are doing is not good enough and still feel positive about yourself.

Peggy, L1792

I don't always have to be nice. I don't feel threatened as a teacher now if students don't like me. That's not the issue. I try to be a good teacher.

Peggy, L1795

Working with nurses who had been students in the past kept their interactions with students in some sort of perspective.

I had been here at the college as a part time instructor and then went back to the hospital as a nurse. Many of those former students were now my cohorts as nurses. I feel that influenced me. I remember that I might be working with some of the students some day when they are nurses. I'm not out to belittle or to say you're stupid or whatever, because I might be working with them in the future.

Peggy, L1804

Sometimes a colleague or supervisor acted as a mentor to the clinical instructor.

When I first started teaching, it was the support of my peers really, and my supervisor, that helped me. There was one colleague also assigned to this hospital and every day after clinical we would sit down in our office, which was in the hospital, and we would probably talk for about two hours. We would talk about what I did and what I should have done, what other things I could have done, that kind of thing. She is the one who helped me. She had a few years of teaching experience. The biggest thing was that we were geographically separate from the rest of the college. We were three teachers, fifty miles from the college. We were our own little group and both of the other instructors had teaching experience. One had been teaching for quite a while but she had a lot of family commitments so she didn't often have time to stay after clinical. The other instructor was single and she gave hours and hours to my queries every day after clinical. And our supervisor made a habit of coming to the clinical area once a week . She would meet with the administrator at the hospital, the director of nursing. or a supervisor. She'd roam around on the wards and chat with the students. She'd come to conference and she'd have lunch with us. She'd tell us about students having course trouble and that we should be watching for problems. She knew the students better than we did, of course, especially at the beginning because she'd have evaluations passed to her from previous teachers. She was most helpful. I was really lucky that I had those people that were so supportive. I could never have made it without that.

Errin, L1437

As the data respecting teacher preparation was scrutinized, the lack of a pedagogical basis for the professional preparation of nurse educators was striking.

5.3 Summary

The question of how clinical instructors lived within the clinical milieu and in what ways they managed the clinical learning environment to enable students to learn has been the focus of this chapter. The primary interest of the instructor was the student. Instructors viewed the environment in relation to student learning. They wanted to be able to intervene directly without their actions or decisions being mediated, compromised, or thwarted by others. They viewed each clinical situation as a potential learning opportunity for their students, and worked to alter conditions where student learning could have been hindered. Instructors acted to integrate college curricular requirements and clinical experiences, creating circumstances from which students could learn what they needed at any point in time to prepare themselves for their future roles and responsibilities in the nursing profession.

The activities of the clinical instructor as she attempted to manage the milieu in the interests of her students could best be interpreted by ascribing four properties to the clinical learning environment: complexity, structure, stability, and opportunity. Because of its multidimensional nature, the clinical learning environment was inherently complex. Clinical instructors monitored the nature of this complexity and acted to simplify when students required simplification, to rehearse important skills, or to clarify when students indicated they were ready to cope with the challenges posed by the complexities in the milieu. Contractual arrangements and collective agreements imposed structure on the clinical learning environment which in turn defined respective roles and responsibilities and determined the rules and regulations by which clinical practice was constrained. By understanding the parameters within which she could act, the instructor adapted to the

milieu. Any change impinging upon the clinical setting was viewed by instructors as presenting possibilities that the instructor could manipulate in the interests of her student. Power was a recurring issue when the data were analysed. The clinical instructor's experience, personality, and understanding of pedagogical principles determined to what extent she was able to take advantage of opportunities that presented themselves. Opportunity referred to how directly and autonomously the instructor was able to influence the environment to capitalize on situations to enhance student learning. Although the opportunity to transform the milieu to a learning environment was linked with the instructors knowledge and experience, the data revealed the lack of a pedagogical basis for the professional preparation of nurse educators.

In the next chapter the findings of this study are linked to the literature on learning environments, and the implications of these findings for nursing education are presented. Recommendations for further investigation are suggested.

Chapter 6
Summary and Conclusions

The purpose of this research was to describe the clinical learning environment, specifically how the clinical instructor in nursing education interacted with the environment. Three activities were undertaken to repond to the question: (i) to describe what the clinical instructor does and how these activities relate to student learning, (ii) to portray the clinical learning environment, focusing on those aspects which link to student nurses' experience, and (iii) to examine the interaction between the clinical instructor and the milieu.

That an investigation of this nature is critical to the future of nursing education was summed up by Chater (1982):

> *The place of clinical practice as a necessary component in education programs preparing practitioners of nursing, is undisputed. However, because of the complex nature of clinical practice and the long established patterns of clinical practice, which in the main have not been challenged, there is a need for careful scrutiny of how and under what conditions clinical practice is provided.*

In this study, a careful scrutiny was implemented. A rich description of teaching in the clinical milieu was presented in answer to the first research question, followed by a description of the clinical learning environment. This description provided an understanding of the environmental dimensions which impinge upon teaching and learning in the clinical setting in response to the second question. How the instructor managed the environment to facilitate student learning was presented and addressed the third research question, the interaction between the instructor and the clinical learning environment.

This investigation took place approximately two decades after Walberg (1968) and Moos (1968) began their seminal independent research on learning environments. Walberg's work has resulted in the widely used Learning Environment Inventory. Moos, beginning with social climate scales used in psychiatric institutions and correctional facilities and extended to the school system (1974), has produced the well-known

Classroom Environment Scale.

Two major literature reviews have been spawned by the Walberg and Moos research (Chavez, 1984; Fraser, 1985). However, most of the contributions made by inquiry into learning environments focuses on the school system and does not address the post-secondary context or, more particular to this study, the education of professionals.

The review of the literature of nursing and other professions revealed a dearth of studies drawn from actual clinical instructional practice. No investigation has been systematically conducted into the clinical learning environment and how the instructor interacts with it to foster positive student outcomes.

In order to understand nursing education as it is carried out in the context of the clinical setting, a qualitative study was conducted to provide new information and insight into clinical instruction. The purpose was to understand the factors of the clinical learning environment that influenced and directed the clinical instructor as she taught students of nursing. A systematic attempt was made to discover the knowledge the people involved in clinical instruction have and are using to organize their behaviour.

In this investigation a qualitative methodology was used to collect data. Key participants were invited to explain their experiences in their own words. These insights were coupled with participant observation and document analysis to provide a rich source of data.

Robertson (1982) supports continuous observation, to the extent of "shadowing", as a necessity when one seeks to record the work of a clinical instructor. She reasoned that instructor and ward activities are numerous and the milieu is in a constant state of change. A great deal of information can be obtained from many sources by the method of participant observation. Robertson noted, however, that this research method takes considerable time and energy.

Seven weeks were spent in the field observing and interacting with three clinical instructors, their students, three head nurses, and the ward staff on three wards in two

large, urban, university-affiliated teaching hospitals. Exclusive of a pilot study, 92 people signed consents and participated in the study. Others in the environment who may have had contact with the clinical instructors or the students (patients, visitors, physicians, support staff) were not excluded from observation or conversation. Their remarks may have been included only indirectly as data.

The major informants retained a strong commitment to the project throughout the observation, analysis, and writing periods. They devoted time and attention to the transcripts and emerging interpretations, cross checking events with their own records. They made time for member checking exercises and the audit procedures. Student follow up was more immediate because of the nature of their involvement and necessity for timeliness due to graduation and imminent address changes.

While it was clearly advantageous to the investigation that the researcher was a nurse, debriefing sessions with a non-nurse provided insights that guarded against the risk of overlooking the familiar.

An inductive process was used to analyze the data. Because such analysis is descriptive in nature it tends to disguise the interpretive activity engaged in by the researcher as significant data were sorted, categorized, and reconstructed. A microcomputer and data base software facilitated this process. A log was kept of interpretive memos and an audit was conducted to ensure trustworthiness. Findings respecting the three aspects of the research question were reported in three chapters.

6.1 Summary of Findings

Findings are reviewed by organizing them according to the central concepts of teaching in the clinical setting, understanding, and managing the clinical learning environment. Selected literature relevant to the research findings will be included in the discussion.

6.1.1 Teaching in the Clinical Setting

The instructors in the study taught with the belief that students had the ability to learn the skills necessary to become nurses. Further, instructors expected that few, if any, students would be unsuccessful in meeting the objectives. The instructor taught in the clinical setting by carrying out five major functions: personal orientation activities, preparation of the nursing unit to receive students, preparation of students for their clinical experiences on the unit, instructional activities (patient selection, communication, and curriculum translation), and monitoring and evaluation exercises with respect to student progress, personal teaching practice, and the environment.

Other authors have viewed the functions of the clinical instructor similarly. Clinical teaching was portrayed as a difficult teaching challenge by Wood (1987), in a description of the Canadian context of baccalaureate nursing education. She reported five areas of instructor practice: contractual arrangements, teaching activities (assignments for students, supervisions, and evaluation), ensuring standards of practice are maintained by the students, maintenance of personal clinical competence, and maintenance of academic credentials.

Beck, Youngblood, and Stritter (1988), in a study of the implementation of clinical instruction for medical technology students, found that four components comprised the functions of the clinical instructor; expectation-setting, designing learning activities, providing feedback, and evaluating performance. Students progressed through three phases during their clinical rotation; exposure, acquisition, and integration. These stages were characterized by progressively less dependence upon the teacher.

By the process of orientation the instructors in the study familiarized themselves with the wards, initiated constructive working relationships with ward staff, and planned the student orientation programme. Student orientation assisted them to function with maximum ease and safety in a new setting. The clinical instructor prepared the ward for

students by interpreting the nursing programme to the ward staff, the head nurse in particular. The instructor informed the staff about the sorts of experiences would be sought for the students. The staff and the clinical instructors negotiated what sorts of procedures they would put in place to deal with patient selection and student assignment. They discussed their respective roles in terms of teaching, supervising, and evaluating students. The clinical instructor also booked rooms, located locker space, and arranged parking and library privileges prior to student arrival.

Smith (1977) supports orientation as a key function of the clinical instructor in a health care agency, especially in programmes where faculty and students move to different clinical settings for their practical experiences. Orientation helps the teacher and the students adapt quickly to the new clinical setting.

Carr (1983) reported that the orientation process had pervasive effects on teacher and student functioning within the clinical setting. The process established the freedom of movement and access to otherwise privileged information. Instructors in her investigation initiated preparation of the ward as a teaching-learning site to provide a structure for action, to encourage a feeling of mutual comfort, and to establish communication and commitment.

Schweer and Gebbie (1978) charged the clinical instructor with the responsibility to ensure free-flowing reciprocal communication and cooperative working arrangements with all personnel involved in patient care. This was a focus of instructor practice, and proved to be a formidable task.

In the present study, instructional activities were designed by the three instructors to meet clearly specified objectives. The strategies and tactics employed were directed to foster student learning and designed to promote mastery of clinical skills. Patients were matched to student learning needs. Communication and relationships among instructor, student, and ward staff were monitored and nurtured. The notion of partnership was introduced; the instructor was viewed as a partner in learning with the student and a partner in patient care with the staff nurse.

This notion was supported in the literature. Carr (1983) described partnership as having three aspects of shared responsibility; staff and students were always co-assigned for patient care, students carried out certain caregiving activities under the direct supervision of the instructor, and the instructor, students, and staff nurses shared themselves personally and professionally. Quinn (1980) took a narrower view of partnership and did not include the caregiving activities. She viewed the partnership as two-way, the teacher setting the objectives and helping the student attain them by guidance and the provision of appropriate learning situations. The student's sole responsibility in this partnership was to learn.

Because the college had adopted a single nursing theory (model) around which the curriculum had been organized, all student learning activities used the concepts and vocabulary of this model. None of the wards included in the study had an espoused model; nurses practised on the basis of concepts they had derived from their education and experience. This discrepancy between the college and the hospital forced the clinical instructor to spend time as translator of the curriculum. She clarified the milieu for the students in terms of the model. She assisted them in the acquisition of synonymous vocabulary so the staff nurses could comprehend what students were reporting.

Kinney (1985) determined that a process of verbal structuring used by teachers was responsible for initiating and facilitating the overt oral consideration of theory related to practice by students. The process functionally stressed relationships between theoretical knowledge and clinical assignments. It could be suggested, then, that the instructors in this study, through their reported techniques of quizzing and curriculum translation, were verbally structuring the subject matter for students.

Much instructional activity was focused on monitoring student progress and the developing relationships in the ward setting. Instructors also monitored the environment to seek opportunities for student learning, to take advantage of new developments on the ward, and to prevent problems from arising. As part of their monitoring activity,

instructors reflected on their teaching practice. They reported this as a customary activity that was intensified because of the nature of the research project.

Three major ethical dilemmas faced the instructors in the clinical area: patient consent for teaching, maintenance of professional standards for nursing care, and time spent by students in learning activities versus time spent caring for clients.

Four roles were enacted by the clinical instructors in the study: coach, consultant, colleague, and counsellor. As coach, she instructed, directed, and demonstrated skills to the student. She monitored progress, provided constructive feedback, and evaluated achievement. As consultant, the instructor advised students of potential courses of action derived from her knowledge and experience that could be used to interpret clinical data or plan nursing interventions. Once the students became more experienced in the clinical setting and advanced in their academic programme, the instructor was able to act as a colleague, sharing responsibility for learning with the student. As a colleague with the staff nurse, she also shared in the caregiving partnership. As well, the clinical instructor served as a counsellor to assist students in dealing with personal matters. These roles evolved over time and were focused on clinical learning needs.

Magill, Munning, and France (1986) found that educational relationships between faculty and medical students could be didactic, supervisory, collaborative, or consultative. Their definition of the didactic and supervisory roles contain many elements of the coach role found in this investigation; information transfer, close direction, and careful feedback. Their collaborative role relates to the colleague role, emphasizing shared responsibility for decision-making and performance. The consultative role matches closely with the consultant role in this study, focusing on teacher response to specific student requests for information or assistance. An additional role, counsellor, was proposed in the present study of nurse clinical instructors. This role focuses on personal needs of the learner.

The counsellor and colleague roles were reported by Pugh (1976) along with the additional role of facilitator. Carr (1983) reported that the clinical instructor acted as a

leader, information manager, consultant, facilitator, and supervisor.

6.1.2 Understanding the Clinical Learning Environment

As the data were analysed, it became apparent that the clinical learning environment was multidimensional, a finding which supports Carr (1983). She reported three salient qualities of the clinical milieu; multidimensionality, simultaneity, and relative uncertainty. She conceived the milieu as a social setting exemplifying four dimensions; physical, political, social, and emotional.

In the present research the clinical learning environment was conceived as comprising seven dimensions: personal, physical, social, curricular, contextual, political and economic. A model was proposed which illustrated the dimensions in light of their association with the person experiencing the clinical learning environment (See Figure 4.1, p. 123). No attempt was made to determine which dimensions of the clinical learning environment were most important. The intent of the study was to determine which elements existed and to describe them. In any given clinical learning situation all dimensions were more or less present and the teacher responded, based on the prominence or salience of each dimension and its relevance to the teaching, learning, or nursing task at hand.

Since all aspects of the environment are personally experienced, perceived, and interpreted, the personal dimension was viewed as central to the model. The personal dimension was affective and psychopedagogical in nature. As the student experienced the clinical setting, he or she reacted emotionally to the milieu or the people within it, forming attitudes that potentially enabled or prevented learning. Feelings such as emotional safety were viewed as enabling attitudes. Fear, anxiety, and stress were viewed as prohibiting. Maslow (1968) and Knowles (1978) support the notion of fear as an inhibiting factor for learning and a sense of safety and security as necessary conditions for learning.

Raybould (1975) reported that for nursing students the intellect did not function efficiently when it was distracted by anxiety. Anxiety and stress were evidenced by physical symptoms as well as personality and behaviour changes.

Students were found to experience stress and anxiety as a result of clinical practice (Karns & Schwab, 1982). Often they were in a totally new environment with no guarantee for success. They feared mistakes and ridicule. Praise, encouragement, acceptance of their feelings, and avoidance of criticism enabled students to view themselves more favourably. This in turn reduced the stress of learning and was found to be related to improved critical thinking on the part of the students in their investigation.

Rogers (1969) contends that in order for experiential learning to be meaningful, the quality of personal involvement is key. The cognitive as well as the affective aspects of the learner need to be considered. Since learning involves a change in perception of self, Rogers asserts that it is inherently threatening. This threat is easier to manage when external threats are minimal. If, as Quinn (1980) suggests, instructors are able to empathize with the learner's feelings, respect the students as people, and respond to their cues of distress, the learning outcomes can be rendered more meaningful to student nurses.

The immediate and direct experiencing of the physical and social dimensions formed the second layer of perception, represented by the first concentric circle of the model (Figure 4.1).

The physical dimension was presented to the reader by describing the setting through the senses, sensations (size, geography, atmosphere, and temperature), sights (patients, personnel, colour, and equipment), smells (antiseptics, food, and cigarette smoke), and sounds (conversation, paging system, telephone, and call bells). Both hospitals and the three wards were described in detail. Geography was an issue with which the instructor had to contend. The size and unfamiliarity of the institutions was intimidating to the students. The setting was a "peopled" environment; numerous people worked, visited, or received care within the institution.

The clinical setting was viewed as a social setting; a group of people working together and interacting with each other to meet common goals. The goals of the ward staff were related to patient care, the goals of the instructor and student group were related to learning. Since learning activities involved patient care activities, the goals were not mutually exclusive.

Within the clinical setting ward staff, students, and instructor interacted, communicated, and formed relationships. Behaviour of the people on the ward was governed by a set of norms and expectations that were implicitly or directly transmitted. Social characteristics of the group were described in some detail and related to demographics, degree of cooperation among people, the reputation of the school and the ward, morale, and the presence of cliques. The social dimension was found to be a partial determinant of the atmosphere or climate of the ward. Heidgerken (1965) states that since human relationships help make up the social environment and play a vital role in learning and instruction, it is the role of the teacher to maintain control of this environment.

Self concept develops through interpersonal relationships with significant others, according to Griffiths and Bakanauskas (1983). Significant others for student nurses are faculty, nurses, and peers. Self concept is key to successful clinical learning and development of professional role identification. Self concept relates to the feelings, values, and beliefs individuals hold about themselves and which motivate their behaviour. The self-concept is in a constant state of change in response to interactions with others.

The curricular and contextual dimensions were illustrated by the third concentric circle in Figure 4.1; these dimensions were seen as pervasive, but less directly or immediately experienced than the social and physical dimensions.

The curricular dimension included the subject matter, organizing framework (nursing theoretical model), learning objectives, and the hidden curriculum relating to professional socialization. Without the structure provided by the curriculum, there would be little purpose or continuity in student learning.

Haukenes and Mundt (1983) suggest that clinical learning experiences be selected on the basis of nursing as a profession, health care needs of the population, and the educational environment. They characterize the environment as consisting of four components; the curriculum model, the nature of the faculty, the nature of the community, and the nature of the student. The model, they say, is the conceptual framework which specifies the relationship between the nature of nursing, the meaning of health, the view of the patient, and the environment. It provides direction for selection of learning experiences for students, patient assessment, pertinent data collection, and the analysis and intervention activities of the nursing process.

Ethnicity, language, and organizational culture constituted the contextual dimension. The cultural mix and the predominant languages of the community are reflected in the hospitals and the student group. The culture of the individual organizations and their relationship with each other were discussed. The nursing department (both faculty and students) remained somewhat separate from the college. Close interconnections were reported within the college nursing department, however. The relationship between the college and the hospital can be termed loosely-coupled (Weick, 1976). Each organization was responsive to the needs of the other, but each preserved a distinct and separate identity as well as a physical separation.

The political and economic dimensions were less immediate and had less direct impact on the student as a learner or the instructor as a teacher. These dimensions were illustrated by the final concentric circle of the model (Figure 4.1).

The political dimension contained the policies and procedures by which clinical experiences were structured, and related to decisional jurisdiction and process. The economic dimension referred to funding, costs of providing learning experiences, and student financial needs.

Smith (1988) asserts that the economical considerations of clinical practice are largely invisible but points out the potential impact on the nursing educational system.

Nursing programmes are concentrated primarily in urban areas, decreasing opportunities for selection of clinical facilities within the finite amount of hospital space available. As well, the increasing number and types of nursing programmes are competing for the use of these crowded clinical facilities. Student numbers have increased to meet the demand for nurses, and many students must travel long distances and bear the costly burden of housing, transportation, and other living expenses. Smith reports that even though a supportive climate generally exists between nursing service and eduation, the demand on the system caused by the presence of several levels and types of students is straining the relationship. Typically, hospitals receive little or no financial consideration in return for the services they provide in support of clinical experiences for students. As funding for health care becomes increasingly constrained, Smith predicts the diversion of funds and resources to support student education will become increasingly difficult to justify.

In a specific clinical situation, more than one of the seven dimensions of the clinical learning environment may be represented. Certain dimensions may be more prominent or salient and will therefore receive the attention of the person experiencing the situation. Just because priority is placed on the more immediate does not mean, however, that other dimensions are ignored.

6.1.3 Managing the Clinical Learning Environment

The clinical learning environment, as perceived by the clinical instructors as they attempted to manipulate it to enhance learning, was characterized by a set of four properties. These properties were found to be complexity, structure, stability, and opportunity. In their attempt to manage the environment, the instructors viewed the clinical milieu in relation to their connection to the students and their learning needs. They wanted to be able to intervene directly in the clinical setting without their actions or decisions being mediated, compromised, or inhibited by others. They viewed each clinical situation as a

potential learning opportunity for their students and worked to alter conditions where student learning might be hindered. Instructors acted to integrate college curricular requirements with clinical experiences, creating circumstances from which students could learn what was required to prepare themselves for their future roles and responsibilities as nurses.

A model of the properties was presented in Figure 5.1 (p. 197). Each property is described as if it were bipolar in nature. Complexity is presented as either simple or complicated, structure as either highly organized or informal, stability as changing or stable, and opportunity as autonomous or indirect.

The property of complexity referred to the number of differences, degree of variety, and the range of activity relevant to the ward (delivery of care) and the school (delivery of the course). Complexity was introduced into the clinical learning environment by the unpredictable nature of the setting, the many distractions and interruptions, time demands, and the number of people and situations involved in the clinical setting. The instructors viewed the complexity of the clinical learning environment either as a challenge against which they could pit their skill and wit or as a frustrating condition that prevented achievement of clinical teaching goals. In fact, complexity was sought as students advanced in their skill and knowledge. The main strategies used by instructors to manage and cope with complexity were clarification, simplification, and rehearsal.

Heidgerken (1965) viewed the physical and social aspects of the clinical learning environment as tremendously complex because of the vast web of interpersonal relationships within the hospital and outside, the unique administrative nature of the hospital due to its salaried employees (nurses, allied health and support staff) and private practitioners (physicians). She asserted that in addition to acquiring nursing skills the variety of people with different personalities, educational preparation, occupational interests and goals, and a wide variety of patients (of different gender, age, race, education, socioeconomic status, and health problems) with whom the student nurse must relate

renders the complexity of the environment immediately apparent.

Structure as a property of the clinical learning environment related to the organization and regulation of participants in the clinical setting (hospital) and the educational setting (college). The nature of structure was characterized as either highly organized or informal. The organizational framework, managerial structure, lines of authority, the role of unions and associations, and the closeness of monitoring and supervision of work reflected the degree of structure placed on positions and people within the clinical setting. Included in this property were also the unwritten rules and policies determined by history or tradition. Power was a pervasive force in structure. The rules and regulations which governed their activities caused the instructors to view structure as either conflicting or constraining creativity or as liberating. The clinical instructors sought to understand and manage the structure imposed upon them by such strategies as clarification and adaptation.

Heidgerken (1965) reported several problems arising in clinical settings such as conflicts among the many different types of students using the hospital for clinical experiences, conflicts between the ward staff and the instructor, requirements to perform duties which are unrelated to patient care, inability to render adequate nursing care because of time pressures, and poor communication among personnel. She noted that many of these conflicts were human relation problems and therefore influenced the social climate on the ward.

The primary goal of clinical experience, according to Ma (1984) was to apply theory taught in class to the reality of the clinical setting. Conflict between head nurses and faculty was found to create one situation which prevented this goal from being attained. In a study of 32 faculty and 35 head nurses, 146 conflict incidents were reported. The two most commonly perceived sources of conflict were roles and goals. The head nurses' value systems were oriented toward bureaucratic values, while the value system of the faculty was more professionally oriented. Factors producing conflict were related to

educational preparation, working and teaching experience, age, school of graduation, and the nature of clinical settings used for the experiences.

Stability was defined as the degree of change that was present within the two organizations, and how firmly established the work practices, roles, and relationships were. Aspects of the the setting were seen as either stable or in a state of change. Instructors viewed the instability of changes occurring on the wards as either possibilities being generated for student learning or sources of confusion and conflict. Communication was the key method used by instructors to deal with instability. Instructors used change as a chance to expedite student learning, viewing all caregiving situations within the clinical setting as potential opportunities for student learning.

Opportunity was viewed as either confining to instructor activity or as allowing the transformation of clinical situations from a work situation to a learning situation. Instructors accomplished this transformation by autonomously or indirectly influencing people, situations, and decisions.

Hinchliff (1986) characterized ward learning as a set of opportunities and problems. Opportunities cannot be left to chance, she asserted; she outlined several sources of opportunity; the presence of skilled clinical staff, patients appropriate to the skills to be learned, nursing procedures to be implemented, and the variety of teaching and learning strategies available to the instructor. Problems such as conflict between education and service demands, many interruptions, lack of time, lack of equipment, unpredictable bed occupancy, patient acuity and staffing levels, and the geography of the ward were seen as challenges for learning and adaptation. Whether or not students took advantage of opportunities and whether they learned was more a function of the student than the teacher. Motivation, interest, and anxiety had an effect on learning.

From the complex and dynamic clinical environment came opportunities for learning and problems to be addressed. Structures mandated how the instructors acted in certain situations; in others they had the opportunity to innovate. How the instructor

reacted to the environment in any given situation depended upon her personality, career experience, educational specialization, the demands and requirements of the instructional role, and the immediate task at hand. Her influence on the environment was viewed as either autonomous or indirect.

As the data respecting teacher preparation were scrutinized, the lack of a pedagogical basis for the professional preparation of nurse educators was striking. Instructors learned to teach on the job by a process of trial and error. Most had personal experience of excellent and poor teachers and sought to model themselves on the excellent teacher and avoid the behaviours of the poor one. Their own knowledge, experience, and common sense provided guidelines for their actions with students. The one instructor who had a mentor considered herself fortunate.

6.2 Implications of the Research

The study of learning environments is a relatively new field of investigation. Most research conducted over the past two decades has relied heavily on outcome measures. These measures, although indisputedly worthy, have not been able to provide a complete picture of the educational process. In particular, the main focus has been on relationship, affective, achievement, and system maintenance dimensions and has been correlative in nature.

In this investigation the broad nature of an educational environment was described, not attempting to attribute causality to any dimension. The personal, social, physical, and contextual dimensions receive support from previous investigations on learning environments (Fraser, 1986) however, the political and economic dimensions are, for the most part, subsumed under political definitions by previous researchers. The area of subject matter, the curricular dimension reported in this study, has received no mention in the literature. In terms of professional education, this makes a significant contribution.

The rich description of the activities three clinical instructors actually performed in the clinical setting and their rationale for decisions made in order to fulfill their teaching mandate has, up until the present, not been attempted. The lack of research of this type had been noted by many investigators. Perhaps little research has been conducted because of the need to obtain informed consent from all involved, not only the clinical instructor but also the institutions involved, their students, staff nurses, and patients.

The quest to more fully understand the process of clinical teaching in nursing education reveals a phenomenon exceedingly more complex than merely placing students in the practice setting to experience real life clinical situations and integrate this experience with the knowledge of nursing theory they have acquired in the classroom.

The results of this investigation highlight the importance of collaboration between nurses in education and service settings and the need to develop mutual goals for the education of new entrants to the profession.

Clinical instructors must begin to practice their craft with theoretical rationale for their strategies. There is a need for more planned educational and experiential preparation of clinical instructors. It is no longer sufficient to familiarize novice clinical instructors with the simple rituals of teaching. They must be inducted into a professional specialty that demands not only content mastery but also psychopedagogical awareness and insight. Research, such as this investigation, that seeks to understand the clinical setting and not merely to provide prescriptions for action will be useful in assisting the professional preparation and development of novice and expert nurse educators alike.

This study poses implications for other disciplines which engage in clinical practice. The model of the clinical learning environment which has been proposed has potential for application in other disciplines, especially those which, like nursing, utilize a health care agency for practical experiences. Although the investigation was conducted in one particular setting, the results are potentially transferable to other similar settings.

The research methodology has particular implications for nursing and nursing education research. To discover knowledge embedded in experience, one needs to explore and apply methods which are considered non-traditional. Qualitative methods have a great deal to offer nurses at this stage in the development of knowledge about the clinical act and the process of professional preparation.

6.3 Recommendations for Future Research

The findings of this inquiry provoke several areas for consideration as future topics for investigation into the processes of clinical instruction in nursing education.

Clinical teaching is an individual enterprise. Clinical instructors prepare themselves to teach by developing expertise and competence largely on their own. In addition, the act of clinical instruction is primarily conducted on a one-to-one basis. As teachers think, plan, make decisions, and act in the clinical setting, certain educative environments are created. These environments are intended to produce specific results in terms of student achievement of the learning objectives. Further investigation of the proposed model to reveal interactions among dimensions and the relative importance of each dimension to the teacher and the student is required.

Investigation of practical curriculum theory which addresses interaction of the teachers, students, subject matter, and milieu may serve as a fruitful undertaking for further research development. If clinical teaching activities and clinical learning environments are systematically studied in conjunction with research on nursing students and nursing theory, propositions that can be tested and applied to improving the effectiveness of teaching and the efficiency of learning can be developed. Nurse educators will then be able to move on to meet the demands and challenges of the future with some creative suggestions for the cost-effective use of precious clinical resources.

The model of the clinical learning environment proposed in this report needs to be applied in a wider variety of settings and with a broader range of teaching programs (baccalaureate, continuing education, graduate studies) in order to determine its general utility to the nursing education community.

Further qualitative research and analysis should be conducted to derive additional insights into the decision models and teaching frameworks used by clinical instructors and how the use of such models influences the clinical learning environment and student outcomes.

This study is but a starting point in the examination of clinical instruction in nursing education. I hope the questions raised will generate further research and eventually lead to a theory of clinical instruction that will inform the craft, and improve the art of clinical teaching.

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Appendix A
Consent Forms: Instructor

The Clinical Instructor and the Learning Environment

Researcher: Ardene Robinson Vollman, R.N., B.Sc.N., M.A.(Ed.)
Doctoral Candidate, Faculty of Education
University of Ottawa Telephone: 521-3182, 564-4296

The purpose of this doctoral research is to describe, define and explore the elements which comprise the clinical learning environment. The focus of the study is on the clinical instructor of nursing, the head nurse, the student nurse, and the staff nurse coassigned for patient care, their perceptions of the clinical environment as a learning environment, the roles which are assumed in the clinical area, the relationships which are developed, communication patterns, and the actions which take place during the clinical instructional process that relate to the learning environment. Data will be collected during Winter 1987, specifically January to May.

I agree to participate in this research by:

- ◊ allowing the researcher to observe me during my regular activities as a clinical instructor, particularly when I am interacting with students and hospital personnel,
- ◊ responding to questions the researcher may pose in her attempt to understand my perspective as an instructor on a nursing unit which is used as a clinical experience site,
- ◊ allowing the researcher to tape record interviews, and to take notes during discussions, and
- ◊ helping the researcher decide which information will be shared with others.

I understand that my participation is voluntary and I can withdraw from the study at any time without penalty. Participation will not affect my standing at the College. No remuneration will be received for my part in the study.

The researcher will respect the confidentiality of all conversations and observations. Privacy will be maintained, and no names will be used.

The researcher will negotiate the time and venue of all conversations so that the participant will not be unduly inconvenienced.

All interpretations and descriptions will be checked and rechecked. Information will only be used (oral or written) in the report after the researcher and the participant agree on which examples and quotations to include.

I have read the consent, and I understand the nature of my involvement in this research project. I agree to participate according to the above conditions.

Name: _____ Signature: _____

Address: _____

Telephone: _____

Date: _____ Researcher: _____

Appendix A (cont'd)
Consent Forms: Student Nurse

The Clinical Instructor and the Learning Environment

Researcher: Ardene Robinson Vollman, R.N., B.Sc.N., M.A.(Ed.)
Doctoral Candidate, Faculty of Education
University of Ottawa Telephone: 521-3182, 564-4296

The purpose of this doctoral research is to describe, define and explore the elements which comprise the clinical learning environment. The focus of the study is on the clinical instructor of nursing, the head nurse, the student nurse, and the staff nurse coassigned for patient care, their perceptions of the clinical environment as a learning environment, the roles which are assumed in the clinical area, the relationships which are developed, communication patterns, and the actions which take place during the clinical instructional process that relate to the learning environment. Data will be collected during Winter 1987, specifically January to May.

I agree to participate in this research by:

- ◊ allowing the researcher to observe me during clinical practice hours particularly when I am interacting with the clinical instructor and hospital personnel,
- ◊ responding to questions the researcher may pose in her attempt to understand my perspective as a student nurse on a nursing unit which is used as a clinical experience site,
- ◊ allowing the researcher to tape record interviews, or to take notes during conversations,
- ◊ allowing the researcher to read notes I or the instructor keep about my clinical experience, and
- ◊ helping the researcher decide which information will be shared with others.

I understand that my participation is voluntary and I can withdraw from the study at any time without penalty. Participation will not affect my grade in the course. No remuneration will be received for my part in the study.

The researcher will respect the confidentiality of all conversations and observations. Privacy will be maintained, and no names will be used.

The researcher will negotiate the time and venue of all conversations so that the participant will not be unduly inconvenienced.

All interpretations and descriptions will be checked and rechecked. Information will only be used (oral or written) in the report after the researcher and the participant agree on which examples and quotations to include.

I have read the consent, and I understand the nature of my involvement in this research project. I agree to participate according to the above conditions.

Name: _____ Signature: _____

Address: _____

Telephone: _____

Date: _____ Researcher: _____

Appendix A (cont'd)
Consent Forms: Staff Nurse

The Clinical Instructor and the Learning Environment

Researcher: Ardene Robinson Vollman, R.N., B.Sc.N., M.A.(Ed.)
Doctoral Candidate, Faculty of Education
University of Ottawa Telephone: 521-3182, 564-4296

The purpose of this doctoral research is to describe, define and explore the elements which comprise the clinical learning environment. The focus of the study is on the clinical instructor of nursing, the head nurse, the student nurse, and the staff nurse coassigned for patient care, their perceptions of the clinical environment as a learning environment, the roles which are assumed in the clinical area, the relationships which are developed, communication patterns, and the actions which take place during the clinical instructional process that relate to the learning environment. Data will be collected during Winter 1987, specifically January to May.

I agree to participate in this research by:

- ◊ allowing the researcher to observe me during clinical practice hours particularly when I am interacting with the clinical instructor and students,
- ◊ responding to questions the researcher may pose in her attempt to understand my perspective as a nurse on a unit which is used as a clinical teaching site for student nurses,
- ◊ allowing the researcher to use a tape recorder during formal discussions, and to take notes during spontaneous conversations, and
- ◊ helping the researcher decide which information will be shared with others.

I understand that my participation is voluntary and I can withdraw from the study at any time without penalty. Participation will not affect my standing at the hospital. No remuneration will be received for my part in the study.

The researcher will respect the confidentiality of all conversations and observations. Privacy will be maintained, and no names will be used.

The researcher will negotiate the time and venue of all conversations so that the participant will not be unduly inconvenienced.

All interpretations and descriptions will be checked and rechecked. Information will only be used (oral or written) in the report after the researcher and the participant agree on which examples and quotations to include.

I have read the consent, and I understand the nature of my involvement in this research project. I agree to participate according to the above conditions.

Name: _____ Signature: _____

Address: _____

Telephone: _____

Date: _____ Researcher: _____

Appendix B
Attestation of Auditor

The Clinical Instructor of Nursing and the Learning Environment: A Qualitative Study, Doctoral Dissertation by Ardene Vollman

An audit was conducted to assess the trustworthiness of this study. Specific attention was paid to the dependability and confirmability of the inquiry and the openness of the investigation to alternative explanations and interpretations of the data.

A modification of the audit procedures suggested by Halpern (1983) and outlined in Lincoln and Guba (1985) was used. An audit trail was established and randomly selected items were reviewed in detail. These included raw data (tapes, transcripts, and field notes) and descriptions of data analysis and synthesis. A peer debriefing process was used to explore the methodological approach and assess inquirer bias. One key participant was selected at random and contacted to verify participation and the member checking process. Two nurse educators who had not participated in the study were asked to verify that the inferences drawn from the data were logical. These procedures were implemented intermittently from the time the pilot study was planned until the final report of the study was drafted.

Findings of the audit are reported below. There is evidence that audio tapes were transcribed accurately. There is a complete record of interview transcripts and field notes. For findings sampled, there were linkages in the audit trail from raw data to synthesized data to reported data. Examples used were representative of others found in the data base. Categories generated were congruent with the data and there was agreement that inferences drawn were reasonable. There was evidence that the investigator worked to identify personal values, interests, and beliefs that could influence the selection and interpretation of study data. Indeed, there is record of shifts from the initial entry perspective as data were collected and analyzed. In summary, introspection, reflective writing, and peer debriefing were used to control inquirer bias. Findings sampled were grounded in the data collected and conclusions drawn were logically consistent with the data base.

Dianne Bloor
August 29, 1989

Appendix C
Selected Data: Raw Transcript

Ardene: All of these things would be cultural things within an environment.

Yes, and I made a selection last week. I don't meet all the patients that I select for my students and I assigned, I didn't know that she was Muslim, because she had a Canadian name.

Ardene: You had assigned her a male student!

Yes I did (laughter) but the staff intervened, and they said that they didn't think that she would appreciate it and I was very grateful for their input, so, and the student adjusted very well. In fact, he came to me, he said that they didn't think that this was very (laughter) right so I didn't think anything of it. But I was glad. The staff felt comfortable in telling me and that was good.

Ardene: Do you, again, do you have any major cultural mix among the students?

Not in this group, no. And I, I mean, no cultural differences.

Ardene: And what about the staff on the floor?

Well, there's one nurse on one ward who's probably from the Philippines perhaps, I'm not sure. She's been very good with the students. She's been here for awhile and so she's ...

Ardene: Very Canadianized.

I think so. Westernized in her ways.

Ardene: When you look at culture, you look, you know, beyond sort of the ethnic and religious things and look also at organizational culture. So if you're looking at the organizational culture at the [redacted] what kinds of things..., do you have any, sort of impressions on that?

Okay, I'm not sure that I understand what you're ...

Ardene: What do they value? What are their expectations of you and the students? What things are done, not done, sort of?

They allow us a large amount of freedom. They are quite, very co-operative with the students and myself. They don't really interfere, they offer things to us which is most appreciated but they do allow us to pretty much do our own thing, I guess. I haven't really had any concerns at all.

Ardene: They're very open to education?

Appendix C (cont'd)
Selected Data: Raw Transcript

Well, they're very used to students. The only thing that we had to clarify was really the level of these students because this is the first time this year that they have this level of students. They're used to having 2nd year students, not 1st year, and 2nd & 3rd year university students. And so, since my students don't give medications or don't do other things, the staff have to sort of rethink that. But they adjusted very well, and we had no problems at all.

Ardene: What do they like from the students? (silence, confusion about question) What do they expect? What do they value?

They seem to really value the communication. They like the students to show interest, I think, in what they are offering them, and in questioning and so on. I think they like it when the students use them as a resource person. They really value communication because they are assigned those patients themselves and if the students are keeping them well informed then they feel good about what's happening. If the student isn't going through them and informing them, even if things are fine, I noticed in one situation, at least, where the staff member seemed a little bit agitated and I'm sure it was purely because the communication wasn't there. Everything was fine, but she didn't know everything was fine. But for the most part they have a positive attitude towards the students, they are very helpful with the students, they offer them suggestions, they offer them assistance, but they don't take over my job, they leave things for me but at the same time they are willing to help. I can't be everywhere at the same time.

Ardene: They don't take over for the students?

No. No, they don't. They like to give them experiences. If they hear of something that's happening that's different, they invite them to be involved. Even as an observer, just to see what's going on.

Ardene: In the literature we read that the head nurse is very important to setting the climate or the tone on the unit. How would you respond to that?

I don't think that I've ever seen it quite as evident as it is. Certainly, I credit both the nurses in charge for the very positive attitude and atmosphere that's been created. I think [redacted] is a very positive person, particularly positive about the students and friendly and that has really made a nice situation for us to be in. The other Head Nurses are relief Head Nurses who took over the role just shortly after we came. Again, she's not as outgoing, but very efficient and helpful whenever we question her. So it's been really good for the students.

Appendix C (cont'd)
Selected Data: Unitized Transcript

Ardene: All of these things would be cultural things within an environment.

Yes, and I made a selection last week. I don't meet all the patients that I select for my students and I assigned, I didn't know that she was Muslim, because she had a Canadian name.

Ardene: You had assigned her a male student!

Yes I did (laughter) but the staff intervened, and they said that they didn't think that she would appreciate it and I was very grateful for their input, so, and the student adjusted very well. In fact, he came to me, he said that they didn't think that this was very (laughter) right so I didn't think anything of it. But I was glad. The staff felt comfortable in telling me and that was good.

Ardene: Do you, again, do you have any major cultural mix among the students?

Not in this group, no. And I, I mean, no cultural differences.

Ardene: And what about the staff on the floor?

Well, there's one nurse on one ward who's probably from the Philippines perhaps, I'm not sure. She's been very good with the students. She's been here for awhile and so she's ...

Ardene: Very Canadianized.

I think so. Westernized in her ways.

Ardene: When you look at culture, you look, you know, beyond sort of the ethnic and religious things and look also at organizational culture. So if you're looking at the organizational culture at the [redacted] what kinds of things..., do you have any, sort of impressions on that?

Okay, I'm not sure that I understand what you're ...

Ardene: What do they value? What are their expectations of you and the students? What things are done, not done, sort of?

They allow us a large amount of freedom. They are quite, very co-operative with the students and myself. They don't really interfere, they offer things to us which is most appreciated but they do allow us to pretty much do our own thing, I guess. I haven't really had any concerns at all.

Ardene: They're very open to education?

CULTURE
[Teacher activity]
Patient Selection

Staff intervention

Student response

* Cross check this
Student data indicates one black and one native Canadian

ORGANIZATIONAL CONTEXT

Freedom to teach
↓ interference from hospital

Appendix C (cont'd)
Selected Data: Unitized Transcript

Well, they're very used to students. The only thing that we had to clarify was really the level of these students because this is the first time this year that they have this level of students. They're used to having 2nd year students, not 1st year, and 2nd & 3rd year university students. And so, since my students don't give medications or don't do other things, the staff have to sort of rethink that. But they adjusted very well, and we had no problems at all.

Many students
· confusion re level
· staff adapt

ask H.N. about this

Ardene: What do they like from the students? (silence, confusion about question) What do they expect? What do they value?

They seem to really value the communication. They like the students to show interest, I think, in what they are offering them, and in questioning and so on. I think they like it when the students use them as a resource person. They really value communication because they are assigned those patients themselves and if the students are keeping them well informed then they feel good about what's happening. If the student isn't going through them and informing them, even if things are fine, I noticed in one situation, at least, where the staff member seemed a little bit agitated and I'm sure it was purely because the communication wasn't there. Everything was fine, but she didn't know everything was fine. But for the most part they have a positive attitude towards the students, they are very helpful with the students, they offer them suggestions, they offer them assistance, but they don't take over my job, they leave things for me but at the same time they are willing to help. I can't be everywhere at the same time.

Recurring theme *

Interpersonal
· relationship
· communication

reporting
? Is it reciprocal?
watch for it

Staff-teacher role definitions.

Ardene: They don't take over for the students?

No. No, they don't. They like to give them experiences. If they hear of something that's happening that's different, they invite them to be involved. Even as an observer, just to see what's going on.

watch for this

Ardene: In the literature we read that the head nurse is very important to setting the climate or the tone on the unit. How would you respond to that?

I don't think that I've ever seen it quite as evident as it is. Certainly, I credit both the nurses in charge for the very positive attitude and atmosphere that's been created. I think [redacted] is a very positive person, particularly positive about the students and friendly and that has really made a nice situation for us to be in. The other Head Nurses are relief Head Nurses who took over the role just shortly after we came. Again, she's not as outgoing, but very efficient and helpful whenever we question her. So it's been really good for the students.

CLIMATE

Role of H.N.

ref. Orton (83) in Davis, B.

Appendix C (cont'd)

Selected Data: Database Record

Transcript Unit

Yes, and I made a selection last week. I don't meet all the patients that I select for my students and I assigned, I didn't know that she was Muslim, because she had a Canadian name.
Ardene: You had assigned her a male student!
Yes I did (laughter) but the staff intervened, and they said that they didn't think that she would appreciate it and I was very grateful for their input, so, and the student adjusted very well. In fact, he came to me, he said that they didn't think that this was very (laughter) right so I didn't think anything of it. But I was glad. The staff felt comfortable in telling me and that was good.

Unit Identifiers

Name: Errin | Date: 02-20-87 | Int. #: 1 | Line #: 554

Hospital: East [ ] West [y]

Occupation: SN1 [ ] SN2 [ ] SN3 [ ] HN [ ] CI [y] RN [ ] Other [ ]

Applicable Categories

Properties: Complexity [ ] Structure [ ] Stability [ ] Opportunity [ ]

Roles of the Clinical Instructor: Coach [ ] Consultant [ ] Colleague [ ] Counsellor [ ]

Environmental Dimensions: Personal [ ] Social [ ] Physical [ ] Curricular [ ] Contextual [y] Political [ ] Economic [ ]

Functions of the Clinical Instructor:
Personal Orientation [ ]
Preparation of Unit [ ]
Preparation of Student [ ]
Instructional Activities [ ]
a) Patient Selection [y]
b) Communication [ ]
c) Curriculum Translation [ ]
Monitoring & Evaluation [ ]
a) Student Progress [ ]
b) Self Reflection [ ]
c) Environment [ ]

Comments

male student
patient religion

Appendix D
Summary of Research Data

Category	Sub-Category	Name	Date	Pages	Words
Pilot:					
Head Nurse		Mae	13-Feb-87	11	4,120
Teachers		Nathalie #1	11-Feb-87	32	14,276
		Nathalie #2	11-Jun-87	36	16,551
Research:					
Head Nurse		Helen	26-Mar-87	6	2,602
		Lil	8-Apr-87	16	6,072
		Michelle	6-Apr-87	19	8,284
Nurse		OC	24-Mar-87	5	1,823
		LE	23-Mar-87	6	2,439
		ES	23-Mar-87	7	3,276
		NR	23-Mar-87	7	2,808
		YE	26-Apr-87	9	3,534
		HT	26-Mar-87	5	1,825
Students	Year 1: Civic	RO	5-Apr-87	7	1,434
		LO	12-Apr-87	8	2,349
		IS #1	5-Mar-87	1	311
		IS #2	5-Apr-87	14	4,472
		AA	12-Apr-87	10	2,723
		IU	25-Apr-87	6	1,950
		ON	12-Apr-87	12	3,967
		OA	5-Apr-87	8	2,633
		TK	12-Apr-87	12	3,143
	Year 1: General	NO	25-Apr-87	4	1,709
		NL	26-Apr-87	5	1,950
		NA	26-Apr-87	9	3,147
		Group-General	26-Mar-87	21	6,830
		EE	25-Apr-87	7	2,614
		NS	12-Apr-87	9	3,030
		SN	26-Apr-87	6	2,289
		AC	25-Apr-87	19	6,671
	Year 2	AW #1	1-Apr-87	11	3,422
		AW #2	15-Apr-87	6	1,963
		HC	15-Apr-87	11	4,212
		EA & HC	1-Apr-87	14	5,267
		EA	7-Apr-87	9	2,526
		IO	14-Apr-87	14	4,998
		AR #1	24-Mar-87	11	4,227
		AR #2	14-Apr-87	12	4,575
		TE	14-Apr-87	13	3,940
		UO	14-Apr-87	14	5,742
Teachers		Errin #1	20-Feb-87	15	6,211
		Errin #2	12-Jun-87	34	17,302
		Peggy #1	16-Mar-87	30	14,379
		Peggy #2	15-Jun-87	41	18,940
		Sara #1	25-Feb-87	21	10,983
		Sara #2	1-Apr-87	20	11,419
		Sara #3	16-Jun-87	48	26,465
Notes:					
Pilot				26	7,323
Reasearch				65	21,385
Student				11	4,653
Totals				**743**	**298,764**

Appendix E
Glossary of Clinical Terms

Ambulant	Able to walk, not confined to bed.
Antenatal	Pregnant, prior to the onset of labour.
Analgesic	Painkiller.
Antepartum	The time before the onset of labour.
Blood values	Laboratory results of blood tests.
Buddy nurse	The staff nurse co-assigned to a patient with the student nurse.
Caesarian section	Operative procedure for birth, as opposed to natural delivery.
Case Room	Specialty area dedicated to labour and delivery.
Catheter	A tube into the bladder to drain urine.
Chem strips	A procedure used to monitor blood sugar levels.
Cyanosis	Bluish discolouration of skin related to decreased oxygen in the system.
Epidural	Procedure of spinal anaesthesia used to minimize the discomfort of labour and delivery.
Episiotomy	Incision of perineum prior to delivery to avoid tearing the perineum by the vaginal delivery of an infant.
Fetus	The child in utero from the third month to birth.
Gestational diabetes	Diabetes of pregnancy.
Gynaecology	Surgical specialty related to female reproductive organs.
Incubator	A covered bassinette in which newborn infants who require close supervision and environmental control are placed.
Insulin	Medication used in the treatment of diabetes.
Isolation technique	Procedures instituted to prevent the spread of infection.
IV	Abbreviation for intravenous(ly), within or into a vein.
Jaundice	Yellowish discolouration of the skin related to increased levels of bilirubin.
Kardex	Portable filing system which contains cards on which relevant information pertaining patients is written.

Appendix E (cont'd)
Glossary of Clinical Terms

Lochia	The discharge from the uterus of blood, mucus, and tissue, during the postpartum period.
Meds	Abbreviation for medications.
Nasogastric	A tube from the stomach through the nose for the purpose of draining stomach contents.
Nonstress test	A particular diagnostic test to assess the condition of the fetus in antepartum women.
Obstetrical	Relating to the management of pregnancy, labour, delivery.
OR	Abbreviation for Operating Room.
Pallor	Pale skin, often a sign of shock.
Peri-care	Hygienic care of the perineum.
Perinatal	Surrounding the time of birth.
Perineum	The region between the vulva and anus.
Postpartum	After childbirth.
Prn meds	Medication as required, based on patient request, at the discretion of the nurse.
Proctosedyl	Medication for the treatment of haemorrhoids.
RN	Abbreviation for Registered Nurse.
RNA	Abbreviation for Registered Nursing Assistant.
Scrub dresses	Special garments worn in operating room and case room. Also called "greens" because of their colour.
Staple remover	A device used to remove metal surgical staples from an incision.
Toxemia	A complication of pregnancy which causes high blood pressure and is considered to place the mother and fetus at considerable health risk.
Universal precautions	Normal procedures used to prevent the spread of infection.
Vitals	Colloquial term for vital signs; the measurement of temperature, pulse, respirations, and blood pressure.