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Best practice in clinical facilitation of undergraduate nursing students

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ABSTRACT

Clinical facilitation is critical to successful student clinical experience. The research reported in this paper used an interpretive case study to explore perspectives of clinical facilitators on what constitutes best practice in clinical facilitation of undergraduate nursing students.

Eleven clinical facilitators from South East Queensland, Australia, participated in focus groups, interviews and a concept mapping exercise to gather their perspectives on best practice. The data gathered information regarding their prior and current experiences as registered nurses and facilitators, considering reasons they became clinical facilitators, their educational background and self-perceived adequacy of their knowledge for clinical facilitation. Analysis was through constant comparison.

Findings of the study provided in-depth insight into the role of clinical facilitators, with best practice conceptualised via three main themes; 'assessing', 'learning to facilitate' and 'facilitating effectively'. While they felt there was some autonomy in the role, the clinical facilitators sought a closer liaison with academic staff and feedback about their performance, in particular their assessment of the students. Key strategies identified for improving best practice included educational support for the clinical facilitators, networking, and mentoring from more experienced clinical facilitators. When implemented, these strategies will help develop the clinical facilitators' skills and ensure quality clinical experiences for undergraduate nursing students.

1. Introduction

In clinical practice nursing student learning is supported by experienced registered nurses who are variously called clinical facilitators, clinical supervisors or clinical teachers. In the context of the study reported here the term clinical facilitator is used to reflect this student support role. This role is distinctive from mentoring which can be undertaken by anyone in the students' learning environment, whether in the clinical or the academic setting.

As a practice-based discipline the quality of clinical facilitation of nursing students is critical to their success in both education and practice. Supporting student learning in the academic environment with effective clinical facilitation is integral to their ability to consolidate and translate theoretical components of their program to practice (Courtney-Pratt et al., 2012; Levett-Jones and Bourgeois, 2011), yet the evidence base for this type of support is as yet undeveloped. Little is known of what constitutes quality in clinical supervision, as there are no reports in the scholarly literature describing best practice in clinical facilitation. The study reported here explored best-practice in clinical facilitation from the perspectives of clinical facilitators themselves, on the basis that they would have in-depth understanding of the skills and knowledge required to support student nurses' learning. The study aimed to understand what facilitators perceived to be best practice, the barriers and enablers to providing best practice, and the aspects and expectations of educational preparation they considered beneficial to undertake the role. The study is important and unique educationally because it seeks to address an important theory-practice gap in nursing professional practice as it relates to student nurses, as outlined next.

1.1. Background

The evolution of Australian nursing demonstrates a gradual shift

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from the Nightingale model of education, where students learned through clinical experience with only a moderate level of classroom teaching, to University education. In the pre-World War I era the Nightingale system was considered world's best practice (Kelly and Joel, 1996; Wood, 1990). Today both practice and education have evolved in conjunction with the technological revolution, the growth in knowledge, and an increase in patients' expectations (Smith, 2009; Walsh et al., 2012). Such trends have created the need for nurses to have a broader scientific knowledge base for practice. Advances in knowledge and technologies and the importance of evidence-based practice also reflect an increasing professionalisation of nursing and, in many cases, a broader scope of practice (Fairbrother et al., 2015; Schmalenberg and Kramer, 2009). The professional status of nursing is epitomised in the transfer from its basic education foundations from the hospital to the tertiary sector (Ralph et al., 2015; Wellard et al., 2000). A uniquely Australian nursing development involved the complete transfer to University education by 1994, effectively making the baccalaureate degree the entry level for practice (Ralph et al., 2015; Smith, 2009).

The transfer to University education globally has been well received by nurse educators, who have pursued higher academic degrees themselves to provide appropriate teaching and research as a foundation for tertiary nursing students (Sayers et al., 2011). However, the educational needs of clinical facilitators have been generally overlooked, with many appointed to supervise students' clinical learning on the basis of their prior clinical experience rather than formal educational preparation (McCallister et al., 2014). Typically, in Australian university-hospital partnerships, clinical facilitators are employed as casual or sessional university staff to cover the term of the clinical placement. However some hospitals provide their own staff to undertake the role. The disparity in different types and levels of knowledge among those responsible for educating students has led to concerns among both University educators and clinicians about the theory-practice gap (Kramer, 1974; Napthine, 1996). This 'gap' between the theoretical and clinical foundations for practice has led a number of nursing scholars to examine the processes of integrating knowledge and skills to prepare graduates for the reality of clinical practice (Higginson, 2004; Landers, 2000; Scully, 2011). The influence of the clinical facilitator is pivotal to student success, yet few researchers have investigated the extent of the role, including workforce influences or educational requirements for the role. Scanlan (2001) conducted a seminal study on how clinical teachers develop the skills to facilitate student learning. The study reported here adapted and extended Scanlans' work to investigate what clinical facilitators perceived as best practice. Models of clinical facilitation also vary, as does the extent to which facilitators are affected by health, education and workforce issues respectively. For example, casualisation is pervasive in the nursing workforce, with nurses often seen as a soft target for staff reductions (Aiken et al., 2014). Anecdotal feedback from casually employed facilitators indicates that they often have limited formal preparation for the role or continuity of interactions with the students (personal communication professional practice coordinator, Griffith University). This lack of congruence with the level of education with academic staff can be an impediment to student learning. In turn, their academic mentors may also be casual employees, with few opportunities to share educational or clinical knowledge.

The ageing of the nursing workforce also affects the availability of adequately prepared nurses to supervise students in clinical practice (Health Workforce Australia, 2010; International Council of Nurses, 2006; Lisko and O'Dell, 2010). Expansion of the nurses' scope of practice is another workforce issue, particularly in rural areas, where nurses are assuming some responsibilities of other health professionals, such as GPs and allied health professionals, because of shortages in their respective workforces (HWA, 2010; Health Workforce Insights, 2013; Lisko & O'Dell, 2010). Expanded roles can create ambiguity for educators attempting to keep up with contemporary developments in health and education, reflecting the disadvantage of distance experienced by both students and educators.

An extensive search of the literature using search terms clinical facilitator, clinical teacher, fieldwork supervisor, clinical facilitation and clinical supervision, undergraduate student nurse, nursing history, educational theories and adult education/learning revealed that there has been limited research on what constitutes best-practice in clinical facilitation. Sanderson and Lea (2012) explored the experiences of eight clinical facilitators, investigating the facilitators' perceptions of the barriers to clinical learning for undergraduate nursing students and the understanding of their role. The study identified three themes from the narratives, although their report focused on two main aspects: i) structuring the rural clinical placement and ii) structuring student learning in the rural health service (Sanderson and Lea, 2012). The authors concluded that the clinical facilitator role is complex, requiring the ability to liaise with staff to ensure students were provided with practice opportunities across a diverse range of areas in the rural setting. They recommended further research into how the role is enacted was required to understand how facilitators enact the role. Price (2012) identified that assessment of learning in the practice setting is complex; attitudes and values are particularly difficult for the clinical facilitators to assess although crucial to the clinical facilitation role. While the author outlined key principles in assessing practiced-based learning from his own experience; including working with student insights, consulting on assessment and examining knowledge in use, concluding that upskilling of staff may be required, there was no discussion on best practice of facilitating.

Educational preparation for practice as a facilitator is another challenge. Many registered nurses who undertake the role do not have any formal advanced teaching qualifications, such as a graduate certificate in higher education, diploma/master of teaching (Conrick et al., 2001; Minter, 2011). Variability in their educational qualifications and preparation for the role indicates a crucial and timely need to investigate facilitators' perspectives on the role as it exists, and their understanding of the requisite education, support and performance needs that would help them undertake the role at a 'best practice' level. Ultimately, in-depth understanding of existing clinical facilitation practice will provide a baseline for developing the appropriate educational strategies to ensure student success.

The purpose of the study was to explore and interpret clinical facilitators' perceptions of best practice in the clinical facilitation of undergraduate nursing students in Queensland, Australia, including any barriers to facilitation of best practice, educational preparation, the adequacy of the clinical facilitator knowledge and resources for the role.

1.2. Method

The study was conceptualised within Schon's (1983) theory of reflective practice; which consists of deliberating and considering what has happened, how something has transpired, and whether what has been done could have been done better or in a different manner. While reflection has been described by many scholars, two interrelated concepts converge on the notion of active learning, also called experiential learning. The concepts are embedded in Schon (1983) description of 'reflection-in-action'; "a process of thinking about something while you are undertaking the task" and 'reflection-on-action', which considers "the process of analysing

something after the event or task has happened" (p. 54). Schon (1987) and Taylor (2006) suggest that when a person is encouraged to think about their 'knowing in action', particularly in illustrating their knowledge and how it is used, they inevitably develop deeper awareness and understanding that could ultimately change their practice. Schon (1987) referred to tacit knowledge or knowing in action, as the kind of knowledge which a person may not be entirely aware. His theory was used to guide the current study of clinical facilitators' perceptions by focusing on reflection on their current and previous actions in the role.

The study used an interpretive case study design. Case study is "an empirical inquiry that investigates a contemporary phenomenon within its real-life context" (Yin, 2009, p. 18). Stake (1995) categorises three types of case study, including intrinsic, instrumental and collective. The intrinsic case is when there is an interest in what is happening, and there is a need to learn about a particular case in question for its own sake (Stake, 1995). The instrumental case is guided by a research question where the researcher wants to elicit a general understanding of the problem by studying a particular case or the issue at hand, so the researcher endeavours to gain insight into the issue or problem. Collective case studies analyse multiple cases. This case study of what constitutes best practice clinical facilitation is an instrumental case study, drawing on multiple sources of primarily qualitative data in the particular context of clinical facilitation of undergraduate nursing students.

1.3. Study setting and participants

The study was conducted in southeast Queensland, Australia with a group of 11 clinical facilitators who volunteered to participate in the study following a request by the researcher. The participants were experienced clinical facilitators, each having greater than 5 years' experience as both registered nurses and clinical facilitators.

1.4. Recruitment and data collection

Following approval by the Griffith University Human Research Ethics Committee (HREC) clinical facilitators on the list of facilitators previously employed by the University were sent an email invitation to participate in the study. The study was conducted in accordance with the approved protocol with no variations or complaints received.

Phase 1 consisted of concept mapping; Phase 2 was comprised of focus groups and a third phase involved individual interviews with six volunteer participants. Concept maps were completed at the commencement of the focus groups. Concept mapping as a research strategy was informed by Taylor (2006) reflective practice method, and her recommendation that various forms of illustration such as drawing, painting and montage can be a way of mapping ideas. Concept maps have been described as a useful tool used to clarify ideas and show understanding of meaningful relationships and associations of concepts and ideas (Schneider et al., 2013). In the current study, they were used to help guide the participants towards self-understanding; that is, to become more reflexive in considering best practice in their role. The concept map strategy assisted participants' link their ideas in diagrams to stimulate focus group discussions. Participants were encouraged to continue adding to their concept maps during the focus groups, as a way of connecting their ideas as they immersed themselves in the reflective process. They were encouraged to use their initial insights and develop these throughout the focus group discussions and individual interviews. Participants were provided a basic illustrated design with a circle for best practice surrounded by six empty circles, within which to describe their perspectives of facilitation, prompted by; (i) how do we do it; (ii) students' characteristics and their lives; (iii) facilitation strategies; (iv) influences on knowledge; (v) assessing students, and (vi) liaising with university/health care agencies.

In the focus groups participants were encouraged to share their ideas and reflections on influences on best practice, barriers and enablers to best practice; any influences that attracted them to the role; their perceptions of appropriate educational preparation, and personal and professional characteristics that influence clinical facilitation (see Appendix 1 for prompts).

At the completion of each of the two focus groups volunteer participants were sought for individual interviews to elicit further understanding of their perceptions of the role. Data were collected using a modified set of questions adapted from a Canadian study by Scanlan (2001). Scanlan's research considered how the clinical facilitator learns to be a clinical teacher; she used five questions in individual interviews with two groups of clinical teachers; one of whom had less than 2 years' experience and another who had greater than 5 years' experience. The current study used nine open-ended interview questions with the final question asking participants to summarise what they considered constituted best practice. This was an extension of Scanlan's research, which had focused on how the clinical teachers learned their role and the differences between novice and expert clinical teachers. The interviews were conducted about 5–6 weeks after the concept maps and focus groups, which allowed the clinical facilitators further reflection on their participation in the focus groups and their role as clinical facilitators.

Interview participants were encouraged to immerse themselves in reflexive thinking about their experiences to generate discussion and encourage critical awareness of clinical facilitation. They were asked what attracted them to the role, how they learned about clinical facilitation, and their educational preparation for the role. The interviewees were also asked to describe some of the changes they have made in their facilitating over time, and what barriers, strengths and constraining factors they had encountered (see Appendix 2).

The focus groups and interviews were digitally recorded and transcribed contemporaneously to ensure accuracy, increase the credibility of the findings and indicate any areas where further data should be collected (Seidman, 2006). Transcripts were completed after each interview, and the participants were asked to read their accounts to verify accuracy.

1.5. Data analysis

Thematic analysis was used to analyse the data from the concept maps, focus groups and individual interviews. Braun and Clarke (2006) identify one of the benefits of thematic analysis as its flexibility to provide a rich and detailed, yet complex, account of data, by finding relationships between ideas and how these link together. For all phases of the study, data were categorised and re-categorised through several iterations to reduce data into meaningful themes. The transcripts were read in an interpretive manner, looking for significant statements that were associated with the study objective – to understand the perceptions of the participants about best practice in clinical facilitation. Initial impressions and categories were developed from the data of each focus group and individual interview on the basis of repeated concepts arising in the conversations. The transcripts were compared using constant comparison, by going back and forth through the data and noting provisional categories and themes during each iteration (Braun and Clarke, 2006). Several iterations through the data involved identifying and combining categories and headings to compare emergent themes. Interpreting the data into categories ranged from a single

word to a full sentence or paragraph to an entire page of text (Saldana, 2009) where the theme represented the primary essence of the content of the data. The process involved continuously moving between the text as a whole and individually through stages or cycles as noted by Saldana (2009) and Stake (1995).

The concept maps identified key words and descriptions of clinical facilitation, providing a visual representation of ideas that were expanded in the themes and ultimately informed development of a model of facilitation (see Fig. 1).

1.6. Findings

The analysis revealed best-practice in clinical facilitation as comprised of the following elements; assessing, learning to facilitate and facilitating effectively with sub themes identified under each theme (See Table 1).

1.7. Theme 1 — 'assessing'

Assessment was identified by the participants as core aspects of clinical facilitation. They identified clinical facilitation as a staged process where they would initially spend time assessing the student and their goals in relation to the course and the local environment, as illustrated in the following excerpt;

> … knowing the whole range of students' activities and their capabilities … so that [I] can understand and support the ones that need a bit more than others (Mental Health specialist).

While the clinical facilitators are provided with some information from the university they typically questioned the students to ascertain their individual needs. This was intended to ensure they provide a meaningful clinical placement experience tailored to the students' particular needs. They described working in partnership with the students to ensure that the goals are fulfilled. The clinical facilitator approached assessment by what Schon called 'reflection-in-action'; by assessing the local environment to ensure that goals were realistic and achievable in relation to their ability to match up student needs and goals. One participant suggested:

> I look at what year level the student is, what specialty they are going to … the learning possibilities in the area … I plan my day considering the students' personalities, finding out if any have a nursing background (FG 1).

Another used the metaphor of marriage in explaining this concept:

> What the wards can actually offer them in terms of learning environment and marry that up (FG 2).

'Marrying up' student needs was a common refrain, exemplified by the following:

'*I want them all to have the best possible prac, the best possible experience*'. The participants also acknowledged that they checked their own knowledge of clinical areas to ensure that they were familiar with the area and therefore had the knowledge and capability to match student needs to the experiences available for students in the area.

1.8. Theme 2 — 'learning to facilitate'

Participants all held bachelor degrees and were experienced registered nurses, and most revealed that they had commenced clinical facilitation with no or limited knowledge and no guidelines to follow. Some had deliberately applied for the role while others had been approached by clinical staff who recognised their expertise, but because of their limited formal education they primarily relied on their experiences and those of other clinical facilitators, underlying the value of experiential knowledge. One recounted:

> I have been continuously told over the years that this is a very, very important role; however, there doesn't seem to be a great deal … there isn't much formal education related to specific facilitating (FG 1)…

Most facilitators reported that a university course for facilitation would be helpful, although, one participant with over 15 years' experience as a clinical facilitator relied on experiential learning, and reported not being convinced of the benefit of a formal course.

> [I] am not convinced that the graduate certificate has made a difference to me it may, [I] think [I] knew that some of that's what I'd known from working with them [students] over years and years. Some of those strategies looking at different learning styles, even though you didn't have a formalised theory behind it. It [graduate certificate] probably will help … but I think a lot of that I knew was knowledge that I already had gained even around assessing (FG 1).

Experiential learning (learning on the job) was at the core of their skill base and development. They networked with other facilitators and the clinical coordinator to develop their skills.

> [I] think the learning on the job has been the most important part because there hasn't really been any formal education on how to do it … [I] don't know that the certificate IV really helped me in the clinical facilitation role in the hospital … the first workshop the university conducted helped although the first of those [I] went to [I] had been doing the role already for a year (Paediatric specialist).

Fig. 1. Best practice in clinical facilitation model.

Table 1
Themes and sub-themes.

Themes	Sub − themes
Assessing	Assessing general needs
	Assessing student specific needs
	Assessing the local environment
	Matching Up
Learning to Facilitate	Formal preparation
	Maintaining knowledge
	Networking
Facilitating Effectively	Interacting and communicating effectively
	Being Supported
	Exemplars of best teaching practice: The uniqueness of clinical teaching

Networking was also considered a major influence in guiding their development through the sharing of knowledge and experiences, particularly as they were employed on a casual basis and felt they were not aligned to a particular ward. Workshops were considered beneficial although the participants reported that they often felt alone and by themselves while they were working in the clinical environment with the students. The comment below reflects what Schon described as reflection-in-action. Reflecting on her role she concluded that her role was to act as a bridge between the academic and clinical settings.

> You are in no man's land; you do not belong, you are out of the university, and yet you are representing the university, but meanwhile you don't belong to the staff environment that you are working in, so you are this bridge between the two (FG 2).

1.9. Theme 3 − 'facilitating effectively'

The facilitators unanimously agreed that to provide quality clinical placements they had to ensure that their interactions with staff, students and patients within the health care agency were enacted appropriately. They explained that effective communication was paramount to the students' clinical experience being individualised, which was often negotiated between the student, university staff and agency staff. In the context of these negotiations, they questioned each student individually to tailor their teaching strategies to the student's learning needs. They saw support as essential for best-practice clinical facilitation, particularly during the early days of clinical facilitation to maintain a standard of facilitation expected by the university:

> [I] think the new facilitators certainly need much more support and I tend to give that to the new ones in mental health during our networking sessions, because some of them are really quite lost. I think just supporting them will help to overcome inconsistency so they are aware of what the expectations are (FG 2).

Participants were asked to reflect on memorable incidents in facilitating, and to conclude their reflections by identifying six main features of what they considered best-practice in clinical facilitation as a summation of the concept mapping exercise. While there were some areas of overlap the following is a composite of their comments. First, it was important for them to assess the student needs and clinical environment. Second, interpersonal skills were important for appropriate communication and responses. Third, professional role modelling of clinical and academic knowledge was beneficial, to liaise between student, RNs, agency and university. Fourth, maintaining knowledge of current research, nursing policies and procedures of facilitation assisted in providing students with direction. Fifth, maintaining knowledge of teaching and learning processes − knowledge of curriculum, goals and scope of practice. Finally, it was suggested that all clinical facilitators need to build on knowledge through experience. These features are incorporated into the model of best practice (Fig. 1).

A number of barriers to best practice were identified. The participants explained that they had had to learn how to facilitate, yet there was limited information or support in their early experience. They all reported that some ward staff thought the role was easy and that the role had not been valued.

> I think they don't value the role … a lot of people see you … that you are just swanning around and not doing a whole lot … and it's you know an easy job (FG 1).

While this facilitator reiterated that some people still think the job is easy most are now coming to realise that the role is important and of value.

> Their attitude to us has improved, so they are much more welcoming now, - because most of the people there are university trained now … you develop a rapport by working in the same place repetitively … people get to know that you are experienced (FG 1).

These comments highlight that the clinical facilitator role has emerged over time but there is still work required to educate staff about the role of the clinical facilitator, including expectations of the role from both the health care agency and education provider. Considering that the role is often referred to as important the facilitators were frustrated with the lack of research into the role and also advised that feedback on their performance was limited. They saw the lack of research as undervaluing the role by both educational and clinical partners.

Participants clearly indicated that their main sources of knowledge for the role were experiential and networking with other clinical facilitators, and through this they developed their practice in clinical facilitation. Through their reflection on practice, the clinical facilitators highlighted that the clinical facilitation role was an ever evolving role which required the person to have excellent communication and interaction skills to deal with both the students and staff in health care settings and the university. They had no problem reflecting on their experiences, and this underlines the fact that reflection was considered part of their normal role.

2. Discussion

As in Napthine (1996) study of two decades ago, the current

study found that many of the clinical facilitators were employed sporadically on a needs only casual basis. Yet despite their somewhat tentative employment status they played a public relations role for the university, being the face of the university within the health care agency, negotiating closely with the agency educators to better support the students. In terms of assessment Price (2012) argued that clinical facilitation is one of the most complex and sophisticated forms of assessment that a registered nurse will be required to undertake as they are required to have an understanding of the expectations of the education providers, curricula, health care policy and a knowledge of the clinical arena in which the students are placed. The current study also found that assessment was a major part of the role. The clinical facilitator is responsible for ensuring that the student is safe and knowledgeable to provide safe, quality care for patients in health care settings. New clinical facilitators found that assessment was a challenge and that through networking with other clinical facilitators they had learned the processes and strategies of assessment and developed a greater understanding of the role.

While Scanlan's (2001) research focused on clinical teachers and learning to be teachers, some of her findings had notable similarities to the current study; particularly in that clinical teaching and clinical facilitation are primarily learned 'on the job'. Reflection was used by clinical teachers and facilitators in both Scanlan's and the current study to explain the roles they undertake and assist them develop and change their practices. Scanlan's study did not explore what best practice entailed although some of her interview questions were modified to explore best practice with the clinical facilitators in the current study. Scanlan also compared five expert and five novice clinical teachers, whereas the sample for this study consisted of 11 clinical facilitators who had more than 5 years' experience in the role of clinical facilitation, all of whom were assumed to have in-depth understanding of the role.

Some clinical facilitators explained that they needed formal education, although without a clear notion of what they want, even though they found the existing workshops very helpful. The current study highlighted that the experiential learning that the clinical facilitators had gained was extremely valuable and through ongoing networking with peers they continued to expand their knowledge. The use of reflection by the clinical facilitators also highlighted that they were able to think about their actions and consider the implications of these actions on students and their role as clinical facilitators. At the university where this study was conducted there is an expectation that clinical facilitators will have similar theoretical knowledge to academic staff as well as the expert clinical knowledge and skills to provide support and education to the students (personal communication professional practice coordinator, Griffith University). The transformation of their clinical role into the clinical facilitation role was seen as a major shift in their perspective of themselves as clinicians, and often quite challenging.

Generally speaking the term *best-practice* is used in nursing to reflect the goal of maintaining the highest quality clinical placement experience. Best practice in the context of clinical facilitation by the study participants was underscored by a high level of knowledge about clinical practice as well as effective learning and teaching strategies, which assist students to realise their learning goals. Their role is crucial to student learning, particularly given current financial constraints on education which have meant that nursing curricula have been forced to reduce the amount and breadth of clinical placements (Girot and Albarran, 2012). This situation means that each clinical experience tends to compress a substantial amount of learning to students' rather brief exposure to some clinical areas. It is therefore imperative to maximise opportunities for learning from every clinical experience, making the role of clinical facilitators even more important than in the past. Close engagement with students and other staff, clinical knowledge, effective communication skills as well as personal and professional commitment were perceived as most important aspects of their clinical facilitator role. This evidence corroborates the study Sanderson and Lea (2012) conducted in rural Australia which included the insights of both students and clinical facilitators into the model of clinical facilitation. Their study illustrated the importance of structuring the students' learning and ensuring congruence between theory and practice, effective communication and the importance of clinical facilitators being provided with the opportunity for students to develop professionally and personally. These strategies promote structured learning and scaffolding the learning experiences in various ways to optimise student learning experiences.

Scaffolding supports learners to construct new knowledge, building on the person's existing knowledge (Hydo et al., 2007; Jordan et al., 2008; Sanders and Welk, 2005). This statement infers that without the assistance of someone else providing the support system to guide the learning, the knowledge or tasks may be unachievable. The process of scaffolding was further elaborated by (Vygotsky, 1978) whose theoretical model explored the psychological processes involved in learning, and through strategies such as modelling, feedback, questioning, instructing and cognitive structuring all of which support the student to learn. Many clinical facilitators without formal educational preparation may be unaware of processes such as scaffolding, and other strategies to optimise student learning.

These experienced clinical facilitators reported a perception that their experiential knowledge as both a registered nurse and a clinical facilitator has allowed them to develop best practice processes for clinical facilitation. The development of networks for novice clinical facilitators to work with experienced facilitators to provide guidance, giving clear direction on clinical facilitation and the expectations of universities, curriculum and health care agencies, would provide future facilitators the opportunity to learn about clinical facilitation and balancing the role from experienced staff. While the clinical facilitators are given the opportunity to be autonomous they would like contact with academic staff at the university and are eager to have feedback on their performance as facilitators and, in particular, their documentation of student progress. Like other professionals they want to develop their role and be acknowledged. The clinical facilitators identified a need for feedback on their performance as clinical facilitators in the combined role of educator and clinician in ward areas. While the clinical facilitator is predominantly a sessional staff member it is important to remember that all staff requires both positive and negative feedback to improve performance. Fig. 1 below illustrates a model of best practice based on participant perspectives of their role.

3. Conclusion and recommendations

The model of best practice presented in this paper could be used as a template for further study, particularly in examining the relative contribution of experience, existing knowledge and interaction with students to student learning. Further studies should examine the dimensions of the model with a broader sample of clinical facilitators across different contexts. Their reflections 'in-action' and 'on-action' indicated that participants were able to generate invaluable insights into the importance of assessment and student support in their interactions with students. The study also confirmed the contributions of clinical facilitators to the

educational preparation of undergraduate student nurses, integrating theory with practice through the use of *best practice*.

Some concern is warranted in relation to the gaps in knowledge, as revealed by the inadequacy of existing literature. This study raised issues that would help advance the knowledge base for clinical education, including inquiry of student perspectives into best practice of clinical facilitation. Other possible research opportunities would include exploration of the clinical facilitators' skills and what essential elements are required of everyday practice in clinical facilitation; examination of the student outcomes from varying models of facilitation and the impact that clinical facilitators have on health care staff while they are supporting the learning needs of students.

Educationally, the study highlighted that while clinical facilitators are provided with some education there is a need to develop well-structured accessible courses which would be the key to providing meaningful education for clinical facilitators however there is also a need for universities to value experiential learning. A recommendation from this study would be that clinical facilitators are invited into the university on a regular basis for formal and informal sharing of clinical knowledge with academic staff. Findings from this study concur with studies of nursing student perceptions of a good clinical facilitator in that they want someone who has excellent knowledge, clinical competence and strong interpersonal skills to communicate with both clinical and academic colleagues and settings.

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Nil.

Conflict of interest statement

The authors declare that no conflicts of interest exist.

Appendix

Appendix 1

1. When you are allocated your group of students what types of strategies do you use to facilitate the students learning?
2. What has helped shape your knowledge of clinical facilitation?
3. Can you explain what best practice in clinical facilitation might include? Do you believe that you engage in best practice?
4. Has anyone found any difference in facilitating different levels of students and what have these differences been? If there have been differences, how have you managed this? (For example, do you judge the students ability/performance differently, is there a difference in how you assess them clinically? Are there differences in liaising with the university?)

Appendix 2

1. Tell me about your clinical facilitating. How has it changed from the first time you facilitated until now? In your opinion what factors have influenced those changes over time?
2. What attracted you to the role of the clinical facilitator?
3. Tell me about your experiences (both as a learner and teacher) facilitating the students and some of the influences.
4. Tell me how you learned about clinical facilitation?
5. What education have you received to undertake the role of clinical facilitation?
6. If you think back to when you first began clinical facilitation, can you describe to me some of the changes you have made in your facilitating?
7. What are the barriers you encounter in the role as clinical facilitator?
8. What are the strengths and constraining factors in the organizational structures and processes of clinical facilitation?
9. In your opinion: What constitutes best practice in clinical facilitation?

Appendix B. Supplementary data

Supplementary data related to this article can be found at http://dx.doi.org/10.1016/j.nepr.2016.08.003.

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