Everything matters: Exposing the complexity of stakeholder collaboration in clinical education for undergraduate nursing students

Cara Poffley

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Abstract

The question asked in this study is *how do stakeholders collaborate to support the development of clinical competence in undergraduate nursing students in the acute care setting?* In 2015, a Bachelor of Health Science (Nursing) programme underwent two audits. The first audit carried out by Janice Muller, an independent auditor from a private consulting company, focused on the clinical model being used within the programme. The second audit was carried out by the Nursing Council of New Zealand in accordance with the regular accreditation and monitoring of AUTs pre-registration programme. Both audits questioned the effectiveness of stakeholder collaboration in relation to student learning in the clinical setting. Feedback from clinical partners highlighted a desire to be more actively involved with student learning experiences.

The study explored the complexity of values and beliefs along with contextual factors that enable and constrain stakeholder collaboration between student nurses, registered nurses in clinical practice, and academic clinical educators. Gaining insight into this complexity helps to explain how stakeholders collaborate. Using interpretive description (ID) underpinned by complexity theory (CT), data were collected through focus groups and individual interviews, and analysed using a Complex Adaptive System (CAS) principle framework. Interpretative analysis identified collaboration occurs on a contextually influenced continuum comprised of five interrelated dimensions: 'the individual(s)', 'the relationship', 'clinical practice', 'acute care environment', and 'clinical education'. Within these interrelated dimensions are notions related to values and beliefs, as well as other factors that both enable and constrain collaboration.

Findings show that student nurses are usually positioned on the peripheries of collaboration, even though they are central to the purpose of interaction between stakeholders. Valuing stakeholder relationships and the registered nurses' clinical responsibilities will enable organisations to invest in collaboration by providing protected time for both patient care and student learning. Teaching students how to collaborate with other stakeholders will empower them to meet their learning needs within this complex system. Helping students to develop both confidence and competence is key to creating a safe learning and practice environment for all stakeholders, including patients. Attending to these recommendations early in the

students' programme of study will improve outcomes for students as they progress through their nursing programme and become registered nurses.

Contents

List of Figures

List of Tables

Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

25 June 2022

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Signature Date

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Ethics Approval

Ethical approval was obtained from:

- Auckland University of Technology Ethics Committee: Reference number 18/88: 22 March 2018 (Appendix A)

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Chapter 1 INTRODUCTION

As an experienced nursing lecturer in a Bachelor of Health Science (BHSc) nursing programme, the quality and delivery of undergraduate nursing education has, and continues to be, a priority for me. This thesis presents doctoral research undertaken to explore a significant aspect of undergraduate nursing education—the complexity of stakeholder collaboration in clinical education for undergraduate nursing students. Using an interpretive description (ID) approach underpinned by complexity theory, (CT) findings identified a collaborative context comprising five interrelated dimensions, influenced by notions held by stakeholders. Notions are ideas that reflect the values and beliefs held by individual stakeholders, as well as ideas related to environmental factors which influence interactions between stakeholders. Chapter one introduces the impetus and background for the study and provides key definitions. The study aims, research questions, methodology and methods will be outlined, along with my own position within the research topic and process. Finally, the structure of the thesis itself will be presented.

Impetus for the Study

In 2015, the Department of Nursing at AUT University underwent two audits. The first audit carried out by Janice Mueller, an external consultant, provided a review of AUT's clinical placement models for undergraduate nurses (Mueller, 2015). The Nursing Council of New Zealand (NCNZ) then carried out a routine monitoring audit of the entire BHSc nursing programme (NCNZ, 2015). With 16 similar programmes of nursing education throughout New Zealand, the NCNZ (2015) is responsible for ensuring all Tertiary Education Providers (TEPs) are implementing curricula that produce nursing graduates who are safe to practice. One recommendation from the second audit was for AUT to "undertake a review of the clinical model including Clinical Educator roles with a view to increasing their presence and accessibility within clinical areas" (NCNZ, 2015, p. 4). The NCNZ (2015) report also noted there was "limited evidence of triangulation between the clinical experience staff and academic staff in the final assessment against the Council competencies" (p. 16). Moreover, the report identified that clinical providers wanted more involvement

with university clinical educators (CEs) when they were supervising students on clinical placement, and improved liaison and collaboration at a strategic level.

Mueller's findings had already highlighted the need for greater collaboration between the university and clinical placement providers, the rationale being to optimise student learning and improve stakeholder relationships. However, I believed, more importantly, that greater collaboration needed to occur closer to the student's learning experience—between the student nurse, registered nurse, and the academic clinical educator. The potential positive outcome of more effective collaboration is the production of graduates who are well prepared to transition into beginning registered nursing practice. More effective collaboration may also identify students who are not progressing as expected earlier in their nursing programme. In order to understand how collaboration influences student outcomes, I needed to establish ***how stakeholders currently collaborate*** to support the development of clinical competence in undergraduate nursing students. For the purpose of this study, I therefore focused on a triad of stakeholders i.e., the student nurse (SN), the supervising registered nurse (RN), and the academic CE employed by the university.

Terminology: Defining Key Terms

Collaboration: Daniels and Khanyile (2013) defined collaboration as

> a process in which autonomous actors interact through formal and informal negotiations, jointly creating rules and structures governing their relationships and ways to act or make decisions on the issues that brought them together. It is a process involving shared norms and mutually beneficial interaction. (p. 956)

This definition is appropriate for this study because it reflects the complexity inherent in clinical learning and recognises the contribution of values, beliefs (shared norms), rules and structures influencing the ways in which stakeholders work together.

Competence: The NCNZ (2020) have defined competence as "the combination of skills, knowledge, attitudes, values and abilities that underpin effective performance as a nurse" (p. 33). While there appears to be significant critique of a clear definition for the term competence (Fernandez et al., 2012; Lingard, 2009), I am using this term in the study because it is currently used by nursing students and RNs referring to

assessment of SNs' clinical practice (NCNZ, 2020). Competence is also the premise of the HPCAA (2003).

Stakeholders: Gerwel Prochers and Bodhanya (2015) defined stakeholders as "a group of people who work together to accomplish a common goal" (p. 2507). These authors bring to attention that stakeholders may have a shared objective but at the same time are working towards competing goals. This definition is appropriate for the study because there is the shared objective between stakeholders of providing a good learning opportunity for students, alongside the competing goals of providing patient care and participating in assessment processes for students.

Background to this Study

Formal nursing education in New Zealand commenced in 1883 when Wellington and Auckland hospitals introduced the Nightingale system of lady probationer training (Kinross, 1984). At this time, nurses learned much about obedience (Lusk et al., 2001). However, the training focused on more than obedience and included "control of the environment, nutrition, hygiene and the prevention of cross infection" (Kinross, 1984, p. 194). Since 1883, nursing education has undergone many changes for a variety of reasons. It is important to explore this history because learning about the past, helps to shape the future of nursing education in New Zealand (Birchenall, 2003). Knowledge of how nursing education has developed over the intervening years, between 1883 and 2022, empowers those involved to actively contribute to current developments because it explains the complexity of the profession (Madsen et al., 2009). Additionally, Manchester (2015) believes that understanding the past enables nurses to reach their full potential. This section explores the evolution of nursing education in New Zealand to ascertain how the profession has come to where it is today. Consideration will be given to the social, political, and legal contexts that have influenced the changes, while making relevant international and professional comparisons.

Nursing in New Zealand was legislated in 1901 when the profession responded to the introduction of the New Zealand Nurses Act and became the first country in the world to register nurses (Lusk et al., 2001; Wood & Nelson, 2013). At this time, the educational design, based on the Nightingale Model, was a hospital based,

apprenticeship-style training that originated in England (Woodham-Smith, 1952). The global influence of Florence Nightingale provided the foundations for significant similarities in nursing education across New Zealand (NZ), Australia, the United Kingdom (UK) and the United States of America (USA) (Lusk et al., 2001). Nursing students were employed by hospital boards and trained for a period of three to four years as part of the nursing workforce. In NZ, at the end of this training and employment, the students sat a State Examination that enabled them to become RNs.

Significant influences on nursing during this time were external stakeholders such as the medical doctors and hospital administrators who dictated and managed what nurses learnt (Kako & Rudge, 2008; Matejski, 1985). However, one influential nurse, Hester Maclean, the founder and first editor of the NZ Nursing Journal *Kai Tiaki*, challenged this domination (Wood, 2008). Maclean, who originated from Australia, published journal articles written by both doctors and nurses attempting to spread what constituted best practice of the time. According to Maclean (1908, as cited in Anonymous, 2008) the purpose of the then NZ Nursing Journal was to create a bond that connected all nurses, as well as creating a method of communication aimed at improving the work and knowledge of the profession. It could be argued this was an early form of collaboration between nurses for the development of current and future nurses.

In 1912, it was suggested by a doctor at Auckland Hospital that nursing education should be situated within a university as recognition of its professional status (Kinross, 1984). However, Maclean was not in agreement because she believed that hospital-based training was appropriate for nurses who wished to devote themselves to caring for the sick. She was open to the idea that nurses aspiring for leadership and educational roles may benefit from post-graduate (PG) studies; however, she did nothing to promote the implementation of such education at this time. Wood (2015) identified World War I as a time when nurses were exposed to settings and circumstances that were starkly different from the environment in which they had trained. What nurses were learning was dependent upon the setting in which they were employed. Thus, there was significant variation in what they knew and how this impacted the quality of the care provided (Wood & Nelson, 2013). During this period,

NZ nursing education was under review, and it lead to a time of great innovation in the 1920s.

The first significant change occurred in 1920, when the Department of Health was restructured and the first Division of Nursing was formed (Kinross, 1984). Maclean took on the position of chief nurse within the Division of Nursing but only remained in the post for two years before retiring. Jessie Bicknell took over and began making plans to move nursing education into universities. In 1925, Otago University launched a 5-year Diploma of Nursing. Kinross (1984) described the Diploma as a "sandwich-type programme" (p. 194), with the first two years focusing on learning sciences, the following two years in hospital training, and the final year back in the university specialising in either hospital or public health nursing. However, the Diploma was short lived and closed in 1927 due to financial constraints.

Another dominant focus of this era was on the standardisation of a nursing curriculum across NZ's 27 hospital-based training programmes (Lusk et al., 2001; Wood, 2008; Wood & Nelson, 2013). From the 1930s, nurses began to have greater influence on nursing education and practice. Nurse leaders established what is now recognised as the beginnings of evidenced-based practice through the distribution of procedural instructions. Distribution of surveys to RNs ascertained what was common and effective in practice, and it was from this informal research that the procedural instructions were developed. However, Wood and Nelson (2013) reported concerns that nursing education focused on technical aspects of practice, which limited the thinking capacity of nurses and did not promote the individuality of patient care needed to provide high quality levels of care.

During the 1940s, schools of nursing situated within the hospitals implemented a standardised nursing curriculum. Wilkinson (2006) described her training in the 1940s as commencing with an initial period of three months which included weekly visits to the wards. The focus of learning was relevant to the duties of the nurses at the time such as bed making, washing patient lockers, and mopping the floor. After this initial period, some students became residents of the onsite nursing home for the remainder of their four-year training, enabling full immersion into the profession while off as well as while on duty. The education provided over these four years included lectures

usually held in off duty time. This is in contrast to Feeney (2013) who recalled that, in the 1950s, formal tuition occurred off the wards for weeks at a time. Immediately following these 'study blocks', students would work for periods of 3-4 months on the wards. Wilkinson (2006) reflected that student nurses (probationers) were poorly paid given the nature of the work and their long hours but that complaints were rare because they viewed their work as something worthwhile.

It is evident that there was already a shift in the education of nurses between 1940 and 1950. The work and, therefore, education of probationers up to the 1960s continued to include menial tasks such as cleaning and meal distribution (Manchester, 2015). Nurses in training were awarded substantial levels of responsibility, such as being left in charge of wards, and, therefore, patients, overnight. This isolation of nurses in training highlights the lack of collaboration provided to support their practice development. Judy Kilpatrick, a well-known nurse leader in NZ, remembers her experience as a junior nurse in the 1960s as a time of survival (Cassie, 2016). Yet neither Cassie nor Manchester discuss the safety implications of having junior nurses, with very little knowledge or experience caring for patients. Wilkinson (2006) does refer to the mistakes that young nurses made and Wood (2008) expressed concerns about the standard of nursing care provided by probationers as being a driving force behind standardisation of nursing practices. However, the attempt to standardise nursing practice and education progressed slowly over a period of at least six decades and remains problematic today.

A number of other contextual factors influenced changes to nursing education during the mid-1900s. O'Connor (2014) suggested that hospital training was no longer adequately preparing midwives for practice and it can be presumed that the same could be said for nurses. Developments in practice were not being implemented by those who were employed to use them because there was insufficient understanding of how new technologies worked and/or affected patient care. Hughes (1969, as cited by Anonymous, 2008) acknowledged that the education of nurses needed to respond positively for the future of nursing. The key message from Hughes was that nursing practice was changing at such a pace that nursing educators needed to prepare nurses who were curious to find information for themselves, rather than following

instructions on how to nurse. Doing so would require nurses to develop a higher level of knowledge and thinking, compared with expectations of nurses at that time.

Changes during the 1970s were possibly the most significant in the history of nursing education in NZ. At the start of this decade, nursing education was divided into general nursing and psychiatric/mental health nursing (Prebble, 2001). In 1971, at the invitation of the World Health Organization, Dr Helen Carpenter, a Canadian nursing academic, was asked to review how nurses were educated in NZ. Her report found that the hospital-based training system was "outdated and no longer suited to the needs of students or health services" (Carpenter, 1971, p. 9). Carpenter cited a number of reasons for this finding, including developments in health, changes to the roles and expectations of women, and improvements in education. Prebble (2001) expanded on the rationale for change at this time, identifying high dropout rates of student nurses, poor standard of teaching, unnecessarily regimented nursing practice, and a curriculum that did not align theory with where and what nursing students were experiencing in practice. As in NZ, the USA also went through a review process which criticised the treatment of students as employees (Orsolini-Hain & Waters, 2009). Carpenter's (1971) main recommendation for NZ was for one nursing programme situated within universities which included both general and mental health nursing: hence, the creation of comprehensive nursing education.

There was, however, debate about the validity of the Carpenter report. The NZ Public Service Association (NZPSA) (1974), which represented both psychiatric nurses and many general and obstetric nursing students, was quick to point out that Carpenter's recommendations were based on her own experience of the Canadian education system and there was no evidence to suggest that the new system was effective in Canada, let alone NZ. There was also criticism of the committee formed to respond to Carpenter's recommendations. It was believed that educators heavily influenced the committee and there was no representation from the NZPSA on behalf of nurses and students in practice. Despite these concerns, NZ began to introduce diploma level comprehensive nursing programmes into polytechnic institutions in 1973 (Lusk et al., 2001; O'Connor, 2014). It was proposed that these programmes should be two and a half years long, with half of this time spent in clinical practice settings (NZPSA, 1974). The goal of these changes was that NZ would produce graduates who were well

prepared to work in any practice setting. Yet, it is important to note that, for the next two decades, NZ operated a dual system of nursing education: certificate from hospital-based apprenticeship and a tertiary qualified diploma.

Once hospitals were staffed by 'diplomates' (an informal name given to nurses who graduated from polytechnics with diplomas), the role of the RN changed (Wood & Nelson, 2013). The higher level of education lifted the nursing profession and nurses began to take on more responsibility. The District Health Boards (DHBs) were happy for nurses to use their newfound scientific knowledge by increasing their scope of practice and taking on tasks previously assigned to medical staff. While potentially perceived as valuing the nurse's ability to practice at a higher level, there was potential exploitation of nurses as well (Jacobs & Boddy, 2008)—because nursing could be viewed as a cheaper workforce, it could be manipulated politically.

The NZ health reforms of the 1980s were an attempt to create a more efficient health system (Jacobs & Boddy, 2008). Nursing was not immune to changes that occurred at this time, especially in nursing leadership roles. Brinkman (2006) reflected back to when the 'Division of Nursing' within the Department of Health had 16 staff, including seven nurse advisors who worked primarily on matters that affected nursing, such as policy development and legislation revision. They were also advisors to DHBs and education providers, along with influencing planning of the nursing workforce. However, the structure of the Division of Nursing was eroded and nursing was left with one lone person to represent all of NZ's nursing concerns. This resulted in nursing becoming less visible and effective at the political level. These political changes significantly impacted professional changes in the 1990s, when all nursing education shifted to tertiary educational providers and entry to the register required that all applicants had an undergraduate bachelor's degree in nursing (Jacobs & Boddy, 2008; Lusk et al., 2001).

Concurrently, there was a drive to further increase the professional status of nurses practicing in NZ (Cassie, 2016). Likewise, Australia justified their transition to tertiary-based education as being related to past knowledge limitations, a narrow focus of practice provided by hospital-based training, and the desire of nursing to lift its professional status (Fetherstonhaugh et al., 2008; Harwood, 2011). Yet, according to

Madsen et al. (2009) curricula in Australia were not adequately addressing identity development in nursing students. The inability of students to recognise that they were joining the 'family of nursing' was problematic. Madsen et al. (2009) pointed out that this 'family' had a past that significantly influenced nurses' practice. They claimed that this aspect of professional development was being squeezed out in time-precious curricula, giving precedence to the technical skills of nursing practice.

Both nursing practice and nursing education are in a constant state of evolution. The Ministerial Taskforce on Nursing established in 1998 by the Minister of Health was an acknowledgement that contextual barriers were preventing nurses from reaching their full potential (Jacobs & Boddy, 2008). Since then, to support nurses to work to their potential, advanced education and practice roles such as nurse specialist and nurse practitioner have been established. Yet how advanced education and practice roles provide collaborative opportunities to support development is not clear. Jacobs and Boddy (2008) referred to the New Zealand Nursing Organisation's perspective that experience alone is insufficient for confirming advanced nursing practice positions. Practice experience must be supported with ongoing PG study, acknowledging the lifelong relationship between clinical practice and the ongoing formal education of nurses. However, there is disagreement. Hardcastle (2006) challenged the idea that PG education, in the form of university papers, is appropriate for all nurses, acknowledging that over half of the RNs employed in the year 2000 were hospital trained and not prepared for the academic demands of PG study. That is not to say that they would never be ready; rather, they had to find ways to transition into PG study.

Some nurses chose to embark on bachelor's degrees, while others were given provisional entry into PG programmes, based on the notion that years of clinical experience had promoted a higher level of thinking required for PG study. Professor Jenny Carryer, a leader in nursing academia in New Zealand, supported Hardcastle's (2006) perspective, suggesting PG papers often included within Nurse Entry to Practice (NEtP) programmes set up to support new graduate nurses to transition into their practice roles, can be seen as a distraction (Cassie, 2015). Conversely, McKillop et al. (2016) claimed there are significant advantages attached to PG education. They reported that nurses participating in PG study demonstrate greater critical thinking,

increased confidence, enhanced patient assessment, are more likely to advocate for patients, and make fewer medication errors. Over time, the one consistent perspective is the divergent views on how best nurses should be educated.

While the NZ Nurses Act underwent various amendments during the 20th century, it was superseded by the Health Practitioners Competency Assurance Act (HPCAA) (2003). The new legislation was designed to "protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practise their professions" (Vernon et al., 2011, p. 103). In response to this legislative change, in 2004 the NCNZ set up four distinct nursing roles and attached scopes of practice (Jacobs & Boddy, 2008)—nurse assistants, enrolled nurses, RNs, and nurse practitioners. The most common of these roles is the RN who has the responsibility of supervising nurse assistants, enrolled nurses, and student nurses.

Unfortunately, the current system of educating students for registered nursing practice is not without its problems. Rae Brooker, a nurse who trained in the late 1950s claimed that the current training system is very specialised (Manchester, 2015). This perspective of Brookers is somewhat ironic given the notion that this was the perception of hospital-based training with its lesser emphasis on community and mental health nursing. Brooker also suggested that current nursing students are not exposed to the companionship provided among nurses when they lived in the nurses' home on hospital grounds. This companionship offered ongoing opportunities for students to collaborate in their learning through the sharing of stories once they were off duty (Anonymous, 2008). There is a sense that nursing students were previously more immersed in learning about the profession than they are today.

This suggestion may be substantiated with the variety of competing demands for attention and the reduced clinical hours that university structures enable. Auckland University of Technology (AUT) currently offers a three-year Bachelor of Health Science (BHSc) degree in nursing. Yet, when accounting for semester lengths, students are only engaged in formal education for approximately six 12-week semesters in total. This equates to 3,300 hours over three years, with only 1208 hours offered in clinical practice (see appendix D). In NZ, the Nursing Council requires candidates to have

completed a minimum of 1100 hours clinical experience, with a maximum of 1500 hours (NCNZ, 2022). AUT offer only 120 hours more than the minimum requirement of 1100 hours. While this is more than the minimum required 800 hours in Australia (Australian Nursing & Midwifery Accreditation Council, 2012), it demonstrates that student nurses are currently engaged in clinical practice for a fraction of the three years previously attached to the hospital-based nursing training. Furthermore, the 50-50 theory-clinical proposal of the 1970s is no longer required.

While NZ maintains a 3-year undergraduate requirement, Australia, the UK, and the USA all offer 4-year degrees alongside the option of a 3-year degree; or, in the case of the USA, the option of a 2-year associate degree. NZ has addressed this difference in length through the implementation of the NEtP which is offered to a large percentage of new graduate nurses in their first year of employment. This is an area of nursing education/practice that has received a great deal of attention in the literature, with generally pleasing results on staff retention rates and improved levels of practice (Cassie, 2015; Haggerty et al., 2012, 2013; McKillop et al., 2016; Tuckett et al., 2015). However, the issue of quality and effectiveness of the 3-year degree programmes remains in question because NEtP does not assist those graduates who gain employment in settings where the programme is not available. While considering insufficient time as a limitation to learning, this is further exacerbated when the quality of clinical learning during that time is also impacted (Harwood, 2011; Lamont et al., 2015; Williams, 1992). Furthermore, the financial demands on most contemporary university students means that students are also often holding down a part-time job. For many, this may distract from 'becoming' a nurse.

In summary, it could be argued that the system currently preparing the future nursing workforce in NZ is fragmented and inadequate, limiting the opportunities for students to gain confidence, achieve competence, and develop a strong professional identity. It is, therefore, not surprising that the expectation that today's nursing graduates will 'hit the ground running' is unrealistic (Harwood, 2011).

History of Collaboration in Nursing Education in NZ

To understand the current situation more fully, it is important to recognise how the history of nursing education has contributed to contemporary stakeholder

collaboration. In response to the Carpenter Report (Carpenter, 1971), nursing education in NZ transitioned from hospitals into the tertiary sector between the 1970s and 1990s (Jacobs & Boddy, 2008; Lusk et al., 2001). It was argued that nursing education needed to incorporate higher levels of critical thinking, reasoning, and knowledge (Wood & Nelson, 2013). Yet, during this transition, some practicing RNs were advised not to interact with the student nurses from the educational institutes because it would "tarnish their thinking" (ADHB Senior RN, personal communication, October 3, 2017). This would suggest that a precedent was set for limited, if any, collaboration between stakeholders and I wonder if remnants of this belief persist today. It is imperative that the values and beliefs underpinning stakeholder collaboration are identified, along with other contextual factors, in order to better understand what influences stakeholder interactions.

It is also important to recognise there is recent history of collaboration between stakeholders. In 2009, Auckland District Health Board (ADHB) instigated the 'student integration model' for two Tertiary Education Providers (TEPs), one of which was AUT (Spence et al., 2012). This clinical model focused on students becoming part of the clinical healthcare team. Evaluation of the student integration model demonstrated that the model strengthened relationships between TEPs and the DHB. However, this finding focused on relationships between organisations rather than individual stakeholders as such. Furthermore, when the NCNZ refers to triangulation, it suggests that three stakeholders are involved in this relationship. Yet, in their monitoring report to AUT, they only identified two stakeholders—clinical staff and academic staff. I believe the SN is the third stakeholder in this triangulation. In order to strengthen the collaborative relationships within the clinical learning environment for SNs, it is essential that all three stakeholders are acknowledged at the individual level. That is, the SN, the RN, and the CE.

Attempts at collaboration were also evident during a clinical visit with some AUT CEs and students in 2017. I observed the CEs making a concerted effort to collaborate with other clinical staff members, visiting with ward nurse educators and RNs *before* interacting with the student. However, several CEs had difficulty locating the appropriate staff, let alone being able to collaborate with them. These examples support the findings of the 2015 audits and suggest that little had changed in the two

years since 2015. The triangulation that the NCNZ expects is not always evident in practice. Rather, various stakeholders attempted to collaborate and support the development of clinical competency in undergraduate nursing students, but there seemed to be factors that impeded stakeholders from collaborating. Identifying the factors that enable and constrain stakeholder collaboration was, therefore, an essential prerequisite to more effective collaboration.

Study Aims

While AUT's Department of Nursing has implemented some strategies to address the triangulation required by the NCNZ, further exploration of how stakeholders collaborate is necessary. This study explores current collaborative practices, seeking understanding of the complex factors enabling and constraining stakeholder collaboration, ensuring that underlying values, beliefs, and assumptions become transparent. Results from this study will inform the process of facilitating stakeholder relationships with the aim of benefiting SNs' learning experience and the development of clinical competence in acute care settings. This, in turn, will benefit not only the graduating student nurse, but also the patients and the teams with whom nursing graduates will work in the future.

Research Questions

The main research question for this study is: ***How do stakeholders collaborate to support the development of clinical competence in undergraduate nursing students in the acute care setting***? The following sub-questions are designed to help answer the main research question:

- How do the key stakeholders **interact** to support nursing students in the clinical setting?
- What **values and beliefs** underpin stakeholder collaboration and support of nursing students?
- What **factors enable** and **constrain** stakeholder collaboration?
- How does stakeholder collaboration **affect** nursing students' clinical learning?
- Who are the other stakeholders who **support** nursing students in this clinical setting?

Study Design

As I approached the design of this study, I knew I wanted to expose the complexity of stakeholder collaboration in undergraduate clinical nursing education, identifying the multitude of factors that influence how stakeholders interact. This included revealing the values and beliefs of individual stakeholders along with other factors within the context that impacted collaboration. In order to capture this complexity, a qualitative research approach was required. While I explored a number of possible qualitative approaches, including case study and phenomenology, I chose to use Interpretive Description (ID) because it resonated with the constructivist epistemology underpinning this study. ID is a research methodology which originated in nursing, with overtones of other qualitative methodologies such as ethnography, grounded theory, and phenomenology (Thorne, 2016). The flexibility of ID enabled me to explore the factors influencing stakeholder collaboration, while at the same time honouring the complexity inherent within this topic. Recognising that I was researching a complex topic, I supported the study with complexity theory (CT) as outlined by Brand et al. (2015). These medical researchers provided a framework that helped to identify the various factors that contribute to a Complex Adaptive System (CAS), along with explanation of how the system itself operates. Brand et al. (2015) developed the framework within a clinical setting, incorporating many of the elements that I wanted to explore. Thus, it provided a suitable theoretical framework to form the basis for the data analysis phase of this study.

In order to capture the perspectives of the three stakeholder groups, focus groups and individual interviews were used. Participant recruitment initially posed challenges; however, using two approaches to data collection enabled greater flexibility for participants to share their views and experiences on this topic.

Positioning Myself Within the Study

Thorne (2016) recognised that the qualitative researcher using ID is in a position of influencing all stages of the study. As a RN and nursing lecturer, I recognise myself as being an ‘insider’ within the topic being studied. This position brings advantages, such as having familiarity with the context and people I needed to recruit for my study. As a RN previously working in clinical practice, there were times when I worked alongside

SNs embarking on their clinical experience within the acute care setting. With 20 years' experience as a nursing lecturer, I have had a variety of roles supporting and assessing students during clinical placement, along with supporting the CEs while they worked with students and RNs. One of these roles was as clinical leader, responsible for the clinical component of the BHSc nursing programme. This role required me to work closely with the CE team employed at AUT, as well as develop relationships with stakeholders within the DHB, usually at a management level rather than with RNs directly working with students on clinical placement in the wards. This role gave me insight into the bigger picture of the stakeholder relationships and some of the values, beliefs, and other factors that impacted stakeholders' ability to collaborate. I saw first-hand, and from the side-line, both the challenges and the benefits of stakeholder collaboration. My personal experience of developing stakeholder relationships informed my thinking and interpretation of the topic. However, I was cautious that my position did not unduly bias data analysis. To ensure trustworthiness of the research process, I implemented strategies such as: completing a presuppositions interview, being challenged by my supervisors when they recognised my bias, and use of the CT framework provided by Brand et al. (2015). These strategies enabled me to remain open to new insights within the data.

Although I am no longer in the clinical leader role, I have a vested interest in the topic because I still believe in the importance of providing high-quality learning experiences across the whole undergraduate nursing programme, including clinical practice. Knowing that improvement in collaborative relationships within clinical placements has the potential to improve learning experiences for SNs, which may also result in quality nursing graduates, was the catalyst for this study.

Structure of the Thesis

The thesis is structured over nine chapters as follows.

Chapter one

Chapter one is the introductory chapter which explains the impetus and background of this study, along with key definitions. The aims of the study, research questions, methodology and methods are introduced, and I explain my position within the study. An overview of the thesis is presented.

Chapter two

Chapter two presents what is already known about clinical learning for nursing students. Using a traditional literature review approach, two literature searches were completed; the first prior to commencing this study and the second towards the end of the study. Literature highlights the complexity inherent in this topic, including the purpose of clinical education, clinical models used within the NZ context, and recent changes due to the global pandemic. I also explore the importance of stakeholder relationships in nursing education, the various pedagogical approaches used, as well as the limitations of previous research studies related to clinical learning. I highlight relevant gaps in the literature to provide justification for this study.

Chapter three

Chapter three explains how I came to decide on ID as the methodology for the study. I identify alternative approaches that were considered and explain why they were not selected. I also justify why I chose to underpin the methodology with CT. In the latter section of this chapter, I expose personal assumptions about the topic which were identified through a presuppositions interview with my supervisors prior to commencing the study.

Chapter four

Chapter four describes the study methods, including the processes related to gaining ethical approval and locality agreements with clinical and educational organisations. I explain how participants were invited, selected, and recruited; how data were collected and analysed; and discuss issues of rigour and trustworthiness.

Chapter five

Chapter five is the first of four findings chapters. It provides a brief overview of the collaborative context, a metaphorical space wherein collaboration can occur between stakeholders, along with the various notions that influence how stakeholders interact. It was important to describe the whole collaborative context, including all five interrelated dimensions before explaining in greater detail, each of these dimensions in the following findings chapters. Due to the complexity of the topic and findings, I outline how findings will be presented.

Chapter six

Chapter six describes two interrelated dimensions of ***the individual(s)*** and ***the relationship*** along with the inherent values, beliefs, and assumptions, identified as notions that matter. These notions have the capacity to both enable and constrain collaboration between stakeholders.

Chapter seven

Chapter seven articulates a further two interrelated dimensions: ***nursing practice*** and ***acute care environment***, again revealing the notions that matter within each dimension. The focus is on the context in which collaboration occurs, highlighting the contextual factors that enable and constrain collaboration between stakeholders.

Chapter eight

Chapter eight describes the fifth interrelated dimension: ***clinical education***. It focuses on the notions related to the purpose of collaboration between stakeholders, which is to promote the development of clinical competence in undergraduate nursing students in the acute care setting. Continued emphasis is placed on what enables and constrains collaborative relationships between stakeholders.

Chapter nine

In chapter nine I bring together the five interrelated dimensions in order to discuss the dynamic nature of the findings. Using the CAS principle framework used by Brand et al. (2015), along with examples provided from the study findings, the complexity of stakeholder relationships is revealed, emphasising that collaboration between these people, within this context, for this purpose, sits within a CAS. Using the metaphor of a continuum, I explain how this CAS both enables and constrains collaboration between stakeholders highlighting the importance and relevance of my findings. I finish the chapter by offering recommendations to promote effective collaboration while acknowledging factors that cannot be changed within the collaborative context. Study limitations are identified along with future research potential.

Conclusion

This introductory chapter has provided a summary of the research topic, impetus for the study, and background context related to nursing education and collaboration

within stakeholder relationships. The aims of the study, the research questions, methodology, and data collection and analysis methods used have been outlined. I have acknowledged my position within the research and briefly explained how the thesis is structured. Chapter two provides a review of the literature related to clinical education for nursing students, considering various aspects that may impact stakeholder collaboration.

Chapter 2 LITERATURE REVIEW

Introduction

In this chapter, I present the results of a traditional literature review (Chinn, 2021). I have explored the literature related to clinical learning of nursing students, highlighting the complexity inherent in educational and health systems working together. I start by outlining the search strategy used to obtain relevant literature, providing rationale for presenting a traditional review. I then explore the purpose of clinical education and three models commonly used in NZ to provide clinical learning experiences for SNs. This includes consideration of recent changes due to the COVID-19 pandemic. I also explore the importance of relationships between stakeholders in clinical education and the role of the supervisory and role-model relationships. Discussion of pedagogical approaches used in the clinical setting is presented, noting the importance of experiential learning and the use of reflective practice to promote competency in nursing practice. Barriers to learning along with concerns related to the quality of the clinical learning environment are considered. Throughout this chapter, I explore the limitations of previous research approaches to justify the need for this research study.

Strategy for Literature Search

In preparation for embarking on this study, a review of the literature related to clinical learning was undertaken. I chose to present a traditional literature review which is usually triggered by an area of interest or concern in order to find out what is already known about the topic and to identify a gap in the literature (Chinn, 2021). Literature reviews using this approach enable a respectful critique of the literature and provide a comprehensive synthesis presented in a way that is logically aligned with the purpose of the review (Thorne, 2016). In relation to this study, the comprehensive nature acknowledged the complexity of the topic and enabled me to include literature that was both directly and indirectly aligned with my study. Chinn (2021) has provided guidelines to ensure objectivity and transparency in the traditional review process, including describing the procedures followed in the review, establishing a timeframe, and elements for inclusion. The remainder of this section outlines the processes that I followed, along with inclusion criteria, providing transparency to my literature review.

In April 2017, I accessed two databases commonly used in nursing literature—CINAHL Plus with full text (via EBSCO) and SCOPUS. I then used the search terms 'clinical learning' OR 'clinical model' OR 'clinical experience' AND 'student nurse'. These terms needed to be present in the title or abstract. The relevance of selected literature was determined using the following inclusion criteria:

- Published within the last 10 years (2007-2017)
- Focus on acute or hospital placements
- English language
- Primary research or literature review
- Pedagogical or relational perspectives
- Must be available

Results from each database search are identified in Table 1 below:

Table 1: ***Results from first literature search***

Database	**Number of articles that met search criteria**	**Number of articles that met inclusion criteria**
CINAHL Plus with Full Text (via EBSCO)	60	7
SCOPUS	555	60

SCOPUS yielded such a large number of results that I decided to limit the results to the time period 2013-2017. Although 555 articles were identified, only 60 met the inclusion criteria. Sixty articles were identified in CINAHL, only 7 met the inclusion criteria.

This same search strategy was repeated in 2022 to ensure that recent literature was incorporated into the literature review. I noted that CINAHL Plus was now called CINAHL Complete. Dates of publication needed to be amended in the inclusion criteria to between 2018 and 2022. Results from the repeated literature search are identified in Table 2 below.

Table 2: ***Results from second literature search***

Database	Number of articles that met search criteria	Number of articles that met inclusion criteria
CINAHL Complete (via EBSCO)	10	2
SCOPUS	989	59

A total of 128 articles were selected from both searches for inclusion in the review, demonstrating that the topic of clinical learning is well researched and documented. When reviewing the literature, I noted the country and context in which the reported research was undertaken. I was particularly interested in the research approach used in each study and the main findings as they related to the purpose of clinical education, clinical education models, stakeholder relationships, and pedagogical approaches in the clinical setting. These areas of interest provided the framework for this chapter.

The Purpose of the Clinical Learning Experience in Nursing Education

Clinical education has a significant role in the development of SNs. The clinical learning experience contributes to the consolidation of practice knowledge and skills which are reflective of competent nursing practice (Adjei et al., 2018; Basour Adam et al., 2021; Berhe & Gebretensay, 2021; Cooper et al., 2015; Flott & Linden, 2016; Glynn et al., 2017; Hill et al., 2020; Hilli et al., 2014; Mikkonen et al., 2022; Ramsbotham et al., 2019). Opportunities to reduce the gap between theory and practice are provided when students can apply their learning with real patients in practice (Birks et al., 2017; Brand, 2020; Kim, 2007; Mamhidir et al., 2014; Nielsen, 2016; O'Mara et al., 2014). Clinical learning also contributes to the socialisation of the SN into the clinical team (Hilli et al., 2014; O'Mara et al., 2014) which includes exposing students to the culture of nursing (Liljedahl et al., 2016) and helps students to develop confidence in their nursing practice (Cooper et al., 2015; Flott & Linden, 2016; Grobecker, 2016; Ó Lúanaigh, 2015). Ultimately, the purpose of clinical education is to prepare the student to become a competent RN who contributes to the workforce (Glynn et al., 2017).

Despite the reported benefits of clinical experience within nursing education, concerns continue to be raised about graduates' readiness for practice (Flott & Linden, 2016;

Hegney et al., 2013; Kumm et al., 2016). This suggests that the transition from hospital based to tertiary education has not been the panacea that the Carpenter Report (1971), as discussed in chapter one, was expecting. Various factors are believed to contribute to graduates not being work ready, one being insufficient clinical exposure. Hegney et al. (2013) argued that increased clinical hours would help to improve readiness for practice. However, increasing hours alone does not address the quality of that experience (Adjei et al., 2018; Beddingham & Simmons, 2016; Bergjan & Hertel, 2013; Dimitriadou et al., 2015; Doyle et al., 2017; Liljedahl et al., 2015; Papastavrou et al., 2016; Ramsbotham et al., 2019). Another factor that negatively impacts the quality of students' clinical learning is stressors both within and outside clinical placements (Adjei et al., 2018; Andrew et al., 2022; Jansson & Ene, 2016). These stressors distract students from their learning and, in response, students tend to focus on completing clinical tasks rather than developing critical thinking for nursing practice, which further limits their learning experience (Adjei et al., 2018; Nielsen, 2016). Several authors have suggested that the structure of clinical education experiences can address these issues (Ekstedt et al., 2019; González-Garcia et al., 2021; Ramsbotham et al., 2019). For this reason, consideration of the various clinical models is required.

Clinical Education Models

The shift of nursing education from clinically based apprenticeships to tertiary education providers required considering how clinical learning would be integrated with theoretical learning. Over time, a number of clinical education models have been used. These include preceptor models (Dahlke et al., 2016; Ebu Enyan et al., 2021; Hegenbarth et al., 2015; Hilli et al., 2014; Jansson & Ene, 2016; Kim, 2007; McClure & Black, 2013; McSharry & Lathlean, 2017; Renda et al., 2022; Smith & Sweet, 2019), mentorship models (Brand, 2020; Brown et al., 2020; Cassidy, 2009; Chen et al., 2016; Coventry & Hays, 2021; Heinonen et al., 2019; Mikkonen et al., 2022), and Dedicated Educational Units (DEUs) (Glynn et al., 2017; Grealish et al., 2018; Greene & Turner, 2014; Hardy et al., 2015). While other models are identified in the literature, most recently these three have dominated the NZ context, thus are worthy of further exploration.

The Preceptor Model

The term ‘preceptor’ can be defined as an individual, usually a RN, who provides support and clinical instruction for an individual SN during their clinical placement (Dahlke et al., 2016; Ebu Enyan et al., 2021; Hilli et al., 2014). The preceptor model usually involves the SN being allocated to work alongside a clinical RN. Assisting SNs to connect theory to practice, through application of knowledge and skills, is a key element of the role of the preceptor (Grealish et al., 2018; Kim, 2007; McClure & Black, 2013). In the preceptor model, academic support is also offered by faculty who provide supervision of students, both directly and indirectly. Furthermore, the faculty role includes being responsible for assessment of the student and support for the RN preceptors (Dahlke et al., 2016; Ebu Enyan et al., 2021; Papastavrou et al., 2016), suggesting that the RN has fewer responsibilities related to student assessment and that they may not be able to prioritise their preceptor role (McClure & Black, 2013; McSharry & Lathlean, 2017). Concerns are raised when there are insufficient resources for preceptors and the role is not recognised adequately (Ebu Enyan et al., 2021). Lack of preparation for preceptors is highlighted when RNs report feeling stressed in anticipation of precepting students, an addition to their clinical role increasing their workload (Doyle et al., 2017; Grealish et al., 2018; Jansson & Ene, 2016; Mamhidir et al., 2014; Ó Lúanaigh, 2015). It is argued that the one-on-one nature of the relationship between the RN and student is a strength of the preceptor model (Birks et al., 2017; Hilli et al., 2014; Kim, 2007; Smith & Sweet, 2019). However, students often work with a variety of preceptors over the course of their clinical placement, limiting the benefit of a one-on-one preceptor model (Cooper et al., 2015; Jansson & Ene, 2016). It is possible that working with a variety of preceptors would also adversely impact stakeholder collaboration; however, this is not specifically discussed in the literature.

The Mentorship Model

‘Mentoring’ can be defined as a relationship between two nurses, one more experienced than the other, that is advantageous to both parties (Coventry & Hays, 2021). While mentoring often refers to inducting RNs new to a clinical setting, in the literature related to SNs, mentorship is presented almost synonymously with precepting, with the terms mentor and preceptor being used somewhat interchangeably (McClure & Black, 2013). Therefore, it is not surprising to see

similarities in these roles. For example, mentors are responsible for helping students apply theory to practice (Brand, 2020). Mentors also require the support of the academic staff (Papastavrou et al., 2016) and are still required to integrate their teaching role with their patient care role (Brand, 2020; Devlin & Duggan, 2020). However, some differences are noted. Mentors are required to provide a greater commitment to the professional development of the student than preceptors (Brand, 2020; Kim, 2007; McClure & Black, 2013). Developing a deeper and more meaningful relationship between student and mentor suggests that the mentorship relationship requires more time to develop than the preceptor relationship (McClure & Black, 2013). Mentors also embrace the students' place within the clinical setting, providing them with a sense of belonging within the team (Brand, 2020). As a consequence of this deeper relationship, some authors suggest that a mentor has the clinical competence and responsibility to assess the student (Christiansen et al., 2021; Papastavrou et al., 2016). Yet, in Norway, the academic support role is also involved in the assessment of students within the mentor model (Christiansen et al., 2021). This can result in the mentor taking a passive role in the assessment of students which can result in divergent assessment results from different stakeholders (Christiansen et al., 2021). Conversely, recent changes in the UK suggest that the mentor should not assess the student; rather, the mentor should only facilitate learning within the clinical setting (Brand, 2020; Brown et al., 2020). The assessment of nursing students in clinical placement thus remains a concern for all stakeholders.

In some European countries, the mentor is required to be qualified to take on the role (Mikkonen et al., 2022). This requirement commenced in Germany (Bergjan & Hertel, 2013) before being implemented in the UK (Brand, 2020; Brown et al., 2020; Devlin & Duggan, 2020). Qualified mentors are expected to take a reduced clinical load to enable dedicated time to supporting nursing students (Devlin & Duggan, 2020). An allocation of time and being qualified would suggest that the mentor is both prepared for and understands how to support student learning. Yet, learning in the clinical setting is taken for granted, reflecting limited understanding of how mentors actually support student learning (Brand, 2020). This may be due to factors such as insufficient time, staff, and understanding of role expectations, all of which constrain mentors' ability to fully engage in their responsibilities (Devlin & Duggan, 2020). A lack of

consideration of how the mentor collaborates with the student and CE is noted within the literature.

It is important to note that both the preceptor and mentorship models focus primarily on the role of the RN, possibly due to the student being dependent upon the RN to help interpret and facilitate learning opportunities (Brand, 2020; Ó Lúanaigh, 2015). Consideration of the relationship as one of equal standing between all stakeholders, including the student and academic support, appears to have been an impetus for the development of DEUs.

DEUs

DEUs are developed through a collaborative partnership between academic and clinical organisations with the intent of creating a positive clinical learning environment for students (Glynn et al., 2017; Grealish et al., 2018; Greene & Turner, 2014). DEUs were established to address concerns regarding the gap between theory and practice that were evident in the previously used clinical models, and because nursing practice and patient care had become increasingly complex (Glynn et al., 2017; Grealish, et. al., 2018). Immersing students in the 'real-life' of nursing practice, working with RNs at the bedside, is believed to assist development of a competent future workforce (Glynn et al., 2017).

A significant difference between other models and DEUs is that the latter has overt philosophical underpinnings that promote a learning environment alongside care requirements of patients (Glynn et al., 2017; Grealish et al., 2018). Students learn about the realities of nursing (Greene & Turner, 2014) and, instead of focusing on tasks alone, they develop the critical thinking skills required in nursing practice (Glynn et al., 2017; Grealish et al., 2018). Additionally, RNs are more accountable for clinical learning through a modified mentor role, which includes both assessment and feedback for the student (Greene & Turner, 2014; Glynn et al., 2017). It is important to note that considerable preparation is required for DEUs to be successful (Glynn et al., 2017). Additionally, ongoing academic support is provided to the RN preceptor or mentor rather than the students (Greene & Turner, 2014; Glynn et al., 2017); although some would suggest that academic support is still required for development of students' reflective learning capacity (Grealish et al., 2018).

Limitations related to the DEU model include financial considerations (Greene & Turner, 2014). There is a belief that more RNs are required with the increased workload of teaching in this model; however, Greene and Turner (2014) reported that investment of time provided early through an orientation and clear setting up of the model means that staff and students quickly adjust to the increased workload. Thus, no additional RNs are required and the model is budget neutral.

Another potential limitation of the DEU model relates to the number of organisations involved in its establishment. Relying on a robust level of collaboration between a single clinical setting and a single educational provider is seen as a strength of the model (Grealish et al., 2018). However, when there is more than one clinical setting or educational provider, the clarity of expectations between collaborative partners may be lost (Grealish et al., 2018). Furthermore, increased demands from educational providers seeking clinical placements from a broader range of placement providers requires DEUs to review the model to ensure it is sustainable (Grealish et al., 2018). This is the situation in Auckland, New Zealand, with five educational providers now placing students across three DHBs at any one time.

Choosing a Clinical Model

Numerous factors must be taken into consideration when choosing a clinical model; for example, the length of the clinical placement, which can be influenced by availability of placements and the financial costs of clinical access (Birks et al., 2017). Most of the time, clinical access is provided in blocks, usually weeks at a time (Adjei et al., 2018; Birks et al. 2017). Block models are favoured by clinical staff who are more likely to take ‘ownership’ of the student and their learning, especially for senior students who are deemed more confident (Birks et al., 2017), and reinforced by students who prefer longer clinical placements (González-Garcia et al., 2021; Ramsbotham et al., 2019). In other models, access is more sporadic and distributed over reduced days each week (Birks et al., 2017). Distributed models are preferred for junior students who need time away from clinical to reflect on their learning experience and help link theory to practice (Birks et al., 2017). However, shorter placements can be challenging for students who are developing effective relationships with the RNs (Gilbert & Brown, 2015). Unfortunately, the focus tends to be on how clinical placement experiences are structured, rather than how stakeholders work

together to support student learning (Hendricks et al., 2016). In order to maximise clinical learning opportunities for SNs, more consideration needs to be given to how stakeholders work together to support the development of clinical competency in undergraduate nursing students.

The Impact of COVID-19

More recently, since 2019, the arrival of COVID-19 has required stakeholders to reconsider how to implement clinical access and learning during the current pandemic (Beauvais et al., 2021; Diaz et al., 2021; Duprez et al., 2021; Godbold et al., 2021; McSherry et al., 2021; Ulenaers et al., 2021). Initially, students were removed from clinical placement in the hopes of protecting them from contracting the virus (Beauvais et al., 2021; Diaz et al., 2021; Michel et al., 2021). Clinical learning was replaced with remote or online learning (Diaz et al., 2021; Leighton et al., 2021; McSherry et al., 2021; Michel et al., 2021). Internationally, researchers began to explore how being a student during the pandemic was impacting their learning experiences (Diaz et al., 2021; Duprez et al., 2021; Godbold et al., 2021; Ulenaers et al., 2021). Findings showed that students preferred clinical learning experiences to screen-based simulations (Leighton et al., 2021) and that online forms of learning are not an adequate replacement for clinical experience (Michel et al., 2021). Equally, while many students experienced fear in response to the pandemic, there was also an increased resilience and commitment by these same students towards becoming nurses of the future (Diaz et al., 2021; Duprez et al., 2021; McSherry et al., 2021).

Recognising the negative impact that the pandemic was having on student nurses' clinical learning, it was deemed essential that the production of competent nursing graduates was maintained (Beauvais et al., 2021; Duprez et al., 2021). Students, while needing protection, still needed to be educated and graduate to meet workforce demands (Beauvais et al., 2021). Collaboration between educational institutions, registration boards, and placement providers, along with workforce development and union representatives, was essential (Beauvais et al., 2021; McSherry et al., 2021). Decisions on how to maintain clinical learning experiences for student nurses during the pandemic needed to occur quickly, mindful of the emotional stress for students during a pandemic, as well as the unique learning opportunities the pandemic provided (Duprez et al., 2021; Godbold et al., 2021; Michel et al., 2021; Ulenaers et al.,

2021). Safety of patients and the students themselves was a concern (McSherry et al., 2021). Importantly, these factors provided a new lens for viewing how to structure clinical learning for students.

In the UK, this resulted in student nurses being offered the opportunity to be employed as “high-level health care assistants” (Godbold et al., 2021, p. 103186). Some third-year students were in favour of this opportunity, because they felt a sense of duty towards patients, the health system, the nursing profession and their future colleagues (McSherry et al., 2021). However, becoming a member of the pandemic workforce was problematic. In Belgium, the supervision of nursing students was reviewed due to reduced staffing and increased workloads that were a consequence of the pandemic (Ulenaers et al., 2021). Students reported feeling tension between their employment status and student role (McSherry et al., 2021). They initially felt unprepared for their positions and did not have time to meet their student obligations (Godbold et al., 2021). However, students also reported the benefits of a revised model: four days practice with one day study wherein they felt able to contribute to patient care and developed confidence over time (Godbold et al., 2021; McSherry et al., 2021). They also reported feeling better prepared for their RN role following experience as healthcare assistants during the pandemic (Godbold et al., 2021; Michel et al., 2021). It seems, therefore, that immersion in the clinical setting enhanced their sense of belonging. Feeling part of the team highlighted the importance of relationships in the clinical education of student nurses.

Importance of Relationships in Clinical Education

The importance of fostering and maintaining purposeful relationships between stakeholders who are involved in clinical learning in nursing education cannot be underestimated (Adjei et al., 2018; Beddingham & Simmons, 2016; Bisholt et al., 2014; Brown et al., 2020; Cassidy, 2009; Chan et al., 2017; Gilbert & Brown, 2015; McSherry et al., 2021; Papastavrou et al., 2016). When the relationship between stakeholders is positive, students feel a sense of belonging in the clinical setting (Gilbert & Brown, 2015). Positive relationships are also associated with sharing power between stakeholders (Chan et al., 2017). Students generally report satisfaction with their clinical learning if they have a positive caring relationship with the RNs with whom they work, irrespective of other factors (Papastavrou et al., 2016; Subke et al., 2020).

For these reasons, some authors suggest that students should be allocated to RNs who are more experienced and have a positive attitude towards their teaching role (Chan et al., 2017; Gilbert & Brown, 2015). Such RNs possess the skills required to support students as they encounter challenges associated with being new in a busy clinical setting (Gilbert & Brown, 2015). However, other authors suggest that students should be taught how to set up and manage such relationships (Cooper et al., 2015). Indeed, Doyle et al., (2017) argued that placement and educational providers along with students all have a responsibility to ensure that the clinical placement provides a positive learning experience. How that responsibility is actioned by individual stakeholders is not explicitly identified. Instead, Doyle et al., (2017) make recommendations at an organisational level which do not include students despite them being regarded as a stakeholder in their own learning.

One factor that impedes the development of effective relationships is the constancy of a single RN allocated to work with a nominated student (Birks et al., 2017; Cassidy, 2009; Cooper et al., 2015; Dahlke et al., 2016; Jansson & Ene, 2016). Literature reinforces the notion that learning is more effective when the student works consistently with the same RN. However, working with a variety of RNs can also expose the student to more various ways of practice, which can be beneficial (Cooper et al., 2015). RNs' workloads appear to be the main barrier to constancy and can result in the student being ignored (Dahlke et al., 2016; Jansson & Ene, 2016); thus, preventing the development of a positive relationship between student and RN (Cooper et al., 2015). Length of placement is another factor, with short or sporadic placements constraining stakeholders from developing effective relationships due to a lack of constancy (Adjei et al., 2018; Gilbert & Brown, 2015). Furthermore, some RNs are overtly unwelcoming of students, once again creating a barrier to effective positive relationships (Brown et al., 2020). Such negative relationships impact student learning and impose increased risks for the students, staff, and patients. This is problematic because all RNs have a responsibility to supervise SNs during clinical placement, either in a preceptor or mentor role. This responsibility is outlined in the Nursing Council of New Zealand competencies for RN practice (NCNZ, 2016).

Supervision and Role-Modelling in Clinical Relationships

Supervision of nursing students is a vital component of their clinical learning and is dependent upon the relationship students have with the RN preceptor/mentor (Bergjan & Hertel, 2013; Bisholt et al., 2014). Positive relationships between stakeholders promote a sense of safety for students, enabling them to ask questions to develop both safety in practice and their own knowledge (Hilli et al., 2014). Furthermore, a positive relationship, reflected through being welcoming, approachable, and caring, can enable the student to raise practice concerns with their RN (Brown et al., 2020). These behaviours reflect some of the hallmarks of effective collaboration.

However, not all students have positive RN supervisory relationships (Dimitriadou et al., 2015). Using a quantitative approach to explore the clinical learning environment and supervision (CLES) of nursing students in clinical placement, Dimitriadou et al. (2015) identified six different approaches to supervision of nursing students: not having a named supervisor, having a named supervisor but unhelpful relationship, a named supervisor who changed during the placement, having various supervisors depending on shift and place, a named supervisor with several students, and a named supervisor with a helpful relationship. The first three approaches usually result in a negative supervisory relationship. The remaining three were more positive. These same authors also found that most students valued their relationship with their supervising RN over their nurse teacher. These findings again demonstrate how important relationships are in clinical learning for SNs.

Conversely, Hill et al., (2020) in their study on Collaborative Learning in Practice (CLIP), found that when the supervisory role was approached from a coaching perspective, students spent less time developing relationships with the RN. Instead, students took more ownership of their clinical role and provided support to fellow students, which, in turn, more effectively prepared them for their graduate nursing role. Additionally, not all students value the importance of being supervised. Another quantitative study that evaluated the clinical learning environment, supervision and nurse teacher (CLES+T), from the students' perspective across all three years from one nursing programme, found that only 54% of students thought supervision was important in practice (Bergjan & Hertel, 2013). This ambivalent finding may be due to where the

students were within their programme of study. Third year students in another study using the same CLES+T quantitative scale, expressed desire to practice independently, feeling frustrated when not given the opportunity to practice without direct supervision (Bisholt et al., 2014).

Experience over the student years naturally shifts students' dependence on the RN for supervision and guidance to being empowered to self-direct their own learning (Kim, 2007). This reflects scaffolding of learning to ensure that learning opportunities reflect where the student is positioned in their development (Grealish et al., 2018). It seems that supervision is something that occurs on a continuum, with students who are new or junior requiring more supervision compared with senior students or students who have had more clinical exposure. Knowing when and how to move along this continuum is something that stakeholders need to collaborate on, but this is not overtly discussed. Instead, it is noted that RNs are not sufficiently prepared to identify learning for students (Grealish et al., 2018).

Role-modelling within clinical relationships is also helpful to student nurses (Dimitriadou et al., 2015; Grobecker, 2016; Hilli et al., 2014; Mathe et al., 2021; Ó Lúanaigh, 2015; Tomietto et al., 2016). Role-modelling demonstrates essential nursing skills and can contribute to students' learning of humanistic and ethical attributes of nursing practice, as well as development of their emotional intelligence (Mathe et al., 2021). Students perceive RNs as both positive and negative role-models (Grobecker, 2016). Ensuring that the student is allocated a positive role-model promotes a safe practice environment (Dimitriadou et al., 2015) and has been shown to be a great motivator for students' learning (Ó Lúanaigh, 2015; Tomietto et al., 2016). RNs have a responsibility to role-model a professional nursing identity and enable clinical learning for students (Ó Lúanaigh, 2015). However, there are limitations noted with role-modelling. For example, negative role-models can adversely influence the development of a student's professional identity (Mathe et al., 2021). Additionally, if the student takes an observational role with their allocated role-model, support is often required by the academic staff to help the student make sense of what they are encountering (Morrison & Brennaman, 2016). There is a reliance on students actively learning through observation of their role-model (Mathe et al., 2021) but students

cannot learn through observation only; therefore, consideration of the pedagogical approach used in clinical learning must be explored.

Pedagogical Approaches in the Clinical Setting

Experiential Learning

The dominant pedagogical approach used in clinical settings is experiential learning, because of the 'authentic' or 'real-life' working conditions provided (Bergjan & Hertel, 2013; Birks et al., 2017; Bisholt et al., 2014; Killam & Heerschap, 2013; McSharry & Lathlean, 2017). Experiential learning provides students with the opportunity to apply theory to practice while caring for real patients in the clinical setting (Killam & Heerschap, 2013). Benefits of the 'real-life' learning experience include managing shift work, taking responsibility for patient care, and adapting to changing circumstances (Birks et al., 2017). Doyle et al., (2017) referred to this as a rehearsal for the future RN role of SNs. Contributing to the success of experiential learning is the idea that SNs are welcomed on to the ward by clinical staff and educators (Doyle et al., 2017; Subke et al., 2020) where they will become part of the team (Bergjan & Hertel, 2013; Birks et al., 2017). Being included in the team creates a pedagogical atmosphere which enables RNs to invest in student learning, providing a safe atmosphere with less hierarchy where the student feels cared for (Bergjan & Hertel, 2013; Subke et al., 2020). However, this is dependent upon the RN having some understanding of educational theory (Chen et al., 2016; McSharry & Lathlean, 2017) and acceptance that mistakes are interpreted in relation to the fact that students are learning (Doyle et al., 2017).

When students are provided with 'authentic' or 'hands-on' learning experiences, there is concern that it may increase the risks for students, clinical staff, and patients (Killam & Heerschap, 2013; Ó Lúanaigh, 2015). Ó Lúanaigh, (2015) suggested this is related to the unpredictable nature of practice within the acute care setting. For this reason, exposure to hands-on experience is usually staircased. Students first observe RNs, then switch to being observed by the RN (McSharry & Lathlean, 2017). Students are, therefore, dependent upon RNs, allowing them to be involved in the delivery of care (Flott & Linden, 2016). Consequently, RNs act as gate keepers. Some may only delegate menial tasks to students, limiting development of their clinical competence (Adjei et al., 2018; Ironside et al., 2014; Killam & Heerschap, 2013). Such hesitancy may also

manifest in clinical settings offering fewer placements for students (Fletcher & Mayer, 2016) or only offering placements where there are limited opportunities for students to actively participate in care (Bisholt et al., 2014). These restrictions limit the development of students' confidence (Killam & Heerschap, 2013).

A lack of control over the learning opportunities to which students are exposed can be referred to as "education by random opportunity" (Ironside et al., 2014, p. 185). Prioritisation of patient care by RNs results in many missed learning opportunities (Hendricks et al., 2016). While the clinical setting may be busy and unpredictable, limiting the possibility of structured learning for students by RNs who are unwilling to provide students with the full exposure of experiential learning exacerbate these limitations to student learning (Killam & Heerschap, 2013). Unfortunately, this situation creates a vicious cycle of potentially producing graduates who have had insufficient clinical exposure to develop competent nursing practice.

Reflective Practice

Another pedagogical approach frequently used in combination with experiential learning for nursing students is reflective practice (Cassidy, 2009; Chan et al., 2017; Fletcher & Mayer, 2016; Hilli et al., 2014; Ironside et al., 2014; Jansen et al., 2021; Jansson & Ene, 2016; Matshaka, 2021; McSharry & Lathlean, 2017; Needham et al., 2016; Netto & Silva, 2018). Reflective practice was originally developed by Schön, (1983, 2016) in response to a divide between theory taught at university and what professionals thought was important to know in practice. Defined as a pedagogical tool to bring theory and practice together (Jansson & Ene, 2016; Netto & Silva, 2018), reflective practice enables individuals to critique their own, and others', practice; gain insight into their behaviour, actions and decisions; which then influences future actions (Jansen et al., 2021; Jansson & Ene, 2016; Matshaka, 2021; McSharry & Lathlean, 2017; Needham et al., 2016). Reflection can occur in the moment, known as 'reflection in action', as well as after an event, known as 'reflection on action' (Needham et al., 2016; Nielsen, 2016; Schön, 1983, 2016). As a pedagogical approach that contributes to knowledge development, reflective practice supports students in identifying their own strengths and weaknesses, promoting ongoing professional development (Cassidy, 2009; Jansen et al., 2021; Matshaka, 2021; Nielsen, 2016).

In the UK, there is a requirement for students to use a critical reflective approach to analyse their practice to both problem solve and support clinical decision making (McSharry & Lathlean, 2017). Reflective practice enables the student to explore their thoughts and feelings which inform their nursing practice in a holistic manner, taking into consideration both the art and science of nursing practice (Cassidy, 2009). In turn, this enables the student to reflect on their performance as a form of self-assessment against competencies for nursing practice (McSharry & Lathlean, 2017).

However, there are challenges for students when they are expected to achieve purposeful reflective practice on their own. As with other pedagogical approaches, students need to be guided through this educational approach, either by an RN or with academic support from the educational provider (Cassidy, 2009; Grealish et al., 2018; McSharry & Lathlean, 2017; Netto & Silva, 2018). A student having reflective dialogue with a more experienced person about their own practice exposes students to perspectives that they may have otherwise not have considered (Fletcher & Mayer, 2016). Furthermore, being able to talk openly is dependent upon a positive relationship between these stakeholders which includes RNs recognising their own limitations and acknowledging that they are also learning (Cassidy, 2009). The RN also needs to be able to stimulate thinking through questioning and engage the student in higher level critical thinking (Fletcher & Mayer, 2016; McSharry & Lathlean, 2017; Netto & Silva, 2018). Netto and Silva (2018) referred to the interactive dynamic when teachers reflect actively with students, with the intention that the behaviour of one will create a change in the other. However, learning through reflective practice can be compromised with insufficient time and competing priorities such as patient care (McSharry & Lathlean, 2017). It takes time for stakeholders to engage in meaningful reflection; and for some stakeholders, including students, time is viewed as better spent completing tasks (Ironside et al., 2014).

Barriers to Learning in the Clinical Setting

While the purpose of clinical education has been outlined above, along with the importance of the stakeholder relationship, there are contextual factors that create barriers to the pedagogical approaches; for example, clinical settings have their own culture (Birks et al., 2017; Cooper et al., 2015; Doyle et al., 2017; Flott & Linden, 2016). Birks et al. (2017) noted that, in some instances, the culture pertains to preconceived

ideas related to student status which is reinforced by the student uniform. Sometimes student status can result in students being used as an extra pair of hands, rather than being primarily present in the clinical setting to learn (Chen et al., 2016; Dadgaran et al., 2013). Interestingly, findings from a reflective qualitative inquiry study that explored third-year students' early transition into practice, due to COVID-19, found that the removal of supernumerary status provided students with the opportunity to take initiative, develop skills, and build confidence (McSherry et al., 2021). While the study also found that students appreciated the support offered in supernumerary status, the preceding finding suggests that it can be a barrier to student learning.

Staffing is another contextual factor that directly impacts the pedagogical approaches explored above (Beddingham & Simmons, 2016; Hegenbarth et al., 2015). While lack of continuity in students working with the same RNs can negatively impact the relationship between stakeholders, it can also have a negative impact on the student's learning experience (Birks et al., 2017; Jansson & Ene, 2016). A mixed method study that explored student perspectives of what helped and hindered their clinical learning found that students felt stuck in their learning, constantly proving themselves capable to different RNs (Jansson & Ene, 2016). A lack of continuity can result in students having to negotiate conflicting ideas about how nursing is practiced as well as a lack of clarity about the student's scope of practice (Birks et al., 2017). For these reasons, there is a strong belief that both staff and the environment need to be prepared for the student's arrival (Birks et al., 2017). Preparation includes the need to consider how these contextual factors may impact stakeholder collaboration, which is another area that appears under researched. Instead, the focus related to clinical learning appears to be on the quality of the learning experience (Atakro et al., 2019; Basour Adam et al., 2021; Beddingham & Simmons, 2016; Bergjan & Hertel, 2013; Berhe & Gebretensaye, 2021; Birks et al., 2017; Bisholt et al., 2014; Brand, 2020; Cooper et al., 2015; Flott & Linden, 2016; Hegenbarth et al., 2015; Ironside et al., 2014; Smith & Sweet, 2019).

Quality of Learning

Concerns about the quality of learning invariably relate to the quality of the clinical learning environment (Adjei et al., 2018; Beddingham & Simmons, 2016; Bergjan & Hertel, 2013; Dimitriadou et al., 2015; Doyle et al., 2017; Liljedahl et al., 2015; Nepal et al., 2016; Papastavrou et al., 2016; Ramsbotham et al., 2019; Subke et al., 2020;

Tomietto et al., 2016; Warne et al., 2010; Ziba et al., 2021) which is constructed predominantly through stakeholder relationships, as previously discussed (Bergjan & Hertel, 2013; Dimitriadou et al., 2015; Doyle et al., 2017; Papastavrou et al., 2016). There are many other factors that contribute to the clinical learning environment, some of which are encompassed within the research tool known as the CLES+T scale (Bergjan & Hertel, 2013; Bisholt et al., 2014; Dimitriadou et al., 2015; Doyle et al., 2017; Ekstedt et al., 2019; González-Garcia et al., 2021; Khan et al., 2020; Nepal et al., 2016; Papastavrou et al., 2016; Tomietto et al., 2016; Warne et al., 2010; Ziba et al., 2021). Taking a quantitative approach, researchers use this tool to ascertain SN perspectives of five categories that influence the quality of their clinical learning environment: pedagogical atmosphere on the ward, premises of nursing on the ward, leadership style of the ward manager, supervisory relationship, and the role of nurse teachers (Bergjan & Hertel, 2013; Bisholt et al., 2014; Doyle et al., 2017; Tomietto et al., 2016; Warne et al., 2010). Using a Likert scale, respondents either agree or disagree with statements made about each category. Interestingly, Bisholt et al. (2014) found students valued hospital placements over other clinical settings because they believed more meaningful learning occurred in hospital wards. Students claimed that other settings, such as Primary Health Care (PHC), provided limited opportunities to meet their learning outcomes. Yet, despite this difference in the quality of learning, students reported feeling satisfied with their clinical placement.

Other researchers also found students were satisfied with their clinical placements (Doyle et al., 2017; Papastavrou et al., 2016; Warne et al., 2010). However, it is not clear how students can be satisfied when their anticipated learning needs are not met—other than to suggest that students may not have full insight into what learning is available in different settings or what is important to learn. This assumption can be supported by Ironside et al. (2014), whose descriptive qualitative study found that students tended to miss the complexity of learning available when caring for patients in a busy hospital setting. These authors attributed this finding to students equating ‘doing’ with ‘learning’. The finding that students are satisfied also does not correlate with the belief that students are not adequately prepared for clinical practice once graduated, as previously discussed.

While the CLES+T research tool has been used internationally to ascertain student satisfaction with the quality of their learning experience, adding to its validity as a research tool (Bergjan & Hertel, 2013; Doyle et al., 2017; Nepal et al., 2016; Tomietto et al., 2016), there are some limitations which need to be considered. Liljedahl et al., (2015) believed that this quantitative approach does not account for the complexity inherent in clinical learning. This may be why some researchers added opportunities for participants to include qualitative statements at the end of the survey (Bisholt et al., 2014; Doyle et al., 2017). Other researchers have tried to capture the perspective of another stakeholder within the same study, such as the clinical RNs working with students (Tomietto et al., 2016). However, Tomietto et al. (2016) used a different quantitative tool from the CLES+T which focused on work engagement of RNs, effectively asking very different questions of this stakeholder group.

Liljedahl et al. (2016) noted that the quantitative approach did not adequately capture learning from the constructivist perspective, which needs to consider dynamic interactions between the student and their learning environment. Accordingly, other authors have chosen to use only a qualitative approach to explore quality of clinical learning for nursing students (Atakro et al., 2019; Beddingham & Simmons, 2016; Birks et al., 2017; Chan et al., 2017; Cooper et al., 2015; Dadgaran et al., 2013; Dahlke et al., 2016; Glynn et al., 2017; Liljedahl et al., 2016). A qualitative approach enables greater flexibility to encompass a broader range of factors that may influence the quality of learning.

Some authors have explored student perceptions of elements such as comparing different clinical models (Birks et al., 2017), experience of being mentored (Brand, 2020; Heinonen et al. 2019), power dynamics in the student-teacher relationship (Chan et al., 2017), what is helpful and unhelpful in clinical placements (Cooper et al., 2015), along with how broader sociocultural factors influence motivation for, or access to, clinical learning (Andrew et al., 2022; Dadgaran et al., 2013). Others have chosen to examine perspectives of other stakeholders. For example, what clinical faculty staff believe supports or hinders clinical learning for students (Dahlke et al., 2016), preceptor evaluation of a new learning facilitation role (Beddingham & Simmons, 2016), preceptor sense of being prepared for their preceptor role (Hoffman & Daniels, 2020), preceptor experiences of assessing students in clinical placements (Christiansen

et al., 2021), and the challenges RNs face as they mentor or precept student nurses (Devlin & Duggan, 2020; Ebu Enyan et al., 2021; Hagqvist et al., 2020). Another qualitative descriptive study explored the nurse managers' perception of multigenerational mentoring (Coventry & Hays, 2021). Interestingly, King's (2019) descriptive phenomenological study included two stakeholder participants—students and academic lecturers—and explored these stakeholders' experiences of what constituted 'reasonable adjustments' for students with disabilities, such as dyslexia, in clinical practice.

The diversity of qualitative studies reported in the literature highlights the complexity of the clinical learning experience for SNs. Including participants from only one stakeholder group could be viewed as a further limitation of these studies. It would be helpful to know how all stakeholders perceive this complexity and whether they understand and value the diversity of issues at play. Knowing how stakeholders collaborate to navigate the diverse and complex factors inherent in quality learning would help with evaluating the current approaches to supporting development of SNs' competence in practice. It is clear there is limited evidence within the literature.

Absence of Collaboration Between Stakeholders for Student Learning

There is limited evidence regarding the role of stakeholder collaboration in relation to student learning. Glynn et al. (2017) explored collaboration between the tertiary education provider and the clinical placement provider only; while Beauvais et al. (2021) considered collaboration that occurred at a Nursing Council and Nursing Association level. Hendricks et al. (2016) reported on interprofessional collaboration as it relates to improved patient care rather than student learning, with student learning being a consequential benefit. Despite the plethora of literature which focuses on the students' perspective of their learning experience, it seems the student is notably absent in studies about collaborative relationships. Students want to be actively involved in their clinical learning (Ó Lúanaigh, 2015). While students need to learn how to collaborate with different people as a skill required in nursing, this skill also enables them to take responsibility for their own learning (Hendricks et al., 2016; Liljedahl et al., 2015; Mamhidir et al., 2014).

The importance of the tripartite stakeholder relationship within clinical education needs to be considered (Grealish et al., 2018; Hardy et al., 2015; Tomietto et al., 2016; Warne et al., 2010). However, despite recognising the importance of this collaborative relationship, there is a failure to include all stakeholders in research studies. Tomietto et al. (2016) go so far as to note this as a limitation to their study, which included students and RNs only. There appears to be only two studies that include clinical nurses, faculty, and students (Grealish et al., 2018; Hardy et al., 2015). The two studies used three different data collection methods, one for each group of stakeholders. Hardy et al. (2015) gave students a quantitative tool—the Clinical Learning Environment Inventory (CLEI)—similar to the CLES+T scale. Academic staff were sent an open-ended questionnaire and RNs were invited to participate in a focus group. The aim of the study was to evaluate a DEU clinical model developed around a professional partnership between these stakeholders; however, the authors note the poor response rate of participants across all stakeholder groups as a limitation and that for the student group, this was their first clinical placement. It could be argued that limitations already identified for the use of a quantitative tool used with student participants is exacerbated when students have limited clinical experience. Dimitriadou et al. (2015) and Nepal et al. (2016) believed having second year participants in their study was beneficial because their prior clinical experience provided them with a source of comparison.

The second study to include all three stakeholders, was a feasibility study of a new clinical model—the Collaborative Clusters Education Model (CCEM)—implemented in an Australian health service (Grealish et al., 2018). The CCEM was designed to support student learning by placing the student with an RN who then exposed the student to learning opportunities during patient care, as well as offering academic support to the student using a reflective practice approach, both individually and within a group. It is not clear how this model differs from previously explored preceptor or mentor models of clinical education, other than to have a specific facilitator role which seems to be similar to the current academic clinical educator role used in New Zealand.

Responsible for problem solving during the implementation phase of the CCEM, the implementation reference group comprised 15 members, including nursing students, new graduate RNs, RNs who worked in learning facilitator roles, managers, academics,

and researchers (Grealish et al., 2018). Data were collected from participants in different ways, at different times, and about different aspects of the project. Students provided feedback about the quality of their clinical placement at the end of their practicum. The reference group reported on how the model was being accepted during its implementation, and learning facilitators shared their experiences of the model followed by recommendations for improvement. However, the authors only reported findings from the facilitator group. Further, data collected from the students were shared with the reference group, which may have biased data collected from them. While collaboration is a central tenant of this model, it is difficult to know how all three stakeholders collaborated to support student learning, other than from the facilitators' perspective, which included encouraging students to be active learners and RNs to include students in their workplace. This seems to be a rather simplistic approach to collaboration and does not reflect the complexity of the clinical context.

More recently, consideration of collaboration in research has occurred in response to changes required following COVID-19 (Hill et al., 2020; McSherry et al., 2021). Hill et al. (2020) acknowledged the importance of educational and clinical relationships, and the need to consider the perspectives of all stakeholders in clinical education of nursing students. Reporting on a new clinical learning model being implemented in the UK—the Collaborative Learning in Practice (CLIP) model—Hill et al. noted this model had philosophical underpinnings that enabled groups of students to provide care under the supervision of a RN coach. Their mixed methods study compared the CLIP model of clinical education to the mentorship model previously used in the UK. Data were collected through surveys and focus groups with student participants and individual interviews of other stakeholders who included individuals involved in the oversight or management of the model. Most notably, ward managers and clinical coaches who worked with SNs on the ward were excluded from this study. This seems to be contradictory to their original position of valuing the perspectives of all stakeholders.

An appreciative inquiry study highlighted the opportunity to establish a tripartite collaborative relationship during COVID-19 (McSherry et al., 2021). This research focused on the experiences of third year student nurses working in a hybrid model of clinical learning, where they were employed, yet still students. The authors were interested in noting from the students' perspective if they were sufficiently prepared

to work within this emergency situation given their preceding undergraduate education. Only including the students' perspective in this study appears to be a limitation, given that the authors had recognised the tripartite collaborative relationship required to establish this hybrid model.

Conclusion

This chapter has presented a review of the literature as it relates to the clinical education of nursing students. I began by exploring the purpose of the clinical learning experience in nursing education. Current clinical models used within the New Zealand context were outlined, including the preceptor model, mentorship model, and the DEU model. Consideration of factors that influence choice of model have been incorporated, along with recent changes that were implemented in response to the global COVID-19 pandemic. Recognising that the stakeholder relationship is central to the quality of the clinical learning experience, literature that explored this phenomenon was also included. I then explored pedagogical approaches commonly used in clinical education for nursing students—experiential learning and reflective practice. Consideration of what contributes to a clinical learning environment was required as it impacts the quality of the learning experience.

Throughout this chapter, I presented the various approaches to research reported in the literature, providing critique to these approaches and the limitations in their findings, offering justification for my study. There is a significant gap in the literature related to how stakeholders collaborate to support the development of clinical competency in undergraduate nursing students. My aim is to address this gap, using ID underpinned by CT. The following chapter outlines the philosophical and theoretical underpinnings of the study.

Chapter 3 PHILOSOPHICAL AND THEORETICAL UNDERPINNINGS

Introduction

I begin this chapter by exploring the epistemological positions that inform the methodological approach used to study how stakeholders collaborate to support undergraduate nursing students to develop clinical competency. I then explain the methodological approach used—ID (Thorne, 2008), justifying it in relation to other approaches considered. I will explain how this research approach was informed by CT (Brand et al., 2015). Finally, I identify my own assumptions, exposed through the literature review and a presuppositions interview.

Epistemological Assumptions

Assumptions regarding research and the construction of knowledge are important to identify and explain to ensure the findings from any research are internally consistent. Researchers usually begin with consideration of the broader overarching epistemological position or research paradigm. Denzin and Lincoln (2000) suggested that the researcher is guided by an established epistemological paradigm, underpinned by an established set of beliefs. However, Crotty (1998) claimed that to justify the chosen methodology and methods the researcher must acknowledge their own assumptions about how truth and knowledge are constructed.

I begin by noting that epistemology is defined as being "concerned with what we can know about reality (however that is defined) and how we can know it" (Willis, 2007, p. 9). Willis (2007) further suggested that epistemology is an essential underpinning for research, recognising that the researcher (or knower) is guided by their position within the research process, therefore making knowledge contextually situated.

Interpretivism is the paradigm underpinning this study. Willis (2007) claimed that interpretivism is an approach which recognises that human behaviour is an indirect response to environment; that people are influenced by the perception of their subjective reality of how they see the world around them. This includes consideration of how others see the individuals who are being studied and the individual's perception of this perspective of other. Willis (2007) cited Kant (1781/2003) who asserted that individuals do not understand the world around them until they have

interpreted their experience with it. Therefore, interpretivism is influenced by one's culture and history because these are the frameworks used for such interpretation (Crotty, 1998).

Constructivist epistemology is a branch of the interpretivist paradigm. One assumption is that the construction of knowledge occurs through mindful engagement with the selected topic; that it is socially constructed. Thorne (2008) supported this assumption, believing that individuals' realities are built through experiences of engaging with both the environment and the people within it. This means that there are multiple truths because different people construct different meanings from the same situation. Taking an interpretivist-constructive approach to the exploration of the topic being studied, I am able to highlight what might enable and/or constrain effective collaboration between stakeholders. Identifying barriers to effective collaboration enables the utilisation of strategies to address these barriers or review expectations related to collaboration between stakeholders. In this study, I seek to identify who the relevant stakeholders are and how they collaborate. I am looking for the reasons why they choose to interact the way they do with other stakeholders, specifically what are the values and beliefs that underpin the clinical learning of undergraduate nursing students. My aim is to identify the historical and cultural context that influences stakeholders' thinking and behaviour.

Methodology

The following sections outline the process I undertook in choosing the most appropriate methodology for this study. I then present ID as a methodology and justify its selection.

Choosing a Suitable Methodological Approach

During the design phase of this study, three methodological approaches were considered. First, case study was explored. While case study method appeared to align with the research questions, it was difficult to articulate the boundaries of the case. Forcing the boundaries of the 'case' indicated that it was unsuitable for my study. The second approach considered was phenomenology. This was a fleeting consideration because although the topic could be considered a phenomenon, phenomenology's intention is to find meanings as lived in relation to the topic. The intention of this study

is to identify how stakeholders collaborate, along with factors that enable and constrain collaboration. The third consideration was ID which stems from research methodologies such as ethnography, grounded theory, and phenomenology (Sandelowski, 2000; Thorne, 2008); thus, it has overtones of these methodologies. This methodological approach is well suited to complex topics within health care settings and the aims of my study. ID assists researchers to illuminate the layers of reality that form the clinical practice context. Following exploration of ID, a decision was made to use this approach in the study.

ID

The literature review highlights that the clinical learning setting is complex and contains multiple realities for various stakeholders. Given that the focus of this study relates to how stakeholders collaborate to support the development of clinical competence for undergraduate nursing students, a topic firmly embedded in the clinical practice world, ID is an appropriate methodological fit. ID is a qualitative research approach that attends to "complex experiential questions that are relevant to nursing… but which are not readily answered by traditional qualitative methodologies" (Hunt, 2009, p. 1285). According to Thorne (2008), ID illuminates knowledge relevant to the realities of the practice world. Hunt (2009) claimed that ID aims to develop knowledge that is relevant to nursing practice within the clinical setting. Capturing these realities through the data collection phase enabled me to gain insight into how stakeholders collaborate and the factors that enable or constrain collaboration, including the values and beliefs of the stakeholders. Thorne et al. (1997) proposed that ID offers an alternative methodology for the development of nursing knowledge because it facilitates recognition of what is common and unique within nursing practice. Thorne (2016) further stated that studies designed using ID can explore various components of a topic which helps to construct an understanding of the topic that respects inherent complexity.

My research question straddles two complex worlds (Holmboe, 2018)—the clinical world of healthcare and the academic world of education. Clinical is where patient care is provided and clinical learning takes place. Yet, the world of education also influences the students' learning experience while in clinical practice. Therefore, I needed a methodology and methods that could account for this complexity. I also

needed to use a theoretical framework that helped me capture this complexity, while not losing sight of the research questions. CT provided the theoretical perspective for such exploration.

Theoretical Perspective: CT

Thorne et al. (1997) previously warned against the potential for theory to dominate and the intent of the study to be lost. However, more recently, there is acknowledgement of the usefulness of 'analytic frameworks' including previously constructed theory and research (Burdine et al., 2021). Given the complex nature of the topic being studied, the use of CT as an analytic framework is appropriate. CT is difficult to define because of its use in variable contexts. Originally developed for mathematical and physical sciences (Jorm et al., 2016; Walton, 2016), CT then moved into the fields of business and management in the 1970s and 1980s (Morrison, 2002), and is now well established in the field of social sciences (Gerwel Proches & Bodhanya, 2015), including education (Kincheloe & Berry, 2004). CT can be defined as a collection of entities which are connected or related and combine to contribute to a single system or organisation (Byrne & Gallaghan, 2014). Morrison (2002) viewed CT more simply as "a theory of survival, evolution, development and adaptation" (p. 6). CT is particularly helpful when exploring situations related to relationships and interactions (Kincheloe & Berry, 2004; Thompson et al., 2016). Jorm et al. (2016) claimed that CT is useful within the health care system due to its focus on relationships, adaptation, and collective learning, and its understanding of challenges within collaborative practice. Chandler et al. (2016) elaborated, claiming that CT helps to explain the numerous interactions of different levels of the healthcare system, including the organisational level and the individual level, and rationalises outcomes or consequence that are unexpected.

Brand et al. (2015) believed that healthcare settings are complex because of the relative freedom of the individuals working in this context. This freedom means that interactions can be somewhat unpredictable and non-linear. That is, individuals can interact with a number of different people at different times in a non-routine or random way. Due to this non-linear interdependence between individuals, Holmboe (2018) referred to hospitals as CASs. A CAS is one where there is interconnectedness between individuals; meaning the actions of one individual can influence the clinical

context of another individual. CT enabled me to gain insight into the interactions of stakeholders and how they self-organise to collaborate (or to survive) at any given time. It also enabled consideration of the contextual influences in both the clinical setting and the educational context, along with their inherent demands and agenda.

Brand et al.'s (2015) CAS Principle Framework

Using literature related to CT in social sciences and healthcare settings, Brand et al. (2015) developed the CAS principle framework to explore the complexity of a workplace system as it related to creating healthy workplaces. The CAS principle framework is a presentation of factors that interplay, constantly moving and evolving depending on the individuals and the circumstances in which they are interacting. These interactions between individuals and the context in which they are interacting create a system. This system, in turn, has the power to influence individuals' behaviour. At the same time, the behaviour of individuals also can influence the environment. Therefore, a system within this study is considered dynamic and emergent. CAS principles are not presented in any particular order because it is not possible to create such order within a complex system. Instead, the CAS principles come together in different ways at different times. This was particularly helpful for me because, as a logical and pragmatic person, I initially wanted to create a flow chart to show how each CAS principle interacted. However, once I began data analysis, I came to understand that this was impossible and would not validate the complexity of the system in which stakeholders were trying to support the development of clinical competency in undergraduate nursing students. Key features of CAS principles, as interpreted by Brand et al. are outlined in Table 3 below.

Table 3: ***Key features of CAS principles as described by Brand et al. (2015)***

CAS principle	Key features of the principle
Interrelatedness and distributed control	Recognises that all factors within the system are 'coevolving'
	The behaviour of individuals evolves in response to various elements within the environment
	Control is not reflected through the hierarchy within the system, nor does it occur 'bottom-up'
	Individuals cannot be empowered to make change, rather the context needs to be set up to enable change to happen
	Concerned with quality and quantity of interactions between staff
Order generating rules	Internalised rules that influence how individuals behave within the system
	Rules can be shared by those who work together or belong to the same organisation/profession
	Includes values, beliefs, expectations, assumptions, and priorities
	Rules can both enable and constrain behaviour of individuals
Edge of chaos	Recognises that change occurs in the space between chaos and order
	If the system is too ordered, status quo is maintained
	If the system is too chaotic, change will not occur as the individuals will feel too overwhelmed
	Innovative order generating rules have the capacity to hold the system on the edge of chaos so that change can occur
	A desire to see a change in behaviour in the system should focus on what both enables and constrains the system
	Concerned with how staff currently manage change within the system
Self-organisation	The ability of the system to create an organised pattern of behaviour
	Patterns of behaviour 'emerge' from within as a result of the interrelatedness of individuals within the system, not from external influence or being controlled by authority
	Interactions are enabled and constrained by order generating rules
Attractor patterns	Patterns of behaviour encouraged and enabled through particular conditions in the workplace or system
	A change to the conditions may 'attract' individuals to create a new pattern of behaviour
	Understanding what draws people to behave in a particular way is helpful when introducing change in the system
Re-inforcing feedback loops	Patterns of behaviour demonstrated by individuals within the system, provide feedback to the system to reinforce that pattern of behaviour
	This 'feedback loop' reinforces current behaviour to continue
	Helpful to know what reinforces behaviour if change is desired

CAS principle	Key features of the principle
Co-evolution of system and its environment	Recognises the interplay between the system and the environment Environmental factors influence individuals' behaviour within the system. At the same time, the behaviour of individuals within the system can influence the environmental factors Change at the local level can influence change at all other levels of the system; likewise, change at a broader level of the system can cause change at the local level An understanding of the broader system (e.g., the organisation) helps to identify what might enable and constrain change at a local level of the system (e.g., the ward)
Sensitivity to initial conditions	How the system currently exists, provides the starting point for change within the system, highlighting that the features of a CAS are dependent upon the context Any difference in context at any given time will result in the individuals responding in a different way from any other time Takes into consideration the physical environment of the system
Creation of adjacent possibilities and awareness of path dependency	Historical behaviour of the system determines current behaviour Current behaviour determines what is possible in the future What is possible in the future is determined by the dynamics in the system at the time, which need to be taken into consideration when making changes

An Explanation of How the CAS Principles Were Applied in This Study

While the above CAS principles provided a framework for analysis, the principles on their own could not answer the research question. I therefore created my own framework of questions (see Appendix E) mindful of the CAS principles and the study aims. During the data analysis, I repeatedly asked these questions as I reviewed transcripts. This process of asking questions of the data helped me to identify the values and beliefs held by stakeholders, along with other factors, all of which enable and constrain collaboration between stakeholders. Interpreting these findings helped to explain ***how*** stakeholders collaborate to support the development of clinical competence in undergraduate nursing students in the acute care setting. The CAS principle framework enabled me to manage the multitude of notions that were relevant to this study without losing sight of the complexity of the topic or the research questions.

Exposing My Assumptions: Review of Literature and Presuppositions Interview

Before commencing data collection, congruent with the interactionist assumption of ID (Thorne, 2008), it was important to acknowledge that I already possessed understandings of the research topic that would influence the choices made about the research process (Hunt, 2009). One practice to address this issue is the requirement for the researcher to explore their preconceptions about the topic (Hunt, 2009; Thorne et al., 1997). This can be partially attended to through a literature review. While reading the literature pertaining to this study, I kept notes about what the literature was saying and my thoughts/assumptions about the topic. This process was quite broad initially, but as the scope of the study was refined, there was a need to go back over some of the earlier literature to recapture more specific thoughts/reactions to the literature. I also needed to acknowledge that I had personal experience of the topic under investigation. Therefore, I captured my preconceptions via an interview with two of my supervisors which was tape-recorded and transcribed before data collection began (Hunt, 2009; Thorne et al., 1997).

Analysis of the presupposition interview identified personal beliefs, along with the assumptions that I held about stakeholder relationships in clinical education for undergraduate nursing students based on prior experience with all three stakeholder groups. Because I was a SN myself 30 years ago and, from my perspective as both a RN working clinically and precepting students and as an academic at the university supervising students while on placement, I can confidently state that the clinical model of student supervision in New Zealand is relatively unchanged. Prior experience enabled me to understand each role, and question the systems and individuals involved. Thorne (2016) suggested that prior experience in the field may result in findings that are "beyond mere 'opinion' and in fact are based on recognisable methods for empirical reasoning" (p. 111).

Yet, there are personal limitations. While I am hard working, I expect everyone else to have a strong work ethic. Stakeholders may, therefore, not measure up to my expectations of what it means to 'work hard' and to collaborate as effectively as they could. This means that I may be overly critical in my interpretation of how I look at the

data gathered. It was essential to be open to understanding the perspective of others, especially when they did not match my preconceived ideas or expectations.

The following assumptions were identified during the presuppositions interview:

1. The acute care environment is 'always' busy, due to a 'lack of RNs' trying to care for patients with a high acuity.
2. There are 'competing agendas' or 'different philosophies' (values and beliefs) held by different stakeholders, such as:
   i. RNs are busy and patients are their priority at the expense of supporting the development of clinical competency in the SNs they work with, despite there being a legal obligation to support student development in practice.
   ii. SNs' priorities are to pass, ahead of learning for practice. For example, students sometimes claim that environments are not good for learning; yet I believe learning is available in all environments/situations. Some environments/situations require the student to see things from a different perspective rather than through the lens of assessment.
   iii. CEs understand both above perspectives so spend a lot of time negotiating the 'competing agendas' of the RN and SN. I believe that the CE values learning for practice over passing; yet they still have the ultimate responsibility to pass or fail students. I also believe that CEs act as a conduit between the RN and SN; yet they are present the least often in clinical.
3. There is a perceived hierarchy between stakeholders which may negatively affect relationships or limit the potential for stakeholders to collaborate.
4. There is a perceived risk associated with being an SN and having a student working with the RN in clinical practice. It is also true that there are positives to having a student working with the RN in clinical because it can strengthen the RN's practice.
5. CEs carry the least clinical risk, but also the most power in relation to student achievement.
6. The cultural makeup of the nursing workforce may influence how stakeholders interact. For example, locations of 'training' such as hospital or tertiary institute, and/or ethnicity/country when the RN was educated. The student population is culturally diverse and may match the workforce population, but the focus will

be on expectations of practice within the New Zealand cultural context, in accordance with the NZNC competencies.

Recognising the above strengths, limitations, and assumptions further supported my use of the CAS principle framework as a tool to help expose me to the unexpected. While I had my own interpretation of the framework, it enabled me to see the topic through a lens other than my own.

Conclusion

This study is underpinned by an interpretive-constructivist epistemology. ID is the methodological approach, guided by CT, using a CAS principle framework. Personal assumptions about the topic have been identified, highlighting beliefs about myself, others and the complexity of the clinical context. My understandings of clinical learning and collaboration within clinical learning for undergraduate students have been informed by personal experiences in all three stakeholder roles over the past 30 years. The assumptions and beliefs presented, together with the philosophical and theoretical underpinnings of this study, have informed the research design and methods as further explained in the following chapter.

Chapter 4 STUDY DESIGN & METHODS

Introduction

Chapter four outlines the research design, methods, and data analysis processes used in the study. I begin by explaining the consultation processes undertaken to ensure that I worked with the appropriate stakeholders. I then outline the ethical considerations, including obtaining ethics approval and access agreements. Following, I describe the study participants, including inclusion criteria and an explanation of how they were recruited. Discussion of challenges faced during recruitment will be shared. In the next section I outline the methods of data collection; namely focus groups and individual interviews. The processes followed for data analysis are described, enabling the reader to understand how the findings emerged. Finally, I outline the processes followed to ensure rigour of findings in this qualitative study.

Consultation Processes

During the design phase, I consulted with a number of stakeholders relevant to the study. First, I met with representatives from Waitemata District Health Board (WDHB) and ADHB, where AUT places students for clinical experience, to discuss my plans for the project. Responses were supportive, suggesting that the research would potentially be valuable for improving future collaboration between stakeholders. I was allocated a sponsor at ADHB to support the research project within that context. Later in the research process I reconnected with relevant stakeholders at WDHB and obtained formal access to recruit RN participants working within that DHB.

Consultation with Kawa Whakaruruhau Komiti (KWK) at AUT also occurred. There was the suggestion that potentially Māori participants may prefer to participate in an individual interview instead of a focus group. This was subsequently factored into the design of the study and participants were given a choice of how they would prefer to participate. A Komiti member also offered their services to any Māori participants who wished to be supported while participating in the study. Three stakeholders identifying as Māori participated in this study within a focus group. I am not aware if they sought additional support.

When embarking on doctoral research at AUT, all candidates must develop a proposal which is reviewed by two experienced academics. Feedback from this consultative process suggested that more detail be provided in relation to *how* the participants would be identified and recruited, as well as refining the focus of the study. I completed this process and made the relevant adjustments in response to the feedback.

I then met with an AUT ethics committee (AUTEC) representative. We discussed how best to balance my concerns about including participants with whom I had a direct working relationship, with the need for these participants to be involved. I recognised the importance of including clinical educators from AUT as participants in this study; after all, this is where the original catalyst for the problem was acknowledged. Strategies aimed at protecting participants who are vulnerable are described next.

Ethical Considerations

The main ethical consideration needing to be addressed was the vulnerability of potential for participants who had a pre-existing relationship with me due to my role as an AUT nurse lecturer/clinical leader at the time of data collection. I recognised that the potential participants may feel vulnerable due to a power imbalance between myself as the primary researcher and those participants with whom I had a direct working relationship. Following discussion with the AUTEC representative, strategies were implemented into the study design to address potential power imbalance for these participants (see participant recruitment section).

To ensure safe and appropriate access to recruit RN participants from the DHBs, I also obtained locality access agreements. Initially this was approved by ADHB (project number A+8062). Later, access was approved by WDHB (project number RM14322).

While no formal access agreements were required from each of the three universities in Auckland, out of courtesy I contacted relevant nursing leaders from the universities seeking their support and permissions. Each leader of the three university nursing programmes supported the study and gave approval to recruit both students and academic staff who support students in clinical through relevant contact people in their organisations.

Participants

In keeping with the expectations of NCNZ, I limited study participants to the triad of stakeholders that form the 'triangulation' that NCNZ (2015) allude to in their monitoring report. This included SNs, RN preceptors, and academic CEs. While the report itself identifies 'clinical providers' and not necessarily RNs overtly, I interpreted that the RN was best placed to fit within the picture of collaboration because they are directly involved with the clinical teaching and supervision of students.

Purposive sampling was initially implemented. Theoretical sampling, as discussed by Thorne et al., (1997), was also used for some individual interviews, providing access to participants who were best placed to answer the questions being asked as well as participants who appeared to offer dichotomous perspectives, thus capturing the complexity of the topic.

Inclusion Criteria

Students: Had to be a currently enrolled at an Auckland university and completed or about to complete their second-year nursing placement in an acute hospital setting at one of the two Auckland regional DHBs.

RN preceptor/mentors: Had to be a RN who worked with second year nursing students in an acute hospital placement at one of the two Auckland regional DHBs within the past 2-years.

Academic CEs: Had to be an academic CE who worked with second year nursing students in an acute hospital placement at one of the two Auckland regional DHBs within the past 2-years.

All participants needed to be able to speak conversational English.

Participant Recruitment

Potential participants were accessed via social and professional networks within one local DHB and three universities within the Auckland region. I used emails via location sponsors who informed potential participants about the study. I asked the DHB location sponsor to distribute recruitment posters (Appendix F) within the acute care settings, on medical and surgical wards within the DHB. Potential participants were

invited to contact me or my primary supervisor if they were interested in more information about the study and/or to express an interest to participate. Sponsors from educational institutes also distributed recruitment posters in a manner they deemed most appropriate for both their student population and CE group.

I designed the recruitment phase processes to be managed by my primary supervisor, in case there were potential participants who did not feel comfortable contacting me directly. Information pertaining to this option was available in the recruitment advertisement. As participants contacted either myself or my primary supervisor, they were provided with a participant information sheet (Appendix G), in the first instance, and consent forms for both focus group and individual interview (Appendix H). They were then asked to confirm if they were still interested in participating in the study. This eliminated any sense of coercion to participate in the research. All participants with whom I had a pre-existing relationship were also offered the opportunity to have someone other than me carry out the data collection. None of the participants who volunteered took up this offer, with all participants accepting my role as researcher.

There were four RNs and one SN who expressed initial interest in the study but did not respond when they were sent further information. The remaining 11 SNs, nine CEs, and seven RNs all consented and participated in either a focus group or individual interview. At the time of data collection, all participants were allocated a code that reflected their role (e.g., RN for registered nurses, CE for clinical educators, and SN for student nurses), followed by a number unique to them. I used these codes throughout the findings chapters when sharing direct quotes and/or when referring to individual participants to maintain confidentiality.

Challenges to Participant Recruitment

Recruitment for participants across all groups began in mid-2018 during which time there was significant unrest with many RNs involved in industrial action that had commenced earlier that year (NZNO, 2018a). RNs were dissatisfied with their working conditions and were expending energy negotiating better working conditions within their employment agreements. Furthermore, this was also the middle of winter in New Zealand, a time when the DHB hospitals are notoriously overburdened with patient admissions. Thus, RN recruitment was slow because they were more focused on the

industrial action and managing the increased winter workload, than volunteering to participate in research, and no RNs expressed interest in participating. In August 2018, the industrial action concluded with bargaining achieving a new agreement (NZNO, 2018b). September brought a change of season as winter changed to spring. Again, I tried recruiting RN participants only to find those who were engaged in PG study had assessment deadlines looming. Once again, timing was not right for RN participant recruitment.

I also struggled to recruit SNs in 2018, possibly due to reasons related to assessment demands. However, during the second half of 2018, I managed to complete two CE focus groups and interviewed four individual SN participants as well as two individual CE participants. Early 2019, I decided once more to try and recruit RN participants. I also decided to widen the pool of potential RN participants. I requested ethics approval be amended and obtained a locality agreement at a second DHB within the Auckland region. In March 2019, I completed the first RN interview. While the participants did not flood in, there was intermittent interest. I carried out a second RN interview in May 2019, a SN focus group and two SN interviews in July 2019, with my fourth RN participant being interviewed in March 2020. Three more RN participants came forward in May 2020, thanks to a colleague who shared my recruitment poster with clinical colleagues. This drew data collection to a close, with 27 participants volunteering to share their experiences of collaborating with other stakeholders. A detailed timeline of these focus groups and interviews can be found in Appendix I.

Methods of Data Collection

The following sections describe the different methods of data collection used in the study. Methods included focus groups and individual interviews. I also share the indicative questions used in both, providing some adaptations that were required depending on which cohort of participants was being interviewed. Essentially the intent of the questions were the same.

Focus Groups

In keeping with the notion that knowledge is socially constructed, and to honour the complexity of the topic, initial data were intended to be gathered through focus group discussions (Powell & Single, 1996; Thorne, 2008). Thorne (2008) claimed that focus

groups enable a process that produces “certain kinds of social knowledge, such as beliefs and attitudes that underlie behaviour” (p. 131). A strength of focus groups is that they offer the opportunity for participants to validate data as they emerge (Then et al., 2014); that is, ideas can be confirmed or countered as participants raise them. Sandelowski (2000) noted that focus groups enable the researcher to gather a wide range of perspectives. A benefit of smaller focus groups is that the complexity of the topic studied can be highlighted (Krueger & Casey, 2015). Honouring the complexity of the topic was particularly important in this study.

To promote group dynamics that foster open conversations, focus groups should contain participants that are homogenous (Doody et al., 2013b; Kellmereit, 2015; Krueger & Casey, 2015). That is where participants have similar demographics such as age, ethnicity, and social class. Kellmereit (2015) referred to the notion of ‘broad homogeneity’. Rather than the narrower scope that might be achieved when considering age, ethnicity, and social class, broad homogeneity describes participants who share a common experience or background. Broad homogeneity was the approach taken in this study. All participants had experience collaborating with stakeholders in the clinical setting to support the development of clinical competency in undergraduate students but they came from diverse age groups and a variety of ethnic backgrounds and social classes. Demographic data related to participants is captured within Appendix J. Doody et al. (2013b) referred to the concept of ‘segmentation’—having multiple focus groups, each covering a different category of participant. The concept of ‘segmentation’ fitted with this study because I constructed focus groups according to participants’ role within the triad of stakeholders. That is, there were groups just of SNs or CEs. Focus groups never included a mixture of these participants because I was aware of a potential power imbalance between stakeholders which may impact their ability to speak freely in the group.

There are three cautionary notes to consider when using focus groups for data collection. First, there is consensus that focus groups should not be used as an efficient way to replace individual interviews (Doody et al., 2013a; Then et al., 2014; Thorne, 2008). Second, group dynamics are unpredictable, with participants having varying levels of engagement or energy, or hesitant to share their perspective if they are with others they do not trust or are dominated by (Doody et al., 2013a; Then et al., 2014;

Thorne, 2008). Third, there are the logistics of getting a group of people together, especially ones who are busy with clinical practice (Then et al., 2014). To address some of these potential issues, Doody et al. (2013b) have provided clear guidelines on how to set up focus groups to ensure that they are effective. They suggested that significant planning and preparation is required and highlighted the role of the facilitator as being vital to the success or demise of the experience. While I am an experienced educational facilitator, with previous experience working with groups of students in the classroom, this was the first time that I had used this method to gather research data. Therefore, as I analysed the data, I needed to consider the possibility that gaps would remain in the data at the end of the focus group process.

My intention was to set up six focus groups, two for each 'role' identified within the stakeholder relationship as outlined above (i.e., 2 SN groups, 2 groups of RNs who precept students, and 2 groups of CEs who visit with SNs while on clinical placement). Noting Then et al.'s (2014), warning regarding the challenges of getting a group of people together for a focus group, I offered two opportunities for focus group discussion hoping this would improve participant involvement. This strategy worked well for CE participants. Two focus groups were held, one with three CE participants and one with four CE participants. I was also able to arrange one focus group for four SN participants. However, due to the challenges recruiting RN participants, I was not able to hold any RN focus groups.

Initially I planned to use the services of an experienced group facilitator to run the focus groups that included participants with whom I had a direct or perceived relationship. Participants were given the option of participating through an external group facilitator; yet all chose to interact directly with me as the researcher. To negate any sense of coercion during the focus group, these were run with the support of a research assistant who was not known by participants. The research assistant noted dynamics in the group, such as order of responses to questions and body language responses that were not captured through voice recordings.

I initially aimed to have between 5 and 10 participants per focus group. This number is supported by Kellmereit (2015) who stated that the number of participants should be "small enough that everybody can share their insights but large enough so that there is

enough diversity of perceptions" (p. 46). However, due to the challenges with recruitment described above, I decided to work with smaller focus groups. In hindsight, the smaller groups were better when taking into consideration the purpose of the study and the complexity of the topic (Krueger & Casey, 2015).

Thorne (2016) warned about using focus groups for data collection, suggesting that there is a social dynamic that may incline participants to be reluctant to share views that differ from the group. Conversely, in each focus group, I witnessed participants openly disagreeing with the perspectives of others, sharing an alternative viewpoint. While this did not happen all the time, it suggests that the participants felt comfortable with others in attendance, where they felt able to present divergent perspectives. Therefore, while the potential for this limitation of the focus group is acknowledged, I do not believe it was a significant limitation of the study.

Individual Interviews

I had originally planned to include individual interviews using theoretical sampling. Prior to recruiting participants, I was aware that there was a risk that participants within a focus group may think alike or have had similar experiences, limiting the complexity of data gathered (Thorne, 2008). This is particularly so when participants are self-selecting to take part in a study because it may only be those who have had positive collaboration experiences who choose to participate. Therefore, I thought that individual interviews would help extend understandings of an aspect that may arise out of the focus groups (Hunt, 2009; Thorne, 2008). I was also open to the participants self-selecting the method of participation that suited them, as per my conversation with the Kawa Whakaruruhau Komiti. I quickly found that this data collection approach was useful for participants who were unable to attend a focus group.

Individual interviews were conducted with 14 individuals from all participant groups, including four individual SN interviews, two CE interviews, and seven RN interviews. A further interview was held with two SNs simultaneously. I chose to consider this opportunity for data collection as an individual interview, held with two participants. Where the focus group enables a conversation to occur between participants with the researcher stepping back to take more of an observational stance at times (Krueger & Casey, 2015), the interview with SN09 and SN10 did not result in such an interaction.

Instead, it was more reflective of two participants, each taking their turn to answer the questions asked.

Indicative Questions

The following list of indicative questions was used for both the focus groups and individual interviews. These questions were developed from a combination of the research questions and the CAS principle framework.

1. Who do you interact with to support undergraduate SNs in the clinical setting?
2. Tell me how you interact with these stakeholders.
3. Tell me about an interaction that went well.
4. Why do you think this interaction went well?
5. Tell me about an interaction that didn't go so well.
6. Why do you think this interaction did not go so well?
7. What are your values and beliefs about clinical learning for undergraduate nursing students and collaboration between stakeholders?
8. If you could, what would you change about how you collaborate with other stakeholders?

While the above questions related well to the RN and CE groups, question one was slightly modified for the SN group, to: Who do you interact with to support your learning in the clinical setting? This did not change the intent of the question being asked and yielded similar responses to the other two groups.

While the above list of questions was used as a starting point and were generally included overtly in most focus groups and individual interviews, follow up questions or requests for further elaboration were also made. Once participants responded to the questions, I often presented my interpretation of what was being said. This enabled participants to either agree or disagree with the interpretation, allowing for further clarification or explanation if it did not accurately reflect their intentions. At times, the participant had included the answer to a later question within their answer. For example, why an interaction went well was included when they answered the request to tell me about an interaction that went well.

Data Analysis

This section outlines the processes of data analysis, including the transcription of the focus groups and individual interviews. It begins with a brief description of challenges getting started with analysis, followed by a description of the phases of data analysis used.

Transcribing Data

Once the focus groups and individual interviews were completed, the digitally audio-taped recordings were transcribed by a professional transcriber who had signed a confidentiality agreement. Transcription was completed as each focus group meeting or individual interview was finished, so that insights gained from the initial data collection methods could influence the following ones (Hunt, 2009). This process also guided the need for individual interviews, especially in the case of CE participants.

Analysing Transcripts: Getting Started

On receipt of the transcript, the first step in the analysis process was to clean the transcript. This included editing for clarity and ease of reading, without losing the intent or meaning of what the participants said. Furthermore, all identifiers were removed from the transcript to ensure anonymity because participants sometimes used specific names related to people, a specific hospital, or DHB. This process provided me with an opportunity to both listen to the recording of the focus group or interview while reading the transcript. Thorne (2016) warned that at this early phase of working with data some researchers focus in on specific words or phrases, which can be both helpful and hindering. It can influence the researcher to look for antithesis ideas or not. Instead, Thorne suggested that the researcher remain open to seeing the whole picture.

Once transcripts were cleaned, I started to work with them. In keeping with interpretivism and drawing from CT, my data analysis was guided by the principles of CAS (Brand et al., 2015). This nine-principle framework that explains how complex systems operate was intended to enable me to construct findings that answered my research questions. As I read through the first transcript, I pulled out data as it related to each CAS principle, placing the raw data into a spreadsheet, with one page used for

each CAS principle. I immediately noted that this process was repetitive, and I found myself just describing what the participant had said, rather than interpreting what they were saying in relation to the CAS principles or research questions. I also felt constrained by the structure of an excel spreadsheet. Intuitively, I knew that this approach to data analysis was not right. As Thorne (2008) claimed, nurses are generally not satisfied with just a description of events, instead we like to find meaning through "associations, relationships and patterns" (p. 50), likening this to the clinical reasoning nurses use within clinical practice. Following discussion with my supervisors, I decided to try cutting up the transcripts and allocating the data into envelopes, with each envelope reflecting a CAS Principle. Again, this did not feel right. I realised that the data were not easily pulled apart this way because sections of data did not necessarily fit within only one CAS principle. Rather, data highlighted the integration of the CAS principles. Furthermore, there was a sense that I was trying to match findings with principles without fully interpreting what the participants were telling me. Thorne (2016) stated:

> Interpretive description requires an analytic form that extends beyond taking things apart and putting them back together again. It requires that we learn to see beyond the obvious, rigorously deconstructing what we think we see, testing hunches as to how it might fit together in new ways and taking some ownership over the potential meaning and impact of the outcomes that we will eventually render as findings. (p. 156)

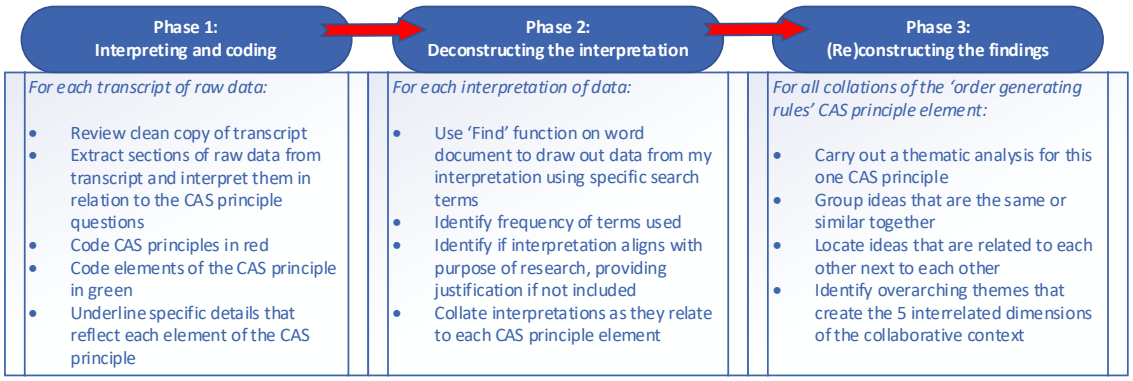
Thorne's (2016) methodology enabled me to slow the data analysis processes to ensure the interpretations were consistent and robust. I needed to find a more effective way of interpreting the data to identify elements of each CAS principle, while honouring the integration of the principles at the same time. I decided to listen again to what the participants were saying by re-reading their transcript, then interpret their message against the entire CAS principle framework. It was too soon and too difficult to consider the principles in isolation. Furthermore, it would not do justice to CT if I pulled the whole apart too early. This enabled me to embark on several phases of data analysis.

Phases of Data Analysis

There were, in total, three phases of data analysis. Phase one helped me to interpret the data as the CAS principles related to each other, while phase two enabled the

identification of the unique elements of data as they related to each CAS principle. Phase three facilitated bringing the contribution of each participant together to find common and divergent views and develop findings that provided answers to the research questions. Figure 1 below provides a brief overview of each phase. Further explanation of each phase follows.

Figure 1: Three phases of data analysis



Analysis Phase 1: Interpretation and Coding

To begin, I created a list of responses which enabled me to generate a list of stakeholders involved in supporting SNs in clinical learning from the perspective of the participants. This list of stakeholders can be found in Appendix K and will be discussed in chapter six under the notion 'interactions matter'.

Following interpretation of participant answers to question one, I then reviewed answers to the remaining questions. Using a word document, I would take a section of data from the transcript, placing it in a textbox so that it stood out from the analysis, and then type my interpretation of that data below. An example of this process can be seen in Appendix L. The use of the CAS principles facilitated working back and forth between the data (transcript) and my interpretation, helping to identify evidence in the data of the various unique aspects of the principles along with the interplay of the principles as they related to collaboration between stakeholders. Analysis involved 'going back and forth' between data and the CAS principles, ensuring that each piece of data were analysed to its full potential at this point in time.

However, trying to remember all nine principles was challenging and I feared that any distraction could prevent me from doing justice to the interpretation. To address this concern, I developed a list of questions relating each CAS principle specifically to my

study (Appendix E). While these questions provided me with a framework for repeating my analysis of each transcript for phase one, there were additional benefits of using the questions at this stage. First, the natural human inclination to forget the approach to interpretation over the course of time was reduced given that data analysis spanned a significant timeframe. Second, the questions helped to elicit an interpretation as it related to the CAS principle framework, while at the same time enabling more open interpretation to occur because the last question helped me to see what else might be relevant beyond the CAS principle framework. Ellis (2011) highlighted that a bonus of using a CAS framework is that it opens up the researcher to accept all perspectives, while at the same time allowing interpretation that brings together a more holistic view of what is happening. Recognising that there may be important findings not captured by the CAS principles, I chose to keep my eye out for different possible findings, labelling each as a 'new finding'. Finally, this approach increased my ability to type directly on the computer rather than writing with pen and paper. Clarity of thinking and ease of flow worked better for me as I interpreted the data while typing.

Coding of interpretations was also used (Thorne, 2016). I decided to colour code my interpretation text red when I could see specific CAS principles coming through in the analysis. If the data were referring to an element of a CAS principle, such as values, beliefs, or assumptions, all elements of order generating rules, this was coloured green. I underlined the specific detail interpreted from the data that represented these elements, such as a specific value, belief, or assumption. Examples of this coding can be seen in Appendix L.

Phase one data analysis process was completed for every focus group and individual interview, except for two individual interviews. I decided not to include one RN participant in this phase of data analysis because during the interview, the participant seemed to take the opportunity to discuss a variety of topics that were not clearly related to the study. I felt that their intention for participating did not align with the aim of the study. The second transcript omitted from data analysis was one obtained from the two SN participants. Reading through their transcript, it seemed there were no new perspectives being offered; rather, they appeared to repeat a number of points already raised by other SN participants. I still included another SN participant

following the dual interview because this person was the only Pasifika participant in the study and appeared to bring in an alternative perspective.

At times, I found myself wondering where this process would lead and whether I would be able to elicit meaningful answers to my research questions. Nevertheless, I continued because it intuitively felt right. I believed I was honouring the whole while identifying the unique. Over time, I developed confidence that this process would eventually tease out the detail of how stakeholders collaborated to support the development of clinical competence in undergraduate nursing students in clinical practice.

Analysis Phase 2: Deconstructing the Interpretation

Phase two exemplified the evolutionary approach to data analysis that is welcomed by this qualitative methodology. Sorting through the codes from phase one enabled me to deconstruct the whole. Thorne (2016) believed this phase enables the researcher to re-engage with the data that is similar, as a way of testing the codes applied, validating it along the way to ensure that the best approach is being taken. This phase also generated preliminary meanings from the data (Thorne, 2016). Using the word documents from phase 1, and the 'Find' function on the Word document, I began searching for use of CAS principle titles. For example, I searched for 'order generating rule'. I began by noting the number of times I used this term. The purpose for using numbers helped keep track of where I was up to during this phase of data analysis. However, I was more interested in how I had used it and what I had said about it. I copied and pasted the relevant sentences related to each CAS principle from the phase 1 analysis document across to the phase 2 document. An example of phase 2 can be viewed in Appendix M.

I then proceeded to review what I had said about that particular CAS principle and noted if there were any key terms that reflected that principle in the data. Using these key terms, I searched through the phase 1 document again for how I had interpreted each CAS principle, once again copying and pasting relevant sentences across to the phase 2 document. Not all sentences were transferred to the phase 2 document, for a variety of reasons. Sometimes the way I had used terms did not relate to the CAS principle being reviewed. For example, when I referred to the construct of 'values', I

sometimes used this term to denote a collective comment about ‘these values’, rather than identifying specific values. Other times the term was captured in the raw data or within the research question.

Concurrently, I developed a list of key terms related to the CAS principles generated from interpretation of the data in phase 1, with the intention that this list would be able to provide guidance as I embarked on phase 2 analysis for the next transcript. Having tried various ways of interpreting and linking my preliminary findings to the CAS framework, I decided upon a final list of key terms used in phase 2 data analysis (see Appendix N).

Movement of the data in phase 2 enabled me to analyse what was dominant in the data (what was discussed by participants multiple times) and what was unique (what might have been a one-off point of view). It also enabled me to deconstruct the data as it related to a specific CAS principle, so that I came to understand each principle on its own and how it related to the integrated practice of collaboration between stakeholders. Maintaining the use of ‘other’ at the end, enabled me to collate interpretation I had labelled as a ‘new finding’ maintaining an openness to identifying ideas and perspectives that did not fit within the CAS principle framework, along with key terms that specifically related to my research questions, such as clinical learning.

Once phase 2 was completed for the first focus group I moved on to phase 3 to test how data analysis would progress. The following section outlines the evolution of phase 3. This was most important phase because it generated the findings for the study.

Analysis Phase 3: (Re)constructing the Findings

I initially intended on carrying out phase 3 as each phase 2 was completed. However, as I moved forward with the next transcript I made the decision to leave phase 3 until I had completed phases 1 and 2 for all transcripts. I wanted to stay closer to the processes associated with phases 1 and 2. Moving to phase 3 too early would delay engagement with the raw data and may result in an altered interpretation to phases 1 and 2 data analysis. I did not want early ‘findings’ closing my eyes to seeing possible alternative findings. Therefore, I put this early venture into phase 3 aside, and started phase 3 again after all phases 1 and 2 analysis processes had been completed.

When I resumed phase 3 analysis, I felt somewhat overwhelmed with the amount of preliminary interpretations I had produced. With four CE transcripts, six SN transcripts, and six RN transcripts, each having nine CAS principle documents for phase 2 plus the 'other' document for new findings, I had a total of 160 documents. I decided to start with 'order generating rules' because these appeared to provide the foundation of how a CAS operates and would help me to answer one of the main research questions: what values and beliefs underpin stakeholder collaboration and support of nursing students?

Using a spreadsheet, I collated the phase 2 data and created a list of all the 'order generating rules' identified, which included *values* and *beliefs* of participants (see Appendix O for an example of this phase). There were 113 values identified by the CE participants, 83 values identified by the RN participants, and 65 values identified by the SN participants. Combined, this provided me with 261 values to analyse. I then took a thematic analysis approach to identify study findings.

Using iterative reasoning to identify patterns from the analysis (Thorne, 2016), I printed off all pages related to each element in the CAS principle. I cut them up into their individual points and, using a very long table, clustered them when ideas were similar or the same or related to each other (see Appendix P). As piles of ideas grew, I gave them names or titles, so that they were easily recognised as being related to a previously established idea; and, if not, they were either put on their own or placed to one side for later review. At the same time, I used a white board to enable a more concise understanding of the complexity of the whole. I found that all ideas related to the CAS principle of 'order generating rules' fitted within five over-arching themes: 'the individual', 'relationships', 'learning', 'nursing practice', and 'acute care clinical environment'. These themes enabled me to identify a continuum of guiding rules and other factors that inform stakeholders on how and when to collaborate. They also explain how they balance the tensions between these rules and factors. The nature of these findings will be presented in the following 4 chapters.

Ensuring Rigour and Trustworthiness of the Research Process

In taking a constructivist epistemological methodological approach, the research process is open to bias which may affect the quality of findings (Thorne, 2016).

Schwandt et al. (2007) suggested this is because I am framing the interpretivist process within prior experience of what I believe to be true, a position from which I am not able to remove myself. Therefore, I need to justify the interpretation through criteria that measure the rigour of the research process, reflecting trustworthiness of the research findings (Burdine et al., 2021; Lincoln & Guba, 1986, 1988; Moule & Goodman, 2014; Schwandt et al., 2007; Thorne, 2016).

Rigour and trustworthiness of the qualitative interpretive research process can be established through quality criteria, developed by Lincoln and Guba in 1985 (Moule & Goodman, 2014; Schwandt et al., 2007). The first quality criteria relates to credibility, which can be defined as producing interpretations that are a true reflection of participants' views or experiences (Moule & Goodman, 2014). Thorne (2016) referred to this as 'representative credibility'. One strategy to achieve credibility is triangulation (Moule & Goodman, 2014; Schwandt et al., 2007; Thorne, 2016). The inclusion of 27 participants from three different stakeholder groups, contributes to the triangulation through cross-checking data from different participants. Moule and Goodman (2014) identified another strategy for credibility, which involves the researcher immersing themselves in the culture being studied. It could be argued that my previous and current experience in the field of clinical education for nursing students positions me in a way that adds credibility to the research process.

Lincoln and Guba (1986) and Thorne (2016) suggested that the credibility of any research study is provided through details of the research processes used, including an explanation of how findings emerged from my interpretations. Providing a detailed description of the research process has the potential to reflect transferability which is another quality criterion (Moule & Goodman, 2014; Schwandt et al., 2007). Chapter four has outlined the details of my research processes. Readers will be able to determine the level of transferability of findings based on variations of context and how these may differ from the context of this study. I would argue that there are some findings which may be transferable; however, to suggest that all findings are transferable neglects acknowledgement of CT. Kincheloe and Berry (2004) noted that knowledge derived from CT does not produce a picture of absolute truth; rather, it comes with an understanding that there is a past and a future which will reflect the

constant evolution and emergent nature of truth and knowledge. This brings me to the final quality measures of dependability and confirmability.

Dependability and confirmability go hand in hand (Moule & Goodman, 2014). If the quality measure of confirmability can be achieved, then data can be considered dependable. Confirmability refers to the objectivity maintained by the researcher throughout the research process (Moule & Goodman, 2014). The three phases of data analysis, outlined above, demonstrate the strategies I employed to ensure dependability and confirmability of the findings in my study, primarily reflexivity and an audit trail maintained throughout the research process (Burdine et al., 2021; Moule & Goodman, 2014). Reflecting on the research process, both internally and with my supervisors, helped ensure that personal biases were not influencing the study findings. I also consistently considered the alignment between my research question, methods of data collection, and analysis. Internal reflections were recorded in real time in my doctoral notebooks and as notes during the electronic data analysis phases. I verbally shared these reflections with my supervisory team who were able to validate the insights I gained through this reflexive process. Hence, changes made during the data analysis phase of the study provide transparency, enhancing the rigour and trustworthiness of findings (Thorne, 2016).

Conclusion

In this chapter I have provided details of the research design, methods, and data analysis processes used in the study. I have included a description of the consultation processes undertaken to ensure that I worked with the appropriate stakeholders impacted by my study. I outlined the ethical considerations, including obtaining ethics approval and access agreements. I have described the study participants, including inclusion criteria and explained how they were recruited. Challenges faced during recruitment were shared before information was provided about methods of data collection; namely focus groups and individual interviews. Three phases of data analysis were described, enabling the reader to understand how the study findings were generated. Finally, I outlined the processes I followed to ensure rigour and credibility of findings in this qualitative research project. In the following four chapters, I present the findings of this study, beginning in chapter five with an overview of the whole.

Chapter 5 STAKEHOLDER COLLABORATION: INTERRELATED DIMENSIONS

Introduction

Chapters five, six, seven, and eight present the findings from this study. Chapter five starts by revisiting the research questions. I then introduce the collaborative context as a whole, formed by five interrelated dimensions that create the context in which collaboration occurs. These five interrelated dimensions capture the complexity of how stakeholders collaborate to support the development of clinical competence in undergraduate nursing students in the acute care setting. Chapter six describes two interrelated dimensions, 'the individual(s)' and 'the relationship'. Both dimensions centre on the people in the stakeholder relationship, hence the title of chapter six is 'people matter'. Chapter seven focuses on a further two interrelated dimensions, 'clinical practice' and 'acute care environment'. These dimensions describe the context of the stakeholder relationship; thus, the title of chapter seven is 'context matters.' Finally, chapter eight, titled 'purpose matters', describes the interrelated dimension—'clinical education'—which focuses on the purpose of the stakeholder relationship. Each interrelated dimension takes into consideration findings that highlight the values and beliefs that underpin stakeholder collaboration and support nursing students in the clinical setting, along with other factors that enable and constrain collaboration.

Revisiting Research Questions

To ensure that the findings correlate with the research questions of the study, it is timely to revisit the latter. The primary research question was; ***How do stakeholders collaborate to support the development of clinical competency in undergraduate nursing students in the acute care setting***?

This question was supported by five sub-questions:

- How do the key stakeholders **interact** to support nursing students in the clinical setting?
- What **values and beliefs** underpin stakeholder collaboration and support of nursing students?
- What **factors enable** and **constrain** stakeholder collaboration?

- How does stakeholder collaboration **affect** nursing students' clinical learning?
- Who are the other stakeholders who **support** nursing students in this clinical setting?

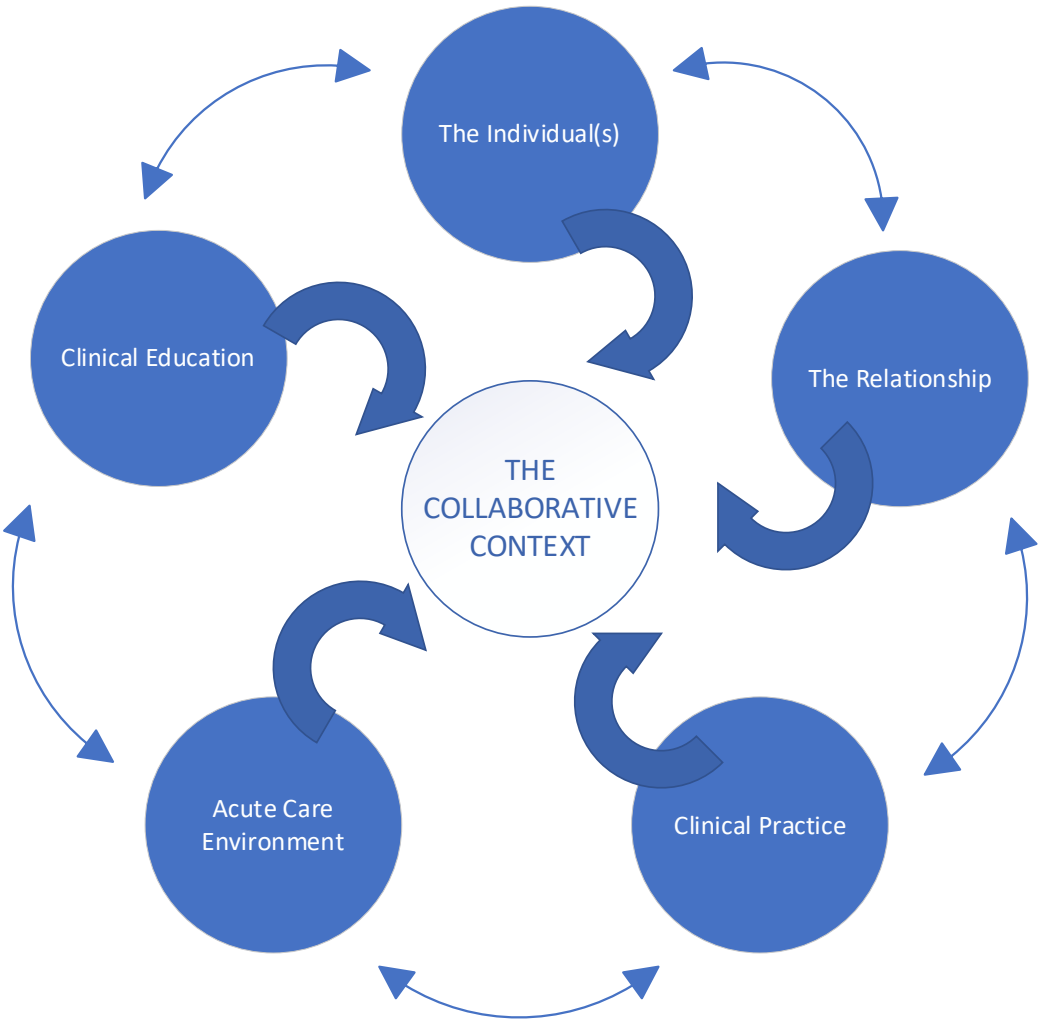
The Collaborative Context: Interrelated Dimensions

Data from focus groups and individual interviews interpreted within Brand et al.'s (2015) CAS principle framework enabled the identification of five interrelated dimensions. According to Brand et al., interrelated can be defined as elements and/or individuals who are interconnected and have reflexive relationships with each other. The Oxford English Dictionary (2022), defines dimension figuratively as, "any of the component aspects of a particular situation, especially one newly discovered; an attribute of, or way of viewing, an abstract entity." The five interrelated dimensions this study identified as contributing to the collaborative context are: 'the individual(s)', 'the relationship', 'nursing practice', 'acute care environment', and 'clinical education' (as shown in Figure 2 below). The collaborative context is a metaphorical space wherein collaboration may or may not occur between stakeholders. Collaboration occurs on a continuum, with informal interactions at one end and formal interactions at the other. These collaborative interactions are intended to support the development of clinical competency of undergraduate nursing students. While collaboration can occur through enabling factors, at times it does not occur due to constraining factors. When collaboration does not occur, the collaborative context still exists because the context for it remains. The opportunity for collaboration is still present but is dependent upon the relative impact of enabling and constraining factors.

Figure 2 shows the five interrelated dimensions and how they relate to each other. Curved bidirectional arrows between each dimension signal the influence that one dimension may have on another dimension. At the same time, each dimension influences how individual stakeholders collaborate within the collaborative context, as shown with curved unidirectional arrows aimed towards the collaborative context. These unidirectional arrows start within the interrelated dimension and move in towards the collaborative context; but then loop back, showing that what happens in the collaborative context can, and does, impact each interrelated dimension. I chose to use curved arrows because they show that collaboration between stakeholders is a

dynamic interaction. Curved arrows denote movement and flexibility, which symbolises the movement and flexibility stakeholders require to collaborate.

Figure 2: The collaborative context: Interrelated dimensions of stakeholder collaboration



Notions Inherent Within Interrelated Dimensions

Notions or 'ideas' were identified from combined stakeholder values, beliefs, and other factors within the clinical context. The notions that influence stakeholders in their interactions with each other were found to enable or constrain collaboration between stakeholders. These five interrelated dimensions, influenced by various notions, create a context where collaboration occurs in different ways, depending on the individuals involved and the notions that are relevant at any given time.

Writing Up Findings

When it came time to presenting the findings of this study, I faced a significant challenge. As expected, the findings themselves were complex because that is the nature of what was being explored. Capturing the common ideas enabled me to create Figure 2 above. While there are only five interrelated dimensions, there are a variety of notions within each dimension. Within each notion, there are divergent perspectives held by stakeholders who participated in this study. I needed to find a way to explain the common and shared perspectives within each notion; and, at the same time, honour the unique or divergent views of individuals. Therefore, the findings chapters have been written in a way that exemplifies shared perspectives as well as individual ideas about stakeholder collaboration. Direct quotes support the explanation of findings where perspectives were shared. When there are contrasting or alternative perspectives, I refer to 'some stakeholders', 'one stakeholder', or 'another stakeholder' to acknowledge this variation in findings. This may or may not be supported with a direct quote. When a direct quote is not provided, the variation will be included within the description of findings.

Another challenge related to presenting findings in the linear manner that textual presentation requires. While the five interrelated dimensions provide some logic and the notions within can be viewed at times as building on each other, this is not how stakeholders actually collaborate. Rather, as expected in a CAS, stakeholders interact in a dynamic and reflexive way, responding to the people, the context, and in relation to the purpose for interacting.

Conclusion

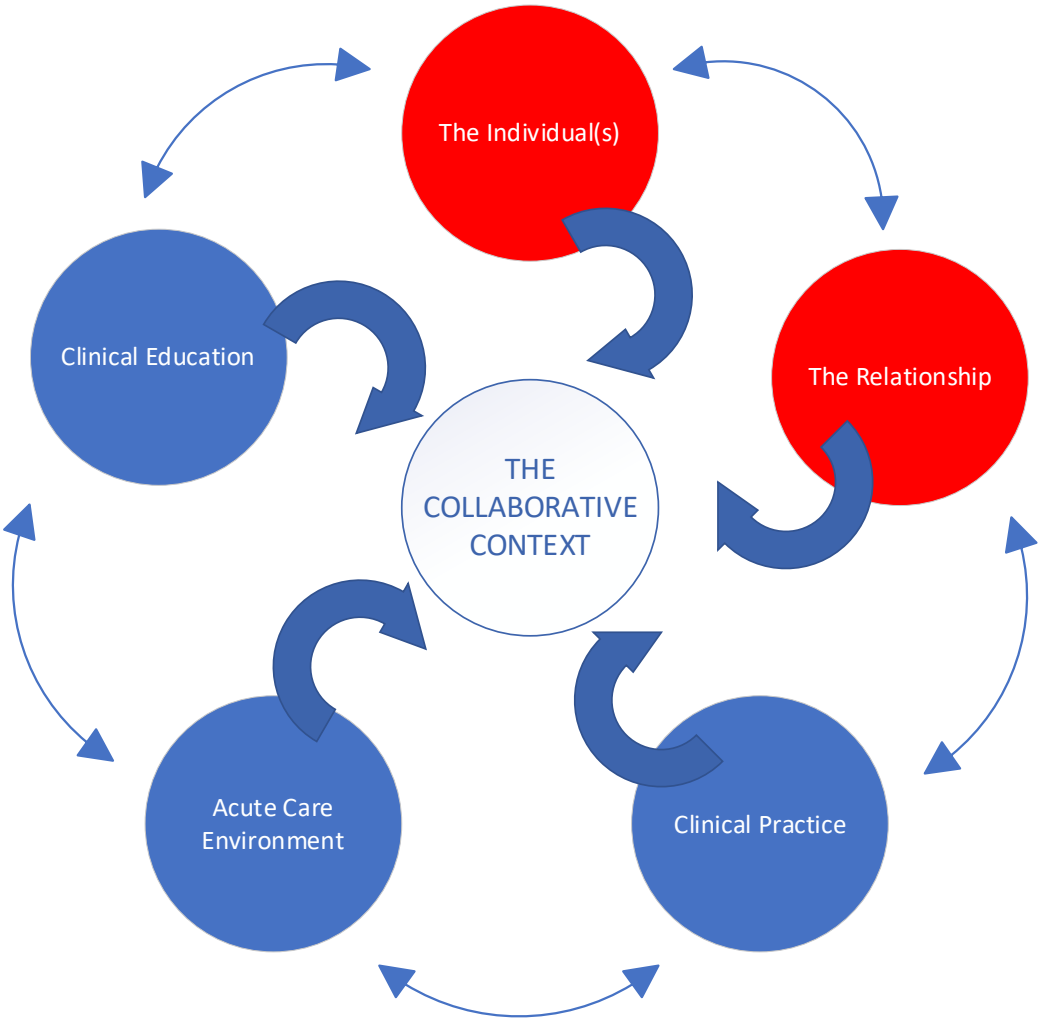
The overview of findings in this chapter, describes how the interrelated dimensions form a metaphorical space where collaboration can occur between stakeholders. Notions within each interrelated dimension have the capacity to influence how stakeholders interact, effectively enabling or constraining collaboration. The following chapters explain each interrelated dimension in detail, highlighting the notions relevant to each dimension and explaining how they influence stakeholder collaboration.

Chapter 6 PEOPLE MATTER

Introduction

Chapter six describes the notions identified within the two interrelated dimensions of the collaborative context— 'the individual(s)' and 'the relationship'. Both dimensions, highlighted in red in Figure 3, are focused on the **PEOPLE in the stakeholder relationship**. These two dimensions recognise that stakeholders are individual people who develop relationships with other stakeholders in order to collaborate, which highlights that people matter in the collaborative context.

Figure 3: The collaborative context: Interrelated dimensions related to people



Articulation of the notions within each dimension exposes the values and beliefs, along with other factors that enable or constrain collaboration to support undergraduate nursing students in the acute care setting. These notions highlight what matters to

stakeholders when they interact or collaborate with others. Notions related to these two dimensions are identified in Table 4.

Table 4: ***Interrelated dimensions – notions that matter in the individual(s) and the relationship***

Dimension 1	Notions	Dimension 2	Notions
The individual(s)	Being different matters	The relationship	Connection matters
	Emotions matter		Rapport matters
	Attitudes matter		Trust matters
	Choice & responsibility matter		Respect matters
			Continuity & consistency matters
			Interactions matter

The Individual(s)

The individual can refer to a single stakeholder, expressed as 'an' individual or 'the' individual. 'Individuals' can refer to a collection of single stakeholders, either from one stakeholder cohort or across stakeholder cohorts. Stakeholders belong to one of three identified groups: RNs, CEs, and SNs, because study participants were identified as belonging to one of these three stakeholder groups for recruitment purposes. Although three stakeholder 'groups' are identified, the study also highlighted individual members within each of the three identified stakeholder groups as being 'individual' stakeholders. Shared commonalities by individual stakeholders within each stakeholder group highlight the unique role each group has in collaboration.

This study found that individual differences derive from past experience and the various identifying demographics that individuals bring to the clinical setting, such as their gender, ethnicity, and culture. Individuals also experience a variety of emotions in response to being in the clinical setting and having to work with other individuals. In response to these emotions, individuals may demonstrate attitudes that illustrate their values and beliefs about nursing practice and clinical learning. Ultimately, individual stakeholders can choose, or not, to collaborate with others, which for some is driven by a sense of responsibility. Differences, emotions, attitudes, choice, and responsibility are all notions that both enable and constrain collaboration. The following paragraphs explore the first interrelated dimension of 'the individual(s)' and associated notions in further detail.

Being Different Matters

All participants believed that all stakeholders differ and that the differences matter. Identifying difference occurs because "people routinely classify themselves and others based on social categories such as age, gender, race, and status" (Tsui et al., 1992, p. 550). Wilson (2014) expanded on this understanding to include ethnicity, culture, religion, class, sexual orientation, and abilities. In Aotearoa New Zealand, differences have historically been noted in comparison to a white heterosexual male, the dominant ethnic group (Cain, 2017). Differences between stakeholders in this study stem from demographic traits such as age, gender, and ethnicity, along with background, education, and personal life of the individual stakeholder. Furthermore, differences in individuals can present themselves through different personalities and working styles. While being different can sometimes be viewed negatively, as a challenge to collaboration, the findings from this study highlight that being different is something to be recognised and valued.

> *See you have got to remember with the RNs, they are not all white middle-class Europeans. Same with the SNs. There is Indian and Chinese and Filipinos and all that to contend with.* (CE08)

> *Well, you get the confident outgoing SN; you get the shy, very smart but internalised SN; you get the middle; and then you get a SN who is clearly excelling and very good at what they do!* (RN05)

> *So, then the poor SN has to go with someone else, and then has a completely different style of RN that he or she has to work with that day.* (RN01)

> *You as an SN, are not homogenous. You are unique and amazing and incredible and different, and I want you to see your patients in exactly the same way.* (CE09)

Believing that everyone is different is generally viewed positively and valued by stakeholders. As one CE stakeholder notes: being different reflects the population for whom RNs care. It is also apparent that there may be challenges associated with working with individuals who are different from them. For example, CE08 above refers to 'contending' with individuals from different ethnicities. Some stakeholders believe that various individual stakeholders' personalities can either promote or constrain collaboration between stakeholders. One student stakeholder understands that they

will need to work with a variety of personalities, while recognising that there may be some with whom they may not get along.

While participants in this study believe that all stakeholders will differ, some stakeholders have expectations and assumptions that there will be commonalities between stakeholders from the same cohort. For example, CE06 holds an expectation that SNs will all need to be learning the same things or will be required to perform in the same way.

> *At the end of the day all the SNs sit the State exam… they have all reached the same outcome. I know people are sort of against standardisation, but I think when you look at patient safety, if we were all learning and doing the same thing the same way, it would make the whole process, the whole health system a lot safer.* (CE06)

Expectations related to standardisation can create tension when valuing the differences of individuals. This suggests that stakeholders all have unique starting points and learning needs, highlighting the erroneous assumption that everyone needs the same input to get to the same end point. These tensions can contribute to the individual stakeholder experiencing emotions that may enable and/or constrain collaboration between stakeholders; therefore, the notion of 'emotions matter' is discussed next.

Emotions Matter

Participants believe that stakeholders experience a variety of emotions which can impact how individuals present. Being scared and frightened are emotions experienced by all stakeholders but are dominant within the SN cohort. Fear can arise from the unknowns that come with being new to the clinical setting and/or working with someone new. Not knowing what to expect of oneself, or what others may expect of you, reduces self-confidence. Furthermore, there is the fear of making a mistake. Stakeholders in this study know that mistakes can result in serious consequences.

> *Because she knew that this was our first actual hospital placement, so she understood that comes with its own set of expectations. It is a big scary thing to go into your first placement. You are like, what is this, what is that? I do not know this. Do not stab yourself with a needle.* (SN08)

> *Most second years… get overwhelmed and they are frightened because the RN expects the SNs to know this and expects them to do that.* (CE02)

> *A lot of SNs are quite tentative to do things like answer the phone, page a doctor or ask a co-ordinator for something… I think they want to do these things, but I think they feel intimidated in the workplace because they are afraid of doing the wrong thing or not being able to answer a question.* (RN07)

For the SN cohort, there is the added fear of failing; that is, not meeting the standards of practice required to demonstrate competency in practice, as expected by the CE or RN. While the fear for the SN rests on the possibility of failure, the SN also fears the CE or RN because they are the stakeholders who will judge success or failure.

> *I would dread the whole three days or whatever, before she came in. I would feel sick with worry that she was going to turn up. I could not really relax.* (SN05)

> *I kind of got scared, just because of the pressure. In the beginning it was like, ok you are doing well, and then, no you are not doing it right… I felt there was so much pressure on what we need to give… I just felt a bit scared after that because I do not know what to tell her or what she is expecting of me… I was scared of failing definitely.* (SN11)

CE02 highlights the possibility that RN stakeholders may fear being seen as being incompetent preceptors. This assumption was confirmed by RN01.

> *The fear of disconnection, the fear of not being worthy of connection. So, if you are not going to speak out because you might be deemed as being incompetent as a preceptor because you are not coping, and you are weak and you are not professional, then you will shut down and say nothing.* (CE02)

> *If you told me today you want this and this, I have tried my best to achieve all that with you. Then, if you still fail your course then you cannot turn around and say, well she was a shit preceptor.* (RN01)

Sometimes the fear experienced is due to assumptions made about others. For example, SN08 remembers how an experienced RN presented herself in a way that she initially found scary.

> *I had an RN who I was not with… she was quite strong headed, like she could be a bit scary… I had never worked with her and then when my RN was off, she goes, I will work with you. I ended up working with her and she was not as scary as I thought, she was alright.* (SN08)

It was not until SN08 had to work with this 'scary RN' that they realised that their fear was based on unfounded assumptions. The assumptions seemed to relate to the hierarchy of stakeholders in the clinical setting. Those in positions of power can induce fear in others, especially SNs.

> *Oh, I was scared of the third year SN.* (SN08)

> *Yeah it was interesting the way she had stepped into the culture already, the hierarchy, like I am a third year, hurry up.* (SN07)

Assumptions can result in stakeholders experiencing varying degrees of anxiety. Other emotions experienced by stakeholders included frustration and feeling like a burden.

> *There were days you felt like, I do not even know what I am doing, and other days you are like: 'man I could nail that, just let me do it'. And the other RN would let you do it but that one will not, so you are frustrated all shift.* (SN05)

> *A lot of RNs would rather just keep everything politically correct and do not want to upset anyone, even though, deep down inside they are really annoyed and frustrated.* (RN01)

> *The only thing that would deter me would be that they are too busy because I hate being a bother and asking a question when they are obviously busy and I am just another chore.* (SN01)

> *RNs are busy and that needs to be acknowledged so that we are not another impediment to their day, another burden to tick off.* (CE04)

Negative emotions such as fear, anxiety, and frustration usually constrain collaboration. While it is important to recognise these negative emotions within individual stakeholders, it seems just as important to recognise the positive emotions that influence collaboration or are an outcome of collaboration.

> *Personally, I felt at that point, you feel kind of rewarded, you feel happy that there is this turn around, that the SN is getting it.* (CE07)

Positive emotions such as feeling rewarded and happy can be reflected in an individual's demeanour and non-verbal communication, conveying positivity through being friendly and approachable, demonstrating a willingness to work with others. Positive emotions enable collaboration between stakeholders which, in turn, can have a positive impact on SN learning.

> *The coordinator was happy with the SN to go with the RN and the RN was also happy for that… everybody was very keen to have this SN work with them…happy to involve them and to help them with what they wanted to achieve… I think we have a very willing team of senior staff as well who are quite keen to involve others and they are willing to take SNs on and show them things.* (RN07)

> *I think it would be good too before going into placement if the RNs are expecting us, to get the RNs to put their hands up, to be happy to take a SN on.* (SN06)

> *If you are a friendly and approachable person I think it would take less time to feel comfortable, teaching someone and being taught by someone.* (SN01)

While these emotions are felt within the individual, they can also be reflected externally through a change in behaviour. The demeanour of the individual stakeholder may reveal the emotions of the stakeholders. Additionally, the demeanour of the individual may convey their attitude towards something, leading to the next notion: 'attitudes matter'.

Attitudes Matter

Individual stakeholders demonstrate attitudes which reflect their personal values and beliefs about collaboration and clinical learning for undergraduate SNs. Stakeholders can demonstrate a 'positive' or a 'negative' attitude. In this study, stakeholders valued individuals who demonstrated positive attitudes. Such attitudes were believed to illustrate a high level of professionalism, reflecting a motivation to collaborate with other stakeholders. This is exemplified by stakeholders who demonstrate enthusiasm and passion towards the development of nursing practice, both their own and that of others.

> *Some SNs were particularly proactive, very willing and that was very apparent to the staff in the unit. Everybody was very keen to have this*

> *SN work with them and were quite happy to involve them with what they wanted to achieve. I think that made a big difference because you know as much as I understand the position that the SNs are in, not all SNs are as forthcoming and proactive.* (RN07)

SNs are expected to demonstrate an attitude of ownership and be proactive about their learning. For CE04, SNs who take ownership of their learning help to maintain the CE's positive image.

> *In terms of feedback, what has worked really well for me is getting the SN to embrace where they are at. What I mean by that is they take ownership of their progress. Rather than me being the director, you are not achieving, my question is open. How do you think you are doing? I know they are not doing well, but I want to hear from the SN … I find that a great way of figuring out where their insight is and it means they take ownership, rather than me telling them and I am this horrible CE.* (CE04)

Conversely, demonstrating a negative attitude constrains collaboration with other stakeholders.

> *There was an SN who I worked with late last year, and they were open about the fact that this area of practice was not where she ideally wanted to be placed. Sadly, that became very apparent through their day-to-day practice.* (RN07)

> *I had so many complaints from the ward, from the preceptors about their attitude and the way they would not work with the preceptors.* (CE07)

> *You know when you meet someone, instantly you know whether you are welcome or you are not welcome. Some RNs have got that 'resting bitch face.' Some are quite vocal "I do not want an SN." The RN is just wanting to do her own thing, get the work done.* (RN01)

Attitudes often convey unspoken thoughts through non-verbal communication which informs other stakeholders about the individual's intentions, as well as values and beliefs about nursing practice and clinical learning. Ultimately, individual stakeholders have the capacity to choose how they present themselves. Some stakeholders choose to communicate an attitude that is negative in the hope they will not be required to collaborate. For others, the internal motivation to collaborate is driven by a sense of

responsibility to others, thus leading to the next notion of; ‘choice and responsibility matter’.

Choice and Responsibility Matter

Individual stakeholders make choices about how and when to interact with others in the clinical setting. At times, making a conscious choice to collaborate requires a concerted effort because the stakeholder may be challenged by their own emotions and attitudes as well as what they are interpreting from others.

> *I mean I choose to go and see all my wards; I am sure every other CE does. I choose to go and introduce myself and see them… so that we are not just another face.* (CE09)

> *It is just a whole lot of stuff had to happen for the SN to get there. The CNM* [charge nurse manager] *had to realise there was something going on with this kid and take it on board. They could have easily just flicked them off as another SN. The SN had to hear those words but also be able to come out of the feedback that was negative and realise that they did have what it took. Then the SN had to turn it around and get back on to that ward knowing that the CNM had been sending us emails, you know she could have been really embarrassed.* (CE08)

This example shows that the CNM could either ignore the SN’s behaviour or do something about it. Choosing to get in touch with the CE may have been driven by a sense of responsibility felt by the CNM but it was still a choice. The CE could have kept the feedback to themselves or shared it with the SN. Once the CE provided the SN with the feedback, the SN then chose how to respond to that feedback. In this situation, the SN could have chosen to ignore the feedback, become defensive about the feedback, or embraced the feedback. For the SN, the choices may have been driven by internal and personal motivation towards their learning and relationships with others.

At other times, it is a sense of responsibility that guides stakeholder interactions. There is an expectation by most stakeholders that RNs will feel a responsibility to collaborate with both the SN and CE because of the requirements for clinical competency set out by NCNZ (2020). Evidence shows some stakeholders take this responsibility seriously.

> *You would expect it to be engrained. They have responsibility for public safety at the end of the day being an RN... it is part of their responsibility but not everyone wants to be a preceptor. It is part of the role that they are there to do whether you like it or not, you have SNs… they do not get to choose.* (CE01)

> *If they are second year, if they have got anything that they need to do, like blood transfusions or something like that, they have never seen before, I will see if there is anything available, even if it is not with me. The SN can go with one of my colleagues for that period of time, just before we get started so that I can make sure that the SNs goals are met.* (RN06)

In some instances, RN stakeholders are not driven by a sense of responsibility. Rather, there is a conscious choice to not collaborate with other stakeholders. This choice is not only overt but accepted by the CNM. Other times, the choice is taken away due to contextual factors.

> *The CNM has staff that they will give SNs to versus other RNs they would prefer not to. That is not due to reasons of incompetence or anything, it is just some RNs have been there for 30 years and they want to do their own thing and they have made that known. But when we do get high numbers of SNs… pretty much everyone is left with an SN, so that choice is taken out of the picture.* (RN05)

Generally, stakeholders, as individuals, have some control over how they choose to behave and interact. However, SNs may not experience this sense of control due to their status as a student. Consequently, they may choose behaviours that keep other stakeholders happy even when this is not in their best interest for learning.

> *I just needed to step back, be quiet, shut up for a minute and then figure out what their personality is like. I then arrange myself around their personality… I find if they like you, you learn more and everything works out better after that… I feel like you learn how to play the game. You orientate your way to how they want it done, how the university wants it done. I feel like there is a sort of humbleness in accepting how other people do things. And my philosophy of it is, I learn how to do it the university's way and then when I become an RN myself, I learn how to do it my way.* (SN02)

Some SNs have a personal background and experience that enables them to take more responsibility and make choices that promote their development. In the following

example, SN04 felt confident enough to say “no” to an RN in order to maximise learning.

> *I worked with an RN that I probably had more of a personality clash with. I found that he treated us like, I guess it was more of a hierarchy thing. It was less about learning and more about, ‘you go clean that bed’, or ‘you go take that sheet out’, or ‘go take them to the toilet’… that is how he was in general because even when you were not with him, if he saw an SN he said, ‘that bed over there needs changing’, and you are like, sorry, I am in the middle of doing this with this current patient so no I cannot do that.* (SN04)

While stakeholders negotiate the tension between having freedom of choice and feeling a sense of responsibility to others, there is some acceptance of the belief that some things are beyond the control of one individual. Stakeholders recognise that they are working within a collaborative relationship with others, which leads to the second interrelated dimension: ‘the relationship’.

The Relationship

Recognising that the behaviour of an individual may impact others, there are notions related to relationships which stakeholders’ value. Having a relationship with another stakeholder requires a sense of connection with the other. Connecting with other is enhanced through values associated with rapport, trust, and respect. Furthermore, continuity in working with others and consistency of expectations of each other enhances collaborative interaction. At the same time, there is significant evidence of a lack of continuity and consistency in some stakeholder relationships, causing stakeholders to seek alternative relationships to achieve consistency. Interactions can be formal and informal, again, highlighting the need for ‘other’. It is recognised that although there can be single relationships between two stakeholders, there is a multitude of connections.

Connections Matter

To have a relationship with another stakeholder there needs to be a sense of connection with other. Connection can be referred to as a “perception of mutually valuing, feeling close to, feeling comfortable with and being cared about by others” (Cornine, 2020, p. 15). Developing connections with other stakeholders begins with getting to know the other stakeholders.

> *I need to know them first. How could I think of the task that I will give to them if I do not interact with the SNs that I am handling?* (RN04)

> *I think that understanding where everybody in the team comes from, is just as valuable as knowing the cardiovascular system. It is just as valuable understanding who your HCA is… because if you are having to work with them, I think it is just as important knowing them as knowing your CNM… I think they have as much to contribute as does your CNM.* (CE09)

> *I had an RN that was really good. Because she was Samoan, and she was in her first year of graduating… I think just on a cultural level, she was kind of familiar to me. Her way of learning I kind of connected with, more than the other RNs… the older RNs I found it quite difficult to connect or feel comfortable with.* (SN06)

> *I felt like she kind of got my learning and understood that I was on the level that I was on. She then guided my practice and encouraged me a lot. She was quite soft spoken as well and reminded me of a few people I worked with, so we kind of clicked straight away.* (SN08)

While developing connections between the RN, CE, and SN is given some priority, findings showed that connecting with others goes beyond this triad of stakeholders. A broader base of stakeholders was identified, including the CNM and others from the university.

> *There was a physio I got friendly with because she was associated with my cousin who is a physio at the same hospital, so we just made a connection that way.* (SN05)

> *Then my second port of call is usually my CNM, who is really invested in SNs on our ward and making sure that they get a really good experience out of their placements.* (RN06)

> *They were really understanding of the difficulties of the position they were putting me in as an educator. Realising that I was now sitting between the university's expectations, the hospital's expectations, and the ward's expectations, they allowed me to go away and talk to the paper leader, then come back. I thought that they genuinely cared about what was going to happen to that SN.* (CE09)

Connections between stakeholders are reinforced through meaningful one-to-one interactions. Such interactions often highlight a sense of being needed by other.

Furthermore, when connections are supported with effective interpersonal communication between stakeholders, the voices of all stakeholders are valued.

> *When we initially meet, I ask them about who they are, how long they will be with us on this placement, what year they are and what stage they are at, what previous placements they have had, and what their current level of practice is, what their intended learning outcomes are for this placement, if they have any.* (RN07)

> *I guess where I was coming from was more giving them a platform and a voice. So, the RNs have a voice, and we have a voice… For me it is that open dialogue. Both parties have a voice, both parties have a space where they are expected to hear each other's point of view and to share.* (CE02)

> *Then there is a lot of discussion about where you are, where you feel you are at, and trying to figure out what you understand about what you are doing.* (SN04)

Once stakeholders have established a connection with each other, conscious effort is required to maintain the relationship. Maintaining stakeholder relationships may be prioritised over SN learning. Stakeholders can maintain their relationships by 'keeping things nice', particularly in the RN and SN relationship. For some stakeholders, such as CE01 below, this means bringing in other stakeholders, such as the CNM, when negative or constructive feedback needs to be given to the SN, with the intention of protecting the RN-SN relationship.

> *Sometimes if there is strong feedback that RNs want to give, they often give it via the CNM to us. Maybe because they do not want their feedback to wreck their relationship with the SN or maybe they feel the CNM is in a position to provide this feedback without having to suffer direct consequences. Because SNs still do go back and question their feedback. Maybe that is why we end up having more conversations which are difficult with the CNMs.* (CE01)

The above data highlights the power imbalance between the SN and other stakeholders that is recognised by all stakeholders. At times, this imbalance results in the perception that SN learning is not prioritised by the RN and CE stakeholders in the clinical setting.

> *I would not say I do not feel like I am not heard… because I am a SN, I have the lowest rank. The CE and RN sometimes overtake a bit, they*

> *are in a powerful position so that is a lot of listening to do. And you are being more reactive to what others want of you, rather than what you want for yourself.* (SN03)

> *When our CE would come in, we would be doing something and then she would go, "I need to speak to you". She got what she wanted… then she would leave, and our RNs would come stating, we need this, or we need that.* (SN08)

Data from SN stakeholders suggest some stakeholders prioritise the needs of the CE and RN over the needs of the SN. At the same time, the SN-RN relationship is seen as being pivotal in successful learning experiences for SNs who believe that they must follow the lead of the CE and RN. Because the SN wants to keep the CE and RN happy, they often accept guidance about how and when to collaborate with the other stakeholder in any given interaction. Guidance is influenced by several values and beliefs which underpin stakeholder relationships, including rapport, trust, and respect. Notions related to these are discussed in the following paragraphs, starting with the notion that 'rapport matters.'

Rapport Matters

Several values underpin stakeholder relationships, one of which is the value of building rapport between stakeholders. Rapport can be defined as a positive relationship which develops through regular interaction between two individuals (Delos Reyes & Torio, 2021). Rapport is more than just getting to know the other stakeholders. Developed through open communication, rapport creates a comfort in the relationship that helps to allay the negative emotions previously discussed. Rapport is about establishing a mutual understanding of how stakeholders are going to work together, creating a metaphorical space for communication between stakeholders, both in the current moment and future interactions.

> *I mean they are not going to come and tell you that there is something the SN's doing well, or not doing something well, if you have not got a relationship with them.* (CE08)

> *It is a lot easier to get to know the SN, build a good rapport and be comfortable with them over time. With all SNs I try and openly communicate from the get-go, discuss how they learn, how they prefer me to teach… obviously open communication again. That is easier said than done when you are a SN, but if you are able as a RN,*

> *CNM or CE to provide therapeutic communication and gain a good rapport with the SN, I believe you would see the SN excel as well.* (RN05)

Rapport enables openness between stakeholders wherein communication is expected to be open and clear. Such communication seems, at times, to be intuitive between stakeholders who have previously built rapport.

> *I had had conversations with that head RN on lots of occasions. We already had some form of professional understanding of where she was coming from and for my subsequent SNs, I would go to her and ask, what do you think? She would say, "fab, great, cool". That is literally all I needed from her. That told me all I needed. They are communicating well; they are working really well. We had almost got down to a shorthand because I understood what she was like.* (CE09)

It is evident that while stakeholders value having rapport with other stakeholders, such rapport is dependent on whether trust has developed in the stakeholder relationship.

Trust Matters

According to Dinç and Gastmans (2012), trust is a process which can be characterised by "an attitude relying with confidence on someone" (p. 223). Trust can be considered from two perspectives; firstly, that the stakeholder has trust in other stakeholders, and secondly, that the stakeholder themselves is trustworthy. Initially, most stakeholders hold a default position of trusting others until such time as there is reason not to.

> *It is a bit of dichotomy because you can only spend so much time with a SN at the bed space. You cannot spend all eight hours with them. You really have to trust the RNs on the wards to actually do some of that teaching.* (CE08)

> *I just start off with a base level of trust and then it is not something I necessarily test but it is something that either gets chipped away at when I see concerning things happening, like not reporting to me about observations or not asking appropriate questions. Or it is built on. I do not necessarily test it as much as it is just something that is gauged based on past experiences.* (RN03)

Trust in others enables stakeholders to 'take a back seat', revealing a more passive approach to collaboration. This is exemplified when the RN allows the SN to take

control in clinical practice; to practice independently without direct supervision rather than the SN needing to shadow the RN.

> *You will have some RNs that like to micro-manage and are not happy to let the SN lead and take a bit of control. Whereas others are a lot more trusting and happier to let them go and stand back. Perhaps just a personality thing as well.* (CE03)

While CE03 believes trust is related to personality, CE06 believes this 'back seat' is more likely to happen when the RN is more experienced. CE06 believes that more experienced RNs have a greater ability in assessing the risks associated with handing over control to the SN.

> *I think it all comes down to the level of experience of the RN. As far as the SNs go, I find the more experienced RNs will let them do a little bit more because they have got their own experience. They have got a bigger, broader experience to call on. They know the potential of what can happen here.* (CE06)

There is also the belief that during the process of handing over control, RN trust in the SN is reinforced. For some SN stakeholders, this default position of trust is less overt, because they feel that they must constantly prove their trustworthiness.

> *I think by the time I reached my third week I kind of gained a bit of trust from all the RNs. It made me feel good the more tasks they gave me; they must actually think I am capable of doing these things… the more tasks they gave me I took that as a compliment, they trust me to do these certain tasks by myself.* (SN06)

> *I did not have to start on day four with just asking to do obs again because they did not trust me with anything else.* (SN05)

A variety of behaviours helps to build trust in the relationship. This include previous positive experience with other stakeholders, the appearance of being confident, and having overt expectations of others, along with going above and beyond those expectations. For one SN stakeholder, trust is developed through honesty in the relationship. RN03 concurs that honesty is important, elaborating that trust is developed when they can rely on support from the CE, that the CE will follow up when given feedback about an SN.

> *Trust I think is the most important one. Trusting that the clinical tutors are going to do something if we have concerns, that they are going to be there to help us… the trust in the SN and hopefully the trust that both parties have back with us. Open communication and honesty I think are important because no one benefits if you are not telling the truth about a situation.* (RN03)

However, trust in others as a default position is somewhat fragile and can be lost very quickly in the relationship. CE08 believes that breaches in trust negatively impact the collaborative relationship.

> *It is hard when you break people's trust. If there is something going on and I find out about it through other sources and not from them, I will be very upset and concerned.* (CE08)

For CE stakeholders, trust represents credibility; that they have validity in their role as a CE and can, therefore, be trusted in the collaborative relationship. This belief is reinforced by one SN stakeholder who indicates that trusting the CE's intentions are positive helps to develop respect for the CE which, in turn, leads on to the notion of 'respect matters'.

Respect Matters

Respect is a core requirement of interpersonal communication and collaboration which reflects an openness, shared focus, and comfort with others (Croker et al., 2014). It can encompass "intentions, attitudes and behaviours towards people", related to differences between people and innate value for human beings (Levett-Jones, 2014, p. 245). Respect can be considered from the perspective of respect for others. Respect needs to be both earned and demonstrated between stakeholders, expressed through the behaviour of the individual stakeholder towards other stakeholders. According to one CE stakeholder, respect includes that shown by patients and the CNM, where everyone has equal status irrespective of their role in the relationship.

While there is a respect for individuals who have equal status, stakeholders in this study emphasised respect for the RN stakeholder. Recognising the complexity of the RN role and the competing expectations placed on them in clinical practice helps CE04 to respect their RN stakeholders.

> *Something that I think is essential is really acknowledging and respecting staff time. There is this assumption we just stroll on in there, grab them and pin them down, ask questions and then stroll on out again. I always say, "I really appreciate your time, I respect you are busy and I value your feedback". I think that is validation of what they have to say matters. Rather than just assuming it is my right for them to spend time talking to me. They are busy and I think that needs to be acknowledged so that we are not another impediment to their day or another burden to do and tick off. That works well for me. I think that it is just respect.* (CE04)

Likewise, one SN stakeholder recognises RNs as nurse experts, thus respecting them as role models. SN11 concurs suggesting that when RNs explain what they are doing and why to the SN, it enables the SN to develop trust and respect in the RN. RNs who role model a high standard of nursing practice are inspirational for SNs.

> *Just seeing the work that they do, what we got taught, like nursing ethics and all of that stuff. Witnessing it. The RNs that I had, followed protocols, and made sure they are going back and double checking. I had one Level 4 RN, even though she is Level 4 she still goes back and double checks everything to make sure that she is doing everything correctly, which was really good to see… Good role models, that even though you are at that level does not mean that you know everything, you still go back and that was really good to see.* (SN11)

While the SNs sees RNs as experts in practice, there is the potential for this expertise to be undermined when the RN does not model high standards of practice; thus, potentially constraining collaboration between these stakeholders.

Although both the CE and SN cohorts acknowledge the value of respect in the stakeholder relationship, there was limited evidence that the RN stakeholders similarly value it. One RN stakeholder believes respect is earned when RNs act as role models who support SNs in developing their practice; but first, SNs need to respect and value the learning opportunities provided in clinical placement. However, CE06 notes that in the early phases of the relationship, RNs have the responsibility for establishing respect in the RN-SN relationship. This begins with how SNs are welcomed on to the ward.

> *Sometimes a negative thing for the SNs is they will go the ward and the ward is not expecting them. Not that they should be there with open arms welcoming them, but it would be quite nice to know that they are acknowledged.* (CE06)

Being acknowledged by the RN sends the message to the SNs that they are a legitimate part of the clinical setting. There were concerning reports in the data that RNs presented the opposite when SNs arrived on the ward.

> *I think it would be good too before going into placement if the RNs are expecting us, to get the RNs put their hands up, to be happy to take an SN on because sometimes during our handover your CNM will be like, okay, you are going with them, and then the look on the RN's face is, oh!* (SN06)

> *Yeah, the RN would roll their eyes. They would be like, oh man, a SN, I do not want a SN.* (SN07)

When RNs overtly express a lack of desire to work with the SNs, SNs feel unwanted and diminished, thus preventing effective collaborative relationships from developing. There is a sense that some RNs view the SN as an 'interloper' or guest on the ward. SNs want the other stakeholders to support them and demonstrate a level of respect for where they are on their learning journey. While stakeholder relationships can start with some level of trust, respect seems to develop over time, when there is a knowing of other established through working together on a more continuous and consistent basis.

Continuity and Consistency Matters

Notions related to continuity and consistency in the relationship between stakeholders are valued by all participants. Continuity can refer to working with the same person or people over a period of time (Jansson & Ene, 2016). When stakeholders work with each other on a continuous basis, the previously discussed notions of rapport, trust, and respect develop with greater ease, resulting in more effective collaboration between stakeholders. For example, one CE stakeholder values being assigned to the same clinical wards each semester. Likewise, one RN stakeholder values having the same CE assigned to their ward each semester. Yet, it seems from the data that there is limited continuity in the stakeholder relationship, especially from the SNs' perspective.

> *That chopping and changing, I think I worked with about 8 different RNs across five weeks, one day on, one day off. They work completely different and it really throws you off. You get on the floor and it looks like you know nothing because you are like, oh what do you want?*

> *You are just trying to please everyone rather than actually learning.* (SN07)

> *The tricky thing is though, what do you do when you have got a different RN all the time because you cannot have that consistency that they know what page you are on right? I know it is good to learn from different RNs and maybe once I had the confidence that would be cool. I feel like I would have benefitted from having the same RN right through who knew where I was at, could help me build up…. Certain RNs would be like, you can do that, and other RNs would be like, what are you doing? And if it meant they did night shift, you did a night shift, you just crack on because you had that consistency of learning.* (SN05)

Continuity in the stakeholder relationship enables more consistent relationships and expectations to develop. Establishing consistent expectations, especially related to level of practice for SNs as they are learning, reduces the mixed messages SNs receive about nursing practice. As SN05 suggests, stakeholders would all "*be on the same page*". Consistency established through continuity enables more effective collaboration to occur, resulting in a deeper level of learning for the SN because they are not starting from the beginning each time they work with a new RN. SN05 clearly recognises the potential benefits of continuity and consistency to their development. Working closely with other SNs enabled some SN stakeholders to see first-hand the beneficial outcomes of SNs working with the same RNs more frequently. One SN stakeholder had the unique experience of working with a limited number of RNs over a five-week placement, with one main RN being identified as the stakeholder they worked with most often. A good working relationship developed between this SN and the RN which promoted a comfort with each other. Yet, there is also some benefit to working with a greater variety of RNs.

Lack of continuity in the SN-RN relationship can mean that SNs are working with RNs who have different expectations, while also caring for different patients, adding yet another layer of complexity to SNs' clinical learning. One RN stakeholder identifies that when the CE enters the SN-RN relationship, further complexity occurs. A variety of factors contribute to this complexity, including a lack of consistency in expectations between the CE and RN, along with different approaches to stakeholder interactions. Some CE participants see a disconnect between what the university expects of SNs and what the clinical environment expects of them. This is supported by SN04 who

experiences a lack of alignment between what the CE expects of the SN and what the SN is doing in clinical. For SNs, the lack of consist expectations results in a perception of unfairness.

> *Even if the RNs themselves do not want to do full respiratory assessment they should be encouraging the SNs to do it because if you do not listen to good chest, bad chest, in between chest, you do not have any idea what is going on. If you get to the end of the degree and you only do a full respiratory assessment because the CE wants to see you do that, but the rest of the time the RNs do not bother or does not want you to do it, I think it is very unfair on the SNs.* (SN04)

This statement suggests there may be variability in the practices of stakeholders, adding to the lack of consistency. Variability between stakeholders is a cause for confusion and frustration for SNs; yet it could be a valid reason for stakeholders to collaborate more effectively in order to achieve similar expectations. While there is some acceptance that there will be some lack of consistency of expectations between universities, it is noted that there is variability in expectations even from CEs who come from the same university. One CE stakeholder believes that collaboration aimed at developing greater consistency in expectations may result in more positive outcomes for SN clinical learning, so long as there is agreement between stakeholders that the expectations are realistic and authentically reflect nursing practice.

To achieve greater consistency amidst the variable circumstances in which stakeholders work, both SNs and RNs try to find someone to collaborate with on a more continuous basis. For the SN, this can be the CE because the CE is the one person who meets the SN more regularly, albeit intermittently, throughout their clinical placement. For the RN stakeholders, it may be the CNM.

> *Sometimes I ask our CNM, is it okay if I could ask the SN to do this, to do that, confirming what they need to be doing in the ward because we have different SNs coming from different schools and they have got different, and not so different policies but, you can see there is some difference.* (RN04)

Confirming what the SN can and cannot do with another stakeholder seems to be a dominant concern for most RNs. The irony here is that general expectations of SNs do not change much from year to year, thus raising questions about the basis of this

concern. Perhaps there is an unrealistic expectation that stakeholders can somehow attain some level of consistency in expectations within the variability of nursing practice. Having consistency in expectations negates the valuing of differences within individual stakeholders. RNs who questions a SN's level of practice may reflect the greater value that individuals matter; therefore, the RN reaches out for a collaborative interaction in the hope of ascertaining the individual SN's level of practice. This is further explained under 'interactions matter'.

Interactions Matter

The final notion that underpins the interrelated dimension of the relationship, highlights that stakeholders do not function independently. Rather, they seek to connect with others through stakeholder interactions. Findings from this study highlight that there are two main approaches to collaborative interactions: formal and informal.

One of the first questions asked in the focus groups and individual interviews was: Tell me how you interact with the other stakeholders. Currently, most collaborative interactions occur in an informal way, with one SN stakeholder describing such interactions as 'quick chats'. Often collaborative interactions are one-on-one between two stakeholders, reinforcing their informal nature. Interactions begin before the SN commences their clinical placement, with the CE connecting with the SN and CNM individually, often through email although sometimes through an unscheduled visit to the ward to meet the CNM in person. The intention of these early informal interactions is to establish clear expectations among stakeholders and to decide how stakeholders will work together.

> *I tend to do an electronic introduction before we actually meet each other one on one, make sure we all understand what our roles are and how we need to be working together. Two separate emails, one to the SN and one to the CNM. Then when I am on the ward, we meet one on one. Normally I meet with the SN first, but I always make sure I am introducing myself to the CNM and the RNs.* (CE05)

For the SN stakeholders, early interactions are aimed at getting to know and appreciate one another. Valuing the RNs' and CEs' knowledge enables one SN stakeholder to initiate early interaction. While developing a positive working

relationship with these stakeholders is important, the hidden message in these interactions is that developing their own practice as a SN is a priority. One CE stakeholder supports the need for SNs to be proactive in their early interactions with RNs, empowering the SN to inform the RN of the SN's level of practice. Early interactions also improve the visibility of the SNs as stakeholders. Findings from this study showed that for some stakeholders, SNs are not visible as stakeholders.

> *For me it is going back to the same things. It is that open dialogue. Both parties have a voice, both parties have a space where they are expected to hear each other's point of view and to share. There is a platform to enable that to happen. Because I think that would reduce the possibility of a 'them and us', more of a 'we'… because I feel our job is to, where necessary, to advocate for the SN. I always try and have the SN self-advocate as the primary option, so they learn to speak for themselves with support. If that is not doable and there is a challenge, I will advocate for them. So, I kind of see that we are a bit of a combined unit in some respects.* (CE02)

When CE02 was questioned about using 'both parties' because the identity of the parties was unclear, it became evident that 'both parties' referred to CE and RN; that the SN was 'represented by' the CE. I was concerned about the visibility of the SNs as stakeholders because the first question I had asked was: "Who do you interact with to support undergraduate SNs in the clinical setting?" While some CE and RN stakeholders identified the SN, there were occasions when prompting was required. When questioned about this, there was an assumption that if there is no SN, then there is no need for the CE. For RN stakeholders, there was some acceptance that the SN is considered 'automatically' or 'subconsciously'. The RN 'automatically' interacts with the SN and does not 'consciously' think about this interaction. It is possible that daily informal interactions contribute to this casual, almost unconscious approach to collaborative interactions between the RN and SN.

For CE stakeholders, interactions with the SN and RN tend to occur weekly. Visits to the ward are not usually scheduled. Rather, visits from the CE occur spontaneously and are unpredictable for the SN and RN, because the SN and RN do not know when to expect the CE. Sometimes CE stakeholders sense they are not really welcome on the ward, reflecting their position as an interloper. Although they should be visible to others, CEs should not disrupt ward function or add to the RN's workload.

> *Maybe the CNM thought that I was just flying in and flying out like this swan that just makes a presence because they must, and then leaves. Whether or not that has been the case with other CE I am not sure… I think it was more they had an assumption of my role as being non-engaged perhaps.* (CE02)

> *Everybody is so busy and there is that perception. They know who I am, I always say hi, I am the CE for SN B. But, you know, I am aware they are running, so it is literally 30 seconds in the corridor. And sometimes the RN says, "I am going to go and give this medication, come with me, I will talk while I give this medication". I know that I have the length of the corridor to get some information about my SN. But then I think, there is a symbiotic kind of relationship, I will do my bit and look after my SN, and part of my job is to stay out of your way because you have them for 8 hours. I will take up this amount of your time because you actually have my SN for this amount of your time, and I will kind of stay out of your way.* (CE09)

This excerpt provides a good example of how the stakeholders' perceptions of others can impact the other stakeholders' behaviour. The messages of busyness constrain collaboration between these two stakeholders. An outcome of this assumption may also be that the CE does not value what the RN has to say about the SN; therefore, the RN may not share valuable feedback with the CE. Findings from this study highlight that stakeholders value open communication between stakeholders, yet their behaviour, however unintentional, also constrains collaborative communication and interaction.

While most interactions between stakeholders are approached informally, there are times when more formal approaches are used. One CE stakeholder uses a formal approach when they do not know the RN or CNM. CE01 recognises that a formal meeting with the RN at the start would help to establish expectations of each other.

> *I would like to formalise my meeting with RNs a little more so that we have time to discuss things. So that there is certain amount of time allocated for us, that would lead to discovery of information around the SN that we generally may not be able to grab in that visit. Often with SNs who are not performing so well, I would have spent a lot of time with the SN. Then again, it becomes a bit tricky trying to spend more time with the RN. So, a formalised meeting maybe.* (CE01)

Use of a formal approach to interactions signals that all stakeholders value the time required to collaborate effectively. Time is required to get to know each other, develop

rapport, trust, and respect. Time is also required to share expectations of each stakeholder role. Furthermore, time is necessary when either the RN or CE stakeholder has concerns about a SN's clinical progress. In these instances, while formal meetings usually involve the RN/CNM and CE to start with, additional time is needed to include the SN in the interaction.

Formalisation of interactions is a way of validating the time required by stakeholders if interactions are to be collaborative. However, there are both positive and negative consequences in setting up regular collaborative interactions. Some of the positives of formal collaborative interaction include SNs spending more time with the CE and knowing exactly when the CE is going to arrive to work with them. Being able to plan for the CE visit helps to reduce the SNs' anxiety about not knowing when the CE will arrive and gives them time to plan for the CE's assessment of them in practice. However, a formally arranged collaborative interaction can also be seen as intimidating by the SN.

> *Well from the SN's perspective, you have got the two people that you are trying to please, that you are trying to come up to scratch to, because they are measuring you, they are in control, well they have a large say in whether you pass. So that might be intimidating to have both of them sitting there in a room with you.* (SN01)

Recognising that the RN stakeholders are busy in clinical practice caring for patients, while also precepting the SN, means that allocating a specific time to meet formally for collaborative interactions can be challenging. Additionally, the lack of consistency in how RNs are working with each SN, means that setting up formal meetings either prior to SNs commencing in clinical or during the SN's placement is almost impossible. Factors in the acute clinical context enable and constrain stakeholder collaboration. These factors are discussed in the following chapter.

People Matter in a CAS

Within a CAS people matter because they are independent agents who have the capacity to self-organise within a stakeholder relationship (Brand et al., 2015). Self-organisation stems from the interrelatedness and distributed control between stakeholders. This means no individual stakeholder operates in isolation. Instead, even

if they wish to practice independently, these individuals still impact other stakeholders in the same clinical context.

When a RN stakeholder is guided by order generating rules of valuing rapport and trust, they make the effort to interact with the SN at the start of the shift, to show interest in the individual SN which helps to build connection in the relationship. Likewise, the SN will engage in this interaction when they are guided by their respect for the RN role as an expert practitioner, perhaps demonstrating an attitude of being proactive in their learning. CEs may demonstrate their alignment with these order generating rules by getting to know the RNs through regular visits to the ward, and respecting the tension the RN may feel in trying to balance their roles of patient care and SN supervision. At the same time, the CE takes time to understand the SN's learning needs, recognising the emotions that the SNs may be feeling as they embark on a new clinical experience. Such actions help the SN to develop trust in the CE. These behaviours reflect the various order generating rules through a valuing of their responsibility as individuals towards the relationship, wherein they have made a conscious choice to engage and interact with others in a positive way. The positive behaviour of one individual evolves in response to the behaviours of others.

Conversely, other stakeholders may not reflect these notions in the same way and instead be influenced by different order generating rules. RNs may actively choose to not work with students or CEs because they lack confidence in this role. Furthermore, they may value the responsibility they have towards patients over their responsibility to support development of the next generation of nurses. This decision highlights the CAS principle related to distributed control because, despite the NCNZ competencies requiring RNs to support SNs, the RN maintains control over how they wish to interact. In this instance, their overt behaviours reflect an attitude that lacks a valuing of connection, rapport, and respect. This may occur in an unconscious way. I would hope that no RN would knowingly project negative emotions towards working with a SN. However, it is clear from the findings that this can occur and, to some degree, it is treated as accepted behaviour. Unfortunately, in this moment, the SN views the RN's behaviour as reflecting a negative attitude towards them as an individual. The SN is likely to experience emotions of fear and/or stress, and they may believe that this RN is not trustworthy. While there is not a direct working relationship between these two

stakeholders, they are working in the same team, within the same environment, resulting in constrained behaviour from the SN. The SN will be less likely to want to interact with RNs who project such negative order generating rules, because they will be making negative assumptions about the RN.

In a CAS, the above examples of order generating rules also reflect an attractor pattern. We understand that when individual stakeholders are confronted with negative attitudes or a lack of trust or respect, the pattern of behaviour likely to emerge is for others to withdraw or make untoward assumptions about the other. This can result in stakeholders being less likely to engage, therefore unlikely to collaborate. Conversely, when individuals reflect positive order generating rules, then a positive attractor pattern is established. Stakeholders are drawn into each other, enabling collaboration to commence and continue through a reinforcing feedback loop. That is not to say that order generating rules create dichotomous situations. Rather they can change and be reprioritised, with adaptations reflecting the variations in context at any one time. In turn, these experiences continually evolve and contribute to a sensitivity to initial conditions. They set the scene for future interactions which has the potential to influence the environmental factors covered in the following chapter.

Conclusion

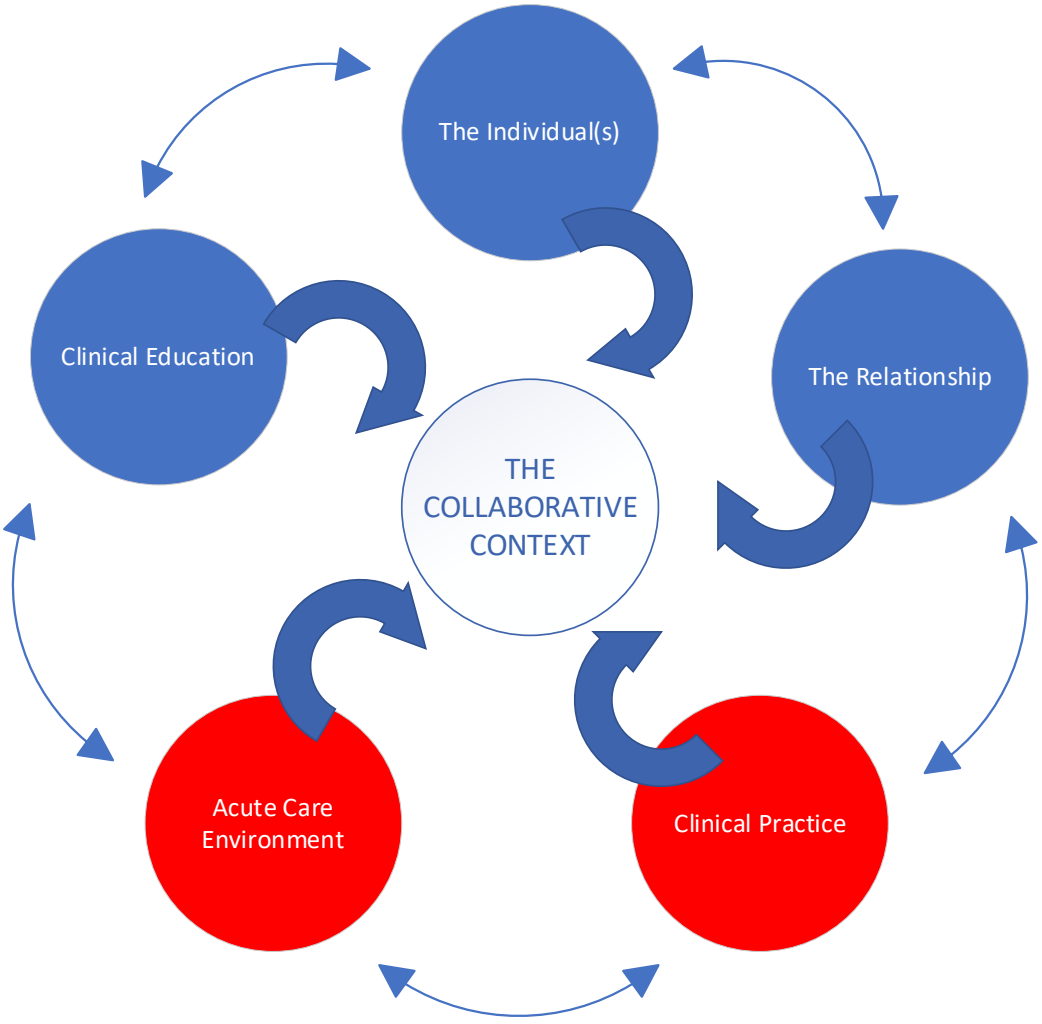
Chapter six has outlined two interrelated dimensions of 'the individual(s)' and 'the relationship'. Notions relevant to each of these interrelated dimensions have been discussed to show how stakeholders as people matter within the complexity of stakeholder relationships in clinical education for undergraduate SNs. Understanding how people matter within a CAS, helps understanding of how collaboration can be enabled and constrained. Identification of the dominant order generating rules shows how stakeholders and the system itself, self-organises. Collaboration between stakeholders begins with people, and includes the environment and context in which people collaborate. Chapter seven explores the context by discussing the interrelated dimensions of 'nursing practice' and 'acute care environment', along with the notions relevant to each dimension.

Chapter 7 CONTEXT MATTERS

Introduction

Chapter seven explores two further interrelated dimensions that contribute to the creation of the collaborative context— 'nursing practice' and the 'acute care environment'. Both these dimensions, highlighted in red in Figure 4 below, focus on the contextual factors that influence where and how collaboration occurs between stakeholders; hence the title of this chapter, 'context matters'.

Figure 4: The collaborative context: Interrelated dimensions related to context



Further notions within each of these two dimensions, which can either enable or constrain collaboration, add to the complexity of stakeholder relationships. These are identified in Table 5 and will be discussed in this chapter.

Table 5: ***Interrelated dimensions – notions that matter in nursing practice and acute care environment***

Dimension 3	Notions	Dimension 4	Notions
Nursing practice	Safety & accountability matters Workload matters Contribution matters Future of the profession matters	Acute care environment	Culture matters Leadership matters Safe learning space matters

Nursing Practice

Nursing practice involves the act of caring for patients within a clinical setting, along with a myriad of other related tasks and skills. Caring for patients experiencing acute illnesses can have associated risks. To reduce these risks, stakeholders prioritise safety in nursing practice. This includes safety for the patient and for the RN, the SN and the CE. A contributing factor impacting the ability for stakeholders to be safe in nursing practice is their workload, particularly for the RN. Working with a SN may, at times, increase the RN's workload. SNs can make a positive contribution to patient care and the RN's workload; however, there needs to be some reassurance that this contribution is beneficial to both the SN and RN, with the SN remaining supernumery and focused on learning rather than being viewed as an 'extra pair of hands'. Safety of the CE also needs to be considered because they are sometimes seen by clinical staff as 'interlopers' or unwanted guests on the ward, putting the CE in a difficult position with the RN and CNM and potentially negatively impacting the collaborative relationship between stakeholders. Collaboration between stakeholders that maintains the focus on SN learning, while balancing both workload and safety, ensures that the SN is developing competency in nursing practice. Recognising the roles stakeholders have in ensuring the future of the profession is vital because the intention of the stakeholder relationship is to develop competent nursing graduates who will become professional colleagues. The following paragraphs explain the notions associated with the third interrelated dimension of 'nursing practice', beginning with the notion that 'safety and accountability matter'.

Safety and Accountability Matter

The safety of everyone, including patients, is a priority for all stakeholders. Safety is important from two perspectives: keeping others safe and keeping oneself safe. A dominant finding in this study is that stakeholders value the safety of patients in nursing practice. While this value influences how and when stakeholders collaborate, it can result in collaboration for SN learning being constrained or perceived as less of a priority. However, RN03 highlights that collaboration which focuses on patient safety can also provide a learning opportunity for the SN.

> *For one SN there were real safety concerns. The SN was not informing RNs when patients' vital signs were outside of normal parameters. Obviously, RNs followed up and just kept an eye on the SN, waiting for the SN to tell them but the SN did not. It happened with me on a particular day. The patient was really deteriorating. I knew it was happening and was doing things in the background, waiting for the SN to notice. I was mentioning things and the SN was not clicking. So, I took them aside and I said, "look, this patient is really unwell and if I had not been paying attention then this could have escalated really quickly, it could have gone really badly". The SN was not seeing it necessarily as a teaching moment. Maybe it was the way I phrased it. I was probably a little bit frustrated. The SN just got very defensive and called the CE. The SN said they felt like they were being attacked. The CE came in and sorted the situation. The CE did not take sides but understood where I was coming from. I do not think the SN necessarily took away from it what I wanted them to, whether or not it was because I did not necessarily express myself well or they just did not understand what was happening, I am not sure.* (RN03)

This example shows that RN and CE stakeholders see the potential risks for patients, something not always apparent to the SN. However, some SNs are aware of these risks and can prioritise patient safety. For example, in the following excerpt SN04 describes a time when they detected patient deterioration before the RN. Despite the RN discouraging the SN from doing more comprehensive assessment, the SN, driven by their value of prioritising patient safety, reassessed the patient and found evidence of deterioration.

> *I said to the RN I was with, "look the patients really not well", and the RN says, "but her vital signs are not bad at the moment". I said, "well, I am going to do another set in 20 minutes". The RN says, "but there is no need, the patient is fine, just do it at our set times". I responded, "no, I am going to do it because I am not happy with what is going on*

> *here. I am going to do a full respiratory assessment". The RN said, "oh there is no need". Long story short, that patient ended up with their next vitals outside of the normal.* (SN04)

While patient safety is a priority for most stakeholders, the safety of other stakeholders is also considered when collaborating with each other. Safety of the RN and their ability to maintain their registration to practice is at the forefront of RNs' thinking. While RNs are supervising the SNs practice, they are fully aware that ultimate responsibility for patient care rests with them, thus they are also accountable for the SN's nursing practice.

> *But we are in the healthcare system, you do not want to get to the point, that 'teach you a lesson' moment. I do not take that risk… I worked really hard on my registration… SNs, they do not have a registration, it is yours. I do not want to take that gamble. I would rather be the bad guy.* (RN01)

> *The planning, notes, that is what I leave them to do, and observations. But other tasks I am with them all the time because some errors you cannot undo.* (RN04)

It is clear from these examples, that safety concerns about the SN's practice can constrain collaboration because of the RN's accountability for patient safety. Professional accountability in nursing practice reflects the ideals and standards held within nursing (Chesterton et al., 2021) and is defined by NCNZ (2012) in terms of "being answerable for your decisions and actions" (p. 43). An adverse impact of RNs taking accountability may be that it limits opportunities for SN learning. However, RNs can collaborate in a way that enables the SN to take some risks and thus be given learning opportunities. RN07 recognises that it is through making some mistakes that learning occurs.

> *I feel that SNs are an investment to have in our workplaces because they are our future RN colleagues. It is in the best interest of the SNs, RNs and the public that these SNs get the best learning opportunities, that they have the opportunities to practice, to make those small errors, to ask questions that might be completely off point. It is their opportunity to refine all of that and make the mistakes, say the silly things, before they become registered. I believe that we have a responsibility to make sure those opportunities are offered. The SN has got three years to learn to take responsibility without having the*

> *stress of that ultimate accountability because it is the RN's signature at the end of the day.* (RN07)

RN07 seems to be comfortable taking accountability for any errors that the SN may make as they develop competency in nursing practice. This may be because the RN accepts that they have a responsibility to support SNs in accordance with the NCNZ competencies. However, errors in the SN's practice can adversely impact safety for both the patient and the RN. Such errors occur on a continuum. At one end of the continuum are 'small errors' which have lower associated risk. At the other end are more 'significant errors' with higher risk which cannot be rectified. When RNs collaborate with the SN and CE, they need to find ways that accept the SN may make 'small errors' while learning, yet keep the patient and RN safe. At times, the safety of the SN is also considered.

> *At least 80% of my SNs do not have the confidence to say, "I should not be doing this". But if they say, "well my CE wants me to focus just on two patients" then they feel safe. Because it is not them being weak or not performing. They can blame me.* (CE02)

> *I always put myself out there. I always ask. I am probably sometimes annoying to them, but I will ask a million questions. I will ask if I am semi sure, if I am unsure, even sometimes when I am confident, I will still double check. Especially if it is something new to me or something I have not done often or I have not done it for a while, I will still ask… Safety is something very important… because I think no question is a stupid question. But also, how can you get better if you do not ask questions?* (SN04)

These excerpts show that SNs are vulnerable and at risk of making errors while developing their nursing practice. In order to keep the SN clinically safe, both the CE and RN stakeholders see their role as being that of a protector for the SN. One CE stakeholder refers to SNs needing to be 'looked after' by the RN because the CE cannot be present every moment the SNs are in clinical. Likewise, one RN stakeholder refers to RNs needing to take SNs 'under their wing'. While the RN stakeholders take accountability for keeping the SN safe, CE09 shows that the CE also plays a key role keeping the SN safe.

> *I do say to my SNs, "yes, I pass or fail you, but I am also here to support you, encourage you and protect you. If there is a problem or you are having a problem with anybody, if anybody is not treating*

> *you very well, tell me about it because that is also part of my role to make sure you have the best learning environment". I am very protective; I am very mother hen about them absolutely.* (CE09)

Establishing boundaries in the SN's nursing practice, as well as boundaries in professional relationships, are strategies used to maintain safety. Knowing the SN capability enabled one RN stakeholder to place limitations on what they allowed the SN to do. This kept both stakeholders safe. However, sometimes the actions of others, including patients, creates risk. In these situations, the SN may not yet have the skills to manage the behaviour of others, so they require the CE or RN to advocate for them and establish boundaries to keep the SN safe.

> *The SN was in pre reg and I came in to find a patient harassing her for her phone number… he kind of started to joke about it, but the way he was touching her. She was taking his blood pressure and he was trying to hold her around the waist. Kind of pull her in. And she was so lovely. She was just trying to back that part of her away. I just came in and got this immediate picture and thought, oh that is all shades of wrong… I took my SN away and got her to tell me what the situation was. I then went straight to the CNM and said, "if your patient complains this is what I have done… I am really sorry, but I told the patient off. I told him it is completely inappropriate to ask for phone numbers, and to not ever touch my SNs again.* (CE09)

Setting clear expectations in the stakeholder relationship is another way to promote safety for the SN and, in the example above, the CE too. Recognising that the CE is only on the ward intermittently, CE09 felt the need to inform the CNM of their interaction with the patient, taking accountability as well as protecting the SN. Furthermore, when there is a lack of clarity regarding expectations of SNs practice, the SNs may be put in situations wherein they work beyond their level of practice.

> *Lots of pressure to administer intravenous (IV) medications. We cannot administer IV medications, but SNs from another institute can. The RNs say, "Just do it, I will not tell anybody". I cannot do it and that is quite an awkward position to be in, and kind of weird.* (SN05)

SN05 recognises the inherent risk and feels reluctant to follow the RN's instructions. Yet, the ultimate aim is the development of SN competency in practice. Finding that balance between knowing what the student can and cannot do with what they need to be doing to develop competence can be challenging. Competent nursing practice

reflects safe nursing practice. However, stakeholders are also aware that there are other factors within nursing practice, such as workload, that impact both safety and collaboration, hence the notion that 'workload matters'.

Workload Matters

The work of the RN is recognised by all stakeholders as complex and can be measured to some extent as workload. Nursing comprises more than just performing tasks. It includes a variety of skills; application of knowledge and critical thinking, along with the relational and emotional work of caring for patients. RN stakeholders recognised that patient care needs must be met alongside their teaching role with SNs. Data showed that RNs valued efficiency and time management in nursing practice. SN stakeholders valued the time it takes to provide patient care. However, from the CEs' perspective, it would seem that most interactions between stakeholders focus more on the practical aspects of nursing practice than on SNs' development of competency.

> *The RNs seem to know when an SN is not meeting the standard. But when you have those conversations and you start picking it apart it is more that the SN is not doing the task or the skills in a timeframe, rather than linking them to the actual competencies… perhaps we could be more collaborative with our communication with the RNs, but it is a time factor as well, the RNs do not always have a lot of time to have that conversation with us either.* (CE06)

> *A thing that I hear with every group of SNs is, "we do not get enough time to sit down, take it all in, read a file and write some notes. You feel like you have to be on the floor, you have to be doing something and that somehow doing something makes you a 'real RN'". I come along and go, "no, what makes you a real RN is thinking. It does not matter how many tasks you can do; it is the thinking". They do not get time to think and they are not encouraged to think.* (CE09)

Interacting with SNs and CEs is generally viewed by stakeholders as being additional to the clinical workload of the RN's nursing practice. However, one CE stakeholder points out that precepting is within the RN's scope of practice, so should be considered within the workload of the RN. Findings from this study show that this is not the case. RN01 highlights RNs are sometimes given a SN to work with when the RN has a higher workload, because the SN is perceived as 'an extra pair of hands'. This experience is reinforced by CE09.

> *From what I have seen, there is more of pairing the SN with the RN that needs help with her load. I have had a few disagreements with my colleagues when I was precepting because I said, "the rules are, when you are teaching, you are supposed to have a lighter load so that you can teach. It does not matter if it is a new grad, SN or new staff. When you are mentoring someone, the rule is, you are supposed to have the lighter load". …How am I supposed to teach, while you have given me a heavier load of patient?"* (RN01)

> *In Hospital [A], the staffing levels appear to be lower. I do not know whether they are, but there is a much stronger sense at Hospital [A] that SNs are completely relied upon to do workloads. I kind of need to get in and get out because they are relying on my SNs to help with that workload.* (CE09)

Another RN stakeholder points out that having a SN creates a dual role for the RN. It tends to increase the RN's workload and, in order to manage the higher workload, patient care is prioritised over teaching the SN. It is almost as if working with SNs is compartmentalised separately from caring for patients, rather than exemplifying integration of both. CE and SN stakeholders value flexibility and believe that RNs should be able to adapt to working with a SN while delivering patient care. At the same time, CEs and SNs value the time that RNs give to SNs in nursing practice, suggesting that RNs should be compensated financially for the time the RN gives to the SN. Yet, as one CE stakeholder points out, if the RN's additional workload is not recognised, then any financial compensation for the increased workload does not actually address the problem. The RN will still have a high workload and will need to rush through things, which constrains collaboration. While stakeholders recognise the contribution RNs make towards SNs' clinical learning, they believe there should also be recognition of the contribution that SNs make in nursing practice.

Contribution Matters

Data show that RNs contribute to the development of clinical competence in undergraduate SNs. Additionally, SNs are recognised as contributing to patient care. CE09 pointed out above that this can be due to reduced staffing levels. SN stakeholders believe that their contribution to patient care is important and should be valued.

> *Taking the time to talk to the patient, I found out little things about him that he had not been communicating with the other disciplines,*

> *doctors and the social workers. I spent a lot of time with him when I was going in to do his vitals, rather than just doing what I needed to do and get out… The social worker came in and she had a few questions about this patient, she was asking the RN and the RN did not know the answers but because I had been talking to him, I was able to contribute. It had a really awesome outcome for him going home because he got the help he needed.* (SN07)

This example from SN07 shows that SNs want to help the RN provide the best level of care to patients. SNs value caring for the patient holistically, not just completing nursing tasks. However, CEs believe that 'helping' the RN shifts the focus of the SN's contribution to 'getting the tasks done' rather than on the SN's practice development. SN08 provides an example:

> *I did have one RN say, "we are really busy today so you cannot be sitting around all day". Every time we would be sitting down that was because we were writing notes… the first time all day that we had sat down… I have not sat down since I got here and then the CNM is walking past, I am like, oh man! I have been doing stuff.* (SN08)

SN08 values the contribution they make while 'doing' the tasks of nursing. Stakeholders believe it is through 'doing' that SNs learn and gain a sense of satisfaction in nursing practice. For some RN stakeholders, valuing the SN's contribution is reflected when the SN is treated as one of the team. Recognising the SN as a team member, encourages RNs to collaborate with stakeholders because they see these interactions as an investment for the future. However, for RNs to see SNs as an investment, stakeholders need to recognise SNs can contribute beyond 'doing tasks.'

> *When you have those conversations and you start picking it apart it's more that they're not doing the task or the skills in a timeframe rather than perhaps linking them to the actual competencies of the actual school… I find the students don't get as much hands on or maybe independent decision making as well. It's like they're perhaps given tasks or told what to do more, rather than just letting them have a little bit more room to explore.* (CE06)

> *Not just understanding everything and doing the tasks but actually taking the time to think about how it feels to be on the receiving end of it and not to forget the big picture.* (CE03)

RN and CE stakeholders need to encourage the SN to learn about the complexity of nursing practice and allow time for SNs to develop comprehensive knowledge and

critical thinking. Doing so shows that stakeholders value the contribution of SNs now and as future RNs in the nursing profession.

Future of the Profession Matters

The final notion in this interrelated dimension is the 'future of the profession matters'. So far, stakeholders negotiate interactions within the previous interrelated dimensions of the individual(s) and the relationship, along with the notions of 'safety matters', 'workload matters', and 'contribution matters'. Most of the findings have focussed on the immediacy of the stakeholder relationship and the values and beliefs, along with other factors, that enable and constrain collaboration between stakeholders. However, data demonstrate that some stakeholders are forward thinking, valuing the future of the profession as they collaborate to support the development of SN clinical competence in the acute care setting. RN07 and CE02 recognise that SNs belong to the next generation of RNs and are likely to be future professional colleagues.

> *I think people focus on the increased workload that you have with an SN working with you as opposed to the investment that it is having an SN working with you. I feel that SNs are an investment because they are our future colleagues, they are our future healthcare professionals. There is only benefit in helping them to achieve the best learning they can and to practice their skills while they are working with us.* (RN07)

> *But these are our RNs of tomorrow. You know we are all invested, all three of us are invested in the outcome of these SNs in terms of their performance and contribution to society as a whole, not just that one SN, not just the ward, not just the hospital but New Zealand and maybe even abroad. So, we should all be invested equally but that looks differently.* (CE02)

RN and CE stakeholders view their teaching of SNs as an investment in both the short and long term, highlighting that the RN and CE stakeholders value their contribution to the SN's development in the immediate context and that they are contributing to the SN's ability to pass the NCNZ's State examination and thus their future employment.

> *The SN came to our ward; I think they had failed a paper or something and were already on the back foot. It was kind of one of those cocoons to butterfly moments for us. We got the CNM involved, we got the CE involved and that was like one of the only times I have actually sat down with the CE and gone through what we could do to*

> *help the SN… I was really glad that we could work together with them and by the end of it the SN was working at this level, probably above, so we were like, we should hire them! They should come and be part of our team… It was such a beautiful moment because the SN ended up coming and working on our ward.* (RN06)

Valuing the SN's potential to contribute to the future of the profession, RN06 describes a time when all stakeholders came together to collaborate and support the student's development. Seeing collaboration as an investment in the profession is recognised by the DHBs. DHBs invest in RN stakeholders by providing preceptor study days that support RNs to be effective preceptors. This suggests that DHBs recognise and value the future employability of the SN upon graduation:

> *Our DHB offers a study day for preceptors to learn how to accommodate SNs better and how be better preceptors… to give you different tips and tricks to address their learning or to know the SN's level of practice… because you want to make sure that you are precepting appropriately.* (RN07)

> *Well in this DHB we get one day teaching on how to precept. So, we need to ask the SN questions, we need to involve the SN, we need to not make the SN feel bad.* (RN04)

While the DHB provides preceptor study days for RNs, the message conveyed is that the organisation values the RN's contribution to the development of the future of the profession. At the same time, ongoing professional development for RNs reflects the value of lifelong learning in nursing practice. This acceptance of ongoing learning helps some stakeholders to accept SNs' learning needs because the RN and CEs see themselves as learners too. Continual learning in nursing practice is necessary because it recognises and values the ongoing changes that occur in healthcare, in particular within the acute care setting (Davis et al., 2014; Kaulback, 2020). This leads to the next interrelated dimension: 'acute care environment'.

Acute Care Environment

Interactions between stakeholders occur within the context of a busy acute care environment. It is one that exerts a high level of stress and pressure on RNs and creates a culture which can either enable or constrain collaboration between stakeholders. Ward cultures are established through values and beliefs, some of which

have already been discussed, such as the importance of safety. Other factors include hierarchy, competing priorities, and the 'culture of busyness'. Furthermore, leadership within the acute care environment has been shown to influence collaboration between stakeholders. The importance of the role of the CNM is a significant finding in this study. The CNM establishes how RNs are expected to work with SNs and CEs because they role model their values about the clinical education of SNs. Effective leadership of the CNM can establish a safe learning space for SNs. The following paragraphs explain the notions associated with the fourth interrelated dimension of 'acute care environment'.

Culture Matters

The culture of the ward where second year SNs undertake their clinical experience, has the ability to enable or constrain collaboration between stakeholders. Gilligan et al. (2014) define culture as, "the ways of thinking and behaving that are socially accepted among a particular group or society" (p. 172). A number of factors were identified as characteristic of the culture of the ward, including 'hierarchy', 'competing priorities', and the 'culture of busyness.'

Hierarchies within the healthcare settings are well recognised in the literature (Eekholm et al., 2021; Hill et al., 2021; Iheduru-Anderson, 2021; Rees & Monrouxe, 2010). In one study, hierarchy was reflected with nurses and nursing care positioned at the bottom because "other professionals' priorities and tasks were apparently attributed higher values than [nursing care]" (Eekholm et al., 2021, p. 13). Another study referred to a 'flat hierarchy' where "nurses were respected and valued by the medical teams" (Hill et al., 2021). Findings from my study showed that in some ward settings, stakeholders, including SNs, perceive RNs as being inferior to other health care professionals. This hierarchy is reflected in the following example by CE03.

> *I found it quite sad when one of my SNs, who was second year, turned around and said, "oh, the doctors do not listen to us because we are just RNs anyway". This whole kind of hierarchical thing had obviously already been in her, or somehow got into her brain. I said, "okay, let us take a step back and have a look at this big picture. You have only just got here and have already got this perception that doctors do not care about RNs, that we are not important.* (CE03)

Moreover, when stakeholders perceive themselves to be less important or less powerful, collaborative interactions are adversely effected, as evident by the excerpt from RN07.

> *I think that the MDT* [multidisciplinary team] *have a part to play. For example, the SN might be comfortable asking the RN co-ordinator a question. The SN then asks one of the doctors and the doctor might not want to give them the time of day because they are a SN or they might be in a rush. I think the SN feels a bit of rejection from those interactions. I think that all the MDT are stakeholders because these are all teams that the SNs will liaise with as SNs and as healthcare professionals when they register so, realistically everybody is a stakeholder.* (RN07)

RN07 acknowledges that all members of the MDT are stakeholders. The CNM has been identified by stakeholders as playing a pivotal role within stakeholder relationships. In the following excerpt, CE05 highlights the role of the CNM, the person perceived to have the highest 'rank' within the nursing team on any ward, because they are seen to have the most power and control within the nursing team. CE stakeholders respect the CNM's position within this hierarchy, believing that the CNM should be their first point of contact on the ward. Because the CNM is 'at the top' of the hierarchy, CE stakeholders believe that information given to the CNM will 'trickle down' to the RNs.

> *One of the wards has a very active CNM… I had 8 second year SNs on the same ward at the same time. A couple of the RNs were feeling very overwhelmed because there were so many different SN personalities to deal with. The SNs came to me and said, "we can tell the RNs are frustrated with us, how can we communicate because one RN does things this way, another RN starts their day out this way?" I said, "neither way is wrong, you just have to understand how the RN you are working with that day works. Absorb all the different ways of working and see what works for you". I gave that feedback back to their CNM to disseminate with the other RNs. The next week was so positive. The CNM sent me a letter thanking me for talking to the SNs about just looking at it from different perspectives and felt everybody became a big team after that.* (CE05)

SN stakeholders believe they are positioned at the bottom of this hierarchy and it seems there is also a hierarchy within the SN population. Second year SNs are ranked below third year SNs.

> *I would not say I do not feel like I am not heard but, as an SN you have got the lowest rank.* (SN03)

> *I found that the RN treated us like… I guess it was more of a hierarchy thing. It was less about learning and was more about, "you go clean that bed" or "you go take that sheet out" or "go take them to the toilet".* (SN04)

> *I got rushed from another SN as well. We were showering a patient and she got very snappy with us. It was interesting the way she had stepped into the culture already, the hierarchy, like I am third year, hurry up.* (SN07)

Commenting on the same third year nurse, SN08 said, *"Oh, I was scared of her".*

The experiences of SNs within the hierarchy of the healthcare setting and the nursing team may reflect feelings of being undervalued. Furthermore, these hierarchical interactions can create fear for SNs when working with others perceived to have greater power. However, these stakeholders are likely to be responding to the contextual influences within the acute care setting. The priority in this context is to provide care to patients who are acutely unwell reflecting a further hierarchy between patient care and student learning. Therefore, interactions between stakeholders in this context, are reflective of hierarchy. When there are competing priorities, patient care is likely to come first.

> *Everyone was always approachable, but everyone is busy as well. You cannot always just interrupt, like, "help me, what is this?" You have got to wait for the right time and all that.* (SN03)

> *Sometimes the SN just follows the RN because they are so busy there is very little time to talk.* (CE03)

> *I said, "where is your preceptor?" The SN said, "Oh, I do not know. They are so fast, move and they are gone". The SN's sitting at the nurses' station and said, "I do not know which way they have gone". The SN had just started and did not know the ward.* (CE06)

Competing stakeholder priorities create a 'culture of busyness' in the acute care environment, wherein being busy is the accepted norm amongst the group (Richards, 2015). Knowing that the RNs are busy, creates acceptance that collaborative interactions related to SN learning may not be prioritised or given sufficient time to be

effective. CE stakeholders, with their prior experience as RNs, recognise the competing demands and acceptance that the acute care environment is sometimes too busy to accommodate SN learning.

> *And if there is stress on the wards, sometimes wards are really busy, they are short staffed. There have been times when the CNM has said, "oh we have not been able to give the level of supervision that we would have liked for the SNs". So, the SN might have been given a lesser role perhaps. But then it is understandable. At the end of the day, it is the patients who are important and their care. Particularly at year two level, SNs still do need a lot of supervision.* (CE06)

Factors such as staffing levels and stress of the RNs contribute further to the 'culture of busyness' on the ward. There is an acceptance by stakeholders that this is how it is. One SN stakeholder views the 'culture of busyness' as part of the routine of the environment with which the RNs are familiar and comfortable. However, such comfort is disrupted when SNs arrive and the RN is expected to also collaborate with stakeholders to support their clinical development. While the excerpt above shows that the CNM may be somewhat accepting of the constraints of collaboration, it is clear that the leadership of the CNM and other senior RNs has great influence within the interrelated dimension of the 'acute care environment'.

Leadership Matters

Leadership within the nursing team is identified in this study as a factor influencing the collaborative relationship between stakeholders. While CEs, RNs, and SNs identified various stakeholders whom they interact with to support the development of clinical competence in SNs, many stakeholders identified nurse leaders as being critical to successful collaboration. Nurse leaders include senior RNs or RNs in senior nursing positions such as clinical nurse educator (CNE), clinical nurse specialist (CNS), and CNMs. Many stakeholders believe nursing leadership contributes to creating a culture of support for SNs in the acute care environment. RN05 believes that the CNM establishes the standards and expectations of how RNs are to interact with each other and other stakeholders. CNMs who have an overt value of supporting the development of SNs in clinical practice, promote collaborative interactions that are more likely to be effective.

> *The whole reason I took my job was due to the management and the support on that ward, so that would be massive for me. I believe it is very important. I believe that your whole team will excel if you have good leadership and a good team, and that is through everything; honesty, communication, skills.* (RN05)

> *I think it is the strong senior RNs as well, not just the one CNM, it is the general collective of the senior RNs, if they are a lovely supportive bunch.* (CE03)

> *From what my SNs have told me, they feel that the culture of the ward comes from the leadership on the ward. I notice they feel if the CNM and the CNE are strong leaders, that they have a strong group mentality, that makes them feel more secure… Likewise if they feel they are afraid of the CNM, almost like if the CNM is going to tell them everything they did wrong, they feel like the RNs are less supportive and they are more worried about getting into trouble so it trickles down to them as well.* (CE05)

> *What challenge I face, comes from the CNM. Not every CNM is supportive or actively engaging in SN learning. For me, if the CNM is really engaging and very proactive, then the RNs do the same.* (CE04)

These excerpts exemplify that ward leadership plays a vital role in establishing a context that is supportive of SNs' learning. However, some nurse leaders do not support SNs in the clinical context. At times, perceived lack of support can be due to contextual factors already identified, such as staffing levels and the busyness of the ward. The behaviour of the CNM can highlight the priority of clinical care of patients and running the ward, over ensuring that SNs get a positive learning opportunity. Yet it is well known that positive learning opportunities arise when SNs feel there is a 'safe learning space' (Kisfalvi & Oliver, 2015).

Safe Learning Space Matters

Stakeholders recognise that there is a culture in the acute care setting with which RNs are very familiar. Because CEs and SNs are generally new to the context, they may not be familiar with this environment. Not having this understanding can create vulnerability for the CE and SN when they attempt to interact with the RN stakeholders. Stakeholders believe that the RNs hold significant power within the acute care setting. Therefore, in order for the SN to feel safe in their learning while

interacting with RNs, they must acculturate to the dominant culture of the ward. This means fitting in and being liked.

> *The more people that like you in that setting, the easier it is. And that becomes supportive to your learning. Also, just being in a positive, friendly environment helps. I am the type, personally if someone is mean to me in the clinical setting, I internalise it a bit much and it puts off my learning and I focus on that instead of what I am meant to be doing.* (SN02)

Wards with a strong team focus and behaviour that reflects a value of SN learning in the acute care environment create a safe learning space for SNs. Feeling safe enables the SN to ask questions, share sensitive information, and be vulnerable while they learn. SN01 highlights the need for an 'uncritical presence' of others who understand and accept SNs as learners.

> *A non-intimidating presence and approach where I feel I can ask a silly question or make a mistake and it will not be the end of the world. If I am allowed to have a go at something and feel like I have got a bit of freedom to mess it up, or not, and I am not going to be shot down by either the RN or the CE, that is good for me. There have been times where I have been invited to have a go at something, but I have been a bit scared or reluctant. I have been told that it is fine, that nothing too bad is going to happen if I make a mistake. I had a go at it, that has gone well, and it has increased my confidence. Hopefully the RN or the CE has felt good about increasing my confidence and helping me learn something… space, time, and just an uncritical presence.* (SN01)

> *I think for them to enjoy what they're doing, rather than they're so stressed out.* (CE06)
> *Yeah find the fun in it.* (CE05)

CE06 and CE05 identify the importance of the SN having fun and enjoying their learning experience. However, having fun does not just happen. CE stakeholders highlight the role that RNs and other clinical stakeholders have in creating a safe and enjoyable learning environment which begins with feeling welcomed to the ward and valuing diversity. Recognising that different people will have different perspectives or ways of thinking is something that should be celebrated. Interactions that are welcoming and value the various perspectives of each stakeholder are enhanced through the CE being present on the ward. However, because the CE cannot be

present all the time, the safe learning space depends on RN collaboration and recognition that there is a team supporting SNs to develop clinically.

Context Matters in a CAS

Within the context of a CAS, the principle 'co-evolution of system and its environment' reflects an understanding that environmental factors can influence the behaviour of individuals within the system. Contextual factors identified in the notions above, such as safety, workload, culture, and leadership have the capacity to both enable and constrain collaboration within the CAS. For example, the workload of the RN or CE signals how much time they have to interact. In this sense, workload could be considered a starting point within the system which determines how much time stakeholders have or not to collaborate. Workload is external to the individual and something over which they may not have much control, given staffing levels and acuity levels of patients which can change quickly, even during a shift. Stakeholders need to be vigilant for such changes in context, reflecting a 'sensitivity to initial conditions'. Being sensitive to conditions within the environment helps the stakeholders recognise a change in context, which can result in a change in how individual stakeholders respond to the different context. Some stakeholders may not fully understand the variation in contextual factors and how this impacts stakeholder collaboration. Assumptions regarding what a 'normal' workload is for the RN and CE are made without recognising that on any given day it may be different. The assumptions stakeholders make about each other, therefore, may result in unnecessary constraints on collaboration.

Another principle of a CAS discussed at the end of the previous chapter are 'attractor patterns'; patterns of behaviour that are encouraged and enabled through particular conditions in the workplace or system. Within the interrelated dimension of the 'acute care environment', it is clear that notions pertaining to culture and leadership can influence the learning space for students. Cultures, established through various leadership styles of both the CNM and senior RNs, convey messages about how staff value the clinical education of students. Behaviours that reflect welcoming of both the SN and CE, validate the importance of clinical learning and acknowledge the contribution that SNs make to patient care. There is also a valuing of the RNs' and CEs' roles as contributing to the future of the profession while balancing safety and

accountability in nursing practice. Conversely, if the culture is one that does not promote learning for the student, then SNs and CEs are unlikely to feel welcomed. Instead, they will feel as if they are intruding and getting in the way, reflecting behaviours that constrain collaboration. Instead of establishing an attractor pattern, we now see an example of 'co-evolution of system and its environment'. This is where there is interplay of both individuals and context and resultant behaviour. A 'feedback loop' is created that reinforces that same positive or negative behaviour to occur in the future. This can perpetuate both collaborative practice and practice without collaboration.

To address the contextual factors that constrain collaboration between stakeholders, changes need to occur among all contextual factors because all factors within a system are co-evolving. Changes in the contextual conditions may attract individuals to develop new ways of interacting; thereby creating new patterns of behaviour where collaboration is enabled. Recognising that some stakeholders are already actively involved in behaviours that reflect collaboration between stakeholders has the potential to influence change at other levels of the system. However, in order for this to happen, these behaviours and examples of how stakeholders collaborate effectively need to be shared.

Conclusion

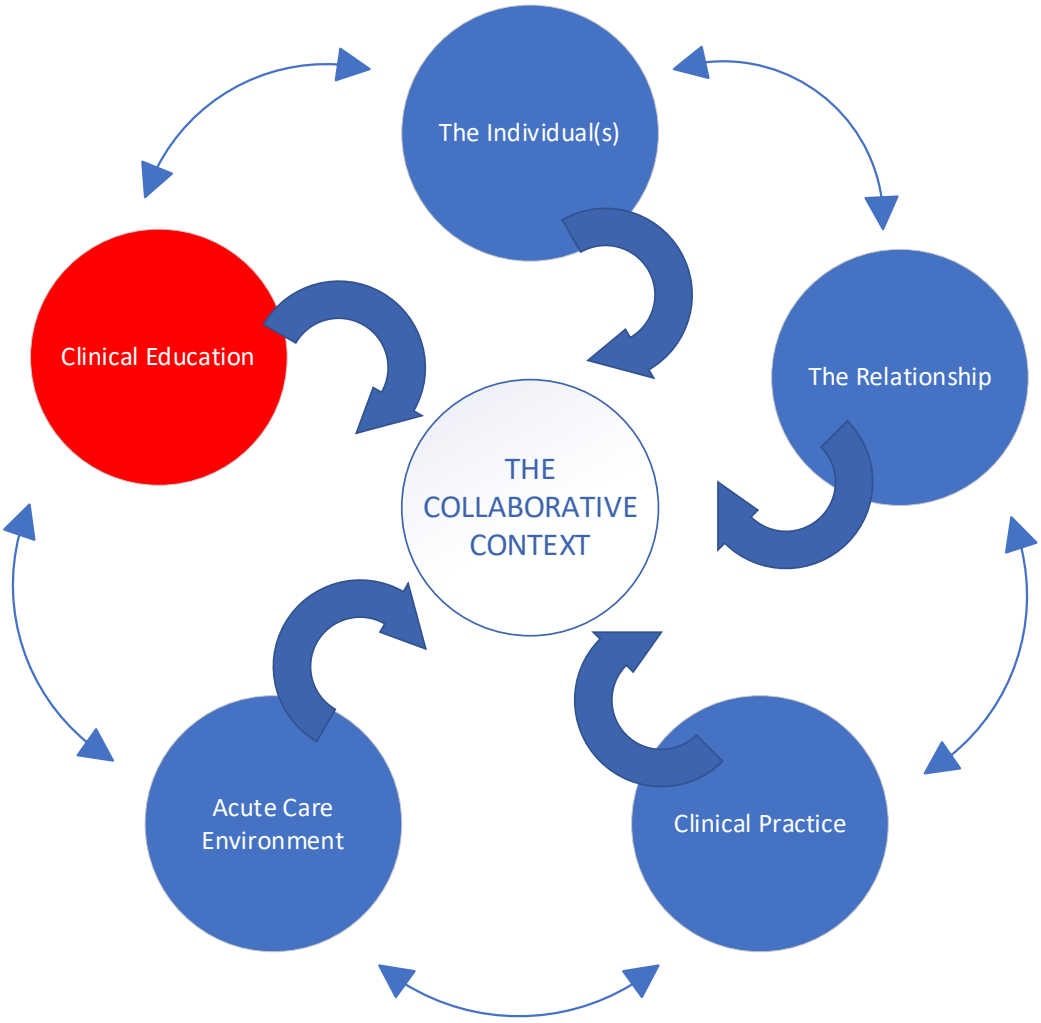
Chapter seven has discussed the interrelated dimensions of 'nursing practice' and 'acute care setting'. Notions related to these dimensions were explained to demonstrate how the context matters when stakeholders are interacting, attempting to collaborate with each other to support the clinical learning of SNs in acute care settings. While collaboration begins with people, it occurs within a context and has a purpose. In this study, the purpose of collaboration between stakeholders is to support the development of clinical competence in undergraduate SNs. The next chapter explores the final interrelated dimension, focusing on the purpose of collaboration, along with the notions relevant to this fifth and final dimension: 'clinical education'.

Chapter 8 PURPOSE MATTERS

Introduction

Chapter eight explores the final interrelated dimension that contributes to the collaborative context; 'clinical education'. Focusing on the teaching and learning processes aimed at developing clinical competency in SNs, this final dimension describes how stakeholders understand the purpose of collaboration (see Figure 5).

Figure 5: The collaborative context: Interrelated dimension related to purpose



Further notions within this interrelated dimension, explain the complexity of stakeholder relationships in clinical education. These notions are identified in Table 6 below.

Table 6: ***Interrelated dimensions – notions that matter in clinical education***

Dimension 5	Notions
Clinical education	Knowledge matters
	Time matters
	Experience matters
	Support matters
	Teaching matters
	Learning matters
	Assessment matters
	Feedback matters
	Concerns matter

Clinical Education

The NCNZ (2022) requires SNs to complete a minimum of 1100 hours clinical practice prior to registration. Within the Auckland region, second year SNs typically complete 200 hours within an acute care environment. During these clinical hours, a number of values and beliefs about the clinical education of SNs influence how and when stakeholders interact. All stakeholders believe that knowledge is essential to guide their nursing practice. Additionally, there is some acceptance that they will have gaps in their knowledge, which need to be addressed to ensure ongoing competence in nursing practice. To develop SNs' clinical competence, both time and support are required. This includes time that is invested by stakeholders such as the CE, to RNs and CNM or similar, recognising and valuing the teaching roles of these stakeholders. At times, SNs also take on a teaching role, supporting RNs to learn about changes in practice.

All participant stakeholders value the clinical learning experience because it provides authentic experiential learning opportunities. Throughout the clinical learning experience, the SN is almost constantly being assessed by the CE and RN, as well as other stakeholders with whom they interact, such as the CNM and patient. Assessment is carried out informally in an ongoing way and culminates in a formal pass/fail at the end of the clinical experience. During and following assessments, the SN should receive feedback from the CE and RN, to assist their developing competency. At times, however, my study found that such feedback is inadequate. When the CE and RN stakeholders have concerns about an SN's development, another level of collaboration is required. The following paragraphs explain the notions related to the final

interrelated dimension of 'clinical education' and how they enable and/or constrain the development of clinical competence.

Knowledge Matters

Knowledge in nursing practice is valued by all stakeholders. This study found that stakeholders believe knowledge informs clinical decision making and thus contributes to competent nursing practice. RNs and CEs develop and use knowledge to inform how they work in their roles within the stakeholder relationships. The notion of 'knowledge matters' needs to be considered from multiple perspectives because each stakeholder uses knowledge differently.

SNs begin developing their knowledge in clinical laboratories at the university, and reinforce and further develop this knowledge during clinical placement. Stakeholders expect that SNs will arrive on the wards with some prior knowledge and appear critical when this expectation is insufficiently met.

> *The SNs go to clinical and they get such limited experience… then, of course they come to another clinical area with another group of RNs who are then saying, "what are these SNs learning? What do you teach them?"* (CE06)

> *I think in the labs that we had at university, we sat down too much... when it came time to do the skill it was rush, rush, rush… The CEs say that we do learn on placement but it would be good to go in with those skill sets and to know that you have practiced and you will not be dumb.* (SN08)

SN08 values developing knowledge prior to clinical because it prepares for safer nursing practice, protecting the student from appearing 'dumb'. The assumption is that knowledge gained prior to clinical will increase confidence in the SN as they embark on their clinical education.

Findings from the data also suggest that SNs develop a broad range of knowledge while on clinical placement including knowledge of fundamental assessment skills; familiarity of the patients' diagnoses and treatment, including medications; along with an understanding of the context in which nursing is practiced. However, SN stakeholders perceive that science knowledge is prioritised by CEs, in particular, pathophysiology.

> *Before going on placement, I felt like it was an opportunity for us to be on the floor for us to create relationships with patients, to start putting everything into practice. What I was not expecting, and I do not know why I was not expecting it, is the CE's expectation of us to be able to be putting everything together, pathophysiological wise, and that was the main focus every time we had a CE visit.* (SN07)

For SN07, the expectation to be able to 'put everything together' results in the SN's perception that they are expected already to have sufficient pathophysiological knowledge. Other SN stakeholders supported this finding. For example, one SN stakeholder recalled noting the greater depth expected in their discussion with the CE in the second week. However, this expectation is not shared by all stakeholders. Rather, CE and RN stakeholders understand that SNs are novice practitioners who need to orientate to nursing practice in the acute care environment; thus, having gaps in knowledge is accepted in nursing practice, especially by some RN stakeholders.

> *If you are honest about what you do not know, that means you know what you do not know, and that in my mind equals safety.* (RN01)

> *There is not necessarily anything that the SN should or should not know. It does not really matter if they should know something. If they do not know it then it is a matter of teaching it to them as opposed to focussing on the fact that they do not know it and they should.* (RN03)

> *We are fortunate enough to have a permanent nurse educator. They are familiar with our policies, procedures and equipment, and are readily available to give best practice advice if I am not sure of something. I can then make sure I am passing on best practice or the correct techniques for SNs. They often come in as well to assist or to do a more in-depth education session with the SN if it is something that I do not feel able to answer.* (RN07)

> *You can see that a second year certainly is not practicing at the level of a third year. So, there is a difference in their abilities and where their knowledge is.* (CE06)

Recognising that even RNs do not always know everything, enabled acceptance by RNs and CEs that SNs will not know everything either. Furthermore, findings from this study found that RNs and CEs are also developing knowledge about their role in supporting students. There was an expectation that RN and CE stakeholders would inherently know how to work with each other and SNs. However, the following excerpt from CE02 highlights this is not the case.

> *Because I would love to learn from the knowledge and wisdom of my peers. And hopefully I have got something to contribute as well. Collectively, that would enhance the student learning outcome because we would have more tools to our toolbox.* (CE02)

Data show that RNs, in particular, do not always know what SNs can and cannot do, or what SNs should know. It would appear that SNs themselves do not always know about what is expected of them either.

> *RNs do not seem to know what the expectations are of a second-year SN. I think a part of that is because the second years come in after the third years. So, the RNs have this fixed idea, on what these SNs are supposed to be able to do. Or they seem to have to figure it out themselves.* (CE02)

> *Even though we got that collaboration with what our CE wanted and what our RN wanted, our CE still wanted a bit more even though we had given everything… But still it was not enough…I was like, oh what do you want?* (SN08)

Knowing what is expected of SNs is important to the SN and RN stakeholders. Some stakeholders believe that the learning experience is compromised when the SN does not know what was expected of them. One RN stakeholder believed that SNs should know what is expected and be able to share this with the RN. In an attempt to ascertain expectations of SNs, some SN stakeholders talked with SNs from previous cohorts.

> *I ask other year groups above me if there is anything I need to know or would be useful for clinical practice and they generally will come back to me with a list of things.* (SN08)

Conversely, one SN stakeholder believed that RNs should be informed by the CE about expectations of SNs. Some CE stakeholders believed that providing a clear list of what the SN can and cannot do would help other stakeholders to develop appropriate expectations. However, most CE stakeholders recognised the limitations of lists, acknowledging that it takes time and effort to develop a shared understanding of expectations related to individual SNs.

> *I find that most of the CNMs want to select RNs that have done the preceptor training… because they know the expectations for the SN and from the university as well. There was an issue that arose*

> *regarding SNs doing IVs. When they asked me about that, I had to clarify for them what the expectation is of the university regarding our SNs at that level, what they could and could not do.* (CE07)

> *I think alignment of what the responsibility of the SN in that particular semester is. So, alignment in terms of the SN knowing what is expected of them, the CNM, RN, and me. Everyone knowing the same and all working together, helps a lot… The moment there is a delay in them knowing what their responsibility is, that is when a lot of issues are happening in terms of not knowing whether they are passing or failing etc.* (CE04)

Drawing on previous experience and spending time with each other helps stakeholders establish an understanding of what each other is expected to know. This leads to the next notion: 'time matters'.

Time Matters

Stakeholders recognised and valued the time needed for effective collaboration, teaching, and learning. It takes time for stakeholders to communicate with each other through one-on-one interactions. CE stakeholders recognise that RNs spend more time with SNs than CEs, because SNs work full shifts with RNs. RN01 supports this perspective, believing that CEs generally do not have much time to interact with the RNs or SNs.

> *It is good but it is brief! I think they have got many SNs to see… half an hour. I do not know, they come in and they look for the SNs. They do what they need to do and then leave.* (RN01)

RN01 assumes that the CE workload limits their ability to spend much time with each SN. Likewise, CE stakeholders make assumptions about the RN being less engaged or invested in the SN's practice development when the clinical environment is busy. For example, one CE stakeholder perceived their visits to the ward as a 'hindrance' to the busyness of the ward. Without checking out the availability of other stakeholders, both the RN and CE stakeholders assume that the other is too busy; that there is no time to interact. While these assumptions constrain collaboration they also illustrate that it takes time for the RN and CE to teach and support the SN and time for the SN to learn.

> *The other thing that massively influences clinical learning for SNs is the organisational factor in the ward… Sometimes just how under resourced are they, are they allowing time for SNs to learn?* (CE01)

> *However, it is a time factor. The RNs are very limited with the amount of time that they can spend with SNs. And some SNs, let us be honest, they need more time than others.* (CE06)

> *I like that we start clinical placements early in the programme. I am appreciative of the fact that we can start like year 1 and then carry on throughout the programme. You need that time to learn.* (SN08)

All stakeholders agree that SNs require time to learn. They need time prior to attending the ward to prepare for their clinical learning experience. Time is also needed during clinical placement to establish effective relationships, prepare for the CE's visit and learn about expectations of nursing practice, including early starts to the day. Time sits on a continuum which SNs have to navigate while on placement. For example, SN03 states:

> *The CE had high expectations as well. Because my ward was very busy, constantly having that in the back of my mind, that she could come at any moment, I need to be prepared because she wants this and that. But I have also got to do this job here... I found it quite harsh at the time, but it made me work hard and then the meeting after that I had all the information and I was well prepared.* (SN03)

Having sufficient time to prepare, despite the busy acute care environment, enabled SN03 to be prepared for the CE's visit. However, this is not always the case, as evidenced in the following excerpt:

> *I think my CE was more interested in the right handover of a patient, then grilled me for 40 minutes on that patient, checked that I knew my pathophysiology and all of that. Unfortunately, I did not and I was shocked at how poorly I was performing. I felt like I have got the passion there but could not show it. The focus was all on that and I was not expecting it. I definitely went in underprepared.* (SN05)

SNs have an expectation that they need to be prepared for the CE's visit. The SN is aware that the CE will have expectations of them and that the interaction involves time spent assessing the SN's learning by being 'grilled'. SNs who have not prepared for the 'grilling', potentially present as less competent in clinical practice. One RN stakeholder suggested that such SNs require more time to be invested in them. Another RN stakeholder highlighted the need for early interactions in order to identify these SNs and collaborate effectively to support development of their competence. However, time is not the only factor that impacts collaboration. Stakeholders also

suggested that the experience of the RN and CE reflected how these stakeholders were positioned to support the SNs.

Experience Matters

A belief held by some CE stakeholders was that RNs who have more experience in nursing practice are better placed to support the learning required by SNs.

> *Experience also helps. For example, because of short staffing a new grad is asked to precept. Their way of precepting or what they actually pass on will be quite different from an RN that has been nursing for 5, 10, 20 years.* (CE07)

> *I think it all comes down to the level of experience of the RN. I find the more experienced RNs have got a bigger, broader experience to call on... Whereas somebody that does not have quite the same level of experience, I find the SNs do not get as much hands on or independent decision making.* (CE06)

The idea that an experienced RN support learning more effectively was challenged by other stakeholders who suggested that new graduate RNs are better placed to support SNs development due to the recency of their own learning experiences, both as an SN and a new graduate RN.

> *Some of the best RNs I have worked with recently are very recent new grads… Those new grads have just gone through the training themselves. They have probably received the most updated training and they are probably the ones that are more paranoid about looking up procedures.* (CE05)

> *A patient was going to be leaving and needed a PICC line removed. The CNM just turned to me and said, "you can do that". The RN I had was a recent graduate and she said, "I actually have not done one of these, let us go look it up". So, we looked it up together*. (SN05)

Recalling this experience, SN05 describes a new graduate RN acknowledging a limitation in their own practice, assuming this was due to the RN's limited experience. While this may have created an opportunity for learning to occur for both SN05 and the RN, SN05 further explained how they, in turn, were able to support an experienced RN learn how to remove this design of PICC line on another day. There had been changes in the way in which PICC lines were being used and the experienced RN had not removed one of the new PICC lines. This exemplifies the continual nature of

knowledge development in nursing practice, emphasising the ongoing need to support all stakeholders as they learn, which leads to the next notion: ‘support matters’.

Support Matters

Stakeholders recognised that everyone needs varying degrees of support and that support can be provided for various reasons. The SN cohort are the stakeholders most in need of support from the more experienced RNs and CEs. SN stakeholders expect to be supported with their learning, and to receive emotional support. If they are not getting what they need from the RN or CE, SNs actively seek support from a broader scope of people.

> *We have formed a bit of a support group with other SNs in our year… other SNs that have looked like they need a bit of a push or support we have invited them along if they need help with something.* (SN05)

> *It helps to draw on everyone in that setting. I will make friends with the ward clerk. I make friends with the cleaners. I make sure everyone knows me so that I have a bigger support base… That becomes supportive to your learning.* (SN02)

These excerpts exemplify how emotional support provided by peers and other clinical employees enables learning to occur. Other SN stakeholders suggested that support took the guise of being listened to, being able to ask questions and guided on how to access support and information to develop their practice. However, SN01 needed more support from the CE and RN. In this instance, support reflected an understanding of all the pressures that the SN was under, including external personal pressures that impacted their performance in clinical.

> *I think as a student there’s a lot of pressures on you, pressures to manage your time, to complete your assignments, make your lunch for clinical the next day, make sure you’ve got fuel in your car and all that stuff. Sometimes I think that the visits from the CE can be an added pressure and stress. Perhaps if … supporting the student could be more emphasised, from the CE, but maybe the RNs could be reminded of that too.* (SN01)

For CE stakeholders, support is demonstrated when the CE encourages the SN to move beyond their comfort zone. CE02 also recognises that support is provided through the act of advocating for the SN when they cannot do this for themselves.

> *I feel our job is, where possible and where necessary, to advocate for the SN. I always try and have the SN self-advocate as the primary option, so they learn to speak for themselves with support. If that is not doable and there is a challenge I will advocate for them.* (CE02)

Encouraging the SN to 'speak for themselves' may take the SN out of their comfort zone, but this is believed to be beneficial. The CE wants to see growth in the SN by seeing changes in practice. However, this can be misconstrued as being unsupportive. To ensure that the intention is communicated as anticipated, SN stakeholders suggest that CEs focus on ensuring that CE behaviour aligns with the intended outcome. For SN07, support was communicated through being 'upfront and honest'.

> *This semester I had really good support from my CE. I went through a personal grievance and she was really supportive and was kind of really upfront and honest about the way she was going to approach my learning. She wasn't going to kind of lay off me but she also wasn't going to add additional pressure, so that communication was really helpful because placement was really important to me during that time, but I didn't want to feel overwhelmed, so that was really good learning support.* (SN07)

While SNs expect to be supported by the CE, the CE also expects that RN stakeholders support SNs. RN05 and RN07 believe that an intention of support is demonstrated through communication and encouragement for the SN to be actively involved in their clinical learning.

> *There was that open communication right from the start, and I think that really benefited the care of the student and their practice… everyone took it a bit slower and everyone was on that same page that they did require that extra support and for this student, that was what they needed. It wasn't that they weren't a good student, it's just that they learned differently and when they were put in the right position, they were able to thrive. And if we didn't know that from that open communication early on, that wouldn't have been the case.* (RN05)

> *So, in terms of the students, I quite like to involve the students as much as possible in the unit, in the life of the unit and the unit culture in all the learning opportunities that they have, I do push my*

> *students. I wouldn't say unfairly, I would say that I'm quite kind and quite generous with my time but also very firm in that this is their opportunity to learn and I intend that they maximise on this.* (RN07)

However, RN01 points out that there are times that RNs require guidance from the CE on how to support SNs.

> *The* [ward] *educator should check in with the RN who is precepting the student. Is everything alright? Is there anything else that needs to be looked at? ...If you don't say anything, you'll never see her. Even when you have said something, I remember she said to me, have you talked to the clinical tutor? She sort of just, pushed the job back to the clinical tutor. But I'm like, no, no, no, no. I need your support because not every single student is the same. I said I'm finding it a little bit challenging with this certain student, so I need some help and guidance around it… At the beginning when I started to have SNs, I had high expectations. I remember the CE saying to me, "you cannot expect them to be you". I think that was a light bulb moment… So, then I was like okay, what do you actually want from me?* (RN01)

RN01 was guided by the CE regarding having realistic expectations. This example highlights that RNs need support from CEs; yet this was not experienced by all RN stakeholders. One RN stakeholder believed their CNM assumes RNs can be left alone with SNs, that additional support from the CE should only be needed when the RN faces challenges or concerns regarding the SN's practice. CE stakeholders highlighted two assumptions underpinning this thinking. The first was that when SNs were progressing as expected, the RN required less support from the CE. This is evident in a comment made by CE02, "*unless there is something really, really good, or something really, really concerning, the disparity has to be great for the CNM to talk [to colleagues]*". CE06 concurred, stating: "*you will always hear if there are issues or problems, but you don't always hear how well students are doing*". The second assumption is that CEs have all the answers. CE06 recalls not having the answer and reached out to other CEs for support by seeking advice.

> *Some SNs will take the feedback, some do not and they can get quite defensive, that can be quite challenging. But then we will have another CE that we can have a discussion with, and say, "look this is what has happened, how did you manage this? How do I manage this?" It is for the SN's benefit obviously… Things do happen but I always feel you have got the support of your colleagues to talk to. That is usually where I go for some advice*. (CE06)

Keeping the SN at the centre of all interactions, even when the focus is on supporting RNs or CEs, highlights the added expectations of teaching and learning within the collaborative relationship, which go beyond teaching and includes each other. The purpose of collaboration, the development of clinical competency in SNs, is what drove both RNs and CEs to be supportive not only of the SNs, but also each other. Findings suggest that both RNs and CEs may require support to develop their teaching role. This leads to the next finding: 'teaching matters.'

Teaching Matters

Most stakeholders recognised and valued the teaching role of the CEs and RNs. Clinical teaching is a complex, non-linear process, underpinned by a philosophy held by the individual teacher, which enables the teacher to "guide, support, stimulates, and facilitates learning" (Oermann et al., 2018, p. 6). Oermann et al. further suggested that the teacher shares information and involves the student as an active participant in the learning process. The teaching role helps the student to gain the knowledge and skills needed to be a competent nurse.

In relation to this study, the CE's teaching role begins prior to clinical placement in university. Once the SN arrives in clinical, the CE continues with their teaching role but the manner of teaching is very different from that used in the university. The CE's role as an assessor becomes more dominant. Some CEs worked hard to balance both the teaching and assessor roles while others appeared to focus predominantly on their assessor role. In clinical practice RNs also took on dual roles when they worked with SNs. First, they were an RN caring for patients. Second, they were a teacher of SNs. Data suggest that most stakeholders valued their teaching role and its positive impact on the development of SN clinical competence. However, because RNs were not given an overt title of 'teacher' when working with SNs, RN04 believed it created some ambiguity in relation to their responsibilities.

> *Because for me teaching occurs in a school. Like what we have done in university, so that is what I am thinking of teaching, as a whole class. I kind of thought that precepting is also teaching but in an environment that is like simulation. This time in clinical practice it is for real. (RN04)*

> Do you think it would help if we changed the title of preceptor to RN teacher? (Interviewer)
>
> *Maybe, yes. And RNs will be more like, 'oh, I am an RN teacher with more privilege', I guess.* (RN04)

For RN04, the teaching role should come with some privilege and status, possibly given through the title of teacher. The ambiguity inherent in the teaching role of RNs was made more overt when SNs compared RNs who were interested in the teaching role with those who were not.

> *The SN was with another RN for the first week and a half, then I got her. Two RNs, two very different people. I know the ward is trying to just give a SN whoever can precept but for the SN's sake, do not give them two RNs that are polar opposite. My style was really different from the RN that she had first. The other RN does the bare minimum, if she was more laid back she would be horizontal. She is not passionate about teaching. She was just told she is having the SN. There were a lot of things the SN should have been taught in that first week, which was not done. So, when I came along, I was just a bit shocked. I was like, "well if this is your second week in and you have been telling me that you have been taking one patient, should you not know these things already?" That was my assumption that she should have known. But I cannot blame the SN because she was not taught… When I was giving her the feedback she was really upset! Subsequently she wrote my CNM an email behind my back and demanded to change preceptor.* (RN01)

RN01 highlighted that SNs who had been working with RNs who did not embrace their teaching role may have experienced less pressure because they were asked fewer questions. When the SN is later assigned to work with an RN who enjoyed teaching, the SN seems to have experienced increased pressure because the RN began to question underlying knowledge. The intention of the RN was probably to support the student's learning and practice development; however, such questioning can be perceived negatively. Paradoxically, SNs also use questions to guide their learning.

> *The RN took me through the whole thing, all the abbreviations, so I felt like I did not need to be scared to ask her questions and feel dumb. Because I had a few experiences when I heard, "you should know that". I had no idea what they were talking about.* (SN08)

The above excerpts demonstrate the importance of the teacher showing an interest, even 'passion', for their teaching role. SN08 compares one interaction with an earlier

one, noting different RN approaches to teaching. Stakeholders recognised that different approaches signalled a difference between teaching and assessment. This was important because it revealed how questions are asked differently for teaching compared with assessment purposes, a difference that may not be detectable by SNs. Keeping SN learning at the centre of these interactions helps guide what needs to be taught. The notion that 'learning matters' is discussed next.

Learning Matters

Most stakeholders value the learning experience provided within the acute care setting because it offers a 'hands on' opportunity for the SN to develop competence. Stakeholders believe learning for the purpose of developing competency in nursing practice included the development of knowledge, critical thinking, and decision making, along with skill development. SNs believe they need to practice skills repeatedly as a SN before using them as a RN. However, RNs believe SNs also need to develop a deeper level of understanding to inform nursing practice. RN06 suggests that SNs need to learn for practice development, rather than assessment.

> *I think giving the SN the time to sit down and say what their concerns were... I think they did not really have any goals. We worked a lot on what they wanted to do and what they wanted to get out of this experience, instead of what they needed to get out of it to pass the paper. I think that was what they were focussed on, but then they started really enjoying it … It was a good turn around!* (RN06)

Motivation for learning was also valued. One CE stakeholder highlights that when a SN does not want to learn, their clinical experience 'falls apart'. RNs and CEs believed SNs who want to learn take responsibility for their own learning, described previously as reflecting a proactive attitude. But, for learning to occur, this attitude must be followed up with actions. One SN stakeholder demonstrated such responsibility by identifying strategies to develop competence in nursing practice. It is important for SNs to share these strategies along with their learning preferences and expectations with the RN and CE stakeholders. However, RN01 notes that SNs are not always aware of the learning opportunities available or that they may not have access to them without the support of other stakeholders.

> *I will say to the ward educator, if there is anything that she could organise and include the SN, like going to theatre to have a look or things like that*. (RN01)

RNs were also challenged when the SNs failed to provide information about what they want to learn. In order for a SN to share their learning goals with the RN, SN stakeholders believe it is important for the RN to demonstrate that they value and prioritise SN learning. Understanding how a SN learned was important to avoid the assumption that the SN and RN learn in the same way. Limited engagement in understanding SN learning further constrained collaboration between these stakeholders.

While all stakeholders valued the practical opportunities for learning that clinical experience offered, one RN suggested that SNs should not use clinical time for book work or assignments. Rather, SNs should learn through engaging in 'hands on' nursing practice. Stakeholders across all cohorts believed that experiential or 'hands on' learning provided the best learning opportunities. They perceived that, in this way, SNs gained real life experience of what it means to be a RN working in the acute care setting. For one CE stakeholder, this included the belief that SNs needed to experience both the joys and challenges of clinical nursing practice.

While experiential learning helped the SN understand what it means to be an RN in the acute care setting, stakeholders also believe that clinical exposure to real life nursing practice helps SNs connect theory to practice. For example, CE02 believes the reality of practice helped to bring the theoretical learning to life for the SN.

> *I think SNs struggle to conceptualise words in books to bring meaning. And until they go to the bedside the words do not have meaning… They almost get into this thing of theory is over here and clinical is over there. In their head they do not seem to have an instinctive linking of the two together, particularly in second year.* (CE02)

One RN stakeholder also valued experiential learning, stating that "*experience is the best teacher*". This suggests that the experience itself is what 'teaches' the student; yet it generally starts with the student learning through the completion of tasks. One CE stakeholder suggests that starting with a focus on clinical tasks could pave the way for

SNs to learn beyond the task. This idea is supported by SN07 who found deeper learning via connecting initially through a task.

> *We were on a ward, it is supposed to be acute general medicine but we had a lot of palliative overflow and there was this one patient, he was on his last days and he had decided to spend his last days in hospital. He had a wife and two young children and an experience that I found really beneficial was walking into that room and kind of sensing the grief that they were all feeling. You could tell that family was paramount to them and they wanted to stay together. So even though it is not necessarily what the ward usually does, I went off and found a whole lot of beds and made them up for the family. They really appreciated that and they stayed there for, it must have been four nights, the wife and sister and kids they all stayed there. And when he did pass there was a lot of gratitude and I found that really beneficial. It was like, okay, I am not just a SN in this situation, I am not just another person walking up and down the corridor, I actually got to engage with that family and it made their stay better and it made my learning better because we connected and I got to see little procedures because they were comfortable having me in the room. So that was a really awesome experience.* (SN07)

One RN stakeholder also assumed that SNs learn in the moment from the experience; yet pointed out that feedback from the RN helped. Thus, SNs benefit from different approaches to learning, which require different approaches to collaboration. Examples of complementary learning approaches include reflective practice and use of tools such as shift planners. These are believed to help SNs develop greater awareness of what they were learning. CE stakeholders also believe that SNs are not always aware that learning is occurring. CE09 believes this is particularly true for second year SNs.

> *Second years do not realise that they are becoming, they do not perceive that they are growing and being, they just see they have got to do this assignment and exam and this clinical. They think they have got to get through clinical. And when I am in clinical, I watch them being and becoming and you know it is amazing. It is this incredible experience.* (CE09)

Developing an awareness of learning highlighted the belief held by most participants that learning is a journey. Most stakeholders recognised that learning occurs in a staircased way, where knowledge developed through learning is built upon with additional learning. This means that students learn at different rates as the SNs climb the metaphorical stairs in different ways and at different times.

> *But if you are a visual learner or if you just learn by watching or by writing it down or reading a protocol, as long as I know that, then I can set that aside for you, do it my way and then we can both, learn in our different ways together*. (RN05)

> *She allowed you to be hands on which, personally, I learn 10 times faster that way.* (SN07)

> *I just think people learn in their own ways and being a RN preceptor, you just have to consider that people learn in different ways. Some people are really hands-on, and some people are better at book reading and things like that.* (RN06)

> *Also, just acknowledging that they are adults. So adult learning and the different way adults learn.* (CE07)

> *Yeah, I think that is the thing, treating them like adults. Because most of our students are younger students, out of school yet they come into this world of complexity and things that they have never seen before. So, helping them make those steps towards that.* (CE06)

While CE07 referred to the importance of SNs learning as adults, CE06 believed that some SNs were still young and needed time and support to learn to become adult learners. Rather than being aligned to a specific age when SNs suddenly become adults, learning as adults for these stakeholders is reflected by SNs becoming more independent and proactive on their learning journey. Expectations of being an 'adult learner' align with attributes of being a professional nurse who is expected to engage in lifelong learning. However, SNs held contrasting views on approaches to learning. One SN stakeholder highlights the constraints of being a SN, such as needing supervision while they learn certain tasks. SN05 also highlights the overwhelming nature of what they need to learn in clinical practice, including how to manage themselves when exposed to traumatic learning experiences related to patients.

> *I built some quite good relationships with different RNs that I worked with. Especially ones that had not long graduated. They took you under their wing a little bit and when they saw it was overwhelming one took me aside into the treatment room for a cuddle and said, "you will be fine, there were lots of tears when I was studying", so that was really lovely.* (SN05)

SN05 highlights how emotions create a barrier to learning, explaining a need to step away from the experience to regather themselves with RN support. At the same time,

the message from the RN was one of normalising the emotions that the SN experienced. This reinforces the full extent of the experiential learning opportunity provided in clinical. However, while most stakeholders believe that the clinical experience provides realistic learning opportunities for SNs, findings also highlighted that despite being exposed to these opportunities, SNs may not actually learn what was intended. For CE05 all learning should be celebrated as 'small victories' that the SN may need help identifying.

> *I feel like my values and beliefs about student* [learning] *are more about supporting them in their own growth… helping them feel comfortable to explore and identify what their needs are and how they are growing as they apply knowledge. Also, helping them recognise small victories… I think it's important for them to be able to recognise and that I help them recognise when they are doing things well… helping them make those small victories and encouraging them to continue growing.* (CE05)

CE stakeholders noted it was important that SNs learned what was required to progress in their programme. To ensure this learning occurs, SNs need to be assessed.

Assessment Matters

All stakeholders recognised they wanted SNs to succeed in their learning. Therefore, the need to assess for the development of clinical competency in SNs was also valued. While some stakeholders considered assessment in relation to success or failure, Crossley (2018) believed assessment has two purposes: to demonstrate if learning has occurred and to guide further learning. One RN stakeholder believes assessment provides an opportunity to celebrate the SN's strengths; however, there was a lack of consensus on what exemplified competence. This makes assessment challenging. For example, one CE stakeholder believes that standardising the achievement expectations of the SN would be helpful. CE05 recognises that the use of competency-based assessment contributed to standardisation of achievement criteria, yet also warns about the pitfalls of such standardisation because CEs could interpret each competency according to their own experience in nursing practice.

> *You can over standardise. That is the concern I have. Coming from another country originally, I think some of the issue is you guys have a lot of structure around your competencies, way more than I have experienced in* [another country]. *Everybody generally understands*

> *but we all have our own interpretations of what each competency means… So even though we are requiring the same thing, we all interpret it differently and that is what we keep trickling down, that is the problem with standardising that specifically.* (CE05)

While CE05 is concerned about individual CEs interpreting the competencies differently, others believed that insufficient time was given for assessment of the competencies. For example, one CE stakeholder believes that the CE's priority was to assess the SN's progress towards competency in their very brief interactions with SNs on the ward. Recognising that the RNs spend more time with the SN in clinical practice contributed to SN11 valuing the RN's assessment over the CE's assessment of their practice.

> *The CE is with us for that small amount of time and I understand that the CE's job is to get through so many students. Because we only get that small amount of time, it will be good to have the RN sit in as well because you are with the RN throughout the whole shift. The RN can actually support us SNs on what they see, what we need to know, or what we need to work on more. Rather than just taking what the CE got from that little amount of time that we had.* (SN11)

At the same time, SN01 understood that both the RN and CE were always assessing them and thus focused on trying to please them both.

> *Well from the SN's perspective, you have got two people that you are trying to please, that you are trying to come up to scratch to, because they are measuring you, they are in control, well they have a large say in whether you pass.* (SN01)

SN stakeholders highlighted that impressing the CE can be challenging depending on the CE's assessment approach. CEs usually used questioning to informally assess the SN's thinking or level of understanding of nursing practice, reflecting their belief that knowledge is a prerequisite for competence. However, because questioning is used both to assess SN's knowledge and to guide teaching and learning, confusion can arise for the SN regarding the intent of the CE. As SN01 suggests, this creates an environment where student feel as though they are being tested.

> *So, depending on the CE, some like to come in and pick your brains, really test your knowledge and kind of quiz you. I felt sometimes, I am not exactly sure what they are wanting from me or what they want me to say, but they are asking me these open-ended questions and I*

> *am not sure what the right answer is. I find that puts pressure on me and I do not really like it. Especially when I am already trying to learn as much as I can. I am stretching my brain to an extent in clinical; then my CE comes and it is another little pop quiz!* (SN01)

SN01 describes the CE visit as a 'pop quiz' because a CE may interrupt their learning in clinical to quiz them. SN01 is unsure of the 'right' answer to the CE's questions and thus feels pressured. CE stakeholders acknowledge that the sense of being formally assessed can put the student in a vulnerable position because the student is at risk of failing in that interaction. When CEs assess SNs through discussions focused on knowledge or thinking, SNs feel pressure to demonstrate competence. Furthermore, some SNs believe that anything less than perfect or a high standard of knowledge underpinning practice felt like failure. For this reason, SN stakeholders valued being assessed on both the 'doing' and 'thinking' of nursing practice, rather than the 'thinking' that CE stakeholders emphasised. For SN05, being assessed at the bedside would have enabled demonstration of practical strengths (i.e., hands on nursing and bedside manner).

> *For me I feel like I was assessed all on the academic, like the pathophysiology. It is all very well if you know all that but if you do not have the bedside manner of a good nurse I do not see how you can apply that for the patient to really get that full circle of care and I do not know if that was recognised enough. I just wish, and maybe that's because I feel that was my strength, it would be nice if it was brought into the full package.* (SN05)

An overarching expectation on the part of all stakeholders is that the assessment should be 'fair' and 'valid'. 'Fair' assessments are reflected when there is a shared and consistent understanding of what is expected as demonstrating competent nursing practice. This is usually defined as reliability (Crossley, 2018). 'Valid' assessments are reflected when the assessment is linked with genuine nursing practice that is a true reflection of the SN's ability in nursing practice.

> *Another SN had been sitting in the nurses' station a lot… preparing for the CE so when the CE came they looked wonderful. Whereas we were not given that opportunity. It builds a lot of frustration.* (SN07)

> *Are you saying the SN is sitting on her laptop in the office all day… she probably nailed her interviews with her CE*. (SN05)

> *Yeah, she did, she told us every time she nailed that.* (SN08)

> *She got awesome feedback the entire time, it was very non reflective of her actual practice.* (SN07)

At times, SN stakeholders were frustrated by what they saw as evidence of unfair and invalid assessment of their fellow students. This suggests that perhaps the assessment of the student is based less on students' learning needs and actual practice and more on the assumption of what SNs think the CE wants to hear, which is knowledge. The excerpt above, taken from the SN focus group, also shows that SNs actively observe and assess the practice of others.

There is also an expectation that SNs should be able to self-assess. One CE stakeholder believes SNs who self-assess show that they have insight into their own abilities. However, accurate self-assessment requires that the criteria of what constitutes a pass needs to be clearly articulated for all stakeholders. One SN stakeholder believed that having all three stakeholders meet to discuss expectations would increase fairness in the assessment process. But a RN stakeholder pointed out that when unspoken expectations appeared to be being met, there was less need for discussion between the stakeholders. Yet, there was also evidence that all SN stakeholders required feedback on their development.

Feedback Matters

Stakeholders believe that feedback is valuable for the ongoing development of clinical competency for the SN. Educational researchers Boud and Molloy (2013) asserted that feedback should be seen from the student's perspective, where they are provided information by themselves or others on how their practice compares to the required standards, with anticipation that they will improve their practice. The current study found that feedback is valued when it is given constructively and has a specific focus on the SN's practice, as evidenced by the following from SN04.

> *I really like feedback on where I'm at because I believe, as great as we all maybe believe we are, and as analytical as we may be of ourselves, we sometimes can't always see where our gaps are. Or can't quite sometimes see where we need to go to then move to that next part, so I think that's where having someone that's on the outside go, "hey, look, you're great at this. You're doing good but if*

> *you want to get to the next level, you need to work on this area". I think that's so pivotal as well.* (SN04)

Stakeholders identified numerous opportunities for feedback to be given and received. However, this does not always directly involve the student. For example, RN stakeholders valued hearing from the CE about how the SN was progressing from the CE's perspective. Stakeholders believed that the CE's feedback about the SN's practice helped guide the RN on how to develop the SN's learning. Conversely, CE stakeholders wanted to hear how the SN was progressing from the RN, reflecting the CE's valuing of the RN's voice. From the student perspective, it is possible that RN feedback about SNs' practice to the CE validates what SNs have told the CE they are doing in practice. CE stakeholders acknowledged that they obtain feedback about the SN's practice from a broad range of stakeholders such as patients, CNEs, and CNMs.

> *Actually, patients are really good. They'll give you feedback too. I think you get a sense from them, how the student is interacting with them, how they're communicating with them. You can get a lot from the patients and they'll quite often be quite open, and they'll even say, "they're good, I've enjoyed having that student being with me today" or whatever the case may be.* (CE06)

> *Even patients from time to time. Because for me, as part of my assessment of the students looking at how they interact with the patient, I need their feedback as well and that supports the feeling whether the student is doing well. Predominantly they tend to say, "oh they're wonderful" and don't always elaborate. But sometimes that gives me help to know how they're going, so I then need to go back to the charge nurse or back to the preceptors to clarify.* (CE02)

> *At Hospital [D], I know some of the clinical nurse educators quite well now. So, I think they're going to be the first ones who are going to give me feedback about my students. They're going to be the first ones who highlight a problem. They're the first ones who normally hear their nurses complaining.* (CE09)

> *Okay, so this was one of the charge nurses from hospital [A].* [They] *called me and left a message and said, "I want to talk to you about positive feedback* [for] *your student". I then went in and they gave a detailed description of how well the student looked after* [a] *patient who was dying… So* [this charge nurse is] *the one who often finds me in the ward. Every time I go past* [they say] *"so and so's doing well, so and so's not doing well".* (CE04)

Data suggest that RN and CE stakeholders view the CNM as an intermediary. The CNM obtains feedback from the RNs—volunteered or actively sought—about the SN's practice. The CNM then passes that feedback on to the CE. Likewise, CEs value being able to provide the CNM feedback on their assessment of how the student is developing. It seems that the CNM acts as a conduit, interpreting feedback about the SN, then sharing what is pertinent with either the RNs or the CE, dependent on which way the feedback needs to go. At times, the CNM also appears to protect other stakeholders from the feedback process by filtering what needs to be passed on or creating a buffer between stakeholders. There is a sense that the CNM has a role of validating the feedback.

All stakeholders reported the expectation that feedback was honest. For one SN stakeholder, honesty is reflected in the communication style when feedback is being provided. Ambiguity, for example, is interpreted as a lack of honesty. RN stakeholders concur, suggesting that open communication between stakeholders promotes honesty in the feedback process. While one CE stakeholder expects SNs to obtain feedback directly from the RN, supporting the need for open communication between the SN and RN, it would appear that this was not a consistent view. The excerpts below highlight differences in practice with some CEs obtaining feedback from the RN without the SN being present.

> *I have assumed that the feedback would be more honest if the SN was not there.* (CE03)

> *I also meet with the RNs one on one as well. Usually, I would ask them about the practice of the SN. We just move somewhere that is private and confidentially discuss the SN and get all the feedback. Then I see my SN and give them the feedback.* (CE07)

Privacy is valued in the feedback process. Privacy provides an environment that enhances safety for the receiver because how the receiver responds to the feedback is not always predictable.

> *I always try to get the SN in a private room though. I do not like to give feedback in the hallway or in the nursing station.* (RN01)

> *If there are some concerns regarding the SN, even the RN will not feel free to speak in front of the SN right there and then. Sometimes I will*

> *get to the ward, maybe the RN will say "oh can I see you for few minutes?" They then lead me to side room to speak and to discuss together about the SN. In those circumstances it would not be in the best interest of the SN to be there.* (CE07)

There can be potential breaches to privacy during the feedback process. In another example, CE09 refers to obtaining feedback from a doctor about a SN of concern.

> *I had a doctor who came to me and said, "I want to talk to you, I'm really concerned about that student". I said, "I can understand that, can you tell me what you're concerned about?" The doctor said, "I noticed that she did this or she told my patient this". And I said, "I'm really sorry about that. I am aware of some of the things she's doing". And then I made a mistake. The doctor said to me, "oh, she's very strange". I said, "yes, we do have issues in terms of* [the students] *mental health". As soon as the words left my mouth I thought, 'oh* [I] *shouldn't have said that' and tried to take it back. I knew that I'd fallen into that trap of just having this very quiet intimate conversation…. I realised that I had mistaken a moment of friendliness and I'd overstepped the mark and she immediately came back and said, 'you shouldn't have said that'. The thing is, she knows. She clearly picked up that we had a student who had issues. And I probably didn't need to tell her, I think she was kind of fishing a little bit. And I gave her the bit I shouldn't have.* (CE09)

While the CE understood the feedback, the CE's response was to share some insights with the doctor in order to provide validation of the feedback. However, the doctor took this as a breach of the SN's privacy, reacting in a way that suggests the doctor did not require such validation. Findings from this study also show that some RN stakeholders want to close the feedback loop, although this does not always happen.

> *The CEs handle the marking; we do not see much of that. We fill out feedback forms, but I do not necessarily know how much of that feedback is passed on.* (RN03)

> *The SN was thinking out of the box but still needed some pushing with the planning, so that is what I told to the CE. I am not sure what happened next with their discussion because they are just asking for my feedback. So, I just asked my SN, "how did it go?"* (RN04)

While gaining feedback from the other stakeholders was perceived a priority for most CE stakeholders, some reported that if they did not hear anything about a SN's practice, they worked off the belief 'no news is good news.' At other times, the feedback is limited and the CE is left to interpret what is meant by the few words

shared. Sometimes the interpretation was that the feedback seemed based on the working relationship between the SN and RN, rather than specifically on the SN's competence.

> *Often with RNs as well, the answers they give is "very good" and often it is based on their working personality,* [and] *personality of the SN. If they do get along, if the SNs do tasks well and if that saves the RN time, then they seem to give a lot more positive feedback even though the knowledge side of things was poor. So, differentiating it into what I want, which area I want to get feedback on, it is a lot of giving them selective questions and trying to keep answers in a certain direction.* (CE01)

> *Some of the CNMs I think might be too busy doing other things. Some of them say "if I do not know anything, it means it is good, it is a positive. I will only know if something negative is going on". But the RNs, I will actually go and say, "can I have 5, 10 minutes of your time" and rattle off a whole lot of questions.* (CE03)

All stakeholders recognised that the CE is dependent upon the RN for feedback about the SN's practice. At times, extra effort was required from a CE to obtain RN feedback. This can be problematic because, from the SN's perspective, RNs do not always prioritise or value giving feedback. RN01 exemplifies this view:

> *Talking to other colleagues, they are not being entirely truthful to the CE. I think it comes back to; I do not want to teach so I do not care. In that instance I feel for the SN, because if they really have things to improve, the RN does not want to tell the SN, and then when the CE comes around they are like, "oh yeah, everything is fine". When they mention it to me, I say, "well why do you not say something?" They say, "oh, I cannot be bothered".* (RN01)

While RN01 values feedback focussed on improving the student's development, other stakeholders value feedback that recognises what the student is doing well. In the following quotes, CE05 and CE06 discuss their beliefs regarding the importance of SNs receiving balanced feedback.

> *What I have seen a lot is, they get feedback in a more negative method. A lot of people when they are asked for feedback tend to give the negatives. Or nothing at all. So, I think it is important for them to be able to recognise and that I help them recognise when they are doing things well, and what they should be doing at an expected level as well as what they could be working on as well. So,*

> *helping them make those small victories and encouraging them to continue growing.* (CE05)

> *That is important, when you see the SN doing something well. Even if it is just, "hey that is really good". Acknowledging what they do well because it is easy for them to get the opposite, which is what they hear more than when you say they do something well. The SN will dwell on something that might have just had a little bit of negative feedback and that is huge you know.* (CE06)

CE06 and CE05 believe that it is important to provide negative feedback and point out strengths in the SN's practice. RN04 concurs, noting that giving positive feedback is easy.

> *There was this one student, the CE visited them and then they asked me about the student's progress. Well, that student is really good, like they're thinking out of the box. So that's easy for me… But sometimes I'm quite hesitant with that clinical educator because they might give them a fail grade and I just like for them to pass. That's why we just talk to each other like, "okay, so maybe next time you let your educator know that you have done this, so you get good feedback from them".* (RN04)

RN04 goes further, suggesting that the emphasis should be kept on keeping things positive, rather than providing too much negative feedback which may result in failure for the SN. This is not to say stakeholders should not give negative feedback, but that a blend of both positive and negative feedback is important because it acknowledges what is going well and what needs improvement. 'Negative' feedback is intended to help improve the SN's nursing practice. However, some stakeholders noted that SNs can make incorrect assumptions about the feedback. One CE stakeholder refers to students dwelling on negative feedback. Others interpret negative feedback as a personal attack—that the RN giving the feedback was a 'bully' and not speaking to the SN respectfully. SN11 remembered a similar experience, suggesting that being given an indication of failure midway through clinical was interpreted as threatening.

> *I was scared of failing, definitely. I felt on my catch ups with the CE it was going well and then I got some feedback. It felt intimidating… I just could not say anything on my third catch up because I felt like, oh my gosh, is it me or is she growling me fully? I felt intimidated… their tone of voice and the body language as well. It was just like, "you have to do this, you are doing this wrong". There was a lot of hand gestures. To me it was like a growling, angry that what I was giving*

> *was not right. So, I just went a bit quiet throughout that whole catch up because I did not know what to say.* (SN11)

SN11 felt intimidated by the feedback from the CE, the fear of failing loomed large. The CE's tone of voice and body language may have intended to convey the importance of the feedback and the need for the SN to change their practice. However, it seems that it had the opposite outcome. The student withdrew. Similarly, another SN stakeholder interpreted negative feedback as a 'personality clash' between the SN and RN, rather than recognising limitations in the SN's practice. These examples emphasise the SN's motivation to pass, rather than develop their clinical competence through constructive feedback. How feedback is given to SNs must be considered if the message being conveyed is to be received as intended. Feedback needs to be communicated in a way that enables the SN to focus on their practice development, rather than merely passing or failing.

While ensuring that SNs receive feedback is valued by most stakeholders, some RNs recognise that it is timely feedback that best enables the SN to respond appropriately. The SN's response to feedback enables stakeholders to gauge the SN's level of insight into their practice and can validate the original assessment. Stakeholders expect to see a difference in the SN's practice following feedback.

> *I try and talk it through with the SN first, but if I think they are still not processing or getting to grips with the issues I have raised with them, I look to escalate it.* (RN03)

> *One SN had a bow in her hair, makeup on, eye lashes for Africa and a chip on her shoulder the size of Mt Wellington. She was there for the first two or three days and the staff kept coming up to me going, "where did you get this student? How the hell did she get this far?" She was walking around like she did not want to be there… I met with the SN and I talked to her… Then the next day the staff came up to me and said, "we don't know what you did but that kid is just completely turned around". We even got the bow out of the hair and the eye lash extensions came out.* (CE08)

When it was evident that the SN had not responded to feedback, this signalled to RN03 that they needed to collaborate with the CE. Likewise, CE08 understood that some RNs require the CE to intervene to ensure that the SN hears the feedback in a way that enables the SN to respond positively instead of seeing feedback as criticism. It helped

to have the CE interpret the feedback for the SN. At the same time, the CE's presence provided safety and support for the RN in the feedback process. The notion 'feedback matters', has the best intentions for the SNs. It promotes collaboration between all stakeholders, either through one-on-one interactions or through meetings where all attend. In practice, however, such meetings are usually only set up when a stakeholder has concerns about the SN's practice.

Concerns Matter

When RN and/or CE stakeholders are concerned about a SN's practice, there is an overt purpose for stakeholders to collaborate. Stakeholders recognise that concerns usually relate to unsafe practice. Having a social conscience and wanting to keep others safe draws stakeholders together to share and address their concerns. RNs believe support is needed from other stakeholders because of the risks to patients and others, including the SN. Likewise, CE06 expects to interact more with senior clinical staff, including the CNM, when there are problems.

> *If I have any concerns with a SN, then I will speak to the RNs and I will tell them whatever the issue might be… If I have got real concerns, I will speak to the CNM … At that point I feel that the RN may need support with working with the SN as well, the CNM needs to know that.* (CE06)

There seems to be a continuum of concern, with smaller or more basic concerns being managed locally between the RN and CE. As concerns get bigger, or more significant, the CE recognises that greater support is required for both the SN and the RN, thus the CNM's expertise is sought. While safety seemed to be the dominant focus of concerns, it was not always clear what was the cause for concern.

> *I have had the odd occasion where I have had to establish, is it a learning knowledge issue or is it a communication language issue? Because they are different*. (CE02)

While most concerns related to the SN's nursing practice, there are times when the CE or SN may be concerned about the RN's capacity to support the development of SNs' practice. In the excerpt below, CE02 has concerns relating to 'preceptor fatigue'.

> *Whether the RN is already fatigued is another thing. SN after SN after SN. The RNs are just over tired. That is not a blame thing. I am simply*

> *saying if you are already fatigued and you add that dimension it is another thing. Are the CNMs giving their staff enough of a break? How does that fit within the context of having high numbers of SNs coming through? I do see the RNs get fatigued.* (CE02)

RNs constantly working with SNs clinically can become overburdened by their workload and cope by limiting their engagement with students. In these instances, the CE is likely to discuss their concerns with the CNM. The assumption here is that the CNM has the power and influence to make changes that will enable greater RN support for SNs. However, CE07 warns about the potential negative implications of raising concerns with the CNM. In the following example, CE07 describes having to debrief SNs following a significant event on the ward because no formal debriefing was offered by the ward staff.

> *Sometimes you want to tread carefully, and you do not want to appear as if you are telling them how to run their ward. I know I am in charge of my SNs, I just needed to look after them and their interests.* (CE07)

There is an overarching assumption that stakeholders have the ability to articulate their concerns. Yet, it appears that there are many limiting factors pertaining to the individuals involved and the relationships between these individuals. Furthermore, with a focus on priorities relating to students' clinical competence and the contextual factors within the acute care environment, it would seem that having a collaborative conversation between stakeholders is not always possible.

Purpose Matters in a CAS

Understanding why stakeholders need to collaborate brings attention to purpose within a CAS. While purpose itself it is not overtly aligned with any of the CAS principles, it underpins collaboration between stakeholders because the principles reflect interactions guided by values and beliefs, along with environmental factors. In this study, these guiding influences have been identified as notions, ideas that reflect the values and beliefs of stakeholders, along with other factors within the clinical context. The CAS principles present the hallmark of how individuals interrelate, how control is distributed, and how self-organisation evolves (Brand et al., 2015).

The purpose for most stakeholder interactions is associated with the interrelated dimension of 'clinical education'. The notions within this dimension highlight values related to stakeholder knowledge and experience. Knowledge is developed through experiential learning, by hands-on experience working with real patients in the clinical setting. However, it is clearly evident that some theoretical knowledge is given greater value than other knowledge, namely pathophysiology. There is an expectation that students will learn, both before attending clinical and during their placement. This is supported by the order generating rule of valuing the teaching role of both the CE and RN in the clinical setting. Yet, there is also the belief that these roles can be exchanged, with the student taking on the role of teacher for RNs who may be exposed to ongoing learning due to changes in practice. This change reflects both the value of lifelong learning in nursing practice and the emergent nature of a CAS in that changes occur in response to the context and people's needs within that context.

To ensure that the purpose of clinical education is met, stakeholders value interactions that contribute to assessment. This connects back to notions within earlier dimensions, such as *responsibility* from 'the individual(s)', *trust* from 'relationship', *safety and accountability* from 'clinical practice', and *safe learning space* from 'acute care environment'. When stakeholders are assessing students' knowledge and experience, values across all dimensions influence how stakeholders interact for assessment purposes. Understanding that students are learning, guides stakeholders to provide feedback. When there is limited or no feedback, this is interpreted as the student is progressing as expected, resulting in informal collaborative interactions. However, consideration of the risks associated with students with limited knowledge and experience being exposed to real patients can cause concern for some stakeholders. Concerns for all stakeholders, including patients, guides RNs to provide more detailed feedback to CEs.

Increased feedback which highlights concerns about the SN's clinical practice creates a commotion, resulting in a sense that something needs to change. This situation is identified in the CAS principle 'edge of chaos'. From chaos, changes to how stakeholders collaborate emerge. Knowing that in order to keep everyone safe, more time and effort is required to invest in collaboration, a more formal approach is adopted. At the early stage of these formal collaborative interactions, guided by

assumptions about what is best for the student, rather than what the student may value, the student is not included. Only when the perspective of all other stakeholders is obtained, is the student drawn into these formal interactions. The message is that the student's perspective is not valued. Their role on the peripheries as a silent stakeholder is reinforced. Not including the student has the potential to disrupt trust between the SN and other stakeholders, adversely impacting their clinical learning.

Furthermore, these behaviours create new ways of working together, evident in the CAS principle of 'creation of adjacent possibilities and awareness of path dependency'. Losing trust in the stakeholder relationship, the students feel a sense of pressure, as though they are constantly being assessed rather than supported in their learning. Knowing that SNs are dependent upon RNs and CEs to pass their clinical placement experience, a fear of failure can dominate the student's perspective of their learning experience. Instead, students should be focusing on the care they are providing to patients, with real and complex health needs. Students need to be supported and supervised by experienced RNs who work within a complex health care setting to ensure that everyone is kept safe. All stakeholder interactions need to keep this at the forefront of their minds as they embark on the collaboration essential for practice development.

Conclusion

Within the interrelated dimension of clinical education, findings show there is a need for stakeholders to collaborate. Equally, there is a purpose to collaboration. Recognising and accepting that no one knows everything provides a starting point for individuals to interact, because there is an accepted understanding that knowledge underpins nursing practice. However, investment of time is required for interactions to be collaborative. Assumptions about the priorities of stakeholders can, at times, constrain collaboration; yet articulating these assumptions provides opportunities for more collaboration. Effective collaboration occurs through prioritising support, teaching, and learning. None of these can occur without stakeholders interacting either through one-on-one conversations or via group meetings. An agreed purpose for collaboration needs to be at the centre of all interactions. Stakeholders want to see growth and development in the SN's clinical competence. Therefore, it is essential to

assess, provide timely and honest feedback, while anticipating that learning will happen and be evidenced through the observation of changes in the SN's practice.

Findings suggest that stakeholders are constantly trying to balance these five interrelated dimensions and their inherent notions that matter in order to navigate the collaborative context. Dipping in and out of the collaborative context is sometimes approached in a casual way, suggesting that to collaborate with others requires little thought and/or planning. However, more often than not, collaboration is challenging, often resulting in ineffective or non-existent collaboration and less than ideal outcomes.

Chapter 9 DISCUSSION AND RECOMMENDATIONS

Introduction

The aim of this study was to gain insight into ***how*** stakeholders collaborate to support the development of clinical competence in undergraduate nursing students in the acute care setting. Using ID, underpinned by CT, findings have identified ***who the key stakeholders are*** and ***how these stakeholders interact*** to support nursing students in the clinical setting. The ***values and beliefs*** that underpin these interactions, as well as ***factors that both enable and constrain*** collaboration have been revealed. Furthermore, findings show these interactions can have both a positive and negative ***effect on nursing students' clinical learning***.

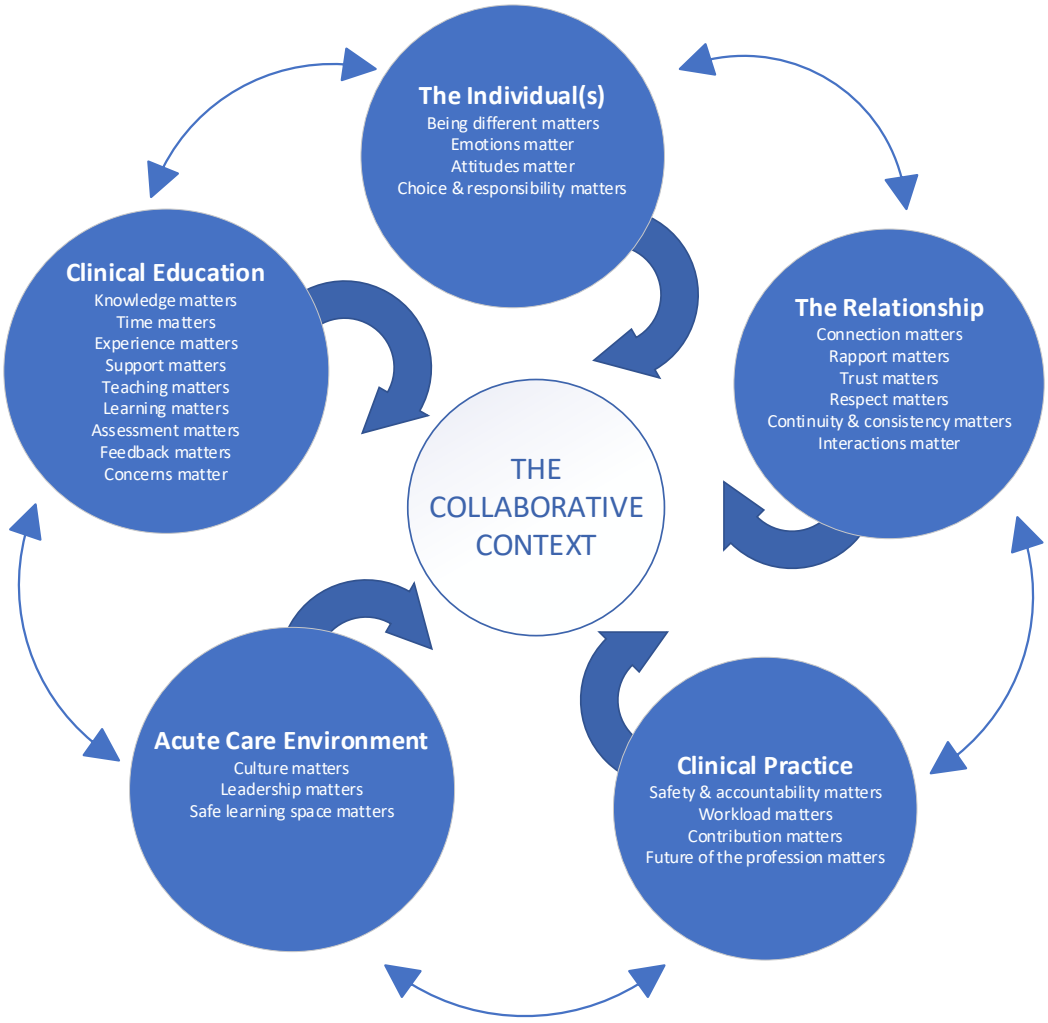
Study findings highlight that stakeholder collaboration designed to support the development of clinical competence in undergraduate nursing students occurs within a CAS. Within this system are five interrelated dimensions relating to people, context, and purpose; including 'the individual(s)', 'the relationship', 'clinical practice', 'acute care environment', and 'clinical education'. Understanding the various notions within these interrelated dimensions highlights the complexity of the topic. However, further discussion is needed to explain the meaning, importance, and relevance of these findings. Comparing my findings to what is already known helps to clearly identify the original contribution that this research offers to clinical education of nursing students. I will argue that stakeholders need to negotiate and manage how they interact to achieve balance in this CAS, while collaborating to support clinical learning for SNs. I will present recommendations to enhance collaborative practice, reflect on the methodology used, acknowledge study limitations, and finish with concluding statements that focus on assisting the necessary collaborative conversations to begin.

Summary of Findings

Stakeholder collaboration in clinical education for undergraduate nursing students occurs within a CAS. Being non-lineal is a key characteristic of a CAS (Ellis, 2011; Notarnicola et al., 2017). There are a number of dynamic parts that interact with each other, often in an unplanned and unpredictable way (McNamara & Teeling, 2021). Stakeholder interactions evolve in response to the people who are attempting to

interact with each other, the context within which the interactions occur, and the purpose for interacting. Reflecting a non-lineal and dynamic system, I identified five interrelated dimensions of; 'the individual(s)', 'the relationship', 'clinical practice', 'acute care environment', and 'clinical education'. Within each dimension are notions that matter; ideas that are constructed by stakeholders' values and beliefs regarding people, context, and purpose. The notions related to the five interrelated dimensions are presented in Figure 6.

Figure 6: The collaborative context: Notions that matter in interrelated dimensions of stakeholder collaboration



These notions help identify the values and beliefs held by individuals, and the contextual factors that enable and constrain collaboration. Equally, these notions influence how individuals interact within the system, including stakeholders beyond the triad of study participants. Understanding these notions helps to describe how

stakeholder collaboration occurs on a continuum within a collaborative context, with potential positive and negative impacts on clinical learning for nursing students.

This study found that while these notions have the potential to bring stakeholders together to collaborate effectively, considerable effort is required by all stakeholders to meaningfully engage with each other to achieve effective collaboration. Some stakeholders work from assumptions that result in limited opportunity or desire for collaboration. Others have different or competing priorities, constraining or limiting possibilities for stakeholder collaboration. While the purpose of collaborating centres on clinical learning for SNs, this does not mean that the student is always included in stakeholder interactions. More often, the student is positioned on the periphery of the collaborative context, diminishing their involvement to being passive bystanders, while the needs of other stakeholders are prioritised over the learning needs of the students. These variations to stakeholder interactions reflect the complexity of how stakeholders interact, and highlight important findings related to the visibility of the student within stakeholders' collaborative relationship.

Given the complexity of this interlinked collaborative context, it is surprising that any collaboration occurs. This study found that collaboration usually occurs informally, with limited opportunities for more formal collaboration. While it may not be possible to address all of the contextual factors that constrain more formal collaboration, or collaboration that involves all three stakeholders simultaneously, recognising and understanding them can help stakeholders interact in ways that take these factors into consideration. Brand et al. (2015) referred to this within their CAS principle of 'creation of adjacent possibilities and awareness of path dependency'. Greater investment by individual stakeholders is required to make overt their values and beliefs about stakeholder collaboration and clinical learning of nursing students. Exposing the priorities and assumptions held by these individuals has the potential to improve the experience of collaboration for all stakeholders, thereby improving the learning experience for students. It is important to note that for this to happen all stakeholders need to recognise and value this potential.

Understanding Stakeholder Collaboration within a CAS: Interpreting the Results

This study is the first to consider how stakeholder collaboration aligns with a CAS. Taking this unique perspective, a number of important findings need further discussion. I begin by exploring the principle of interrelatedness and distributed control of key stakeholders, namely the CNM and SN. I then identify relevant order generating rules such as valuing individuals, the belief that CEs and SNs are interlopers, and the value of investment. Co-evolution of system and its environment is discussed in relation to context of culture and diversity, and time pressures within the acute care setting. Finally, discussions on formal and informal collaboration, along with complexity of the collaborative continuum, help to explain self-organisation within the collaborative context. This culminates in a discussion on how the stakeholder collaboration impacts the clinical learning experience for SNs and the need for balance if stakeholder collaboration is to be effective.

Interrelatedness and Distributed Control of Key Stakeholders

Prior to the commencement of this study, three key stakeholders had been identified: the SN, RN, and CE. During the study it became apparent that these stakeholders work in a setting where there are many other people with whom they interact. Identifying these people is important because within any CAS individuals have the capacity to influence the behaviour and practice of others and the system itself (Hannigan, 2013; McNamara & Teeling, 2021; Notarnicola et al., 2017).

CNMs as Key Stakeholders

This study found that the CNM has a pivotal role in stakeholder collaboration. As a leader in the clinical setting, the CNM is responsible for establishing the culture of the ward and promoting professional development of nurses (Currie et al., 2007; NZNO, 2018c). In relation to SNs' development, this includes how student are welcomed into the ward, how RNs are assigned to students, and the philosophy of how students and CEs are viewed while on the ward. Identified as a conduit, the CNM can either enable or constrain learning opportunities within the clinical setting, dependent upon the level of support they offer in relation to clinical learning (Currie et al., 2007). While Currie et al.'s (2007) research is focused on RNs who are attempting to apply academic

learning to advancing practice roles, findings from the current study suggest the CNM's attitude and level of support they offer also influences how stakeholders collaborate to support SNs in their clinical learning. The CNM can be viewed as a 'dominant stakeholder' who has the capacity to construct what needs to be learnt to be a RN and, at times, holds the power to shape the context for learning to occur in practice (Currie et al., 2007; McNamara & Teeling, 2021; Yen et al., 2021).

CNMs are often caught in the middle of the system and can become overloaded by the operational responsibilities they hold (Yen et al., 2021). The complexity of the CNM role may explain why findings in my study showed that some CNMs are less engaged in student learning than others, and/or their decisions on how to allocate students to RNs are influenced by contextual factors reflecting prioritisation of their operational responsibilities. Identifying stakeholders beyond the triad and the CNM may be helpful in distributing leadership responsibilities related to clinical learning, including clinical nurse educators, clinical coaches, and senior RNs (McNamara & Teeling, 2021). Furthermore, leadership is possible throughout all levels of a system and is not just the responsibility of those in formal leadership positions (McNamara & Teeling, 2021). Stakeholders need to generate a sense of ownership and responsibility both for themselves and the system in which they work. For this to occur, nurses require authority (NZNO, 2018c) to make decisions regarding how RNs work with students and CEs in clinical practice which will empower RNs to make decisions that are helpful to stakeholder collaboration. This study has found that some RNs avoid this aspect of their role, with some choosing not to work with students. Providing adequate support for students to learn and apply their learning in clinical practice is a moral issue because it has a direct impact on the future practice of the student and the care they will provide to patients (Currie et al., 2007). If RNs are to meet their obligations towards meeting competencies for practice, then all RNs need to be supported to engage in supporting SNs' learning while in clinical placement.

Students as Key Stakeholders

While this research found that stakeholders identified the CNM as pivotal to the stakeholder relationship, there were a plethora of other stakeholders identified by study participants, including other health care professionals, patients, and university staff, such as course leaders. However, when students are not supported by the

stakeholders immediately around them, they often seek support from other students. This finding is supported by Fenton-O'Creevy et al. (2015) who validated 'peer support' as justified because other students are presumably having similar experiences. Furthermore, other students can offer support for learning and emotional support (Hill et al., 2020). In the current study, students reported experiencing a variety of emotional reactions when working in the clinical setting, while also feeling scared and vulnerable about working within a health practitioner hierarchy. Peer support can be beneficial because senior students develop coaching skills that they can carry into their careers as RNs, while also being role models to junior students (Hill et al., 2020). However, a more immediate potential outcome of peer support may be increasing confidence for the students themselves, empowering them to place themselves at the centre of their learning and providing a sense of belonging within the clinical context (Hill et al., 2020; Jamieson et al., 2017; Maccabe & Fonseca, 2021). With increased confidence, students may view themselves as active learners, positioned more centrally to collaborate with other stakeholders. Furthermore, students who graduate with increased confidence may be well placed to provide feedback to others in the future, including RN colleagues and nursing students whom they are supervising.

It is clear there are a number of stakeholders who interact to support students in the clinical arena, interactions which exemplify interrelatedness and distributed control. While it is helpful to identify who these stakeholders are, it is also important to understand the values and beliefs that influence how these stakeholders interact.

Order Generating Rules

This research has identified the key values and beliefs, or notions, held by stakeholders within the five interrelated dimensions that create a collaborative context. These notions create the order generating rules that influence how stakeholders interact at any given time (Brand et al., 2015; Ellis, 2011; Notarnicola et al., 2017).

Valuing Individuals

Usually, it is commonality among individual people within an organisation that can draw them together, ignoring the differences inherent in individuals (Bogren et al., 2016). Conversely, a significant value held by all stakeholders in this study was the individuality of people. Principle One of the Code of Conduct for nurses, states that

nurses must respect the individuality of health consumers (NCNZ, 2012). As a core value of nursing, respecting difference in health consumers may transcend how nurses see and work with other stakeholders as individuals. This shared understanding may explain why this was a finding for the RN and CE participants, but it is not clear how SNs may acquire this value so early in their programme of study. Valuing individuality may be an inherent trait or characteristic within some students due to their experiences interacting with diversity in their everyday life and learning about their own identity by comparing themselves to others (Kahu, 2017). It may be something that influences them to become a nurse, or they may learn this early in their programme of study.

Reinforcing the valuing of individuals, Brand et al. (2015) noted that people in a CAS are 'individual agents' who belong to a 'group' but have freedom to behave independently. This creates some unpredictability for stakeholder interactions. While valuing individuals is commendable, it is also important that individuals recognise the impact their behaviour and decisions have on others with whom they interact. Findings from my study support stakeholders being aware of their impact when interacting with each other because these interactions can impact the development of trust and rapport between stakeholders both positively and negatively (Heemskerk et al., 2021; Hill et al., 2020; Shorey et al., 2021). However, it is not clear whether stakeholders fully understand the potential 'wave of consequence' because it may not be immediate or overt (Hannigan, 2013). The wave of consequence was exemplified by one student participant who made assumptions about an RN in the team, whom she had not actually worked with (see p. 78). The student stood by and observed the behaviour of the RN, then interpreted their behaviour as 'scary'. Likewise, when RNs roll their eyes (see p. 92) or overtly declare to the team that they do not want to work with a SN, the consequence is that the student does not feel valued. The student may consequently lose respect for those RNs or mistrust them when assigned to work with them. Unfortunately, the wave of consequence is somewhat unavoidable due to the interdependency between stakeholders (Brand et al., 2015). Yet, it is something that I believe stakeholders need to develop an awareness of if conditions for positive stakeholder relationships are to be established and maintained.

The Belief that CEs and SNs are Interlopers

While relationships and interconnectedness are important for stakeholder collaboration to occur, the belief that both the CE and SN are 'interlopers' is another important finding in this study. Students and CEs are often not viewed as being a member of the clinical community of practice; rather their trajectory is one of 'passing through' (Fenton-O'Creevy et al., 2015). Positioned at the boundary between the educational and clinical settings, students and CEs are labelled as 'tourists' and 'sojourners' (Fenton-O'Creevy et al.). The distinction between a tourist and a sojourner rest with the level of participation these stakeholders have while on clinical placement. If they have a low level of participation, such as when the RN restricts opportunities for hands-on learning experiences for students, the student is considered a tourist because the learning experience is more likely to be observational with limited practice development. Conversely, a sojourner level of participation—as shown when the CNM encourages the student to take out a new PICC line, which enables the student to become a teacher (see p. 127)—contributes significantly to the development of the student's practice. Furthermore, within a community of learning, newcomers are known as 'legitimate peripheral participants' (Heemskerk et al., 2021; Lave & Wenger, 1991). This highlights the student's and CE's positions in clinical practice as having legitimacy, despite the fact that they are 'passing through'. Both student and CE have the right to be present within the clinical setting for teaching and learning purposes, supporting the need for collaboration with RNs and other clinical staff. However, the extent to which clinical staff and RNs engage with these stakeholders is dependent upon clinical staff beliefs about whether the student and CE are worthy of 'investment'.

Value of Investment

When collaboration occurs, the values and beliefs supporting engagement pertain to the order generating rule or belief that stakeholders need to 'invest' in the stakeholder relationship. Investing was a common factor associated with the notions of 'connections matter' and 'contributions matter'. Connecting and contributing relates to the CAS principles of 'interrelatedness and distributed control' (Brand et al., 2015), which requires an investment of time by individuals. Protected time is required in the mentor-mentee relationship, enabling the mentor to meet the expectations of their

role, including supporting mentees, addressing concerns, promoting problem solving as a learning strategy for the mentee, as well as "develop[ing] mentees' ability to give and take criticism" (Turnbull, 2020, p. 7). Furthermore, communication between stakeholders across clinical and educational organisations takes time (Turnbull, 2020). However, it is clear from this research that time is not always available for stakeholders to interact in a way that is overtly collaborative, highlighting another CAS principle; 'co-evolution of system and its environment'. This finding is supported by Turnbull (2020) who noted that it was not always possible to have protected time due to staffing levels. Less than adequate staffing can raise safety issues for stakeholders (Beaver, 2017). Without the time needed to ensure safe practice, it is easier to limit the exposure to risks associated with working with a SN by limiting the student's hands-on learning experiences. All stakeholders need to invest time to provide practical learning opportunities for students if SNs are to develop competence in nursing practice. This would result in potential positive outcomes for nursing; both for students as they gain seniority and as RNs in the future.

Investment was also referred to in relation to the notion that the 'future of the profession matters'; that stakeholders are investing in the future of the profession. In this sense, RN and CE stakeholders recognise that students are joining the community of nursing. Nursing can be considered a 'Community of Practice' (CoP) where individuals invest themselves to enable learning to occur with others (Lave & Wenger, 1991; Pyrko et al., 2017). The requirement for stakeholders to 'invest' brings challenges when there is a planned intention to develop a CoP, because CoPs develop somewhat spontaneously (Iverson, 2011; Pyrko et al., 2017). The way in which stakeholders work together to support students' clinical learning seems congruent with an informal CoP. However, consideration of the broader context should take into consideration factors that situate the learning needs of students, referred to as 'Landscapes of Practice' (Pyrko et al., 2019). Similarly, the findings of my research show it is necessary to consider both context and learning within this collaborative context.

Use of the term 'investment', when associated with the clinical education of student nurses, draws on connotations of value and worthiness, as though there is a financial element to this stakeholder relationship. Nursing graduates have made their own financial and time investments throughout their undergraduate education (NZNO,

2018c). In the clinical setting, students are dependent upon other stakeholders investing their time to achieve the required levels of competence. For stakeholders to invest, their motivation to collaborate must be considered. Findings from this research identified a belief held by many stakeholders that working with students may increase the RN's workload, which, in turn, could reduce the RN's motivation for collaboration. This finding is supported by McLean et al. (2011) who reported that mentoring medical students increases workload for senior doctors. To ensure a 'return on investment', they proposed prioritising medical students showing interest in their learning which reflects my finding that collaboration is more likely to occur when the students are proactively engaged in their clinical learning. However, it raises questions as to what constitutes 'showing interest' and who decides. There also remains a need to address the increased workload of preceptor nurses so that all students are deemed worthy of investment. With educational providers paying clinical placement providers for clinical access, it may be timely to explore how the placement providers use this income to see if it can be used to address the workload of preceptors.

Co-evolution of System and Its Environment

Workload was one contextual factor identified by participants which clearly impacts stakeholder collaboration in the acute care setting. Stakeholders were able to identify several other contextual factors that both enable and constrain collaboration. Recognising that all collaboration starts and ends with individuals interacting, the first contextual factor that needs to be discussed pertains to the cultural differences between individuals.

Context of Culture and Diversity

While stakeholders in this study generally valued differences which may draw individuals together, it was evident that these differences can constrain collaboration. For example, returning to the collaborative approach where CE and RN stakeholders meet without the student present (see p. 142), ostensibly to protect the student while they discuss the student's progress, the view of students was that they wanted to be part of these discussions for reasons of honesty and open communication. These divergent perspectives may occur due to the transient nature of the relationship during clinical placements (Fenton-O'Creevy et al., 2015), where RNs have little regard

or interest for relational investment due to perceiving the student as just ‘passing through’.

Alternatively, these different perspectives could be due to generational differences between stakeholders. Gen Z refers to anyone born after 1996 and it is likely that this group currently make up most of the nursing student body. Millennials, those born between 1981 and 1995, are likely to be the next largest group in the student population (Shorey et al., 2021) as reported by NCNZ (2021) who stated that 42.5% of new graduate nurses are under 25 years of age, with 25-29-year-olds following at 20%. These statistics reflect the participant demographics of my study. While the statistics show that RNs may also fall into the ‘Gen Z’ and ‘Millennial’ generations, it is possible that they have been acculturated into the dominant cultural ways within their clinical ward, where it has become standard practice to meet without the student. This practice of meeting without the student may have been passed down through generations of nurses to the point where it is now normalised by all nurses, including CEs.

Furthermore, reflecting the CAS principle of ‘sensitivity to initial conditions’ (Brand et al., 2015), if the RNs and CEs themselves were not included in stakeholder interactions when they were students it is likely that this has set up standard practice for how they will engage with other stakeholders when working with students. Being left out of collaborative opportunities as students is being passed down to the next generation of students, effectively reinforcing this practice as the accepted status quo. Like Ó Lúanaigh, (2015), this research found that students want to be involved in stakeholder collaboration, to be active members within stakeholder interactions. Therefore, it is vital that collaborative practice changes to ensure that students are centered and included in all stakeholder interactions and that collaboration is effective for students and their learning.

The diversity of individuals coming together in stakeholder interactions contributes to the unpredictable nature of a CAS (McNamara & Teeling, 2021; Notarnicola et al., 2017). Yet, at the same time, there is an overt expectation that these individuals need to work together and collaborate. Acknowledging this cultural diversity and checking out the assumptions inherent in these findings through open discussion on the part of

all stakeholders, would enable these assumptions to be checked. However, a significant challenge to achieving such openness is the lack of consistency in the allocation of a student to the same RN; hence the importance of maintaining consistency in relationships between the three key stakeholders.

Time Pressures Within the Acute Care Setting

The second contextual factor pertains to pressures within the acute care setting which can impact time available for collaboration. Pressures within the system, such as staffing and busyness, constrain collaboration; yet makes collaboration even more important when ensuring safety of the students in the moment and in the future (Devlin & Duggan, 2020). However, the impact of these pressures is that it creates less time for stakeholders to invest in students (Turnbull, 2020; Ulenaers et al., 2021). Belmi and Schroeder (2021) suggested this is because in the work context people are more strategic about how they use their time and, in this context, people are objectified rather than being seen as humans with needs. In this sense, an individual will calculate the costs and benefits of engaging collaboratively within the broader picture of their overall work objectives, highlighting time as a significant contextual factor in stakeholder collaboration. If there is enough time, then connections are made, individuals experience a sense of belonging, and collaboration can occur with ease. Formal meetings can be held, where discussions can go to greater depth and detail, resulting in students being better supported as they develop clinical competence. However, when there is limited time, collaboration may be viewed as a cost rather than a benefit. Ironically, if stakeholders do not invest time into the stakeholder relationship and the necessary collaboration, it ultimately 'costs more' (Belmi & Schroeder, 2021). In relation to the findings of this study, reduced collaboration may negatively impact students' learning experiences and likely result in graduates who are less ready for RN practice.

Stakeholders in this study were able to identify contextual factors that both enable and constrain collaboration. Yet, stakeholders tend to make assumptions about other stakeholders, without considering the impact of these contextual factors. This is known as 'systems blindness' (Oshry, 2020), and occurs when individuals are not able to see how the context impacts behaviour of others. Individuals view themselves as separate from the context, resulting in individuals feeling unable to change how they interact

with others (McNamara & Teeling, 2021; Oshry, 2020). Developing 'systems literacy' (Oshry, 2020) means stakeholders can be empowered to establish how they will work together. More importantly, they can determine how they will communicate and collaborate in a way that is effective for all stakeholders.

Self-organisation Within the Collaborative Context

Expectations that stakeholders will collaborate for the purpose of clinical education is explicit in two critical documents published by the NCNZ that underpin clinical education for SNs in New Zealand. The first document details the regulatory requirements that need to be met through regular accreditation reviews by the university when offering a nursing programme of study (NCNZ, 2020). The nursing programme is expected to outline their beliefs and assumptions that underpin the learning experiences for students; identify a model of clinical supervision that ensures both the quality of the learning experience and support for the RNs supervising the students; outline communication pathways between educational and clinical organisations; negotiate roles and responsibilities for teaching, learning, and assessment; and explain how risks will be managed within the clinical learning environment to ensure the safety of patients, students, and staff. Students must also have RN supervision when in clinical placements and RNs must be equipped for the teaching role. Supervision from academic or clinical teaching staff will also be provided.

In the second document, "Competencies for Registered Nurses", the NCNZ (2016) outlines expectations of RNs in practice. The RN is to take "accountability for directing, monitoring and evaluating care that is provided by… others" (NCNZ, 2016, p. 23). 'Others' would include SNs when they are working with RNs in clinical practice. RNs are also required to maintain professional development, which includes "sharing knowledge with others" (NCNZ, 2016, p.28).

The overt expectations and requirements outlined above provide a clear foundation for stakeholder collaboration to occur. However, these documents have two significant limitations which may account for why students are left out of important collaborative interactions. First, while one focuses on the responsibilities of the educational organisation and the other on the RN's responsibilities, neither document considers

the responsibilities of SNs themselves nor how they will be involved in this collaborative relationship, other than as passive bystanders. Without the student's position being more overt, there are implications for the student's accountability and self-determination as an active participant in this relationship. This leads to the second limitation, which pertains to how the requirements provided in these documents are implemented in practice by the stakeholders who are expected to be collaborating. This limitation has been highlighted by my research findings. Oermann et al., (2018) suggested this finding highlights the difference between an 'espoused curriculum' and the 'curriculum in use', meaning that what is written down on paper as happening, may not be what is actually happening in practice. More importantly, despite these expectations from NCNZ (2016, 2020), collaboration between stakeholders evolves in a self-organising way determined by individuals, with varying degrees of success.

Formal Collaboration

Insight into ***how stakeholders interact*** to support SNs on placement for clinical learning is explicated in this study. The findings reveal a variety of approaches taken by stakeholders; approaches that are positioned on a continuum which highlights the CAS principle of 'self-organisation' (Brand et al., 2015; Notarnicola et al., 2017). At one end of the continuum are formal interactions set up as meetings that can include all stakeholders, including some beyond the triad included in my study, such as the CNM. Unfortunately, formal meetings do not occur for all students. In fact, only a few students are offered an opportunity to collaborate with all other stakeholders in this way. This is concerning, because formal meetings provide an opportunity for all stakeholders to discuss how best to support the student in developing competence (Heemskerk et al., 2021). An even more concerning finding is that these formal meetings usually fail to include the SN in any collaborative way; instead, other stakeholders meet without the student, with the aim of having an 'honest' conversation about the students' practice. The belief that having students present will negatively impact on the ability of other stakeholders to be honest is supported by the belief that this action protects both the student and the relationship that they have with other stakeholders, particularly the RNs. However, students, particularly those from Gen Z and Millennials want feedback that is honest and constructive, as close as possible to their learning event (Lovecchio et al., 2015; Shorey et al., 2021). Shorey et

al. (2021) have noted that Gen Z students generally have underdeveloped interpersonal communication skills due to their high rate of online socialising, reducing the opportunities to learn face-to-face communication skills. This may increase stakeholders' reluctance to include students in initial conversations. Honesty, which is reciprocal, is key to establishing an effective relationship between students and RNs (Rebeiro et al., 2021). The findings from the current study clearly indicate that students should be involved in all conversations about them.

When the student is not included in the early phase of the feedback process, the collaborative relationship may be compromised, as supported by those participants who interpreted ambiguity within the feedback process as a lack of honesty. This leads to a lack of trust in other stakeholders, negatively impacting the stakeholder relationship. Turnbull (2020) recommended establishing ground rules for the relationship, and the need for following through on these rules to help build trust between stakeholders. While some of my research participants recalled meetings with other stakeholders to discuss expectations, these meetings were often limited to **what** the student could or could not do rather than how stakeholders might work together. Establishing ground rules for the relationship would be helpful in future stakeholder interactions to promote a collaborative relationship.

Informal Collaboration

At the other end of the continuum are informal interactions that occur as brief corridor conversations, usually involving only two stakeholders, such as the RN and CE, the CE and student, or student and RN. Occasionally these conversations occur outside of the triad of stakeholders included in this study (i.e., between the CE and CNM or the CNM and RN). Having these conversations in such a public place is concerning and raises questions about maintaining privacy for students who may be vulnerable in their learning journey. Reedy and Jones (2018) noted a lack of privacy should be expected due to the student's public performance while they learn in the clinical setting. However, corridor conversations only provide limited time to discuss a student's practice or learning, or to identify teaching strategies that may be of help to the RN (Dahlke et al., 2016; Ebu Enyan et al., 2021; Papastavrou et al., 2016).

I suggest that there are also concerns about what is being discussed in the absence of the other stakeholders, especially the student. When the student is absent from the conversations, there is the capacity for ambiguity regarding expectations of stakeholders, increasing the likelihood of conflicting information being shared between stakeholders. The danger that these conversations are somewhat invisible and therefore not collaborative is important. However, these informal collaborative interactions should be beneficial to the collaborative relationship (Daniels & Khanyile, 2013). My research findings show that these informal interactions provide opportunities, however brief, for stakeholders to get to know each other as individuals, including their attitudes and emotional states (Hill et al., 2020; Shorey et al., 2021). This, in turn, helps stakeholders to build connections (Ellis, 2011; Hannigan, 2013), develop rapport (Shorey et al., 2021) and trust (Heemskerk et al., 2021; Hill et al., 2020).

Complexity of the Collaborative Continuum

Stakeholders constantly move back and forth along this collaborative continuum, choosing who to interact with and how, depending on the purpose for the interaction (Notarnicola et al., 2017). This continuum sits within the collaborative context of a CAS made up of both vertical and horizontal connections that empowers individuals to take leadership of their own behaviour (McNamara & Teeling, 2021). Horizontal connections are noted when people work in teams, usually ward or unit based, within the acute care setting. Conversely, vertical teams exist when teams come together from different organisations (McNamara & Teeling, 2021). This is true of the stakeholders involved in my study. There are RNs who work in different wards or DHBs, along with SNs and CEs who come together from different universities. This creates a need to consider how individuals interact within a system that comprises vertical and horizontal connections because individuals will be drawn in different directions at any given time, depending on the competing factors of all connections. Patterns of behaviour emerge within the system as individuals take account of these connections. The more connections a stakeholder has, the greater complexity within which they work (Notarnicola et al., 2017). This was particularly true for the second-year nursing students in this study who reported that they were often placed with a

variety of RNs during the course of their clinical placement. At the same time, they were trying to meet the needs of the CE who was assigned to support and assess them.

Aligning interrelationships with distributed control is reflected in the notion that stakeholders have a choice about ***how*** they enact the expectations and requirements from NCNZ (2016, 2020) and to what degree, if at all. The idea that RNs choose to collaborate with each other contradicts the requirement to do so if the RNs are to meet the NCNZ competencies for practice. Without the explicit prescription of who and how stakeholders should collaborate, it appears that the crucial stakeholder group of the students is seldom included. My study findings show that being excluded from collaboration intended to support their clinical development, results in a negative learning experience for the student.

The Impacts on the Clinical Learning Experience for SNs

The purpose of the clinical learning experience for students is to both apply their knowledge to practice (Birks et al., 2017; Brand, 2020; Kim, 2007; Mamhidir et al., 2014; Nielsen, 2016; O'Mara et al., 2014) and continue with the development of their nursing practice (Adjei et al., 2018; Basour Adam et al., 2021; Berhe & Gebretensay, 2021; Cooper et al., 2015; Flott & Linden, 2016; Glynn et al., 2017; Hill et al., 2020; Hilli et al., 2014; Mikkonen et al., 2022; Pedregosa et al., 2021; Ramsbotham et al., 2019). It is vital that students are exposed to real life clinical opportunities to achieve this purpose. Findings from my study identify that when stakeholders collaborate, even informally, students are given such opportunities. However, when individuals choose not to collaborate or are prevented from collaborating, clinical learning is negatively impacted.

Stakeholder collaboration occurs on a continuum within a collaborative context. At the formal interaction end of the continuum there appears to be a greater level of collaboration aimed at having a positive impact on student learning. Noticing that there are concerns about a student's practice development means greater input is required to develop the student's competence (Christiansen et al., 2021). At the other end of the continuum, the informal interactions are often brief. With notions related to workload and time influencing how long stakeholders have to interact, it seems this common approach to collaboration is accepted. There may be several reasons for the

informal approach being taken. Educationally, stakeholders may already deem students as being competent or because the student is proactive in their learning it is perceived that little input is required. In this sense, the stakeholder's assessment of the student's clinical practice or behaviour in placement informs them of the need for further collaboration beyond this status quo approach (Christiansen et al., 2021). The assumption may be that there is little or no collaboration in informal interactions. However, the example of the CNM instigating the student learning how to remove a PICC line shows that even a brief collaborative interaction can lead to a valuable learning opportunity. Thus, clinical stakeholders can be viewed as gatekeepers to student learning, with collaboration providing the access to learning opportunities.

As gatekeepers to student learning, clinical stakeholders make active choices about when and how to work with other stakeholders and, in particular, students. They can control what the student can and cannot do in clinical practice (Adjei et al., 2018). Experiential learning with hands-on practice for students increases the safety risk of students and staff (Killam & Heerschap, 2013; Ó Lúanaigh, 2015). This means that safety becomes something that matters to stakeholders. While limiting opportunities for hands-on practice reduces this risk, it can also limit students' development. There are significant implications as the student progresses in their undergraduate programme and transition into becoming RNs if they are not provided with opportunities to fully develop their practice in each clinical placement, ensuring they feel prepared for practice as an RN (Marcellus et al., 2021).

When stakeholders believe that learning matters, they will provide students with more opportunities for experiential learning. Creating a culture that values clinical learning for second year nursing students rests with the CNM (Currie et al., 2007; Pedregosa et al., 2021). This does not mean that the CNM must be fully involved with students or CEs when they are on a ward; rather, they can actively encourage staff in their teaching role and promote a context that enables learning to occur (Pedregosa et al., 2021). Recent local and international examples of an experiential learning culture being established are provided in DEUs designed to create effective clinical learning partnerships between an academic and a clinical institution (Jamieson et al., 2017; Marcellus et al., 2021; Pedregosa et al., 2021). However, within the Auckland metropolitan area, there are three DHBs and five educational providers of nursing

programmes. Constructing a DEU that meets everyone's requirements is almost impossible (Grealish et al., 2018) and would require considerable effort and investment. The CNM is well placed to support strategies that promote a culture of learning, irrespective of educational providers.

Finding Balance for Effective Stakeholder Collaboration

My research findings have exposed the complexity of the collaborative context. Multiple notions are competing at any one time to be given priority across five interrelated dimensions. Control is distributed amongst individuals who have diverse relationships with others, resulting in interactions that are highly dependent on the behaviour of others. These interactions take place within a context where some stakeholders' needs may not be given priority. Instead, tensions occur within the acute care environment while stakeholders make choices about patient care alongside clinical education of nursing students. Findings show that stakeholder collaboration may occur formally but is more likely to occur informally, if at all. Balancing these notions within their interrelated dimensions is complex.

The implications of finding balance within stakeholder collaboration is pivotal. Without balance, patient care and safety may be prioritised at the expense of student learning, potentially resulting in graduates who are not work ready which perpetuates risks to patient care and safety. Likewise, if student learning is prioritised over patient care, then immediate safety risks may be high for all involved, including the patient. Increased collaboration is needed so that both patient care and student learning are integrated in a way that balances these competing agendas. Recognising the legitimacy of the CoP within a Landscape of Practice must be valued at the immediate stakeholder and organisational levels if balance is to be achieved (Pyrko et al., 2019).

Students need to be taught how to collaborate; and be included in all formal and informal interactions about their practice from the commencement of their programme. Power held by individual stakeholders needs to be balanced. Students must be empowered from as early as possible in their nursing education to have a voice about their practice development to ensure that learning is helping them develop competence and confidence, and improve outcomes for students throughout their programme of study. Furthermore, when power is balanced between

stakeholders, there are benefits for both the nursing profession and patients receiving nursing care as these students transition into beginning RNs. This is a crucial finding, one that has implications for clinical teaching and learning in all nursing programmes.

Answering the Research Questions

How stakeholders collaborate in clinical practice to support SNs' development of clinical competency occurs on a continuum within a collaborative context. This context comprises five interrelated dimensions: the individual(s), the relationship, clinical practice, acute care environment, and clinical education. Within each interrelated dimension are notions held by stakeholders that represent their values and beliefs, along with other factors that both enable and constrain collaboration.

- Interactions between key stakeholders are influenced by order generating rules, notions that reflect the values and beliefs held by stakeholders related to each of the five interrelated dimensions. These interactions can occur both formally and informally, with both approaches having the potential to be collaborative.
- Informal interactions may appear non-collaborative, yet this seems to be the dominant way most stakeholders collaborate. More significantly is the likelihood that one key stakeholder is left out of this interaction—most often the student.
- There are some stakeholders who choose not to collaborate with other stakeholders. Perceiving the CE and student as 'interlopers' causes clinical stakeholders to question the legitimacy of students and CEs in the clinical setting.
- All interactions are reflective of the distributed control held by individual stakeholders to self-organise as they adapt to the behaviour of others, while trying to prioritise their values and beliefs within each of the five interrelated dimensions.
- Values and beliefs held by stakeholders highlight that people, context, and purpose matter. These values and beliefs have the potential to both enable and constrain collaboration between stakeholders.
- There are many factors within the collaborative context relating to people, context, and purpose that both enable and constrain collaboration. Two of the main factors are leadership and workplace culture.

- When collaboration is constrained, due to competing notions held by different stakeholders, clinical learning opportunities are limited. Hands-on learning for students is reduced undermining the purpose of clinical placement.
- Collaboration is enabled when there is investment in the teaching role of clinical staff, and they are enabled to enact their role through the provision of adequate time.
- While the key stakeholders remain the student, the CE, and the RN, there are other stakeholders who support nursing students in the clinical setting. Pivotal is the CNM who has a leadership role and may be drawn into collaborative discussions with other stakeholders.
- Peer-support is sought by students when their emotional or learning needs are not being met by other key stakeholders. This is helpful for students and should be encouraged.

Recommendations for Future Collaborative Practice

Creating a culture wherein clinical learning is integrated more effectively with patient care begins with clinical leadership. However, all stakeholders have a responsibility to develop a context that fosters a cultural shift. Further consideration of the principles underpinning the clinical model used within each clinical setting is required for collaboration to occur. Discussions at all levels within the stakeholder relationship are essential and need to include consideration of the following:

- Work needs to be done to empower students to take a more active role in the collaborative relationship. Formal learning on how to self-advocate, identify and share their individual learning goals, will help drive clinical learning for students. All stakeholders need to encourage students to take a proactive approach to collaboration.
- Consistency in RN preceptors working with the same students for the duration of their second-year acute care placement needs to occur. Optimal consistency will help to establish connections through the development of rapport which, in turn, helps to build trust in the stakeholder relationship. Furthermore, this change will enable all stakeholders to take the time to invest in establishing ground rules for how individuals will work together in a more overt and collaborative way.

- Dedicated time at the beginning of clinical placement for stakeholders to establish expectations of how they will work together. This will enable open and honest communication to develop as the basis for a collaborative relationship and ensure that all stakeholders have a voice (including the student), enabling the student to reach their full potential. Likewise, closure of the feedback loop is essential. RNs need to know what happens to their feedback and how it influences the outcomes for students.
- Greater investment from organisations to ensure protected time for development of the collaborative relationship, especially earlier in SNs' clinical experience or rotation.

Reflections on the Methodology

This study was carried out using ID underpinned by CT. I have honoured both the complexity of the topic and the perspectives of the participants. However, the process of data analysis using such an approach was time intensive, perhaps more so than I had imagined. Delays were frustrating and could have caused issues regarding inconsistencies in the data analysis. I believe using the CAS principle framework helped me to effectively manage a large volume of data, ensuring a consistent approach to analysis that kept me focused on the research questions, despite the delays. Using the CAS framework enabled me to keep my interpretation open to how stakeholders interacted, the values and beliefs influencing these interactions, as well as the factors that enabled and constrained collaboration. Greater understanding of how CAS are organised has strengthened this research and significantly enhanced the way I now practice.

Strengths of the Study

Use of the CAS framework has facilitated deeper understanding of how stakeholders collaborate and addresses a significant gap identified in the extensive review of literature pertaining to clinical education of nursing students. This research has also provided insight into some of the values and beliefs, along with contextual factors, that influence how stakeholders collaborate. The framework takes account of what needs to be considered if change is to occur in practice. Noting differences in how stakeholders currently collaborate along a continuum acknowledges that collaboration

may be occurring without stakeholder awareness. Reflection on and acknowledgement of informal interactions as a type of collaboration is helpful; however, more helpful is knowing what is required for formal collaboration to occur. Noting the differences between formal and informal collaboration has helped to identify areas that need to be addressed in practice for more effective collaboration between stakeholders.

Limitations to the Study

Participants: Voluntary inclusion in the study was more likely to be taken up by stakeholders who valued collaboration. This is a common limitation of qualitative research.

Numbers: The number of participants in this study is relatively small compared with the number of stakeholders currently working in their respective roles. It is possible that with higher numbers more divergent perspectives may have been found.

Auckland region: This large metropolitan city differs from other regions in New Zealand. With five educational providers offering undergraduate nursing education using clinical placements within three of the largest DHBs in the country, it is likely that some of the findings will be less relevant in regions where there is only one DHB and one educational provider.

Hospital versus primary care settings: The context for this study focused on the acute care clinical setting within a hospital environment. While some findings may apply in other health care settings, such as primary care, it is important to note that others may not.

Generalising the findings: The findings are positioned contextually and historically. This is the nature of qualitative research, especially noted when using CT (Cilliers, 2002).

Opportunities for Future Research

Further research on the topic of stakeholder collaboration should be broadened to include the perspective of other stakeholders identified within this study, including the CNM. There is the potential to research this topic as it relates to learning within interdisciplinary collaboration. With ongoing changes to how stakeholders collaborate,

it will be worthwhile repeating this study to ascertain how the implemented changes impact nursing and educational practices.

Conclusion

This Doctor of Health Science thesis describes research designed to explore the complexity of stakeholder collaboration in clinical education for undergraduate nursing students. Using ID underpinned by CT, the study was designed to answer the main research question: **how do stakeholders collaborate to support the development of clinical competence in undergraduate nursing students in the acute care setting?** In exploring this special topic of stakeholder collaboration, I have endeavoured to produce findings that contribute to the body of knowledge in the field of clinical education, with the aim of bringing about changes in practice. By including participants from three key stakeholder groups—SNs, RNs, and CEs—I was able to value a diversity of perspectives. Using focus groups and individual interviews, data were collected and analysed using a CAS principle framework. Findings show that a collaborative context exists, made up of five interrelated dimensions, each comprising notions held by stakeholders that reflect their values and beliefs, along with other factors that guide how they interact. Understanding of the collaborative context helps to acknowledge that informal collaboration often occurs, with formal collaboration occurring less often. However, the SN is often notably absent from this collaboration.

Identifying how stakeholders collaborate and the values and beliefs that underpin such interactions, helped to identify appropriate recommendations to enable students to take a more active role in this collaborative relationship. These recommendations include: creating a collaborative culture that integrates patient care with clinical learning where students are empowered to self-advocate; greater consistency in the RN-SN preceptor relationship; investing dedicated time for stakeholders to establish clear expectations on how they will work; closure of the feedback loop; and increased investment from organisations to protect time needed for this collaborative relationship. With improved collaboration bought about through these recommended changes in practice, it is anticipated that student nurses obtain a clinical learning experience that promotes the development of competency in their practice not only for today, but for future generations.

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Appendices

Appendix A: Ethics Approval

AUTEC Secretariat

Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

22 March 2018

Deb Spence
Faculty of Health and Environmental Sciences

Dear Deb

Ethics Application: 18/88 **Exploring the complexity of stakeholder relationships in clinical education for undergraduate nursing students**

I wish to advise you that the Auckland University of Technology Ethics Committee (AUTEC) has **approved** your ethics application at its meeting of 19 March 2018.

This approval is for three years, expiring 19 March 2021.

Non-Standard Conditions of Approval

1. The offer of counselling in the Information Sheets may be removed;
2. In the Information Sheet please explain that any identifiers will be removed from the transcripts before the research receives them for analysis. Also, please distinguish the return of transcripts for interviews from focus groups (since it is not ethical for a person to edit or confirm another's voice).

Non-standard conditions must be completed before commencing your study. Non-standard conditions do not need to be submitted to or reviewed by AUTEC before commencing your study.

Standard Conditions of Approval

1. A progress report is due annually on the anniversary of the approval date, using form EA2, which is available online through http://www.aut.ac.nz/researchethics.
2. A final report is due at the expiration of the approval period, or, upon completion of project, using form EA3, which is available online through http://www.aut.ac.nz/researchethics.
3. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form: http://www.aut.ac.nz/researchethics.
4. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
5. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.

Please quote the application number and title on all future correspondence related to this project.

AUTEC grants ethical approval only. If you require management approval for access for your research from another institution or organisation then you are responsible for obtaining it. You are reminded that it is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard.

For any enquiries please contact ethics@aut.ac.nz

Yours sincerely,

Kate O'Connor
Executive Manager
Auckland University of Technology Ethics Committee

Cc: cara.poffley@aut.ac.nz; andrea.gilkison@aut.ac.nz

Appendix B: ADHB Locality Agreement

Auckland DHB
Research Office
Level 14, Support Bldg
Auckland City Hospital
PB 92024, Grafton, Auckland
Phone: 64 9 307 4949 Extn. 23854
Fax: 64 9 307 8913
Email: mwoodnorth@adhb.govt.nz
Website:
http://www.adhb.health.nz/health-professionals/research/

Institutional Approval

2nd May 2018

Cara Poffley
School of Clinical Sciences
North Shore Campus
AUT

Dear Cara,

Re: Research project A+8062 Exploring the complexity of stakeholder relationships in clinical education for undergraduate nursing students.

The Auckland DHB Research Review Committee (ADHB-RRC) would like to thank you for the opportunity to review your study and has given approval for your research project. The term of this approval is one calendar year from the date of this letter. If you wish to extend the approval after that date contact the Research Office.

Your Institutional approval is dependent on the Research Office having up-to-date information and documentation relating to your research and being kept informed of any changes to your study. It is your responsibility to ensure you have kept Ethics and the Research Office up to date and have the appropriate approvals. ADHB approval may be withdrawn for your study if you do not keep the Research Office informed of the following:

- Any communication from Ethics Committees, including confirmation of annual ethics renewal
- Any amendment to study documentation
- Study completion, suspension or cancellation

More detailed information is included on the following page. If you have any questions please do not hesitate to contact the Research Office.

Yours sincerely

On behalf of the ADHB Research Review Committee Dr Mary-Anne Woodnorth
Manager, Research Office
ADHB
c.c. Linda Chalmers

...../continued next page

Appendix C: WDHB Locality Agreement

Application for Approval of Research

Waitemata District Health Board
Best Care for Everyone

RM14322 **Exploring the complexity of stakeholder relationships in clinical education for undergraduate nursing students**

WDHB Contact: Jacqui Finch — External C.I.: Cara Poffley, AUT University
Department: Director Nursing & Midwifery — **Short Title:**
Project Type: Observational research — **Ext Reference:**
Duration: 1/03/2019 - 30/09/2019

Description: This study aims to explore the collaboration that is happening between student nurses, registered nurses in clinical practice and academic clinical educators, to gain insight into the complexity of factors that enable and constrain stakeholder collaboration, ensuring that underlying assumptions are transparent. I plan to invite members of these three stakeholder groups to participate in focus groups and/or individual interviews, asking:
• How do the key stakeholders interact to support nursing students in the clinical setting?
• What values and beliefs underpin stakeholder collaboration and support of nursing students?
• What factors enable and constrain stakeholder collaboration?
• How does stakeholder collaboration affect nursing students' clinical learning?
• Who are the other stakeholders who support nursing students in this clinical setting?
Analysis of the data collected will be guided by the principles of complex adaptive systems (CAS) as outlined by Brand et al. (2015). This framework has nine principles that help to explain how complex systems operate. Initially the data will be analysed as it relates to each stakeholder group. Then I will look for aspects in the data that correlate or conflict between the groups. Themes or concepts that help to explain how stakeholders collaborate to support the development of clinical competence in undergraduate nursing students in the acute care setting will emerge.
Results from this study will be used to inform how stakeholder relationships will be facilitated with the aim of benefiting the nursing students' learning experience and development of clinical competence in the acute care setting. This, in turn, may benefit not only the graduating student nurse, but also the patients and teams that nursing graduate's work with in the future.

Locality Review

The undersigned agree to the following:

- The study protocol and methodology has merit.
- The local lead investigator is suitably qualified, experienced, registered and indemnified.
- Resources, facilities and staff are available to conduct this study, including access to interpreters if requested.
- Cultural consultations have occurred or will be undertaken as appropriate.
- Appropriate confidentiality provisions have been planned for.
- Appropriate arrangements are in place to notify other relevant local health or social care staff about the study, and for making available any extra support that might be required by participants.
- Conducting this study will have no adverse effect on the provision of publicly funded healthcare.
- There is a stated intent that the results of this study will be disseminated and where practical and appropriate the findings of the study will be translated into evidence based care.

Research & Knowledge Centre can assist in the determination of ethics approval requirements, budgets, contracts, funding applications and statistical consultations. Enquires to research@waitematadhb.govt.nz

Dept/Org	Role	Name (Print Clearly)	Signature	Date
Director Nursing & Midwifery	*Head of Division*	*Jocelyn Peach*		5/03/2019

Return completed form to the Research & Knowledge Centre. Alternatively, emails from approvers are acceptable as electronic sign-off.

Appendix D: Learning Hours in AUT BHSc Nursing Programme

Review of Theory, Clinical and Self-Directed Hours in the BHSc (Nursing) Programme at AUT as of August 2016

Paper	TTH Hours *	Clinical Hours	Self-directed Hours	Total Hours
HAP 1	66	0	84	150
KEC	30	0	120	150
H&E	42	0	108	150
LD&C	48	0	102	150
HAP 2	46	0	104	150
NURS501	90	56	154	300
NURS502	47	0	103	150
Pharmacology	44	0	106	150
NURS601	35	192	73	300
Maori Health	21	0	129	150
MoRE	24	0	126	150
NURS602	27	120	3	150
NURS603	50	160	90	300
Elective 1	Unknown	0	Unknown	Unknown
NURS701	57	200	43	300
NURS702	29.5	120	0.5	150
Elective 2	Unknown	0	Unknown	Unknown
NURS703	78.5	360	11.5	450
Total hours for Programme	**735**	**1208**	**1357**	**3300**

*TTH = Timetabled Teaching Hours

Appendix E: CAS Principle Framework Questions for Data Analysis

CAS Principles Questions (Developed 16/03/2019)

1. **Interrelatedness and distributed control:**
   - What is the quality of the interactions between stakeholders?
   - Is there evidence that stakeholders need each other?
   - Who has control and how is that control used?
2. **Order generating rules:**
   - What are the stakeholders: shared instincts?
values?
priorities?
Constructs & mental models?
Expectations/assumptions
   - Do these 'rules' enable or constrain collaboration between stakeholders?
   - How do these 'rules' influence collaboration/interactions between stakeholders?
3. **Edge of chaos:**
   - Are interactions between stakeholders: ordered or uncontrolled?
planned or reactionary?
co-incidental?
   - Is there evidence of adaption between stakeholders in relation to how they interact?
4. **Self-organisation: (Is this the outcome of CAS?)**
   - How do stakeholders interact currently?
   - Is there evidence of patterned behaviour? (Question added: 18/03/2019)
5. **Attractor patterns:**
   - Are there patterns of behaviour that are shaped by conditions within the environment?

   (Conditions can be physical environment, values/beliefs or order generating rules)
6. **Reinforcing feedback loops:**
   - Are there behaviours or factors that reinforce collaboration or lack of collaboration?
7. **Co-evolution of system and it's environment:**
   - Does the organisational environment support or block collaboration between stakeholders?
   - Does the physical environment support or block collaboration between stakeholders?
8. **Sensitivity to initial conditions:**
   - Do stakeholders respond to changing demands?
   - Is behaviour determined by interactions between stakeholders (past and present)?
9. **Creation of adjacent possibilities and awareness of path dependency:**
   - Are stakeholders trying out new/different ways of collaborating?
10. **OTHER:**
    - What else is happening in the data that doesn't fit within the 9 above principles of CAS?

Appendix F: Recruitment Poster

RESEARCH PARTICIPANTS WANTED

ARE YOU.....

... A STUDENT NURSE

... who is enrolled at an Auckland University and has completed or about to complete your second year acute hospital placement at ADHB?

... A REGISTERED NURSE

... who has worked with second year nursing students who have completed their acute hospital placement, in the past two years?

... AN ACADEMIC CLINICAL EDUCATOR ...

who has worked with second year nursing students who have completed their acute hospital placement, in the past two years?

AUT
TE WĀNANGA ARONUI O TĀMAKI MAKAU RAU

If you have answered 'yes' to any of these questions, then you are eligible to participate in this valuable research project:

'Exploring the complexity of stakeholder relationships in clinical education for undergraduate nursing students'

Key stakeholders are invited to participate in focus group discussions and individual interviews, exploring how stakeholders interact and the factors that enable and/or constrain stakeholder relationships, within the acute care setting for second year nursing students.

For further information, please contact:

Researcher: Cara Poffley
cara.poffley@aut.ac.nz
921 9999 ext 7137

Primary Supervisor: Deb Spence
deb.spence@aut.ac.nz
921 9392

Approved by the Auckland University of Technology Ethics Committee on *type the date final ethics approval was granted*, AUTEC Reference number *type the reference number*.

Appendix G: Participant Information Sheet

Participant Information Sheet

AUT
TE WĀNANGA ARONUI O TĀMAKI MAKAU RAU

Date Information Sheet Produced:

14 February 2018

Project Title

Exploring the complexity of stakeholder relationships in clinical education for undergraduate nursing students

An Invitation

Hello. My name is Cara Poffley and I am a Doctoral student at AUT University. I would like to invite you to participate in my research, which is exploring how stakeholders of clinical learning collaborate to support the development of clinical competency of undergraduate nursing students. Participation in this study is purely voluntary and you can withdraw from the study at any time.

What is the purpose of this research?

The purpose of this research is to make visible the collaboration that is currently happening, to gain an understanding of what this collaboration looks like. It will also highlight the complexity of factors that enable and constrain stakeholder collaboration. I am hoping that through gaining these insights and with further collaboration with stakeholders, we will be able to develop strategies to address limitations of collaboration so that we have more effective stakeholder relationships, ultimately improving the clinical learning experience for undergraduate nursing students.

How was I identified and why am I being invited to participate in this research?

I am looking for three different types of participants for this study:

1. Registered Nurses who have worked with second year nursing students in the acute care setting (medical and/or surgical wards) in the past two years,
2. Student Nurses who have completed their second year placement in the acute care setting (medical and/or surgical wards),
3. Academic Clinical Educators who are employed by one of the three Universities within the Auckland region that provide nursing education and whom have worked with second year student nurses and RNs in the acute care setting (medical and/or surgical wards) in the past two years.

How do I agree to participate in this research?

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible. You will be required to sign a consent form.

Support for participants who identify as Maori is available at ADHB and AUT. If you wish to contact someone for this support, please contact:

AUT: Debra Gerrard: debra.gerrard@aut.ac.nz, 921 9999 ext 7404

ADHB: Linda Chalmers: LChalmers@adhb.govt.nz, 307 4949 ext 29573

What will happen in this research?

There are two ways I will collect data from participants.

1. Focus groups consisting of 5-6 people within your same participant group. There will be two focus groups scheduled for each group and they will last approximately 2 hours. They will be held at a location that is convenient to the group and will be facilitated either by myself or a research assistant.
2. Individual interviews for participants who are unable to attend a focus group or would prefer to talk about this topic one-on-one. Interviews will be approximately 45 minutes to 1 hour long and they will be held at a location that is convenient to the participant. Individual interviews will be conducted by myself or a research assistant.

All data collection processes will include the recording of participants' perspectives, which will then be transcribed by a professional transcriber, who will have signed a confidentiality agreement.

What are the discomforts and risks?

There will not be any physical discomforts or risks associated with participation in this study. I recognise that some participants may have an existing working relationship with me which poses a potential conflict of interest.

How will these discomforts and risks be alleviated?

Participants with whom I have a pre-existing working relationship (e.g: AUT Clinical Educators and Students) can contact my supervisor (Deb Spence) to arrange participation in a focus group or interview facilitated by a research assistant.

What are the benefits?

You will be supporting me in obtaining my doctoral qualification, but you will also be helping to identify how stakeholders collaborate to support nursing students to develop clinical competence. This will have a positive impact on how stakeholders work together in the future to provide positive learning experiences for students. This in turn will not only benefit the graduating nurse, but also the patients and teams that nursing graduate's work with in the future.

How will my privacy be protected?

To promote anonymity of participants whom may have an existing relationship with me, I have nominated my primary supervisor (Deb Spence) to act as the contact person for you. They will arrange for you to participate in a focus group that is facilitated by a research assistant and the recording of the discussion will be transcribed by a professional transcriber. At no time will I be aware that you are participating.

To promote confidentiality, identifiers will be removed from the transcripts before they are returned to me for analysis. Real names or identifiers will not be used in any final publications such as the thesis or academic articles, which share findings.

What are the costs of participating in this research?

While there is no financial costs to participating, there is the cost of your time. Focus groups may last for up to 2 hours, and individual interviews will last for approximately 45 minutes to 1 hour.

What opportunity do I have to consider this invitation?

I would like to run focus groups and hold individual interviews during 2018 - 2019. I will need to know your intention to participate so that I can set up a time to meet.

Will I receive feedback on the results of this research?

Results of this research will be made available through the publication of my thesis and articles in professional journals. I will also provide a 1-2 page summary of the findings to participants who indicate that they would like this on their consent forms.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Deb Spence, deb.spence@aut.ac.nz, 921 9999 ext 9392.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, ethics@aut.ac.nz, 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Cara Poffley, cara.poffley@aut.ac.nz, 921 9999 ext 7137.

Project Supervisor Contact Details:

Primary Supervisor: Deb Spence, deb.spence@aut.ac.nz, 921 9999 ext 9392.

Secondary Supervisor: Andrea Gilkison, andrea.gilkison@aut.ac.nz, 921 9999 ext 7720.

Approved by the Auckland University of Technology Ethics Committee on *type the date final ethics approval was granted*, AUTEC Reference number *type the reference number*.

Appendix H: Consent Forms

Focus Group Consent Form

Project title: ***Exploring the complexity of stakeholder relationships in clinical education for undergraduate nursing students***

Project Supervisor: ***Deb Spence***

Researcher: ***Cara Poffley***

- O I have read and understood the information provided about this research project in the Information Sheet dated dd mmmm yyyy.
- O I have had an opportunity to ask questions and to have them answered.
- O I understand that identity of my fellow participants and our discussions in the focus group is confidential to the group and I agree to keep this information confidential.
- O I understand that notes will be taken during the focus group and that it will also be audio-taped and transcribed.
- O I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- O I understand that if I withdraw from the study then, while it may not be possible to destroy all records of the focus group discussion of which I was part, I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- O I agree to take part in this research.
- O I am happy to be invited to participate in a follow up individual interview, should the researcher require further participation from me (please tick one): YesO NoO
- O I wish to receive a summary of the research findings (please tick one): YesO NoO

Participant's signature: .....

Participant's name: .....

Participant's Contact Details (if appropriate):

.....

.....

.....

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on type the date on which the final approval was granted AUTEC Reference number type the AUTEC reference number

Note: The Participant should retain a copy of this form.

Interview Consent Form

Project title: ***Exploring the complexity of stakeholder relationships in clinical education for undergraduate nursing students***

Project Supervisor: ***Deb Spence***

Researcher: ***Cara Poffley***

- ○ I have read and understood the information provided about this research project in the Information Sheet dated 14 February 2018.
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- ○ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- ○ I agree to take part in this research.
- ○ I wish to receive a summary of the research findings (please tick one): Yes○ No○

Participant's signature: .....

Participant's name: .....

Participant's Contact Details (if appropriate):

.....

.....

.....

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on type the date on which the final approval was granted AUTEC Reference number type the AUTEC reference number

Note: The Participant should retain a copy of this form.

Appendix I: Timeline of Data Collection

Timeline of data collection

Date	Focus group or interview	Participant group	Number of participants
29.06.2018	Focus group 1	CE's (CE01, CE02, CE04)	3
30.07.2018	Focus group 2	CE's (CE03, CE05, CE06, CE07)	4
11.08.2018	Individual interview	SN (SN01)	1
14.08.2018	Individual interview	SN (SN02)	1
14.08.2018	Individual interview	CE (CE08)	1
24.08.2018	Individual interview	SN (SN03)	1
04.09.2018	Individual interview	SN (SN04)	1
26.11.2018	Individual interview	CE (CE09)	1
15.03.2019	Individual interview	RN (RN01)	1
06.05.2019	Individual Interview	RN (RN02)	1
17.07.2019	Focus group 3	SN's (SN05, SN06, SN07, SN08)	4
24.07.2019	Paired Interview	SN's (SN09 & SN10)	2
24.07.2019	Individual Interview	SN (SN11)	1
11.09.2019	Individual Interview	RN (RN03)	1
14.03.2020	Individual Interview	RN (RN04)	1
07.05.2020	Individual Interview (Zoom)	RN (RN06)	1
08.05.2020	Individual Interview (Zoom)	RN (RN05)	1
11.05.2020	Individual Interview (Zoom)	RN (RN07)	1
TOTAL			**27**

Appendix J: Demographic Data of Participants

Demographic data of participants

Participant	Age	Gender	Ethnicity	Current role	How long in role	Year of study
CE01	26-30	F	Nepalese	RN & CE	15 months	N/A
CE02	41-45	F	NZ European	CE	16 months	N/A
CE03	36-40	F	NZ European	RN & CE	1.5 years	N/A
CE04	36-40	F	Indian American	CE	3 years	N/A
CE05	36-40	F	Caucasian	RN & CE	5 months	N/A
CE06	61-65	F	NZ European	CE	20 years	N/A
CE07	51-55	F	African	CE	1 year 5 months	N/A
CE08	51-55	F	NZ European NZ	RN & CE	15 years	N/A
CE09	51-55	F	European/Pacifica	CE	2 years	N/A
SN01	26-30	F	NZ European	SN	N/A	year 3
SN02	20-25	F	NZ European	SN	N/A	year 3
SN03	26-30	F	NZ European	SN	N/A	year 2
SN04	26-30	F	NZ European Māori/NZ	SN	N/A	year 2
SN05	41-45	F	European	SN	N/A	year 2
SN06	20-25	F	Māori	SN	N/A	year 2
SN07	20-25	F	NZ European	SN	N/A	year 2
SN08	26-30	F	Māori	SN	N/A	year 2
SN09	26-30	F	NZ European	SN	N/A	year 2
SN10	20-25	F	NZ European	SN	N/A	year 2
SN11	26-30	F	Pacifica Malaysian	SN	N/A	year 2
RN01	36-40	F	Chinese	RN	9 years	N/A
RN02	51-55	F	NZ European	RN	10 years	N/A
RN03	20-25	M	NZ European	RN	2.5 years	N/A
RN04	31-35	F	Filipino	RN	1.5 years	N/A
RN05	20-25	F	NZ European	RN	3 years	N/A
RN06	26-30	F	NZ European	RN	5 years	N/A
RN07	26-30	F	NZ European	RN	6.5 years	N/A

Appendix K: Responses to Question One: Stakeholders Involved in Supporting Student Nurses in Clinical Practice

CE participants	Student participants	RN participants
CEFG1: Preceptors (Most often) CNMs CNS CNE Physio Social workers (not often) HCA (not often) Drs Patients Students (After-though with prompting required) **CEFG2:** Charge nurse (most often) Preceptors (Somewhat mostly) Students Nurse Educators (most often) Patients CNS Physios House surgeons (Drs) Relatives/Whanau Chaplains The guy who makes coffee. Social workers Extra health care team Interdisciplinary team Public health nurse in the community Other CEs Kitchen staff Ward Clerks **CE08:** Charge Nurse Preceptors Any nurse on the ward (Depends on what the students wanting, what year the student is in) Hook into networks that I have Doctors -but not many, mainly house officers Physio OT Orderlies **CE09:** Charge nurses Clinical nurse educators (Depends on which wards I have been to before and if I have new wards) 'Senior staff' Students Preceptors (usually students first) Doctors Physiotherapists	**SN01:** The multidisciplinary team, Mainly Nurses Other students Doctors Physio OT University teachers Admin staff (ward clerk) **SN02:** 'Everyone' Cleaner Preceptor Ward clerk **SN03:** CE (mostly) Classmates Friends and family (mum's an RN) RNs (required prompting) **SN04:** CE The nurses HCAs Doctors MDT team including physio's, OTs. Cleaners The people that deliver food The patients Patients families See the CNM every now and then The ward clerks Other nursing students (late add) **SNFG1:** CE Students in the Whanau Room Previous students Preceptor Fellow Students "My partner" My sister RNs Physio RN & CE (with prompting for SN08) **SN09 & SN10:** Preceptor – RN Nurse educator from the ward Charge nurse (once in a blue moon) Clinical educator (not much) Other students **SN11:** Friends in the same cohort The library RN's (with prompting) CE (with prompting)	**RN01:** 2nd & 3rd year students Clinical tutor Charge nurse Own nurse educator (if issues) **RN02:** Admin staff from universities Clinical Tutors Students RN preceptors **RN03:** Students Clinical tutors Colleagues/staff CNM (with prompting) **RN04:** Other RNs/colleagues Clinical educator CNM Students (with prompting) **RN05:** CE Preceptors Charge nurse Ward senior co-ordinator Students (with prompting) **RN06:** Students CNM CE's (less frequently) **RN07:** Senior nursing colleagues Clinical ward nurse educator Teaching assistants Students (with prompting)

Appendix L: Example of Phase One of Data Analysis

Data from Q3: Can you think back to a time that an interaction went really well?

Pg 10-11: SN05, SN07

SN05: "For me there was an experience where I was thrown in the deep end, I kind of thrived in it because it was hands on and that's obviously where my strengths are rather than the, I suck at patho! A patient was going to be leaving so he needed a pic line removed and the charge nurse just turned to me and said, "you can do that SN05." And I was just like, "okay," and the nurse I had was a recent graduate, she was like, "I actually haven't done one of these, let's go look it up." So we looked it up together but because she'd been there a year and a half, so you know not new-new, she's like, "yeah you can do this, I'll just talk you through it." So, they used new pic lines, the locks are different and all sorts of things, but because my nurse had said, "I don't know either but let's look it up and I'll talk you through it you can do it," didn't feel nervous at all. In fact, at the time, pulling out the pic line I'm like, oh boy this is cool, I actually loved it. So that was neat but it took that charge nurse to throw me in the deep end because my nurse wouldn't, I don't think she would have, it wouldn't have even come across her register to let me do it because she hadn't even done it, right? So, then a couple of weeks later, another pic line needed to be removed. A nurse who'd been there for a long time was like, "I don't know how to do this" and my RN said, "SN05 can do it" and so I just was able to step in and teach about five people around there."
SN07: "Oh, that's so cool."
SN05: "And I talked her though it, I didn't take over because obviously, but talked her through it and that RN, who I'd always kind of felt was a little bit 'too cool for school' up until that point but, I hadn't really had to work with her so it hadn't been an issue for me actually, turned around and said, "wow, thanks." So, it just broke down a barrier, it was really cool."
CP: "You disrupted the hierarchy!"
SN05: "Yeah but they didn't mind which was really nice, but that could have also been the way I approached it. I didn't march in and [go] "get out of the way." I just said, "this is how I did it." That was probably one of my most positive experiences because I had all this other stuff where I felt like I was failing miserably so that was quite nice."

Interpretation: There is evidence in this data that the charge nurse took a key collaborative role in providing access to a learning opportunity for the student, highlighting interrelatedness and distributed control, as the student needed the CNM to identify this as a learning opportunity and gave permission for the student to take control in this situation. While the student had never done this particular task before, neither had the RN, possibly due to their somewhat reduced length of service, or also possibly due to the pace at which practice changes, as many of the more experienced RNs had also no completed this task of removing a PICC line before, highlighting the nature of the organisational environment as one that experiences changes. The quality of this situation was enhanced by the RN role

modelling that it is ok to not know everything and how to look up protocols when faced with a new task or skill to complete. The student needed the RN to take this approach in the situation as it gave the student the confidence to proceed with this learning, along with the verbal reassurance that was provided.

Interestingly, SN05 uses the phrase 'thrown in the deep end' which reflects edge of chaos, as no-one knew what they were doing. The student and RN adapted in the moment, reacting to the guidance and direction from the CNM that the student could do this. The message here for the student was that the CNM and now the RN believed in them, a construct that reflected an order generating rule for how the RN and student proceeded in their collaboration. While this resulted in a successful learning experience for the student, it also did not end once the PICC line was removed. Rather, a reinforcing feedback loop was created when the student was later identified as someone who could teach more experienced RNs how to remove a PICC line in another patient, reflected in the behaviour of the RN identifying SN05 as a resource for this teaching, while at the same time reinforcing this learning for SN05.

An attractor pattern of changes in clinical practice is also evident in this data. These changes mean that even the most experienced nurses are always learning, possibly challenging the assumption that only experienced nurses can be in positions to support students with their own learning. Not only was it a relatively junior nurse who supported the student through this new skill, but the roles were completely reversed when the student became the teacher, when the student supported the more experienced RN to learn this new skill (NEW FINDING).

This is also a great example of how students learning through experience, through doing the skill or task for themselves, highlighting the construct/value of experiential learning as an order generating rule that influenced how the CNM, the RN and the student collaborated in this situation. While the student may have still learnt something by watching the RN complete the task themselves for the first time, there was a greater level of learning for the student by enabling them to complete it themselves, resulting in greater levels of competence in the students practice (NEW FINDING). Furthermore, the development of confidence and competence, constructs that reflect order generating rules, resulted in the student collaborating with other RNs whom they may have otherwise not have engaged with, as the student stated, 'barriers were broken down'. The barrier in this situation was

the impression that the RN gave the student that they were better or more important than the student, which stopped the student from wanting to engage with them.

Appendix M: Example of Phase Two of Data Analysis

SNFG1: Data Analysis: Phase 2 (Completed October 2020)

CAS Principle: Order generating rules

a) Order generating rule* (Also denotes 'rules'): 19 times from SNFG1

1. Furthermore, this may highlight divergent order generating rules that guide stakeholder interactions
2. Therefore, the behaviour of the RN, which was likely driven by order generating rules that suggested that they valued the learning of the student and perhaps even the growth of future nursing professionals, enabled the student to trust the actions and teaching of the RN
3. SN05 depicts how scared students can be as they engage learning in the clinical setting, a construct that reflects an order generating rule that influences how students behave in clinical
4. Perhaps being relatively new to the ward meant that this RN understood and appreciated the learning opportunities that were available to them and students, which would suggest that they had a shared instinct of learning, highlighting an order generating rule that guided how they collaborated
5. The message here for the student was that the CNM and now the RN believed in them, a construct that reflected an order generating rule for how the RN and student proceeded in their collaboration
6. This is also a great example of how students learning through experience, through doing the skill or task for themselves, highlighting the construct/value of experiential learning as an order generating rule that influenced how the CNM, the RN and the student collaborated in this situation
7. Furthermore, the development of confidence and competence, constructs that reflect order generating rules, resulted in the student collaborating with other RNs whom they may have otherwise not have engaged with, as the student stated, 'barriers were broken down'
8. The quality of this interaction was one of 'getting to know other' which challenged the assumptions that the student had made about the RN, reflecting order generating rules
9. The construct of confidence reflects an order generating rule that influenced how the student interacted with other stakeholders, including the patients
10. Once again we see evidence that RNs value completion of tasks, reflecting an order generating rule that guides how the RNs interact with the students
11. It would appear that SN07 was aware of what was expected of them as a student working in this organisational environment, they were aware of the order generating rules that guided how they were to behave
12. These values, which reflect order generating rules for SN07, enabled greater collaboration with the patient and their family, as they developed trust in the student which created learning opportunities for the student which may not have occurred if the student did not go above and beyond what was expected of them by staff

13. There is also a refocusing of expectations and priorities, reflecting order generating rules for the students
14. The 'grilling' that SN05 refers to suggests that the value of the CE is the thinking aspects of nursing practice, highlighting divergent order generating rules that pull students into different directions with regards to meeting expectations
15. Once again there is evidence here that there are clearly different expectations between the CE and the RN, highlighting divergent order generating rules for how each stakeholder would work with the student
16. This highlights that the student perceives that the needs of the students is not the priority in clinical for the other two stakeholders, which reflects an order generating rule (priority)
17. This outcome seems to be in stark contrast to the intentions of the CEs, which is to create the best nurse possible in each student, suggesting that while the order generating rules of the CEs are coming from a positive place, their approach or their behaviour during interactions does not align with this intention
18. This highlights interrelatedness and distributed control and order generating rules, in that the quality of the interaction did not meet the students expectations of the CE
19. Once again, there is evidence here that the students value clear expectations and guidance of what they need to do to be successful in clinical practice, highlighting an order generating rule

The following key terms, taken from the above data and CAS guiding questions, were used to identify the order generating rules that were identified in phase 1 of the data analysis. These are the 'rules' that guide how the CEs interact with the other stakeholders.

b) Shared instinct*: 3 times from SNFG1

1. Rather, they demonstrated an ability to cope with both those pressures and the demands of working with a student, utilising times of stress as teachable moments for the student. Perhaps being relatively new to the ward meant that this RN understood and appreciated the learning opportunities that were available to them and students, which would suggest that they had a shared instinct of learning, highlighting an order generating rule that guided how they collaborated
2. Recognising that not all RNs value or appreciate the contribution students can make to patient care, the student took the opportunity to talk with the nurse specialist alone – an RN whom they assumed/presumed they had a shared instinct with, which was everyone wanting what is best for the patient
3. This highlights an attractor pattern for the RN that SN08 worked with, which was a knowing expectations that enabled them to behave in a particular way, established through shared instincts between the CE and RN

c) Valu*: (Denotes: 'value', 'values', 'valued, and 'valuing'): 69 times from SNFG1 – 10 times used multiple times within same sentence + 2 times from research question + 2 times from textbox raw data = [69–14=55]

1. Therefore, the behaviour of the RN, which was likely driven by order generating rules that suggested that they valued the learning of the student and perhaps even the growth of future nursing professionals, enabled the student to trust the actions and teaching of the RN
2. SN07 also recognises the benefit of being in clinical enables more hands-on practical learning, which they understand is the most effective method of learning for them, highlighting the value of the hands-on learning
3. This is also a great example of how students learning through experience, through doing the skill or task for themselves, highlighting the construct/value of experiential learning as an order generating rule that influenced how the CNM, the RN and the student collaborated in this situation
4. This behaviour may be supported by the values of the RN, their desire to support students and to support the development of the profession, possibly even the specific development of Maori nurses given that SN08 identifies as Maori
5. With SN05 acknowledging the task orientated nature of the RNs reflected that RNs valued and prioritised students completing tasks
6. Once again we see evidence that RNs value completion of tasks, reflecting an order generating rule that guides how the RNs interact with the students
7. Yet, they also demonstrated that they have insight into the priorities of the ward and recognised that they perhaps don't align with their own values and priorities, when it comes to patient care
8. SN07's values of treating patients with the best care that they can provide, caring for the person and developing a student nurse-patient relationship, gave them the confidence to go 'against the grain' of being task focused
9. They also recognised and valued the time it takes to care for patients, that communicating effectively takes times
10. These values, which reflect order generating rules for SN07, enabled greater collaboration with the patient and their family, as they developed trust in the student which created learning opportunities for the student which may not have occurred if the student did not go above and beyond what was expected of them by staff
11. The students behaviours are reflective of their past experience, and the values and knowledge (a construct) that underpins their practice in the other setting
12. The student recognises these values and knowledge are transferable into this new, more complex and busy setting and in some sense gave SN05 the confidence to collaborate in the way they did
13. Recognising that not all RNs value or appreciate the contribution students can make to patient care, the student took the opportunity to talk with the nurse specialist alone – an RN whom they assumed/presumed they had a shared instinct with, which was everyone wanting what is best for the patient
14. Furthermore, SN05 identifies this lower standard of work as the culture of the environment, suggesting that it is not only accepted, but is formed by the values and beliefs of the stakeholders who work in that environment

Cara Poffley
Not included in phase three as seems to be more of a reflective statement about values of the RN rather than the student.
Reply

Cara Poffley
As above. Not included.
Reply

Cara Poffley
As above.
Reply

Cara Poffley
Not included
Reply

Cara Poffley
Not included.
Reply

Cara Poffley
Not included in phase three as it is a reflective comment about values rather than a specific value of the student
Reply

Cara Poffley
As above
Reply

15. Once again we see recognition that the dominant culture of the ward is one where being efficient and getting things done is what is valued in the organisational environment
16. This would suggest that to pass, the pre-reg student has to demonstrate similar values of the RNs whom they work with, reflecting a level of acculturation into the dominant culture of the ward, rather than develop practice and interactions that are built on their own values; or conversely, highlighted their priority of passing exceeded their values
17. Talking negatively about their interaction with a senior student it was important for the students to not 'throw the student under the bus' reflecting that they value their interactions with this student as there was still learning in this interaction for them
18. The first is that it reflects the values of fairness/equity along with a further value of authentic/genuine assessment
19. When students witness behaviour of other students as not reflecting these values, this impacts the potential for a collaborative relationship with each other, as the quality of the interaction hinders the development of trust and respect for the student who is not demonstrating the expected behaviours that reflect these values
20. There is also a suggestion here that for the student sitting down preparing for the CEs visit, that they valued being prepared for the CE visit, which was supported by the participants in this study, however, they were not all given the same opportunity to prepare, which had the potential to reflect badly on the students who did not take time out to prepare
21. This further highlighted that the CEs are likely to value students who are prepared for their visit, rather than students who are capable and functioning in practice, which suggests that a lot of nursing practice that the students carry out becomes invisible to the CE
22. Once again, we also see the perception of the value of doing nursing practice, over the thinking aspects of nursing practice, which is a perceived value of the stakeholders with greater power, that influences how students think they should behave in clinical
23. There is an acknowledgement that when a CE visits a student in clinical, they only get to see a fraction of what the student can do in practice, which is problematic if the doing aspects of practice reflect the students strengths, and is somewhat contradictory if the doing aspects of practice are what are valued most by the RNs
24. The 'grilling' that SN05 refers to suggests that the value of the CE is the thinking aspects of nursing practice, highlighting divergent order generating rules that pull students into different directions with regards to meeting expectations
25. Ultimately nursing practice requires both thinking and doing, therefore both of these elements are being considered, however, the suggestion here might be that the thinking element is valued more in the assessment process, compared to the doing aspects of practice
26. From this data it would appear that the students value a more balanced approach to assessment, where both thinking and doing are assessed equally

Cara Poffley
As above
Reply

Cara Poffley
As above
Reply

Cara Poffley
Interpreted as the student's value of 'making practice visible'
Reply

Cara Poffley
Interpreted as the student's value of 'making practice visible'
Reply

Cara Poffley
Not included as seems to read as a reflective statement about values
Reply

Appendix N: Key Terms Used for Data Analysis Phase Two

CAS Principles Key Terms: Phase 2

1. **Interrelatedness and distributed control**
   a. Interrelatedness
   b. Distributed control/distributing control/control being distributed

   *The following terms come from the data above in 1a & 1b and **CAS principle framework questions** developed for phase 1 analysis*
   c. **Quality**
   d. **Need*** (also denotes: needs, needed and needing)
   e. **Control*** (also denotes: controlled, controls and uncontrolled)
   f. Relationship* (also denotes: relationships)
   g. Connect* (also denotes: connects, connected, connecting and connection)
   h. Shar* (denotes: share, sharing and shared)
   i. Together
   j. Reli*/Rely (denotes: relied, reliant and reliance)
   k. Benefi* (denotes: benefit, benefits and beneficial)
   l. Engag* (denotes: engage, engaged, engagement and disengaged)
   m. Between
   n. Support* (also denotes: supported, supporting, supports, supportive and unsupportive)
   o. Contribut* (denotes: contribute, contributes, contributing and contribution)
   p. Work with
   q. Participation
   r. Boundaries
   s. Buy in & Willing
   t. Accountable
   u. Responsib* (denotes: responsible, responsibility and responsibilities)
   v. Visible* (also denotes: invisible)

2. **Order generating rules**
   a. Order generating rule*

   *The following terms come from the data above in 2a and **CAS principle framework questions** developed for phase 1 analysis*
   b. **Shared Instincts**
   c. **Valu*** (denotes: value, values and valuing)
   d. **Prior*** (also denotes: priority, prioritise and priorities)
   e. **Construct*** (also denotes: constructed and construction)
   f. **Mental model**
   g. **Expect*** (also denotes: expected and expecting)
   h. **Assum*** (denotes: assume, assumed, assumption and assuming)
   i. **Enable**
   j. **Constrain*** (also denotes: constrained and constraining)
   k. **Influence**
   l. Belie* (denotes: belief, believe, believes and believing)

NOTE: This principle also considers what enables and constrains change – this can be found in other principles, such as attractor patterns, co-evolution of system and its environment, and sensitivity to initial conditions.

3. **Edge of chaos**
    a. Edge of chaos

    *The following terms come from the data above in 3a and **CAS principle framework questions** developed for phase 1 analysis*
    b. **Ordered**
    c. **Uncontrolled**
    d. **Planned**
    e. **React*** (also denotes: reacted and reaction)
    f. **Co-incidental**
    g. **Adapt*** (also denotes: adapted, adapting and adaption)
    h. Chaotic
    i. Risk* (also denotes: risky and risks)
    j. Tim* (denotes: time and timing)
    k. Structure* (also denotes: structures and structured)
    l. Improve
    m. Flexible
    n. Alternative
    o. Operat* (denotes: operate, operated and operating)

4. **Self-organisation**
    a. Self-organisation
    b. Self-org*

    *The following terms come from the data above in 4a & 4b and **CAS principle framework questions** developed for phase 1 analysis*
    c. **Interact*** (also denotes: interacts, interacted and interacting)
    d. **Pattern*** (also denotes: patterns and patterned)
    e. Negotiat* (denotes: negotiate, negotiates, negotiated and negotiating)
    f. Conversa* (denotes: conversation and conversations)
    g. Contact* (also denotes: contacted)
    h. Connect* (also denotes: connects, connected and connecting)
    i. Manag* (denotes: manage and managing)
    j. Collab* (denotes: collaborate, collaborates, collaboration, collaborative and collaborating)
    k. Effort
    l. Contrib* (denotes: contribute, contributed, contributing and contribution)
    m. Protect* (also denotes: protects, protected, protecting and protection)
    n. Buffer
    o. Role
    p. Power

5. **Attractor patterns**
   a. Attractor pattern*

   *The following terms come from the data above in 5a and **CAS principle framework questions** developed for phase 1 analysis*

   b. **Behav*** (also denotes: behaviour, behaved & behaving)
   c. **Shape**
   d. **Condition*** (also denotes: conditions)
   e. **Environment*** (also denotes: environments & environmental)
   f. **Physical**
   g. Relationship
   h. Trust
   i. Time
   j. Staffing levels
   k. Experience *(as in level of experience)*
      NOTE: Clinical learning experience was excluded here, but it will be noted that clinical learning experience is central to the collaboration within stakeholder relationships, therefore should not be forgotten or lost – was it covered elsewhere?
   l. Confidence
   m. Busyness

6. **Reinforcing feedback loops**
   a. Reinforcing feedback loop*

   *The following terms come from the data above in 6a and **CAS principle framework questions** developed for phase 1 analysis*
   b. **Behav*** (denotes: behave, behaves, behaved, behaving and behaviour)
   c. **Factor*** (also denotes: factors)
   d. **Reinforc*** (denotes: reinforce, reinforced and reinforces)
   e. **Lack*** (also denotes: lacking and lacked)
   f. **Collaboration**
   g. Consisten* (denotes: consistent and consistency)
   h. Develop* (also denotes: develops, developed and developing)
   i. Time: *analysed in 'attractor patterns', so will not be repeated here*

7. **Co-evolution of system and its environment**
   a. Co-evolution of system and its environment
   b. Environment* (also denotes: environments)

   *The following terms come from the data above in 7a & 7b and **CAS principle framework questions** developed for phase 1 analysis*
   c. **Organ*** (denotes: organisation and organisational)
   d. **Support**
   e. **Block**
   f. Barrier
   g. Prevent* (also denotes: prevents and preventing)

h. Enable* (also denotes: enables and enabled)
i. Ward
j. Cultur* (denotes: culture and cultural)
k. Emotion
l. Clinic* (denotes: clinical and clinically)
m. Setting
n. Level
o. Convers* (denotes: converse, converses, conversing, conversation and conversations)
p. Challeng* (denotes: challenge, challenged, challenges and challenging)
q. Casual
r. Random
s. Formal
t. Leader* (also denotes: leaders and leadership)
u. Condition
v. Design* (also denotes: designed)

8. **Sensitivity to initial conditions**
   a. Sensitivity to initial conditions
   b. Sensitive

*The following terms come from the data above in 8a & 8b and **CAS principle framework questions** developed for phase 1 analysis*

c. **Respond*** (also denotes: responds, responded and responding)
d. **Change*** (also denotes: changes, changed and changing)
e. **Demand*** (also denotes: demands, demands and demanding)
f. Behav* - *analysed in 'reinforcing feedback loops', so won't be repeated here*
g. **Past**
h. **Present**
i. Staffing levels - *analysed in 'attractor patterns', so won't be repeated here*
j. Time - *analysed in 'attractor patterns', so won't be repeated here*
k. Situation
l. Choose
m. Opportun* (denotes: opportunity and opportunities)
n. Previous* (also denotes: previously)
o. Prior: Not to be confused with 'priority' as analysed in order generating rules
p. Recogni* (denotes: recognise, recognised and recognition)
q. Aware* (also denotes: awareness)
r. Could be
s. Busy - *analysed in 'attractor patterns', so won't be repeated here*
t. Lack of

9. **Creation of adjacent possibilities and awareness of path dependency**
    a. Creation of adjacent possibilities (including full term)
    b. Awareness of path dependency (not including full term)

    *The following terms come from the data above in 9a & 9b and **CAS principle framework questions** developed for phase 1 analysis*
    c. **Try*** (also denotes: trying)
    d. **New**
    e. **Differ*** (denotes: different and difference)
    f. **Way*** (also denotes: ways)
    g. Change: *analysed in 'sensitivity to initial conditions', so won't be repeated here*
    h. Effective* (also denotes: effectively and effectiveness)
    i. Alternat* (denotes: alternate and alternative)
    j. Create* (also denotes: creates and created)
    k. Might
    l. Desire
    m. Future
    n. Need
    o. Develop*: *analysed in 'reinforcing feedback loop', so won't be repeated here*

10. **OTHER**
    This selection relates to findings that do not fit within the other 9 CAS principles. I have only used one search term for this, as I identified what could be considered NEW FINDINGS as I processed phase 1 of data analysis.
    a. New Findings

    I have also decided to use this section to capture data analysis as it relates to other aspects of my research question that are not captured by the CAS principle framework. The following terms were analysed in full:
    b. **Clinical competency**
    c. **Competence**
    d. **Incompetent**
    e. **Clinical learning**
    f. **Learning**
    g. **Learn**

Appendix O: Example of Phase Three of Data Analysis

Phase three analysis: Order generating rules	Phase three analysis enabled me to focus on elements within each CAS principle, to draw out what was common/shared, or what was unique. At times, further analysis of phase two analysis helped to understand the data findings to a deeper level, bringing together findings that may have been assigned to other CAS principle or element within the same CAS principle. From here, 'findings' have been written up, where clusters of data that align have been put together *in a way to make sense of the data.*	
VALUES: 1st identify data from phase 2 for each participant in each cohort		
CE cohort	**SN cohort**	**RN cohort**
Contribution of various stakeholders (including patients/other HCPs) (CEFG1, CE09 x2)	Uncritical presence of others, creating a safe environment to 'have a go' at something new (SN01) understanding	Giving feedback that promotes student development/competency (RN01, RN03 x2, RN05 & CNM)
Honest, detailed, valid and robust feedback from clincial staff (CEFG1 x3, CEFG2 x4, CE08 x4) who	Being given space to learn (SN01)	Estabishing boundaries to the students practice to ensure safety in practice (RN01)
Transparency in the dialogue between	Being supported (SN01)	Privacy when giving feedback (RN01)
Trust in the relationship between stakeholders	Developing confidence by having a go (SN01)	Individuality of people (RN01)
A professional relationship (CEFG1, CEFG2)	Experiential learning (SN01, SNFG1) 'hands-on' learning	Teaching the next generation of nurses (RN01)
Engagement of clinical staff/RNs working with students (CEFG1, CEFG2) for the entire shift (CE08)	Relationships built on friendliness and being approachable (SN01) Good relationships with	Safety for self and patient (RN01 x3, RN03 x2, RN04) in nursing practice (RN07 x2)
Feedback about all students, not just those who are failing or excelling	Professionalism (SN01)	Time it takes to teach (RN01 x2, RN04, RN05) and learn (RN06 x2) to support students (RN07)
The investment of time/engagement from clinical staff, including the	Engagement in learning, rather than the outcome of learning itself (SN01)	Timely feedback to the student (RN01, RN05)
Knowledge aquistition and application, applying theory to practice (CEFG1	Experience and knowledge of others (SN02)	Consistency and transparency of expectations between stakeholders (RN01 x2, RN05)
Students identifying their own learning strategies	Being known by the CE (SN02, SNFG1)	Fairness for students (RN01)
Conversations with students about their	Open communication lines (SN02, SN04)	Knowledge of the patient (RN01)
Students insight into their own abilities in clincial (CEFG1)	Constructive feedback about their practice (SN02) from the RN (SN03) from others	Honesty of own limitations, for self and others (RN01, RN03, RN07) this relates to it being ok
Validation of the assessment process	Relationships with other stakeholders and being liked	Trust in others (RN01, RN03 x3) and that others trust them

Appendix P: Photos of Phase Three of Data Analysis, Thematic Analysis in Process