THE PEDAGOGICAL VALUE OF A SITUATED LEARNING ENVIRONMENT: DELIVERY OF A PRE-REGISTRATION NURSING DEGREE WITHIN A HEALTH PRECINCT

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STATEMENT OF ORIGINALITY

This is to certify that to the best of my knowledge, the content of this thesis is my own work. This thesis has not been submitted for any degree or other purposes.

I certify that the intellectual content of this thesis is the product of my own work and that all the assistance received in preparing this thesis and sources have been acknowledged.

Charmaine Bonus
DEDICATION

Lahat ng pa sa salamat at pagpuri sa aking Panginoon, Mahal na Ingkong.
Inaalay ko itong ginagawa ko para ibalik sa kanya para sa kanyang kapurihan.
Salamat sa Ate Salve Stuart, aking Ina sa Banal na Pag-aaral.

This work was completed with the love, support and counsel of many.
Thank you to my parents, Ramon Bru, Peter Astbury (may he rest in peace), and Paulina Astbury.
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Abstract

This research was undertaken to explore the pedagogical value of a situated learning environment for the delivery of a pre-registration nursing degree from within a teaching hospital, and the wider health precinct. For the purpose of this study, pedagogical value is defined as being conducive to meaningful engagement of learners (Horsfall, Cleary, & Hunt, 2012). In 2016, the nursing school of a large university in Sydney, New South Wales, Australia introduced a new model of program delivery. For the duration of their pre-registration degree, a cohort of Graduate Entry (GE) students were situated within a Local Health District (LHD), their campus a major teaching hospital. Eight of a possible twenty-two students participated in the study. The epistemology of constructivism was used with the theoretical perspective of social constructionism (Crotty, 1998). Four qualitative data collection methods were utilised – (i) photo elicitation (photographs), (ii), photo feedback (analytical, reflective captioning) (collectively, ‘Visual Participatory Methods’ ‘VPM’), (iii) a focus group and (iv), follow-up semi-structured interviews (Creswell, 2014; Harper, 2002; Prosser, 2011). The Graneheim and Lundman (2004) method of qualitative content analysis was applied, with analysis remaining within the descriptive domain. The findings of this study support the argument for a more integrated, socio-cultural approach to learning and teaching for student nurses within Communities of Practice. (Wenger-Trayner, Fentron-O’Creery, Hutchinson, Kubiak, & Wenger-Trayner, 2015). For these student participants, the pedagogical value of a healthcare setting as their situated learning environment was the meaningful learning experiences that assisted their transition to professional practice. Participants identified and associated themselves with the hospital as part of the health precinct, rather than the nursing school as part of the university program. It became a matter of place and perceived legitimacy that their situated learning environment had over the traditional university campus setting. The authentic hospital environment reassured students of the choice to pursue nursing as a career, and the relevance of their concurrent learning. In this way, there is a constant and visible source of ongoing motivation. Due to the reality of the hospital environment
and dynamics, there is a heightened awareness of the relevance that theory directly has to practice. The realism that the environment holds facilitated student awareness of professional boundaries and identities; something participants would often refer to as “the mindset” of being a nurse. This arose from experienced environmental familiarity and perceived belongingness. Perceptions of hospital environment-associated anxiety decreased over time and experience, expediting the process of adjustment and orientation to the hospital setting and the clinical environments in it. The strength of using the VPM were that memories became more vivid and evoked emotions. Discussions were more in-depth and insightful by the use of photographic depictions and accompanied reflections. Such pairing can be valuable when investigating the role of places in people’s journeys. Recommendations from this study include extending the current research, to include a comparison with the main campus student counterparts or to follow their transition into professional practice as registered nurses. Such research using student or newly graduated nurse experiences could be used to 1. inform ways to better support identity development in the preparation for transition to professional practice; and 2. explore the potential influence that a prolonged and consistent exposure to a situated hospital learning environment has on levels of clinical reasoning and belongingness.
Glossary

**Authentic clinical teaching environment**

The primary setting for this study is a specialised adult tertiary referral and teaching hospital, located in NSW and affiliated with one of the major universities.

**Community of Practice (CoP)**

A model of situational learning introduced in Lave and Wenger (1991), explored further by Wenger (1998) and later in Wenger-Trayner et al. (2015). It is based on the assumption that learning is an integral part of everyday life, and primarily involves active participation in social communities.

**Health Precinct**

A unique combination of co-located health facilities, involving partnerships with the local teaching hospitals (adults and paediatrics), and research facilities (NSW Government, 2016). The health precinct of focus within this study comprises over 400,000m$^2$ of health facilities, including 4 major hospitals, 3 medical research institutes, 2 university campuses and the largest research intensive pathology service in New South Wales (NSW) (Redevelopment, 2016). Within the health precinct, education, research and clinical care have been embedded within an actual or authentic clinical teaching environment (Western Sydney Local Health District (WSLHD), Unknown-b).

**Learning and teaching**

Two interdependent activities as part of the education process (Bastable, 2014). This approach is participatory and shared between both learner and teacher, involving a cyclical process of systematic, sequential and planned actions (Bastable, 2014). In this way, learning and teaching looks at how students learn, based on how they are taught.

**Legitimate Peripheral Participation**

Learning as a situated activity has as its central defining characteristic, a process that Lave and Wenger (1991) term ‘legitimate peripheral participation’. “Learners inevitably participate in
communities of practitioners and ... the mastery of knowledge and skill requires newcomers to move toward full participation in the sociocultural practices of a community. ‘Legitimate peripheral participation’ provides a way to speak about the relations between newcomers and old-timers, and about activities, identities, artifacts, and communities of knowledge and practice. It concerns the process by which newcomers become part of a community of practice. A person’s intentions to learn are engaged and the meaning of learning is configured through the process of becoming a full participant in a sociocultural practice. This social process includes, indeed it subsumes, the learning of knowledgeable skills.” (p. 29)

“The form that the legitimacy of participation takes is a defining characteristic of ways of belonging, and is therefore not only a crucial condition for learning, but a constitutive element of its content.” (Lave & Wenger, 1991 p.35)

**Graduate Entry, Master of Nursing (GEM)**

Students enrolled in the Graduate Entry, Master of Nursing degree. This is a pre-registration accredited course for becoming a registered nurse.

**Graduate Entry (GE) students**

Those students who have already completed an undergraduate degree, enrolled in the GEM program.

**Meaningful**

In the epistemology of constructivism as defined by Crotty (1998), meaning is constructed by human beings as they engage with the world in which they are interpreting.

**Novice Nurse**

Beginners who have had little to no experience of situations in which they are expected to perform in the future (as per Benner’s 5 stages of clinical competence) (Benner, 1984).
Pre-registration program

In Australia, to be eligible to apply for nurse registration (RN), you have to successfully complete an accredited university program. This program is either at undergraduate (BN) level or post graduate level (MN). Registration is through the Nursing and Midwifery Board of Australia. Accreditation and regulation is by the Australian Health Practitioners Regulation Agency (AHPRA) (Australian Health Practitioner Regulation Agency, 2016).

Pedagogical value

For the purpose of this study, pedagogical value will be defined as being conducive to meaningful engagement of learners (Horsfall et al., 2012).

Situated learning

Based on the Lave and Wenger (1991) theory of situated learning, it is through being placed within and learning within a particular situation, that abstract concepts can then be fully understood. Learning occurs through authentic experiences, requiring interaction within a sociocultural context.

Sociocultural

A sociocultural environment within a clinical setting is comprised of the following characteristics: physical, social and cultural. Examples of these are physical layout and space, interactions among participants, i.e., student inclusion in health care team, and beliefs about patient care. (Jessee, 2016 p. 464).
Chapter 1 - Introduction

In 2016, the nursing school of a large university in Sydney, New South Wales, Australia introduced a new model of delivery. For the duration of their pre-registration degree, a cohort of Graduate Entry (GE) students were situated within a Local Health District (LHD), located within a major teaching hospital, which became their campus. These students were provided with, and had access to equivalent services and facilities as their counterparts at the main university campus. This model was in line with the strategic plan of the university to increase involvement and partnerships with a major health precinct. It is important to determine factors which have the potential to facilitate student learning with the introduction of any new model of teaching. Therefore, the aim of this study is to gain an understanding of student nurse experiences and perceptions of their learning in relation to the situated healthcare learning environment.

Background and context

In 2016, a nursing school of a large university in Sydney, New South Wales, Australia extended the campus of a pre-registration nursing degree to be delivered from not only the traditional university campus, but now also from within a health precinct. Within the health precinct, education, research and clinical care have been embedded within an actual or authentic clinical teaching environment.

The GE degree offers a Masters of Nursing (MN) level qualification for a program that is delivered over a duration of 2 years (full-time), as opposed to a 3 year bachelor (BN) degree. Both programs upon successful completion of which, can lead to registration as a nurse (RN) with the Nursing and Midwifery Board of Australia (Australian Health Practitioner Regulation Agency, 2016).
Historically, the movement of nursing from hospital-based training into the tertiary education sector has, and still remains to be a complex matter. In terms of nursing education, the issue of graduate preparedness is central to this argument (El Haddad, Moxham, & Broadbent, 2013; El Haddad, Moxham, & Broadbent, 2017). However, the move has not diminished the importance of the clinical setting as a major site for student learning. It is now a matter of the best way to optimise transitions into professional practice for nursing students as they become registered nurses.

The site of new program delivery was supported by both educational and health authorities, with Australian Nursing and Midwifery Accreditation Council (ANMAC) approval being granted in December of 2015. Representatives from both the LHD and the university were involved in the development and implementation of the program. This highlights the partnership and involvement from both the nursing school as well as industry partners from hospitals and facilities within the health precinct. Shared sentiments across the partnership acknowledged that this presented a great opportunity for students who already have a first degree, and who live in a rapidly growing area of Sydney, to undertake nursing education and seek future employment in their home suburb.

The arrangement between the nursing school and the LHD was that there would be a simultaneous delivery of the program from the university campus, to that which is delivered within the health precinct. The curriculum was to be exactly the same, faculty academic staff would teach across both sites, and there would be no teaching from the locally based clinical staff as part of this current arrangement. In this way, this current model stops short of being a nursing “clinical school” wherein local hospital staff are delivering the educational lessons to students (Davies, Turner, & Osborne, 1999; Fetherstonhaugh, Nay, & Heather, 2008; Turner, Davies, Beattie, Vickerstaff, & Wilkinson, 2006).
Increasingly, the health precinct is becoming a place of integrated learning for the university, with plans to increase enrolments at the site by 6,000 – 10,000 students (Redevelopment, 2016). The precinct located students share access to two student purpose built common rooms for university, health precinct located students (currently Doctor of Dental Medicine, Bachelor of Oral Health, Doctor of Medicine). Students learn across their purpose-built clinical simulation laboratory, pre-existing and newly built tutorial rooms and lecture theatres in the hospital education areas. The delivery of the academic program for the cohort of students is timetabled to coincide with their counterpart students on the main campus. Lectures are shared using video conferencing. The learning facilities are shared with staff from the LHD and students primarily undertake their 800+ hours of clinical placements with partner institutions within the health precinct, and the LHD. Clinical placements, as with other students, are offered across a number of areas, including rural, national and international sites.

Currently, nursing education occurs across formal as well as informal learning environments. Examples of these formal, or more traditional learning environments are lecture theatres, tutorial rooms, clinical simulation laboratories (CSLs) and student common rooms. What differs now in this current delivery model of study, is the extension of the campus; the partnership and location arrangement. Students come each day into what is primarily a healthcare setting, rather than an academic setting. They are continually reminded of the focus, purpose and outcome of their studies.

Many key authors on the topic of pre-registration nursing education conclude that a best practice model for nurse education has, and continues to be the subject for discussion. A number of these authors advocate for more effective partnerships between the tertiary and health care sectors to be established (Benner, 1984; Greenwood, 2000; National Nursing and Nursing Education Taskforce, 2006; National Review of Nursing Education, 2002; Sax, 1978). The delivery of a pre-registration nursing degree within a health care setting as an authentic clinical teaching environment is the
operationalisation of an innovative partnership approach between the tertiary education and health care service industries, integrating research, health care and education. Situated learning experiences in conjunction with a socio-cultural approach are fundamental aspects of nurse pre-registration education, and explorations of these are an important step towards improving both program effectiveness and graduate preparedness.

The aim of this qualitative study was to gain an understanding of the role that a situated learning environment has for pre-registration nursing students enrolled in a GEM degree. This study has been designed to answer the following questions:

What is the pedagogical value of a situated learning environment in relation to the delivery of a pre-registration nursing degree from within a teaching hospital, and the wider health precinct?

Subset research questions are:

1. How do student nurses enrolled in this GEM degree perceive their experiences in the learning spaces within an authentic clinical teaching environment?

2. What do these student nurses describe as integral events in their professional learning across the different spaces in this environment?

Extending research and evidence about the potential pedagogical value of a healthcare setting as a situated learning environment for novice nurses can provide insight into modifiable factors that may influence specific learning outcomes. Figure 1 (ref. pg. 16) depicts an overall structure of the thesis.
Figure 1 Diagrammatic representation of thesis structure
Locating ‘self’ in the research

My view of the world is informed by my background as a 31-year-old female born overseas in a south east Asian country and migrating here with my family while I was still a baby. Education is highly valued in my family and enforced as a lifelong asset during my upbringing. As a family, we lived in various areas around Western Sydney and it was where my nursing education and employment as a registered nurse occurred. I feel a sense of duty and service to contribute back to the community that fostered my family in a significant way and helped to shape us to the kind of people we are today. My interest in this area of nursing educational research in particular is also a consequence of a number of years as an educator in the tertiary sector. These two influences of being nurse and an educator combined, has emphasised the importance to me of wanting to move forward with a model which addresses concerns of graduate preparedness. I have always found the experience and perspectives of others intriguing and valuable in terms of personal growth. This carried over to my qualitative inquiry approach for this study. I feel committed to pursuing and engaging students in an environment which will enhance student learning and engagement as the future RNs of our community and wider society.
Chapter 2 - Literature review

This scoping literature review explores the evolving nature of the nursing education landscape with a focus on situated learning environments. A scoping literature review aims to identify the nature and extent of research evidence, in order to build the context necessary for the thesis topic (Grant & Booth, 2009). In this review, the broad topics and key concepts of nurse and medical education; situated cognition; nursing pedagogy and communities of practice are addressed. This review is not intended to assess the quality of the included studies, nor speak to specific research questions, as this thesis has been informed from a number of different disciplines and concepts (Arksey & O’Malley, 2005). Therefore, the research crosses a number of different genres.

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4. What do these student nurses describe as integral events in their professional learning across the different spaces in this environment?

The broad nature of the main research question provided the general starting point from which database searching occurred. Using the CINAHL and Medline databases, I searched for relevant
studies on the areas of ‘nursing pedagogy’, ‘clinical education’, ‘clinical placement’, ‘clinical reasoning’, ‘critical thinking’, ‘mentoring and preceptorships’, ‘simulation’, ‘medical education’, ‘interprofessional education’, ‘partnerships’, ‘readiness for practice’, ‘theory practice gap’, and ‘situated cognition’. I read widely, sorting information according to key words and issues, which were consistent with the focus of this thesis. Other sources were organisational documents from the university for curriculum information, and manually checking reference lists of key articles. I then collated the pertinent results, which resulted in this descriptive summary of the data.

The first section of the review deals with the broader topics of nursing education in the Australian context and its progression to modern delivery models. Following this, a specific focus on GE nursing students as the population sample for this study will be made, along with the potential implications for the learning and teaching. Throughout these two sections, correlations between medical and nursing education will be drawn upon where relevant as these two professions are intertwined both in theory and in practice, thus providing insightful links. Next, the key concept of the Lave and Wenger (1991) theory of situated learning and the research applications of this within nursing education will be reported. The final section explores the proposition to combine the previously outlined areas through developing innovative models of nurse education delivery, based upon a partnership between health and education providers.

From ‘hospital trained’ to ‘university educated’

A brief historical overview of nursing and medical education in Australia

The role and definition of nursing evolves as societal views change over time, and with it, the approaches to nursing preparation. Health care in Australia during the early nineteenth century was closely linked with the early colonial settlements (Daly, Speedy, & Jackson, 2017; White, 2012). Caregiving during Australian colonisation was primitively delivered by convict settlers, described as
being of poor character (White, 2012), who “performed without modern-day technologies of sanitation, in circumstances where water was obtained from a stream or stagnant pond, where ‘watching’ the patient was done by candelight…” (Daly et al., 2017 p.20). It was the unacceptable state of inferior care which prompted a request to Florence Nightingale in England for trained nurses by Sir Henry Parkes (Russell, 1990; Willetts, 2015). In 1868, Lucy Osburn along with five other trained nurses arrived from Florence Nightingale’s training school at St Thomas’ Hospital in London (Daly et al., 2017; Russell, 1990; White, 2012).

Under the Nightingale system of nursing, a formalised instructional program for nurse training was introduced, with strong educational values placed upon candidate selection and entry (Russell, 1990). A key area of this educational system was similar to that of the traditional apprenticeship model – students would gain experience in various clinical areas under the direct supervision of the more senior ‘ward sister’ in each area (Russell, 1990). Even those supervising the students were themselves to be trained, and were also to be both able and willing to teach and supervise the students (Russell, 2005). However, as Mitchell (1977, as cited in Daly et al., 2017) points out, with the ‘on-the-job’ approach to learning, the service needs of the hospital took priority. Nurse students would attend lectures delivered by mostly medical practitioners, and only when they were freed from their hard work (Mitchell, 1977, as cited in Daly et al., 2017).

The Nightingale principles of care adhered to during the time, carried with it character traits seen of great importance – that of punctuality, cleanliness, sexual purity and obedience (McCoppin & Gardener, 1994, as cited in White, 2012). While it is not the focus of this literature review, nor the wider topic of this thesis, it is worth mentioning the gendered culture of nursing. The very construct of ‘caring’ under a traditional view, has been considered as a feminine obligation (Ekstrom, 1999, as cited in Daly et al., 2017). Nursing as an extension of this was widely perceived as women’s work,
creating difficulties which the profession has had to negotiate in order to legitimise itself as a profession amongst the other healthcare professions (Daly et al., 2017; Willetts, 2015). Significant to note however, is that “One of the most significant things Florence Nightingale introduced into nursing practice was the recognition of nursing observations and nursing notes that were distinct and separate from medical observations and notes, and this was the beginning of evidence-based practice in our nursing work. She went on to lead health reform in epidemiology and healthcare outcome statistics. Overall, her legacy resulted in establishing a respected occupation for women and also the need for formal nursing education” (Willetts, 2015 p.1).

A century later in 1962, there was a focus upon increasing the standard of nurse education to be in line with other health care professions, which had already occurred in other overseas countries such as Canada (Duffield, 1986). The profession would eventually reach the consensus to abandon the Nightingale system of general nurse training in favour of a new system of nurse education (Lusk et al., 2001, as cited in Daly et al., 2017; Russell, 1990, 2005). After continued governmental lobbying from the profession, in 1975, the first diploma-level course was delivered by Colleges of Advanced Education (CAE), and over the next decade, all nursing education programs in New South Wales (NSW) were moved to the CAE sector, and hospital training was ceased (Daly et al., 2017; White, 2012). Nursing organisational lobbying in the 1960s and 70s was reflective of the changing societal views of the role of women. These societal changes were a background for the argument to change the preparation of nurses in Australia, and the governmental pressure was a step towards ultimately validating nursing as a profession (Willetts, 2015). White (2014) states that “Clearly we are in vastly different times to those of Nightingale. We have seen enormous gains in women’s rights, universal human rights, patient’s rights and advocacy, and a rhetoric that has challenged medical dominance…” (p.300). Nurse education in Australia would finally enter a new era in 1983, in which all basic nursing training in New South Wales (N.S.W.) was to be transferred to the tertiary sector (Russell, 1990). After receiving full federal government support for a full transfer nation-wide in
1984, the full transfer completed between 1993-1996 (Heath, 2002; Russell, 1990, 2005; Turner et al., 2006; Willetts, 2015).

Arguments to justify the need to introduce a university course for a limited number of entrants into the nursing profession included: the hospital based course was not challenging enough to attract recruits with an above-average academic ability; and that the discipline of nursing would be studied in greater breadth and depth in a university course, enabling nurse graduates to engage as more equally regarded members of the multidisciplinary healthcare team (Russell, 1990). It was considered key then, to develop nursing as a research-based discipline to disassociate from its history of tradition and servitude (Bolton, 1981 & Watson, 1982, as cited in Grealish & Smale, 2011).

An insightful link can be made through a chronological, paralleled comparison of medical education in Australia. The development of basic medical education and training in Australia originated from the traditional British model of medical education (Geffen, 2014; Prideaux, 2009). From an early date, colonial students were also trained under a traditional apprenticeship system (Ash, Walters, Prideaux, & Wilson, 2012). Between 1813 and 1860, students completed apprenticeships with doctors in Australia (Lewis, 2014). Medical education at this time was governed by the United Kingdom General Medical Council, being the accreditation authority for the registration of Australian medical graduates (Geffen, 2014). The first medical school in Australia was established at the University of Melbourne in 1862, followed by The University of Sydney, in 1883 (Geffen, 2014; Lewis, 2014; Prideaux, 2009).

Abraham Flexner, in his 2010 seminal report titled ‘Medical education in the United States and Canada: a report to the Carnegie Foundation for the Advancement of Teaching’ (Geffen, 2014), advocated for a two-phase curriculum, consisting of medical scientific teaching to be followed by clinical teaching in hospital-based academic departments (Geffen, 2014). Clinical teaching schools
are today considered as a key strength of medical education, wherein a considerable proportion of
the training of future doctors is devoted to teaching, learning and experience in real clinical
environments (Ash et al., 2012). It is acknowledged by Ash et al. (2012) that – “a sense of place or
context is important in pedagogy and, in Australia, establishing that sense of place helps to bring
medical education and the health system closer together” (p.1). Overall, medical training was
established 25 years post colonisation, and entered the tertiary system 49 years later.
Comparatively, nurse training and education would take a similar transition route, but over a much
longer period of deliberation of 80 years post colonisation, and then entering the tertiary system
another 125 – 126 years after this.

**GEM Health Precinct Model (subject of thesis)**

The delivery model of study differs from previously established “nursing clinical schools” in Australia.
Fetherstonhaugh et al. (2008) describe a type of nursing clinical school partnership model
established by La Trobe University (Victoria, Australia) in 2001, and which still functions today (La
Trobe University, 2017). Here, in order to combine both practice-based and theoretically informed
education, clinicians working in the health facility provide the clinical teaching to the students
(Fetherstonhaugh et al., 2008). Davies et al. (1999), though not formally naming or defining their
model as a “nursing clinical school”, shared similarities and principles of a clinical partnership model.
Namely, the secondment of facility based clinicians as clinical teachers who were in turn, provided
with support from the university. This is where the distinction between a (medical or nursing)
“clinical school” and the current delivery model of study, lies. In the delivery model of study, there is
a simultaneous delivery of the pre-registration program from the university campus, and that which
is delivered within the health precinct. The curriculum structure and content is exactly the same, the
faculty academic staff each across both sites, and there is no teaching from the locally based clinical
staff.
The nursing clinical school type of partnership model is similar to the current delivery model under study in this thesis, in terms of the factors that led to establishment. The partnered clinical facilities are considered the practice-based extensions of university schools. Here, students can engage in extensive periods of immersion in the realities of practice and utilise this as a means of both acquiring fluency in clinical competence, and expertise in reflecting on and critiquing nursing practices and health systems (La Trobe University 2001, as cited in Fetherstonhaugh et al., 2008). Pursuing these academic-agency partnerships aims to promote collaborative teaching and research arrangements, and are examined more in-depth in the last section of this scoping literature review.

Neither the current delivery model of focus, or the formally defined “nursing clinical schools” are considered to be the predominant models of nursing education in Australia. Given what Sullinger and Ostmoe (1998, as cited in Turner et al., 2006) term as an ‘historical struggle’ to disengage from the apprenticeship model of hospital training, it has been difficult for the profession to embrace new models of education that rely on direct partnerships between university and health care facilities, yet this has been posited as the way forward in nursing education for many years and by a number of respected leaders within the profession (Benner, Sutphen, Leonard, & Day, 2010; Heath, 2002; Sax, 1978).

In 1977, the Federal Minister of education, after consultation with the then Minister for health, appointed a committee chaired by medical doctor, Dr. Sidney Sax, titled ‘Nurse Education and Training. Report of the Committee of Inquiry into Nurse Education and Training to the Tertiary Education Commission’. The committee was asked to include in its enquiry whether nursing education should take place in hospitals, educational institutions, or both. Within the Sax (1978) report, the committee proposed that one of the ways basic nurse education and training should be offered is in hospital-based schools with contractual arrangements with educational institutions. In this way, the committee at this time recognised that the establishment of tertiary-facility
collaboration were an important way to improve the standards of nurse education. Many years later, the Australian Government commissioned the National Review of Nursing Education (2002) to examine nursing education needs. Thirty-six recommendations were made, relating to seven themes. As a result, the National Nursing and Nursing Education Taskforce (N3ET) was appointed to implement these recommendations (Turner et al., 2006). N3ET published their final report in 2006, with one of their 36 recommendations being that “partnerships are essential for quality practice and education” (Turner et al., 2006 p. 7).

Despite this national stance, the current predominant model of undergraduate nursing education in Australia involves students undertaking both theoretical knowledge and simulated clinical practice from a university campus, as well as periodic clinical practice in authentic, work-related clinical settings whilst on placement (Turner et al., 2006). Student nurses were previously recruited directly by hospitals and they also resided, were educated and worked within the hospital (El Haddad et al., 2013; Russell, 1990). While acknowledging that curriculum formation is a result of collaborative input from discipline representatives, today’s students are recruited by the education sector, and under the current predominant model have little to no contact with the health sector until the clinical placement periods (Fetherstonhaugh et al., 2008).

As a result of the transfer, responsibility for novice nurse education now laid with tertiary education providers as a key stakeholder. This arrangement created a distancing of the health care system from being involved in the decision and processes of clinical education for the nurses who would eventually be employed within it, creating a lack of industry investment and ownership of nurse education (Brown, White, & Leibbrandt, 2006; Elliot, 2002; Fetherstonhaugh et al., 2008). There remains a resultant disconnect between learning contexts, nature of learning, and facilitators of learning, creating a large and complex “gap”, and as such, is a main subject of nursing education perennial debate (Greenwood, 2000).
From a ‘theory-practice gap’ to a ‘practice-education gap’

One of the concerns raised because of the transition of nursing education to the tertiary sector, was to question whether students would be prepared for the practical skills and interpersonal interactions that characterise the nursing discipline, termed ‘the theory-practice gap’ (Corlett, 2000; Landers, 2000). More recently however, The Carnegie National Study of Nursing Education in the United States identified a new common concern (Benner, 2015). This ethnographic study was conducted to examine pedagogies of professional nursing education, comparing and contrasting educational approaches across nine different delivery sites (schools). Within this ethnographic study, the researchers were able to identify this concern referred to as the ‘practice-education gap’. This was in reference to the question of whether nursing education could in fact, maintain currency alongside the rapid changes in advancement of health technologies as well as in research-driven practice that is implemented in clinical settings (Benner et al., 2010).

Even before the transfer, the Institute of Hospital Matrons of NSW and the ACT in 1969 held criticisms of the traditional apprenticeship system. Namely, that - "emphasis has been placed during training on nursing procedures to prepare a nurse as quickly as possible for ward duties without providing the necessary correlated theoretical instruction. This has resulted in the production of a nurse who is restricted in outlook, resistant to change, and unable to cope confidently with the scientific and technical advances in medicine and the social problems of nurses." (Sax, 1978 p.9). Additionally, there were similar concerns at this time not just regarding inadequate preparedness, but also a learning gap - "It is widely held that the education of the general nurse has not kept pace with the advances in medicine and the population and social changes which have taken place in the community" (p. 9).
A central purpose of university education is to facilitate students’ reflective use of theory and knowledge in a variety of clinical areas. However, contemporary criticism exists that nursing education continues to inadequately address the complexity and reality of practice (El Haddad et al., 2017; Gassner, Wotton, Clare, Hofmeyer, & Buckman, 1999). It is important to recognise that as the clinical environment is dynamic in nature, it could be counter-argued that no matter how effective the theoretical input in the classroom, it could never truly reflect the complexities of the clinical situation (Landers, 2000).

Novice nurse preparation through simulation lessons

Clinical skills laboratories act as an intermediate zone between the classroom, where students learn nursing knowledge, and the clinical practice setting, where students learn to apply knowledge for when caring for patients (Edmond, 2001). Simulation aims to imitate reality, and offers a skills-based clinical experience in a safe and secure environment (Edmond, 2001). The aim of simulation is described as replicating “some or nearly all of the essential aspects of a clinical situation so that the situation may be more readily understood and managed when it occurs for real in clinical practice” (Cant & Cooper, 2010).

Kelly, Berragan, Husebø, and Orr (2016) in more recent research, assert that while simulation is an opportunity to rehearse psychomotor skills for competent practice, it is also goes beyond practicing these in isolation. In fact, these skills are integrated with varying clinical scenarios, presenting an opportunity to “refine the skills and holistic practices of their discipline. Simulation also facilitates the development of an understanding of a clinical situation requiring specific responses and professional interactions while fostering the growth of professional identity.” (p. 319).

In a systematic review, research articles from 2000 – 2016 were examined to determine teaching strategies which provide optimal learning experiences and outcomes (Jeppesen, Christiansen, &
Frederiksen, 2017). 502 titles and abstracts were screened, resulting in 45 qualitative and quantitative studies for inclusion (Jeppesen et al., 2017). It was concluded that the teaching which occurs in clinical skills or simulation laboratories develop critical thinking skills, and provides not only a positive learning environment for students, but also the motivation to learn (Jeppesen et al., 2017).

While simulation no doubt, has its place in the initial stages of learning psychomotor skills, it remains unable to replace that which can only be experienced in the ‘real world’ (Edmond, 2001), or by being ‘situated’ within the authentic clinical practice environment.

**Novice nurse preparation through clinical placement periods**

The purpose of nurse pre-registration clinical placements is to immerse student nurses in the clinical practice environment (Patterson, Boyd, & Mnatzaganian, 2017). It is in the clinical area where students consolidate and apply the knowledge and skills they have gained in theoretical and clinical simulation laboratory classes (Taylor, Brammer, Cameron, & Perrin, 2015). There is also the socialisation and interpersonal aspects of working in a clinical environment in a way that only authentic workplace learning in an actual health care environment can provide (Jackson & Watson, 2011).

In Australia, a minimum of 800 hours of clinical work experience in a range of healthcare settings is required as part of pre-registration nursing education (Australian Nursing and Midwifery Accreditation Council, 2012). Arrangements of clinical practicum may be varied, for example, a block placement period, or an integrated (flexible) placement between days located between university campus and hospital environment within each week (Edward, Ousey, Playle, & Giandinoto, 2017). However, even this type of immersion has limitations. The importance of a consolidated period of practice for students to settle in and establish collegial relationships is acknowledged as a significant
influence on their sense of belonging (Levett-Jones, Lathlean, Higgins, & McMillan, 2008). Nolan (1998) identified that a students need to fit in and to be accepted by the locally-based staff was a necessary precursor to student active participation and learning. Novices therefore, require social support and reassurance when starting a new placement. Each hospital, ward and health care setting is different. There are feelings of vulnerability, stress and anxiety associated with starting in a new social and professional context (Donnelly & Wiechula, 2012; Levett-Jones, Lathlean, Higgins, & McMillan, 2009; Levett-Jones, Lathlean, McMillan, & Higgins, 2007). Some of these are due to the problems that any newcomer would face, such as not knowing where things are located, unfamiliarity with locally established routines, having to interact with a number of strangers, and these are often compounded by the lack of perceived competence which is characteristic of novices (Cope, Cuthbertson, & Stoddart, 2000). This is the very issue that the clinical placement is intended to overcome.

Novice preparation through situated learning

The acquisition of clinical skills is largely context dependent, and the ability to consolidate knowledge through competent application depends on familiarity with the specific clinical environment. Many of these issues can be mitigated through effective mentoring, where there is a close linking between the staff assigned to students to optimise learning opportunities (Benner et al., 2010; Douglas, Garrity, Kim Shepherd, & Brown, 2016; Gray & Smith, 2000). This correlates closely with the concept of situated learning, whereby learning occurs through authentic experiences, requiring interaction within a sociocultural context (Andrew, Tolson, & Ferguson, 2008; Lave & Wenger, 1991). A model within this is the Lave (1988) description of learning within a ‘Community of Practice’ (CoP), which is based on collaboration among peers, where individuals work together for a shared purpose (Wenger, 1998). In this way, a CoP is defined by a reciprocal relationship between theory and practice, allowing practitioners to see how research and nursing function together in action within a clinical environment (Andrew et al., 2008). This approach to
community engagement therefore requires belongingness, participation, and collaboration by all members to ensure sustainability (Andrew et al., 2008).

As Lave and Wenger (1991) argue, it is through being placed within and learning within a particular situation, that abstract concepts can then be fully understood. There is potential for situated learning that is integrated on a more ongoing and consistent basis to further bridge the gap between cognitive processes and application of theoretical concepts into practice (Lave & Wenger, 1991; Robbins & Aydede, 2009).

Spouse (2001) in her discussion article, applied definitions of epistemic and phronesis as type of knowledge to further describe how the ‘gap’ in nursing education could be bridged. Epistemic knowledge, in this context, is described as being “the knowledge-in-waiting for recognition of saliency and use in practice (phronesis)” (Spouse, 2001 p.515). A type of situated coaching of a student through clinical situations is a signature pedagogy in nursing. It is one which highly respected and well-renowned nursing academic, Patricia Benner has termed as a form of “cognitive apprenticeship”. Here, the teacher describes for the novice, their understanding of the situation, and what they think is the most relevant, and most salient (Benner, 2015).

“It is dangerous to cultivate the notion of disembodied skills that exist independently of context and purpose... (because) possessing skills...is only one aspect of process knowledge. One also needs to know when and how to use them” (Edmond, 2001 p.94).

By adapting epistemic knowledge through situated coaching, students can emulate their mentor by developing their own sense of salience about should be considered to be the most and least important aspects in a given clinical situation. Benner et al. (2010), not wanting to draw any suggestions of reverting to traditional apprenticeships as it has been historically known, elaborated on the concept of cognitive apprenticeship in nursing education today -

“...by apprenticeship we mean a range of integrative learning required for any professional that includes (1) instantiating, articulating, and making visible and accessible key aspects of
competent and expert performance; (2) giving learners a chance for supervised practice; (3) coaching in the supervised practice to help students understand, reflect on, and articulate their practice, particularly the nature of particular clinical situations; (4) helping novice students recognize the priorities and demands embedded in particular clinical situations so that they gain a sense of salience, that is, what must be attended to and addressed in relation to the significance and urgency in the particular clinical situation; and (5) reflection on practice to help the student develop a self-improving practice. Apprenticing oneself to a health care team, a community of practice, and even to patients and families is essential for learning to grasp the nature of the clinical situation, gaining situated understanding, skill, and the ability to use knowledge.” (p.25-26).

Furthermore, task visibility is a key difference from the traditional apprenticeship model as it is commonly known. Performing a task or skill to be learned is usually easily observable in traditional apprenticeships. In contrast, while the task or skill in itself might be observable in cognitive apprenticeships, there is an emphasis placed upon the thinking that must occur as part of the task process. – “In cognitive apprenticeship, one needs to deliberately bring the thinking to the surface, to make it visible” (Wooley & Jarvis, 2007 p.75).

Cognitive apprenticeship is recommended by Benner (2015) and Benner et al. (2010) to be combined with two other forms of professional apprenticeship, those of ‘practice’ and ‘formation and ethical comportment’ apprenticeships. These relate to the clinical reasoning used to teach students how to problem solve in clinical situations, and performing to the ethical standards and responsibilities of the profession, respectively. Not only are these three forms of professional apprenticeship to be combined, but they must be integrated across all teaching and learning settings (Benner, 2015). “These three apprenticeships work best when they are taught together in a situated way” (Benner, 2015 p.2).

When the tertiary sector was introduced as a key stakeholder (El Haddad et al., 2017), it created a rift between “nurses in service”, and “nurses in education” (Andrew et al., 2008); there was this ideological shift from ‘training’ to ‘education’ (Forber, DiGiacomo, Davidson, Carter, & Jackson, 2015). Andrew et al. (2008) attribute this perceived divide due to the separation of where and how
‘practitioners’ and ‘academics’ operate; that unfortunately, this predicament created conditions for disconnected experiences (Forber et al., 2015), with students unsure of how particular settings meet their specialised or personal learning objectives (Mannix, Faga, Beale, & Jackson, 2006). If students are to develop the confidence and competence essential for transformation into valuable, contributing members of the nursing profession, they must be educated in environments that embrace them as integral members of the health care team, foster positive student–supervisor relationships, and provide ample opportunities for engaging in the cognitive and psychomotor work of nursing (Jessee, 2016).

Spence, Valiant, Roud, and Aspinall (2012) assert that despite the ongoing discourse of similar challenges faced by the profession over time, the movement of nursing into the tertiary sector has not diminished the importance of the clinical setting as a major site for student learning. It is now a matter of the best way to create an appropriate “bridge” so that students no longer see the classroom and clinical practice teaching as separate parts during their education (Jeppesen et al., 2017). In fact, simply requiring more education will not be sufficient to bridge the established and significant gap. The quality of nursing education must be at a higher standard (Benner et al., 2010).

Putting these two together – improving the quality of teaching and learning, will provide strength and durability to the bridge. I propose that the model of study is a type of bridge, as it is about situated learning as part of a partnership model, bringing the two key education providers together. However, there is a need to transform teaching strategies so that student nurses do not experience classroom and clinical practice teaching as separate parts during their education (Jeppesen et al., 2017).

Therefore, the success of any approach to practical education depends on tackling the major problem of availability of mentors or clinical educators, and provision of appropriate structures and resources to ensure that they have the time, the tools, and the training to provide quality practical
education and experience (Edmond, 2001). Collaborative partnerships between nursing faculties and health service providers purposefully engage staff from both sectors in student education. Gassner et al. (1999), promote the idea of industry and academia building collegial relationships with each other, one which should include “cooperation, shared planning and decision making, shared power and non-hierarchical relationships” (p. 21) to best assist student learning (Haitana & Bland, 2011).

From ‘critical thinking’ to ‘clinical reasoning’

The Graduate Entry (GE) pathway to nursing

In Australia, nurse registration is traditionally achieved upon successful completion of an undergraduate baccalaureate degree in nursing (‘standard entry’, or SE) (Australian Nursing and Midwifery Accreditation Council, 2012). For those whom have already completed an undergraduate degree, a GE program option is available (Sydney Nursing School, 2016). Upon successful entry into this type of program, it is expected that students will be required to study as well as critique conceptually and theoretically advanced course materials, usually at an advanced pace than what would be expected at the bachelor’s degree level (Sydney Nursing School, 2014).

The National Review of Nursing Education (2002) reported the GE option for people with degree qualifications in other disciplines to be one of the clear pathways to a nursing career (Heath, 2002). Whilst there is still a developing amount of literature around GE nursing students specifically in the Australian tertiary education system, one particular article from 2001 laid claim to the first GE nursing program within Australia, offered by La Trobe University, which commenced in 1997 (Duke, 2001) (Ref. pg. 24).

In 2006, the National Nursing and Nursing Education Taskforce published Maximising Education Pathways. Within this report, there were approximately 13 universities in Australia which had provided information on their respective websites regarding GE nursing programs (National Nursing
and Nursing Education Taskforce, 2006). In 2016, the Australian Health Practitioners Regulation Agency (AHPRA) list of approved programs of study presented 149 programs, the successful completion of which would allow the student to become eligible for Division 1 nurse registration. Fourteen (9.4 per cent) of these were GE pathways (Australian Health Practitioner Regulation Agency, 2016). It was the perceived benefits for the nursing profession which led the School of Nursing at La Trobe University in Australia to introduce this innovative program. A combination of knowledge and skill from two degrees would provide a graduate to who has five years of academic preparation across different fields (Duke, 2001).

To once again present potential areas of parallel between nursing and medical education, it was the 1988 federal report, Australian medical education and workforce into the 21st century, which initiated reforms, one of which was the introduction of graduate-entry, 4-year programs. The first was at Flinders University in 1996, followed a year later by the Universities of Sydney and Queensland (Lewis, 2014; Prideaux, 2009). Flinders University justified their change by aligning with the Australian Medical Council (AMC) guidelines at the time, and stated that “The overall goal of the School is in accord with the AMC guidelines, ‘to produce broadly-educated medical graduates with the knowledge, skills and attitudes to allow them to undertake further training’ (i.e.; a pluripotential graduate)” (Finlay-Jones & Nicholas, 1993 p.13).

Some of the reasons behind the change were the existing global trend for recruiting diverse practitioners who could keep pace with increases in knowledge, demands for greater interpersonal skills, and who could understand the complexities of the ethical dimensions of modern medical practice (Sefton, 1993). It was acknowledged that diversifying pathways to medicine to those who already had tertiary study skills, would allow for techniques appropriate for adult learning to be used from the commencement of their medical degree such as problem-based learning, and also that
“meaningful clinical relevance and contact could be achieved earlier with a more mature group.” (Sefton, 1993 p. 6).

Critical thinking in GE nursing students

Australian research studies into the academic performance of GE nursing students is largely driven by the intent to examine to what degree, or if in fact, these students do indeed achieve high levels of academic success (Cantlay et al., 2017; Duke, 2001; Everett, Salamonson, Trajkovski, & Fernandez, 2013; Fernandez, Salamonson, & Griffiths, 2012; Koch, Salamonson, Rolley, & Davidson, 2011). This may be expected to be due to their previously demonstrated success of achieving an undergraduate degree as a pre-requisite to program enrolment. Three studies which included data on academic performance additionally aimed to discover the role of other factors which high academic achievement may be attributed to, such as through correlations with Emotional Intelligence (EI), Self-Regulated Learning Strategies (SRLS), and learning preferences (Everett et al., 2013; Fernandez et al., 2012; Koch et al., 2011).

Not without its criticisms of reliability and validity, the importance of utilising EI throughout the nursing process is well established in literature (Bulmer Smith, Profetto-McGrath, & Cummings, 2009; McQueen, 2004). The contribution of EI in nursing becomes evident in looking closely at the intrapersonal nature of the profession. Nursing relationships with colleagues, patients and their families require a level of awareness when processing and conveying emotions and feelings (Bulmer Smith et al., 2009). The guide to reflective practice for student nurses whilst on clinical placement is outlined well by Levett-Jones and Bourgeois (2011). The authors suggest that in students utilising the reflective model, it can be a way of processing their thoughts and emotions experienced during clinical situations. Overall, this can then aid in developing their critical thinking skills for progression of clinical acumen (Levett-Jones & Bourgeois, 2011).
Foster et al. (2017) in their longitudinal study using the validated Assessing Emotions Scale (AES), determined that levels of EI increases over the duration of a pre-registration degree. The study population was comprised of mainly GE students of a pre-registration population, but results of GE students were not compared against the other student group (combined degree, Master of Nursing students). For the study population overall, there was found to be an increase of EI scores, indicating that emotional mastery skills in order to develop EI, can be learned. This provides a basis for value in specific EI education being scaffolded throughout the duration of nursing pre-registration programs (Foster et al., 2017).

Fernandez et al. (2012) examined the influence of EI on academic performance using the Trait EI Questionnaire – Short Form (TEIQue-SF). Results showed that the mean EI score was 148.1 out of a possible 204, a level expected of a cohort of mature aged students and a score which demonstrates positive correlation with student’s Grade Point Average (GPA) results (mean score = 4.9 out of a possible 7) (Fernandez et al., 2012). This same study also determined a positive correlation between EI and three specific aspects of SRLS – that of peer learning, help seeking and critical thinking. Using four dimensions of Pintrich’s Motivated Strategies for Learning Questionnaire (MSLQ), student’s motivations for learning and their use of SRLS were measured. However, one of the four dimensions – extrinsic goal orientation – was found to be negatively associated with both EI and as a predictor of academic success (Fernandez et al., 2012). In particular focus on the critical thinking aspect of the questionnaire, students scored themselves on a Likert scale indicating whether statements such as ‘I often find myself questioning things I hear or read in this course to decide if I find them convincing’ were more or less true of how they employed critical thinking skills as a learning strategy (Fernandez et al., 2012). Everett et al. (2013) reflected similar findings in relation to SRLS and academic performance. In comparing the SE and GE groups, the GE students were more likely to utilise the same three positively correlating dimensions of the MSLQ (peer learning, help seeking, critical thinking) than their SE counterparts, and also outperformed them in their following GPA results.
Assessing learning preferences can be a useful tool to demonstrate the mode in which people tend to respond most positively to when processing information. Koch et al. (2011) used the Visual, Auditory, Read/Write & Kinesthetic (VARK) questionnaire and student 6 month follow up GPAs to determine any correlation between the two. Previously held criticisms of this questionnaire were acknowledged, and as such the authors also recognised the usefulness of the VARK questionnaire in facilitating the development of one’s learning practices simply by being more aware of learning preferences. Out of the four learning styles – visual, aural, read/write, kinaesthetic – findings indicated that student’s whose learning preference was primarily kinaesthetic demonstrated higher GPA levels.

Whilst the study conducted by Kelly, Forber, Conlon, Roche, and Stasa (2013) did not make correlations to GPA levels, this study did highlight the benefit of simulation as an effective teaching method for GE nursing students. Nursing simulation activities typically involve the re-creation of clinical case studies, where participants are to immerse themselves into the scenario and respond to the set situation according to the roles they have been pre-assigned (Kelly et al., 2013). This is a key example of kinaesthetic learning, where there is involvement required in a reality-based learning environment (Kelly et al., 2013). The simulation in this study involved students responding to a patient displaying signs of clinical deterioration. The pre-post survey comprised of questions on their self-reported communication and skill related abilities. The pre-post survey results indicated that the GE student cohort indicated the most improvement in scores, a positive response from the simulation experience when compared to their enrolled nurse and SE counterparts (Kelly et al., 2013). This particular learning preference for contextualised, hands-on student involvement can then be translated into an effective way of developing critical thinking skills for safe clinical practice, and therefore has implications for curriculum design and teaching strategies (Kaddoura, 2010).
What may be derived from the analysis and synthesis of this group of papers and their findings is the crucial role in which critical thinking has in SRLS, EI and the kinaesthetic learning preference, each having evidence to demonstrate positive association with academic performance or experience.

Nursing is an inherently emotional and intellectual experience, affecting the ability to retain knowledge and thus, think critically. Inversely, thinking critically requires one to exercise the ability to process emotion (Bulmer Smith et al., 2009). Critical thinking as a learning strategy also features as one of the components of Pintrich’s Motivated Strategies for Learning Questionnaire (MSLQ) which may not only be positively associated with academic success, but more so in encouraging cognitive engagement in classroom learning (Pintrich & De Groot, 1990; Pintrich, Smith, Garcia, & McKeachie, 1991). Finally, simulation as part of the kinaesthetic learning style can be utilised as a teaching technique in order to encourage critical thinking and to facilitate a greater learning experience (Wagner, 2014; Wittmann-Price & Godshall, 2009). Critical thinking is a common aspect amongst each of these factors, whether through its demonstration of use as a successful learning tool, and as a necessary skill for professional practice as a nurse. Therefore, further investigation is needed into incorporating education exercises and activities which would develop critical thinking ability.

Critical thinking is a cognitive process used for analysing knowledge and information obtained, allowing for judgements of accuracy to be made (Simpson & Courtney, 2002). It is therefore considered a necessary skill for professional practice as a nurse (Simpson & Courtney, 2002). For Australian GE nursing students, critical thinking is a common aspect amongst multiple studies examining factors that are conducive to learning (Everett et al., 2013; Fernandez et al., 2012).

Clinical reasoning in GE nursing students

The terms critical thinking and clinical reasoning are interrelated concepts (Simpson & Courtney, 2002). Recently, there has been a call to place more emphasis upon clinical reasoning (Benner et al., 2010). This change, as described by West, Usher, and Delaney (2012) came as a result of needing to
prepare students for a healthcare environment that is increasingly complex; where the reality of today’s healthcare environment is that situations are frequently or rapidly changing because patient status is of a higher acuity and that clinical information can at times be either incomplete or even delayed. Clinical reasoning, outlined by Benner et al. (2010) is “…the ability to reason as a clinical situation changes, taking into account the context and concerns of the patient and family.” (p. 85). This is where the distinction between critical thinking and clinical reasoning lies – the contextual nature. Critical thinking is based on the knowledge process from knowledge obtained, and is not dependent on the situation at hand (Simpson & Courtney, 2002). Clinical reasoning is the cognitive and metacognitive processes used for analysing knowledge relative to a clinical situation or specific patient; essentially the application of critical thinking to new or unfamiliar clinical situations (Lapkin, Levett-Jones, Bellchambers, & Fernandez, 2010; Simpson & Courtney, 2002).

This contextualised representation of critical thinking would imply that situated learning for the development of clinical reasoning skills is vital, hence the requirements of clinical placements (ref. pg. 28). Graduate Entry nursing students have been shown to have a high ability to critically think, but can they clinically reason? Due to the contextual nature, situated learning could be a potential direction in which to explore this further. Benner et al. (2010) supports this, stating that “students learn by, through, and in situations that involve particular patients, whether the situation involves patients in a clinical setting or in paper cases or simulations. Students must experience practice, or learn experientially, in particular situations” (p.86).

It is a difficult predicament, wherein for nursing graduates to have the skills required for a complex health care environment, they must firstly have the opportunity to practise them in ‘real world’ environment as students. Professor Levett-Jones, in her extensive research surrounding clinical reasoning in nursing shares that opinion that clinical reasoning is dependent on the context in which it occurs (Smith, Loftus, & Levett-Jones, 2013). Clinical reasoning “requires students to have the
ability to recognise and balance the contextual factors that impact on their decision making and actions. Students also need to learn the contextual influences on the sources of knowledge they develop during practice and how to be critical of their developing knowledge base...My research emphasised the importance of thinking carefully about the contextual factors that affect the decisions being made” (Smith et al., 2013 p.272).

From ‘exclusive sector responsibilities’ to ‘collaborative partnership models’

Despite changes intended to improve the educational standard of novice nurses for the benefit of present and future health care consumers, it appears no posited solution will go without criticism. What can be seen is that all arguments have some historical basis and that often, these are ones the nursing profession has faced previously in some similar form. The perennial debate concerning the ‘theory-practice gap’ is a simplistic term for a complex and multi-faceted issue. It is uncertain if this gap is avoidable due to the nature of nursing work (being mindful of the complex interplay between economics and logistics), or if it is a symptom of dated pedagogy lacking innovation and sociocultural contexts which have been unable to cohesively align with one another (Newton, Billett, Jolly, & Ockerby, 2009).

The previous sections – the learning and teaching of GE nursing students occurring whilst situated within healthcare environments – has shown that greater inter-sectoral collaboration between education providers and health care facilities has the potential to result in highly and effectively educated nurses, and close aforementioned gaps. In fact, Greenwood (2000), a nursing professor with affiliations with the hospital of study site, emphasised in an opinion article that pre-registration nursing education is only the beginning of a nurse’s professional development and therefore, nurses in both sectors (‘nurses in education’ and ‘nurses in service’ in health care facilities) must acknowledge this and see a way to move forward. The design of pre-registration programs must be
responsive to the learning needs of the students. In this way, nurses from both should work collaboratively in the construction of these programs (Greenwood, 2000).

Benner et al. (2010) supports this, concluding that-

*Nursing students can, and should, develop ethical comportment in clinical and classroom settings, acquire skilled know-how and clinical reasoning in both, and build nursing knowledge in classroom and clinical settings, preferably integrated. With better integration, students learn that practice is a way of knowing in its own right. In other words, innovation and new questions flow bidirectionally, from theory and science to and from practice (p.30).*

In summary, the delivery of a pre-registration nursing degree within an authentic clinical teaching environment is the operationalisation of an innovative partnership approach; integrating research, health care and education. Situated learning experiences are a fundamental aspect of nurse pre-registration education and explorations of this are an important step for improving effectiveness.

Expanding research and evidence about the potential pedagogical value, the influence or the role of the situated hospital learning environment for novice nurses will provide insight into modifiable factors that may influence specific learning outcomes. In this case, modifiable factors of CoPs in authentic clinical teaching environments, and outcomes such as clinical reasoning and graduate preparedness.
Chapter 3 - Methodology

Overall, the aim of this qualitative study was to gain an understanding of the role that a situated learning environment has for pre-registration nursing students enrolled in a GEM degree. In order to gain this understanding, student participant descriptions and depictions of their experiences and perceptions regarding their learning in relation to the situated environment was elicited. The methodology used reflected this overall aim and the research questions (below). In order to be able to answer the research questions, a qualitative methodology involving data collection through a focus group, photo elicitation (photographs), photo feedback (analytical captioning) and follow-up semi-structured interviews was used.

Research Questions

This study has been designed to answer the following questions:

What is the pedagogical value of a situated learning environment in relation to the delivery of a pre-registration nursing degree from within a teaching hospital, and the wider health precinct?

Subset research questions are:

5. How do student nurses enrolled in this GEM degree perceive their experiences in the learning spaces within an authentic clinical teaching environment?

6. What do these student nurses describe as integral events in their professional learning across the different spaces in this environment?

Theoretical focus

This researcher is concerned with individual student experiences and perceptions of their situated learning environment. The generation of perception and meaningful experiences in regards to
learning within this situated hospital environment requires individual construction and subsequent interpretation. In this way, this research uses the epistemology of constructivism (Crotty, 1998).

Constructivism holds the view that “all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context.” (Crotty, 1998 p. 42). Within constructionism, is the concept of intentionality (Crotty, 1998). ‘Intentionality’ as is taken from the word’s etymological roots and philosophical definition, means referentiality, relatedness, aboutness (Crotty, 1998). The message of intentionality in this context is that as an individual becomes conscious of something, there is an interdependence of subject and object, or subject and world (Crotty, 1998). Consciousness is considered to be intentional, and human beings are intentionally related to their world (Crotty, 1998). The research implications of this is that the role of a situated learning environment for GE student nurses can be studied by their individual interpretations of the meanings they construct, evident through descriptions and depictions.

Constructivism holds that a student nurse’s experience and perceptions of their situated learning environment is developed through social interaction with colleagues.

As this study is concerned with experiences and perceptions that students nurses have within and regarding their situated learning environment, an appropriate theoretical perspective to apply to this study is social constructionism (Crotty, 1998). Social constructionism is concerned with the social origins of constructed meaning, and therefore takes from constructivism. Central to social constructionism is the role of culture or a mix of cultures to influence us as to how we view meanings in objects or of the world (Crotty, 1998). Without culture humans could not function, as culture has to do with functioning in that we depend on it to govern our behaviour (Crotty, 1998). Social constructivism asserts that all reality, as meaningful reality, is considered to be socially constructed, and that these social realities are considered meaningful through interpretation and reinterpretation (Crotty, 1998). Social constructivism is a theory employed in this study as it
accommodates for student participants to construct individual meaning to their learning that has occurred within the situated environment, and therefore links with pedagogical values.

Research strategy and design

A naturalistic inquiry approach through using a qualitative research design and strategy was the most appropriate method to gain an understanding of individual participant perspectives and experiences (Creswell, 2014; Lincoln & Guba, 1985). Within naturalistic inquiry, realities are multiple and different. The aim, therefore, was to develop an idiographic picture to describe each individual participant, rather than making broad applications of the findings (Lincoln & Guba, 1985).

Four data collection methods were used in this research study, which were implemented over two stages (Figure 2, p. 45) -

Stage 1 was a trial to explore the proposed methods, in order to refine the overall planned data collection strategy (Marshall & Rossman, 2016). This stage involved conducting a focus group (Marshall & Rossman, 2016) (ref. pg. 51).

Stage 2 was the implementation of the trialled methods through three data collection methods - photo elicitation (photographs), photo feedback (analytical captioning) and follow-up semi-structured interviews (Creswell, 2014; Harper, 2002; Prosser, 2011). According to Harper (2002) “images evoke deeper elements of human consciousness that do words”, and that “elicitation interviews connect core definitions of the self to society, culture and history” (p. 13).

Multiple data collection allows for the confirmation of findings, in addition to providing for a richer and deeper level of findings (Neuman, 2014). Combined, these proposed methods will allow for the operationalisation of key concept areas within this study (see Appendix A for a summarised, table form).
Figure 2. Stages of the data collection strategy, with corresponding timeline
Research participants

There were 29 \((N=29)\) final year Graduate Entry (GE) students enrolled and located within the LHD and were therefore a purposeful sample. The total number of students enrolled in the Master of Nursing (Graduate Entry) (‘GEM’) program were composed of both GE and combined degree students located at the main campus \((N=202)\). Purposive sampling implies the intent to carefully select certain types of participants who can best enhance understanding of the phenomenon under study (Neuman, 2014). Lincoln and Guba (1985) posit purposive sampling to be a characteristic of naturalistic inquiry as it both increases the range of data to be exposed, as well as the likelihood that the full scope of multiple realities will be uncovered, thus allowing for potential transferability. Maximum variant sampling further facilitates the unique, thick descriptions that can identify essential and variable features of a phenomenon as experienced by diverse respondents (Creswell, 2014; Suri, 2011).

Selecting such a particular population and small subset to sample from is rationalised by the inaugural program implementation. Additionally, there are limited programs nationwide which combine both Master degree qualification level and GE requirement (Australian Health Practitioner Regulation Agency, 2016) \((\text{Ref. pg. 34})\). Therefore, to the best of this researcher’s knowledge of pre-registration nursing degrees, similar models have not yet been implemented elsewhere in the country.

The eligibility criteria for sample selection was:

1. Enrolled in the final year of their studies within the ‘GEM’ degree.
2. Undertaking all Units of Study within the health precinct
3. Participants will have experienced at least 3 semesters of using the simulation, traditional and clinical learning environments within the health precinct or within the Local Health District (LHD).
This criterion was adhered to for 7 out of 8 participants. There was 1 participant who was invited and then consented for voluntary participation for the focus group interview, though they did not fulfil 1 of the 3 criteria for eligibility. This student had transferred from the main campus at the end of semester 1 of first year (of a 2-year full time degree), then joining the health precinct cohort of students in semester 2 of first year. Therefore, this student had experienced 2 instead of 3 semesters of using the simulated, traditional and clinical learning environments within the health precinct or within the LHD, as outlined in criteria 3. The reason why it was deemed appropriate for this student to be included as a participant was because of the potential for this participant to provide disconfirming evidence by offering conflicting viewpoints, a strategy used in qualitative research to improve and evaluate data credibility (Creswell, 2014; Polit & Beck, 2014), drawing similarities to what Lincoln and Guba (1985) refer to as ‘negative case analysis’. Subsequently, this student was able to provide (on their own accord), a comparison of their experience having studied their first semester of first year from the main university campus, to their experience of completing the further 2 semesters within the health precinct.

Participant recruitment

Initial contact with potential participants was made through email correspondence. Students were invited to participate in the whole study. All email correspondence between potential participants and researcher were sent via university email addresses. University email addresses were obtained through the nursing school, upon permission of higher authorities, such as the Associate Deans (academic and education). The HREC approved participant information sheet (Appendix L) was attached to the initial email, which included the statement – ‘Participation in this research study is voluntary’. It was advised to potential participants that the decision whether to participate would not affect current or future relationship with the researchers or anyone else at the university, or any institutions within the LHD. It was also made clear to the potential participants that the decision of whether or not to participate would also not have any implication/effect on their marks or
assessments in any manner, shape or form. Activities as part of this study were undertaken outside of usual class time, and also out of the teaching semester time after all subject results of the previous semesters had already been released. This was to try to mitigate any perceived coercion for participation. Only 3 students from the initial focus group of 8 volunteered to continue with the VPM and individual semi-structured follow up interview, though in agreeing to participate by signing the consent form, they consented to participate in the whole study. It was made known to the participants that they could make the decision to not continue with the study at any time (Appendix L and M).

A final sample of 8 \( (n=8) \) participants was obtained using a maximum variation sampling method in order to represent diverse cases within the student cohort based within the health precinct (Creswell, 2014). Maximum variant sampling facilitates the unique, thick descriptions that can identify essential and variable features of a phenomenon as experienced by diverse respondents (Creswell, 2014; Suri, 2011). Use of this sampling method was originally for the purpose of gaining multiple perspectives across 3 differentiating criteria which may impact on their perceptions of the learning environment (Figure 3, pg. 50):

1. Constituency of the Local Health District (LHD),
2. Undergraduate degree area of study (healthcare related / non-healthcare related); and
3. Gender

The resulting volunteer participants did not complete the maximum variation sampling as intended. Only 1 participant was a non-constituent of the LHD, and another (different) participant was male. The resultant maximum variation sample could be more accurately depicted in figure 4 (ref. pg. 50). This was not completely unexpected, as it is acknowledged that a potential weakness of maximum variation sampling is that where there are the proposed, pre-determined potential categories for
maximum variation in a sampling strategy, it is possible that a grouping may not be represented
(Creswell, 2014). This was applicable in this instance, as no single participant actually met the
particular criteria of being a male, non-LHD constituent who had undertaken an undergraduate
degree in a health-related discipline. Similarly, the criteria of being a female, LHD constituent who
had not undertaken an undergraduate degree in a health-related discipline was also not able to be
recruited. These groups could not be represented in this sample, but it also must be acknowledged
that within the subset population for this study (final year student cohort based within the health
precinct (N=29)), no enrolled student met the criteria for male, non-LHD constituent, therefore
rendering one of the eight potential categories for maximum variation in the proposed sampling
strategy, impossible to be recruited.
Figures 3. and 4.: Visual representations of the original plan for maximum variation sampling

Figure 3 on the left is the visual representation of the original plan for maximum variation sampling. Figure 4 on the right is the visual representation of the actual, resultant sampling which occurred. I have placed them side by side for the purpose of visual comparison.
Data Collection

Instruments and Procedures

Validating accuracy of the outlined procedures through the initial trial process was intended to ensure rigor of this research (Creswell, 2014). As outlined in detail in stage 1 (ref. pg. 44), this also involved seeking external checks to review proposed interview questions (Creswell, 2014). This included research supervisors, who have backgrounds in nursing, a peer review panel consisting of the same research supervisors, as well as 3 other expert panel members from various faculties, and a senior nurse educator from adult hospital within the health precinct. The latter was a LHD ethics committee requirement as part of the local application and eventual approval processes. Based on feedback and recommendations received, a focus group (n=8) was then conducted to further evaluate clarity and application of the interview questions (Marshall & Rossman, 2016). This is a typical number of participants for a focus group, and is an appropriate method for generating dialogue to solicit opinions and experiences simultaneously (Polit & Beck, 2014). A single participant was further recruited from this focus group to then test the proposed visual methods.

The use of two types of VPM (photo elicitation, photo feedback) acted as a way of both gathering more in depth information and maintaining communication between this researcher and the participants (Marshall & Rossman, 2016). These methods use an inductive approach used in qualitative methodology to elicit deeper experiential understandings (Prosser, 2011). Participants were asked to take photographs on an individual basis. These photographs were representative of aspects of their learning experience in relation to the situated learning environment (within the health precinct). Participants of stage 2 (photo elicitation and photo feedback) (n=3) were provided with guidelines for the visual participatory methods (Appendix B).
Students were provided with a reflective cycle image to guide the construction of the captioning process. This is included in the instructions for the visual participatory methods (Appendix B). This reflective cycle was an adaptation based from both the Gibbs (1988) reflective cycle and the Driscoll (2007) ‘the what model of structured reflection’ (Appendix C). Reflection is considered to be intrinsic to nursing education (Levett-Jones, 2007). Structured reflection facilitates the processing of an experience, and the learning that may occur can be both meaningful and memorable (Levett-Jones, 2007). Follow up semi-structured individual interviews were conducted and participant-selected photographs with the associated reflective captions were submitted to the researcher between 7–10 days after the photo elicitation activity.

Interviewing occurred on two different levels: focus group and individually. Both types of interviews were semi-structured in nature (Creswell, 2014). The interviews began with general inquiry and progress to key questions (Creswell, 2014) that are aligned with key concept areas of the research questions (Appendix A). All questions were constructed as open-ended, encouraging a gradual unfolding of participant perceptions and experiences (Creswell, 2014) (Appendix D). The role of the researcher in the focus group was to facilitate discussion according to the interview protocol (Creswell, 2014).

As qualitative researchers collect their data in real-world naturalistic settings (Neuman, 2014), all interviews were held in private meeting rooms within the health precinct. Interviews were approximately 30 minutes – 1.5 hours in duration. The variations in times were dependent on the individual participant responses, though all interview questions were answered. Both interview types were audiotaped and transcribed for data analysis (Creswell, 2014; Neuman, 2014). As a novice researcher at this stage of my learning process, I consider the transcription process to have been an invaluable part of immersing myself in the data, having listened to, typed, confirmed, re-listened, re-confirmed the spoken words over many hours, days and weeks.
The interview questions in Stage 2 were similar to those asked during the focus group in Stage 1. Questioning in Stage 2 provided an additional opportunity for further discussion and sharing of perceptions based on the photographs (photo elicitation) and reflective comments or captions (photo feedback) provided by each participant (Harper, 2002) (Appendix D). This stage was relevant to confirm the correct interpretation by this researcher. Overall, figure 5 (below) depicts the structure and time frame of the research study that was conducted, and provides further evidence of the rigour involved in this research process.

Figure 5 Timeline and processes of the research conducted.
Data analysis

I decided that qualitative content analysis using the Graneheim and Lundman (2004) method would be most appropriate for this research, as it is able to be used to determine the presence and meaning of concepts across multiple forms of collected data (Payne & Payne, 2004). The use of a descriptive content analysis allows for the same analytical approach to be applied across all qualitative data units, whilst simultaneously aligning with the aims of this research project (Graneheim & Lundman, 2004). More detail is provided in the ‘analytical procedure’ section (ref. pg.55).

To ensure I had the relevant skills to manage and analyse the data, I attended a 3 day NVivo workshop. Computer-assisted data analysis through the NVivo program can be used to manage, explore and find patterns in the data (QSR International Pty Ltd, 1999-2016). After this researcher initially analysed the raw collected data, there was a formation of data into codes, then combining these into broader categories to gain a deeper understanding of emergent concepts. I also used this software during the iterative process of Qualitative Data Analysis (QDA) to go back through reading and viewing the data to make reflective memos and annotations. Returning back to the data as an iterative process was both a valuable, recommended and an expected part of the QDA process (Creswell, 2014). As Creswell (2014) summarises, computer software programs can assist researchers to build further levels of analysis, by providing a means for organising codes hierarchically where the smaller units (child nodes), can be placed under larger units (parent nodes) and the relationship between the raw data and broader themes can be better visualised. This procedure is outlined as an excerpt in notes form in Appendix E.

The descriptive content analysis approach taken allowed for a process of pulling collected data apart and putting them back together in meaningful ways, which is consistent with the inductive reasoning
approach in qualitative research (Creswell, 2014). Determining the presence of patterns amongst the formed impressions across all participants in the study sample, placing these into categories, and looking for any correspondence between two or more categories is an overarching approach to qualitative data analysis (Creswell, 2014).

Analytical Procedure

The findings from the research were derived from descriptive content analysis (Elo & Kyngas, 2008; Graneheim & Lundman, 2004). The purpose of this study was to gain an understanding of student nurse experiences and perceptions of their learning in relation to the situated health care learning environment. Therefore, it was more appropriate to operate at a descriptive, rather than latent level (Graneheim & Lundman, 2004).

The first step in the systematic, yet iterative process of descriptive content analysis is for the researcher to firstly decide whether the study will analyse manifest or latent content of the data (Graneheim & Lundman, 2004). I decided that, due to the limited nature of the scope of this current thesis, to remain within the descriptive or manifest content domain. Manifest content refers to ‘what the text says’, i.e. describing the visible or obvious components (Graneheim & Lundman, 2004). Both manifest and latent content analysis involve interpretation, but varies in levels of abstraction and depth (Graneheim & Lundman, 2004). In this way, there is a deliberate choice to avoid an interpretation of the underlying meaning (latent content) to develop themes. The rationale for this is because of the aim for this current study, which is to gain an understanding.

To demonstrate the amount and nature of data that was collected throughout the stages of this study, I have depicted this in a flow chart format (Figure 6 ref. pg. 57). Therefore, to counter any
tendencies to feel overwhelmed by the sheer amount of depth of data before me (Bloomberg & Volpe, 2012; Creswell, 2014), it was necessary to approach the task in a systematic manner (Graneheim & Lundman, 2004). I read and re-read the transcriptions and reflective captions. I viewed the accompanying photographs and I listened to the focus group and individual interviews repeatedly. I did not use the key concepts that were derived from the research questions (Appendix A) such as what would be used in a deductive approach to content analysis (Elo & Kyngas, 2008). Elo and Kyngas (2008) state that in content analysis, a deductive process is appropriate for areas where there is some established closely related literature and theory. Given that this thesis takes from a number of disciplines and concepts such as social constructivism, situated cognition, nursing pedagogy and Communities of Practice, coding needed to be more of an emergent process. Therefore, adhering to a more inductive approach would allow authenticity of the messages participants were wanting to convey to be upheld (Elo & Kyngas, 2008). Elo and Kyngas (2008) justified the inductive process of content analysis as being appropriate when there are no previous studies dealing with a phenomenon, or when it is fragmented (Elo & Kyngas, 2008).

Overall, the best depiction of the content analysis process which I chose to follow is provided in table format (Appendix J). This best illustrates my understanding of the chosen analytical method. The table format depicts a linear process, though actually involves a ‘back and forth movement between the whole and parts of the text’ (Graneheim & Lundman, 2004 p.107). As mentioned previously, this researcher used the analytical software ‘NVivo’, which aided in the analysis process. Use of this electronic software, paired with the Graneheim and Lundman (2004) method of QDA, worked well to not only build self-confidence and proficiency in use of both these complementary methods, but also to enhance rigour of the analysis. Organisation and categorisation of the terms and processes used in the Graneheim and Lundman (2004) is presented in this way in order for me to ensure that I was adhering to the procedure as accurately as possible, while aligning with the
terms processes used through the NVivo software. Appendix I presents the analytical findings as a concept map, which was constructed using NVivo.

Figure 6. Summarised depiction of data types extracted at each stage, by each of the 3 main participants

Ethical Considerations

In accordance with the NHMRC National Statement on Ethical Conduct in Research Involving Humans (Australian Government, 2007 (Updated 2015)), ethical approval through the university Human Research Ethics Committee (HREC) (HREC, 2013) as well as through the HREC of the LHD (Human Research Ethics Committee (HREC), 2015) was sought and granted prior to data collection. The use of photography had strict criteria including the written consent accompanied by additional local hospital ethics and research governance approval. The guidelines can be found in Appendix B. It was agreed by both ethics committees that the research project was of low or negligible risk.
according to the NHMRC National Statement on Ethical Conduct in Research Involving Humans (Australian Government, 2007 (Updated 2015)). A copy of the university ethics approval letter, the approved participant information statement and the approved participant consent form are provided in Appendix K, Appendix L, and Appendix M, respectively.

Trustworthiness

Trustworthiness is regarded as a component of establishing rigour in qualitative research (Lincoln & Guba, 1985). There are four constructs needed to determine trustworthiness, as described by Lincoln and Guba (1985). These are credibility, transferability, dependability and confirmability.

Credibility

Credibility and transferability are two criteria considered to be crucial for establishing trustworthiness in qualitative data (Lincoln & Guba, 1985). Credibility involves a prolonged engagement and persistent observation, which was able to be achieved by this researcher as having been part of the teaching team at the precinct since commencement and throughout the time leading up to the data collection. My prolonged period of engagement at the site and teaching the students allowed for a building of both trust and rapport with the potential participants. It also allowed for a persistent observation, in which I was able to focus on aspects of the current context that were relevant to the social learning phenomena being studied. “If prolonged engagement provides scope, persistent observation provides depth.” (Lincoln & Guba, 1985 p. 304).
Transferability

To seek understanding that might prove useful in other situations (transferability) is a key aspect of qualitative research, and is strongly differentiated from generalisability by Lincoln and Guba (1985). Cronbach (1975, as cited in Lincoln & Guba, 1985) emphasises the argument against generalisability in naturalistic inquiry by stating that the "task is to describe and interpret the effect anew...for when we give proper weight to local conditions, any generalisation is a working hypothesis, not a conclusion." (p. 123 – 124). Enhancing transferability requires the provision of a ‘thick description’, regarding the context of the study, so that others may make inferences about contextual similarities (Polit & Beck, 2014).

Dependability

There was an intended and resultant small study sample of 8 participants which garnered the following units of analysis: 1 focus group; a total of 33 photographs, each with associated reflective captions; and 3 follow-up semi-structured interviews). The rigorous data collection methodology meant that there was variety in order to achieve both data source triangulation, as well as method triangulation. This allowed this researcher to converge upon the truth, and be able to better discern from any erroneous data (Creswell, 2014; Polit & Beck, 2014). Forms of triangulation are a method to address intrinsic bias and works to establish credibility in naturalistic inquiry and qualitative research (Creswell, 2014; Polit & Beck, 2014).

Confirmability

In order for the findings to be corroborated by another researcher, Lincoln and Guba (1985) assert that confirmability must be established through a process of auditing or through the use of a number of different strategies. Whilst I have attempted to demonstrate transparency of research steps and record keeping through the inclusion of Appendices A-M, one suggested strategy has in
fact, broad ranging applicability across credibility, transferability, dependability, as well as confirmability. That of reflexive journaling (Lincoln & Guba, 1985). I understand and acknowledge the potential for bias throughout my dissertation. I believe I have made best attempts to bracket my views through reflexivity. I have kept a 260+ page word document titled “thesis journal” and have made dated entries on my novice research journey throughout this project. In terms of establishing researcher credibility, this current degree (Master of Education, Research) has been invaluable. Prior to this, I have completed a Bachelor degree in Nursing, a Post Graduate Diploma in Nursing (Sub-major in Recovery and Anaesthetics), and a Master of Nursing (major in clinical education). However, these were all coursework degrees and though consisted of elements of research theory, there was never the application of actually conducting research. This current degree suited my need to be orientated to the research-world. I undertook core units of study that not only helped to inform how to conduct my research, but also to teach me the foundations of qualitative research so that I may apply these in future research projects.
Chapter 4 - Findings

The following 3 participant descriptors are to provide the relevant background information of those who participated in both stages and all forms of data collection. This would provide some insight into whether participant previous experiences had any influence on the way in which they responded to the questions, and therefore my interpretations as part of data analysis. Relevant quotations are included for the purpose of reader insight into the main participant perspectives for their respective learning journeys and how they approached the Visual Participatory Methods (VPM).

Background of participants

AA is a 24-year-old female domestic student; whose residence is within the LHD. Her previous degree was a Bachelor in medical science.

We learnt a lot about physiology, anatomy. We do learn about diseases and all of those things, we cover those topics. The thing that we don't learn is what to do about it. All we do is kind of like sitting back, looking at how it affects people and knowing that you can't really do much about it because there's no cures for certain things. It was more theoretical.

I wanted to do something that would be more helpful in the sense that you feel like you're doing something about it. Then I started my nursing degree and I feel like you're working with patients, even though you might not cure the patient, just talking with them and trying to help them, comfort them like their pain and things like that, I think that's very helpful.

On the VPM activity, AA reported feelings of nostalgia and a greater awareness of surroundings from recalled memories. There was a realisation of the deeper emotions and meanings that were directly connected to places within the learning environment, simply because of where they had occurred. AA had provided a lot of content and depth in her reflective captions, choosing to use the
recommended structured reflection in the guidelines (Appendix B) and to type her responses, but not to label each photograph with an overall representing theme.

*It brought back memories of when I didn’t know anything or I felt like I didn’t know anything. It made me realise how much I’ve grown and how much I’ve learned throughout this year and a half, I’ve learned so much about clinical nursing knowledge and things about myself like who I am.*

*It was spontaneous. As I took each photo, it was like - “what next?” What’s something that just really resonates in my mind and just went there and took the photo.*

*Taking the photos made me realise this is pretty much my second home.*

BB is a 26-year-old female domestic student; whose residence is also within the LHD. Her previous degree was a Bachelor in ancient history.

*Before when I would enter hospitals, I would always say to someone ‘Oh I hate the smell. It smells like cleaning agent to cover the stench of death.’ I associated hospitals a lot with death, the plague, sickness. When I did this degree, I got to see the hospital from a nurses perspective and now I love hospitals. I would gladly go into any one and work in any one now and in any hospital. It definitely changed my perception on hospitals and health as well. How important health is. If you just throw it away, what’s the point of living, you know?*

*I’m very passionate about education. Particularly in nursing, I think education is power. On placement in particular, there is an element of fear that a patient will ask me a question and I will not know the answer. It drives me to understand their condition, to understand how they can manage that condition that I can give them the best information possible to make their life better. That is the most challenging aspect for me. I know I can’t sit down and absorb everything all in one day. It’s a journey. And it’s a whole life learning process. That is the most challenging thing. It also has changed me. It’s made me realise how much responsibility I have as a nurse.*

BB had approached the exercise from a very personal perspective, making a deliberate decision to select images of places that could best represent her own learning journey. Out of the 3 participants to complete this activity, BB chose to follow all recommendations as part of the guidelines provided to participants (Appendix B), labelling each photograph with a theme, as well as following the recommended structured reflection process. Her reflective captions were handwritten.

*I just sort of thought ‘okay what do I recognise in [this] hospital, what do I affiliate myself with?’*
CC is a 34-year-old male domestic student, whose residence is likewise, within the WSLHD region.

His previous degree was a Bachelor in Business - Accounting.

_I didn’t like what I was doing in [industry withheld for privacy purposes]. When I quit my job, I ended up working at [hospital name withheld], and a few of the people that I was working with suggested to me that I do nursing. They felt that my personality was suited to dealing with patients. That’s how they said it. I did get a few compliments from patients that said that they like the way I interacted with them. So, they felt that I’d be able to interact well with patients, and be able to leave a good impression...from then on, I started investigating the possibility of becoming an RN, and I made the plunge, and haven’t regretted it since._

CC was the participant who chose to include the least number of photographs for the study, and also to not follow some of the suggestions in the provided guidelines (Appendix B). He did not label each photograph with a representative theme, nor did he choose to follow a structured reflective process. He instead chose to hand write key reflective words that he associated with each image, in the border spaces around each photograph. I did not see this as insufficient to the purpose of this study, as the follow up individual interviews were complementary and in this case, compensatory. The follow-up individual interviews were an opportunity to ask each participant about some of their photographs they had selected for study inclusion, and to comment about them personally and reflectively. CC approached the exercise with the intent to show his personal perspective and share insight into his learning journey.

_When I went through all those different places where I took the pictures, I was just trying to think what normally comes to my mind when I go into those places. In some of the instances, I was trying to be in the places where I might probably be sitting, and looking, and getting that whole experience of being [here]._

**Emergent concepts**

Findings will be structured around the research aim and questions (ref. pg. 41), and presented through an integration of the raw data. To maintain confidentiality of the participants, pseudonyms
as participants (AA, BB, CC, DD, BG, LH, XI, TB) have been used. A data analysis summary table (Appendix G) also displays organisation of codes and raw data across different content areas. This is complementary to Appendix H, which displays a consistency table of analytical findings to the corresponding analytical interpretations. Exemplar VPM images are in Appendix F. Below is a summary table to depict the emergent concepts and examples of corresponding quotations.

<table>
<thead>
<tr>
<th>Emergent concept</th>
<th>Example quotations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General contextual data</strong></td>
<td>CC: The course has been good. Challenging, and intense, but I think it’s a very good course. I’ve actually learned a lot. I like to think there’s been progress, from where I was when I started, to where I am right now. BB: It’s very intense. I guess that’s what happens when you cram 3 years into 2. But it’s do-able. If you plan your life properly.</td>
</tr>
<tr>
<td><strong>Locally situated support</strong></td>
<td>CC: …when you are in a University and part of a big campus, that element of closeness was never there. You didn’t really feel like you could always turn to somebody and ask somebody for help. You know, you felt like you were a stranger in the middle of a big tide. But now there’s that sense that if you have a challenge, you’re not afraid to turn around and “look, did you understand this? Can you explain this?” - There’s that sense of security. Almost like that family feeling. You know, the support. DD: I think because we are in [hospital name withheld], that we get to know even the lecturers, and whoever comes – the tutors quite well. I personally didn’t have this experience when I was doing my bachelor’s degree. Just..the lecturer would come and give lecture and.. that was it. But here, you know them better. So there’s more chance of asking questions and building that sort of relationship that can help you with performing better in that unit. And the staff I think who are in [hospital name withheld], I found very supportive.</td>
</tr>
</tbody>
</table>
| **Social foundations for inter and intra professional dialogue** | BB: Having the med students here is fantastic. Because it breaks down the barriers. Some of them, I’ve seen on placement and they’ve actually come up to me and say “oh, come on – do you wanna see this?!” And I say - “I sure do!” [focus group laughter] you know? and so it doesn’t make doctors as scary as they seem…So breaking down barriers – really important. And I think that this course.. being here did really well. Interviewer: So where did that come about? BB: Just inter-mingling in the common room. AA: ... we kind of have more opportunities to interact with the nurses so say, we finish a placement and then we see them eating lunch, or on their way to the elevator and we say just “oh, hello” and they kind of do a little mini catch up and see how you’re going. Give you tips. Or, yeah just tell you “you know - you’re doing good, keep going, keep studying, stay in there.” ... So I feel like that’s really
important to feel part of [hospital name withheld] as well, not just part of the university.

The health precinct as a Community of Practice

CC: The way I see it is, there’s an interconnectedness that’s there. If you look at the nurses that we’ve come across, and some of the things that they’ve told us about this place, there’s this sense that they are striving to be, possibly, the best version of the RN's that they could be. And they’re working as part of a team...you see the doctors, and nurses...When it all goes well, you see them as a unit....Especially when I imagine...the really positive experiences I’ve had, in terms of placement - when I’ve really seen the teams get into action, and resolve a potential crisis.

Situated affiliation and association

CC: I think if you’re a main campus student, you wouldn't feel that sense of connection that I have with [hospital name withheld], in a sense. Because, having done all my placements here, I almost feel like I work at [hospital name withheld]. I have that sense of - I connect with the place, and I identify with the culture of the place, and the expectations that come with this. I don’t know what main campus students feel, but if I was being sent to [hospital name withheld] one day, [hospital name withheld] the next day, then I wouldn’t have that sense of a connection.

A contextual mindset

BB: I feel in touch with the workplace. You know, like the possibility of me becoming a nurse, you can imagine it even more when you’re here because you’re in a hospital. So I think the goal to become a nurse is more within your grasp because you see it. You know, it’s a goal that you’re living every day.

CC: There’s...a reduced anxiety. Knowing that you’re going to [this hospital] for your placement. You sort of know the policies and procedures. You’ve got a good sense of understanding of how things work. ... there’s always that sense of security. That look – “at least I know how things are in this place”...if you are one moment you’re in this hospital, and the next you are thrown to the next hospital, you don’t know what to expect and how things work...

Heightened relevance awareness

LH: There’s lots more opportunity to integrate the two a lot more. We could get the CNSs to teach that specific, whatever they’re specialising in. We could get them to come down and teach use that so that we could learn it directly. We could have integration with the SiLECT [hospital simulation education] team...learning Advanced Life Support from them...

CC: you tend to feel it’s like a wasted opportunity. If, for instance, say we’re dealing with things like broken bones. It almost feels like such a sad pity that you can’t go at the end of the class to the orthopaedic [ward]. Maybe that might actually help with understanding the theoretical underpinnings.

General contextual data

To understand perspectives that this particular group of nursing students hold, participants shared the impact of their previous degree or life experience upon their current approach to learning. Many of the GE students, regardless of professional or academic background, were keen to engage in the
practical application of previous and concurrently gained knowledge, and appreciated this extension
of their established foundation analytical skills.

BB (Individual interview): ...the fact that I did ancient history helps... in ancient history you
have to gather all this data together and then make a hypothesis...and then act on it...I think
with nursing I’m good at that. I can synthesize data pretty quickly and think ‘what’s the
priority?’ and then just do it.

CC (Focus group): I did business and accounting ... they’re both completely different fields but
in one aspect there is a bit of relationship.. there is always this analysis of: you’ve got a
problem and you’ve got information and you’re trying to bring that information together and
synthesize it to try and come up with a solution so in that respect the critical thinking skills
that I was taught in business school are transferrable when you get to nursing...because you
still got almost the same ingredients just in a different environment.

DD (Focus group): I did...medical science. For me, it really helped me...with the physiology and
pharmacology and the science... But with the practical things we do for nursing, it sort of
provided me with the basics. I think nursing helped me to identify...critical thinking. Whatever
I know okay – ‘so this is the problem’, I know it from my medical science degree but I didn’t
know how they use it, how they assess it, and how they can help the patients so I always
wanted that aspect that now I’m getting it from nursing.

There is a paucity of research on Australian GE nursing students (ref. pg. 33). In the Duke (2001)
mixed methods study, 34 students participated in focus groups to ascertain course perceptions by
students of the first GE pre-registration nursing degree in Australia. Half of these participants had
previously graduated from a science degree. In a study by McKenna and Vanderheide (2012), the
majority of nursing student participants (39.2%) had likewise, previously graduated from a science
undergraduate degree, with the remaining coming from other areas such as business, law,
education, medicine and psychology. The focus of existing research in this area has mainly been on
quantitative analysis of student background and characteristics, as opposed to qualitative reports on
the impact of perceptions of learning or immersion in a clinical environment, upon workforce
readiness.
A GEM program of only 2 years duration offered a challenge and incentive to students. This led to participants commonly reporting that the experience has challenged them intellectually, emotionally, and was a catalyst for personal and professional growth. Their growth took the form of a greater respect and appreciation for nursing and time management to balance study-life commitments.

Xi (Focus group): Because of the intensity of the course, you’re forced to sort your priorities out outside of uni as well so that you have time for everything... your time management. And the importance of looking after yourself, getting enough sleep and eating right...I think we all understand just how much knowledge nurses are required to have. Which you kind of underestimate before.

The intensity of course delivery was even more so for the program within the health precinct due to local timetabling and room booking constraints. The spaces for teaching and learning were also shared with the local hospital staff for meetings, conferences or presentations (Western Sydney Local Health District (WSLHD), Unknown-a). Logistically, this meant that study days for these students have a full schedule usually starting at 9AM and finishing at 6PM. The scheduling of classes was needed to be spread over 3-4 days, as lectures were being video conferenced between the main campus and health precinct. Not only was the course content and pace delivery generally quite intense, but students situated at the health precinct had quite exhausting, long days of study together. To establish this context, participant BB outlines a typical day as a nursing school health precinct student:

BB: Usually lectures are first. I’ll spend four hours in a lecture. In between that, I would probably eat lunch in a lecture theatre and get some coffee because I need coffee. And then lunch time, either I’d buy lunch or I’ll go straight to the common room and that’s where I will...be doing some uni work...and then from there, we go to tutorials.

Participant BB also chose to reflect this sentiment in BBVPM 10 of 15 (p. 127), with the written key words “tiresome days”, “coffee”, and “student”. Image and reflective key words as shown in CCVPM 6 of 6 (p.115) from participant CC shows the interior of this same seminar room. Photographic
depictions of participant learning experiences across the different spaces within the situated hospital learning environment provide insight into the local student learning environments. The expected images were places such as the lecture theatre and seminar room – both of which are hospital venues, but were used by these students for their lectures and tutorials.

**Locally situated support**

Reflections that accompany the photographs show that the recommended reflective cycle guided participants through a structured process of thoughts, feelings and memories, depicting a subjective and personal depth to these learning settings. Many of these images, upon reflection by participants, depict an association between places, moments, feelings and memories to not only the learning which has occurred, but the presence and interactions with other people. Namely, their peers considered to be genuinely friendly relationships. The continual exposure to shared learning experiences was a significant difference to that of main campus students who can self-select tutorial and simulation class times across a 5 day week. The recommended number for a tutorial class is 30, and simulation classes, 20, irrespective of location. This is based on staff to student ratios. The role of support by peers and locally situated staff also emerged during the focus group and other images. Local support throughout their learning development and professional trajectory was subtle, yet significant. What had bonded these students together was the sharing of experiences within a place, along with a consistent presence over time. Essentially, establishing ‘common ground’ both literally and metaphorically. The impact of having a consistent and smaller group of students who share a different experience is described below as being ‘important’, and providing ‘a sense of security’ by many participants across the individual interviews and the focus group participants.

*AA (Individual interview): I think it’s important to have good relationships and strong relationships and support because if you don’t like the environment that you’re in, you’re not going to want to be there and you’re not going to want to learn. You’re constantly with them [the same group of students] from 9.00 to 6.00.*
CC (Focus group): ...there’s been a lot of support, especially if you are looking at us as a group... because we are out here we know each other well. Even if for instance, we were dealing with a complicated subject or complicated lecture and then somebody comes up with an easier way of understanding that concept... when you are in a university and part of a big campus, that element of closeness was never there. You didn’t really feel like you could always turn to somebody and ask somebody for help... you felt like you were a stranger in the middle of a big tide. But now there’s that sense that if you have a challenge, you’re not afraid to turn around and “look, did you understand this? Can you explain this?” - There’s that sense of security. Almost like that family feeling. You know, the support.

AA (Individual interview): What it [the course] has to offer... as in the lecturers and the tutors, they’re really great, they’re very supportive. [Here] you get that one-on-one interaction because we’re such a small group and so whenever we have questions they usually are answered on the spot when they’re there, when they’re present... You need teachers and lecturers and tutors to be available... because we’re a satellite campus, we’re not at [the main university campus], you need to be able to have direct communication with teachers... if you’ve got concerns or questions or things like that. That’s important in the learning experience because if you don’t have access to those things you won’t be able to learn.

BB (Individual interview): This is my parents and uni (BBVPM 13 of 15, p. 116). So this is where I come for support and wisdom and just like the student in search of help. So in the sense like, you just find the sign. It’s like the yellow house sign where there’s help. Safety and help.

Neill (2012) conducted open ended semi-structured interviews of six graduates of a GE nursing course and organised this data through a thematic analysis of course facilitators and detractors.

Participants from the Neill (2012) study acknowledged that it was their level of maturity through gained life experiences that assisted in coping with the intense workload throughout the course. Their motivation to pursue a nursing career aided in maintaining focus, and previous tertiary study experience was attributed to confidence in academic skill and ability. Challenges such as high stress were alleviated by forming support networks with other students. Performing academically well under what is commonly referred to as an intense and demanding program, in addition to meeting family and work related responsibilities is a challenging balance to achieve (Neill, 2012). This stress can be compounded by perceptions of course and curriculum disorganisation, a lack of support by school academic staff and anxiety regarding placement into clinical environments. This has implications for student support initiatives to alleviate stress levels and to optimise academic performance and student experience.
Social foundations for inter and intra professional dialogue

Having the shared student common room was a commonly captured image across each of the 3 main participants (BBVPM 8 of 15 p.117, AAVPM 9 of 12 p. 118, CCVPM 2 of 6 p.120, and CCVPM 1 of 6 p.119). It is described as an area that holds fond memories with their nursing student peers in a relaxed manner. Group study and social interaction with the medical students who also study at the health precinct, but in their clinical school, were also associated with this space. The social experiences in the shared student common room had implications for interprofessional dialogue, resulting in a greater appreciation of the different professional roles, and dispelling misconceptions about their professions. The interaction facilitated an openness to discuss common or shared areas of experience.

CC (Focus group): I’ve actually built some very interesting relationships with some of the medical students. I’ve...got a few guys I get along well with in the medical school which I guess wouldn’t have happened if we weren’t sharing the same common room. It’s put down barriers in a sense that we interact a bit more freely now as we’ve gotten to know each other and we sometimes might meet them on placement and then they will be like “oh can you come check this out?” We all came from the same environment we all went to the same uni I guess it helps build bridges and sort of like bring a better understanding...So it’s helped opened eyes in both respects... for nursing students in respect to medical students and medical student towards nursing students.

Sharing places, moments and memories with other people in the example excerpts has illustrated the impact that these factors have on not only formation of a community, but of the community’s culture. A prominent author in the area of place-based pedagogy, Gruenewald (2003) asserts that places are profoundly pedagogical. That is, places are to be considered as centres of experience and thus able to teach us about how the world functions and how occupants may align themselves. As such, in occupying these places, our identity can be shaped. Essentially: “people make places and that places make people.” (p.621). To further illustrate this role of places and settings, in the following excerpts, participants demonstrated the association between people, places, memories, artefacts within their situated learning environment:
AAVPM 4 of 12 (p.114) - In a way I think we all kind of feel like this is our lecture room. I guess when we’re going to class I always see this big ‘1’ sign, number 1, we’re number one...I remember on orientation I saw number 1 and we were called ‘GEMS’ and we didn’t know what ‘GEMS’ stood for so we just thought we were special... it brings back memories of orientation day.

BBVPM 2 of 15 (p.123) - So the portrait of that man... I looked at him and I was like ’it’s you again’...it’s like that’s comforting. The very first day of orientation...[Hospital Staff Name withheld] said, “These pictures are hand painted.”...every time I come up... look at this man...that is the only painting I see every day properly. He’s just there. So I look at him as my [hospital name] grandfather.

CCVPM 3 of 6 (p.121) - the place that we used to sit down and have lunch, especially in first year. After our lecture... we all sit down there and discuss how we saw our futures...at the time, I remember a lot of people were trying to figure out where they were going with their nursing...It was a place where we all got there and discussed our futures in a relaxed setting...Because, when you’re inside the buildings there’s that sense you’re working through that program, and it’s all serious.

BBVPM 12 of 15 (p.122) – ‘Fear’, ‘knowledge’, ‘things you need to know’, ‘worrying about patients’...it represents my fear of not knowing enough to help a patient or whether I don’t have enough knowledge. It also represents a communal thing, as in education.

AAVPM 5 of 12 (p.128) - This is a memory of when I had my first placement. When I see this photo I remember my heart pounding, “oh my God, this is real I’m in my placement, what’s happening?” But then even after that...I’d always pass these signs and it’s just a reminder of where I’m going...

BBVPM 6 of 15 (p.124) - time management and how, on clinical placement, I break-up my clinical placement based on time...Timing and nursing...So this clock is just representative of that. And also that clock is everywhere at [this hospital]. So whatever ward I go to, I feel right at home.

AAVPM 8 of 12 (p.126) - here you’ve got the NUM [Nursing Unit Manager] and the clinical educator who I actually worked with and an RN.

These excerpts and VPMs are all examples of how places and the people, memories, artefacts and spaces located within can be representative of significant moments across their respective experienced journeys. Memories can be triggered when visiting places or looking at pictures of these places or artefacts. The environment within which their learning was situated was actually a reflective surrounding for these students – their learning and professional career trajectories were projected around them in some form, suggesting that this provided feelings of security and satisfaction when looking towards their respective futures. This type of environmental influence therefore has potential implications upon motivating factors for these situated students.
The Health Precinct as a Community of Practice

Geographical proximity to home was a predominant initial motivator to select the health precinct as their site of program delivery. Ongoing motivation was a result of intrinsic factors, mainly altruistic reasons that were emphasised due to the authentic setting of their learning and by the direct link their learning environment had to their future career.

AA: *When I applied for the course it was so close to home...also wanted to get to know what [this] hospital was like because I've never really been in a hospital previously...I thought if I go in and I see what it's like it might kind of put my mind in perspective, ‘is this what I really want to do?’...those kind of questions that I had about my future career.*

The presence of hospital staff and of patients in the immediate learning environment was been perceived by study participants as a significant role and ongoing motivator in their course progression and overall career path. The dynamics of the hospital environment included interaction with staff and patients. Students situated within this hospital environment could see their own personal learning journey, their progress, their growth. Their surrounds were continually offering a glimpse of what their future may hold. For these participants, their surroundings were a trigger for memories, attention to present day, and the possibility of future experiences. This became a prompt for motivation and a meaningful engagement with their learning. Surface social interaction with hospital staff provided a reassurance, an encouragement, a small validation of their career journey efforts. It was part of the atmosphere of career aspiration and affirmation.

AA (Individual interview): *when you go to placement you...gain a little bit of rapport between staff members...and I feel like if I were to study at [the main university campus] I wouldn’t have such a strong relationship with the staff here...I think that’s important because if you see friendly faces around that aren’t studying, that are actually in the workforce, it kind of gives you that sense of support and like “I can do this”, because if they can see I’ve got the potential then ‘it’s good’, ‘I’m good’, ‘I’m learning and that’s part of the learning experience and I will eventually be there one day’.*

AAVPM 8 of 12 (p.126) : *I wanted to take this photo because it shows how supportive everyone in the ward is of students and not just students, nurses as well and other health professionals...Just because, say I’m an RN, doesn’t mean that I know everything and I will always be learning constantly so I think that’s really important too.*
CC: You are in a hospital, working towards becoming a nurse. There's that sense that you've got a very strong connection with your future career...for somebody who really wants to learn, or study, the space, and opportunity is there for you to actually engage...So, I think it [the situated hospital learning environment] does encourage learning, absolutely...The way I see it, there's an interconnectedness that's there. If you look at the nurses that we've come across, and some of the things that they've told us about this place, there's this sense that they are striving to be, possibly, the best version of the RN's that they could be. And they're working as part of a team...you see the doctors, and nurses...When it all goes well, you see them as a unit....Especially when I imagine...the really positive experiences I've had, in terms of placement - when I've really seen the teams get into action, and resolve a potential crisis.

Though this current delivery model cannot be described as incorporating a formal or structured type of mentoring, there were similar elements demonstrated through student transcripts. Dr. Jenny Spouse, in her research on work-based learning in nursing education, asserts that characteristics of successful mentorship are based on sociocultural theoretical frameworks, such as that of the theory of situated cognition (Lave & Wenger, 1991; Spouse, 2001). With regards to nursing education, the concept of legitimate peripheral participation as part of situated cognition, describes how novices contribute to a community's work. This is through participating in relevant and tailored (scaffolded) learning activities that meet their educational needs whilst under the guidance of an established member of the CoP (Lave & Wenger, 1991; Spouse, 2001). Therefore, the most beneficial learning that occurs in the clinical setting requires effective and supportive interactions and relationships between student and mentor. Spouse (2001), in her naturalistic, longitudinal study, investigated how pre-registration nursing students acquire knowledge in clinical settings. She determined that when students received effective support from their mentor, it helped to establish a trusting relationship. This then allowed students to settle into their clinical placement environment quickly, and gave way to students developing confidence and learning to appreciate the relevance of their theoretical knowledge to clinical practice. For the students whose situated learning environment was the hospital and wider health precinct, their exposure and participation to the CoP may still be on the periphery, but it was on a much more constant and consistent basis.
Situated affiliation and association

It is important to be reminded, that this was a new delivery model being implemented with the intention for students to gain affiliation with the LHD, but to maintain an identity as a student of the nursing school (ref. pg. 12). Associated with the inaugural implementation were professional and academic staffing issues, as well as logistical challenges impacting on perceptions of affiliation and association.

The separation between the health precinct and main university campus was a geographical one, but even this difference in location and staff unfamiliarity seemed to have a deep impact on some student’s learning experiences during the course. Participants identified with the hospital more so than the nursing school responsible for the delivery of their program. This came down to a matter of location - where they learn and the perceived legitimacy that this learning environment has over the traditional university campus setting.

BB: You’d think I’d feel part of [the main university campus], but I don’t. I feel very disconnected from them... I feel like we’re part of the hospital, I don’t feel part of [the main university campus] at all.

CC: I think having somebody here is important, sometimes, especially when people need to ask questions. Sometimes having somebody at [the main university campus] - it’s a bit difficult to get that instant response. There’s a bit of a disconnect. But I think it’s actually better...to have somebody who you can touch base with quickly, and easily...Having somebody who you can actually interact with. It’s much easier to establish rapport with somebody in person, than somebody who is a bit further away.

One student in the focus group, had an anecdote that had resonated with her for well over a year, regarding what she had termed as challenges with “politics, hierarchy and disorganisation”, which was specifically in reference to the nursing school:

LH (Focus Group): first year when we did CPAs [Clinical Performance Appraisals] obviously, they’re run at [the main university campus], which we weren’t really informed of from the start. Do you guys agree? [directed to rest of focus group members] Yeah. ...well they said to
us at the start, they were always working through it trying to see if we could get a change. Which was also fine, but then there was one day we could go get orientated to the [main university campus] labs, and I wasn’t able to attend cause of work commitments. I organised a different day with a certain lecturer who, when I attended she wasn’t there, no one was there. So I was just left wandering around, not knowing what to do. I didn’t want to touch anything and mess up anything so I ended up just leaving and then I emailed her and she accused me of A. Not going and then B. yeah it’s just incredibly frustrating. And she was rude. There was no need to be rude. It’s just unnecessary to be like that. Like okay, common communication mistake, that’s okay – we can get over it. But then.. yeah, that’s my story.

Disorganisation was highlighted with concerns about the videoconferencing technology. The geographical separation was not the complaint; in fact the mode of technology appealed to students, but the technology had to function correctly to provide that delivery effectiveness.

Focus group excerpt:

DD: ...knowing that they knew this was happening they could have planned it before and more effectively...because there were times that they totally forgot about us.
Group: Yeah!
DD: It wasn’t recorded, they didn’t stream it so we were like “really?” and sometimes there was no sound and they say “oh, we can’t fix it”.

CC (Individual interview): we’re getting some of our lectures from [the main university campus]...you’re going to need good technology that enables that delivery of content to be efficient, and less taxing. You don’t want to be stressing about getting a connection to the other side, or thinking, “I’m missing out. I’m not getting good sound. I’m not getting good pictures.” It’s important because, when it works really well, it facilitates that learning, and you only really tend to think about it a lot when things aren’t going well.

Negative experiences and perceived differences (rather than similarities) only exacerbated the geographical disconnect. A lack of interaction with the nursing school as a community, culture and place led to a decrease in association with the nursing school. For these students, in their view, it was the physicality and the presence which mattered significantly. They felt supported by all that is located at the health precinct – even the local nursing school staff. Students appreciated the nursing school staff that would come to teach at the health precinct. But nursing school staff that failed to consider or recognise them only further accentuated feelings of disconnect and subsequent disassociation. Perhaps their tendency to affiliate more so with health precinct, was a reflection of their dissociation with the nursing school. Participants felt they had very little in common with
students and staff at the main university campus. As if the ideals, experience and cultures at the main university campus and the health care precinct were different.

AA (Individual interview): You go in there [the main university campus], not many people know one another… there's a lot of people. Even [main campus] people that I have spoken to they say that they don't have as strong relationships and friendships… Whereas here at [the health precinct]...we're kind of like a family, we all know each other and support each other and we help each other through the good and the bad.

The current program of study was not delivered by distance. Yet, there were similar implications for student learning, engagement and interaction. Learning is fostered through student-teacher relationships (Mancuso-Murphy, 2007), and therefore a crucial factor in distance or online education. Mancuso-Murphy (2007) described the major challenges in those circumstances is to therefore be able to provide an environment conducive to establishing peer support, developing dialogue, and guiding socialisation. However, for the health precinct situated students, this had occurred and these needs were being met on a local base for them. The challenge here is to prevent the dissociation between the two delivery sites, as geographical or physical disconnect is unavoidable.

BB (Individual interview): ...university is seen as a place of education, but it's also seen as a place of socialising...the mindset is very different here [at the health precinct] because you're in a hospital and you can't act like this kid that's just come out of school. You have to present yourself professionally...So I think that's the main difference because you have to be professional. But it also goes beyond that because you see patients all around and I think that also changes your mentality.

AA (Individual interview): ...If I were to study at [the main university campus]...mainly what I would see is students, other students, lecturers and tutors ....at [the health precinct] you don’t just see students and lecturers and tutors you see doctors, you see surgeons, you see cafeteria people, you see physios, dentists, dentistry students. There's a whole variety of professions in this environment. I think seeing that day to day...it reminds you every day 'I'm going to be a nurse'...'This is where I'm going to work or in'... When you see other health professionals it motivates me to learn because eventually I will be working with them in a team. Whereas being [at the main university campus]... you don’t see that. It's more of a general university standard, you know, go to lectures and those kind of things. But being here you see it day to day and it pushes you like 'okay because eventually I'll have to do this... I have to learn... how to do certain things or learn how to communicate certain ways’. Then also seeing patients day to day. You see them walking around, seeing family, seeing visitors. You see them all the time so that
reminds you ‘I’m learning because I’m eventually going to help people like this and I want to make a difference’. Whereas if you’re not constantly shown that I think sometimes your goal it can kind of stray away.

A contextual mindset

There was a perception by participants, that the authenticity of the healthcare setting which their situated hospital learning environment provided, established an ongoing motivational “mindset” regarding their future profession. In this way, not only does the environment have direct relevance to the outcome of their concurrent learning, but it also prepared them for transition into professional identity. Participants wanted to gain a greater understanding of what it means to be a nurse. They struggle with this question as novices, and their situated learning environment provided insight to a certain degree. Even if only peripherally, it was still integrated, and not completely separated.

CC (Individual interview): When you’re at uni, you spend a lot of time - well, I spent a lot of time - imagining what my future career would be like. But, being at [the health precinct], you’d see patients, you’d see people in wheelchairs, you’d see ambulances rushing in and out. And you get to see doctors, and nurses, and you get to see all those professionals... within this environment. And there’s more of a realistic sense of expectation, at least, as in, what you’re going to get at the end of your program.

BB: It [the situated hospital learning environment] influences me because I am in a hospital. So I’m a very goal-oriented person and yes, I have a very good imagination, but when you come into a place where your imagination is a reality and you know what’s going to happen, it’s exciting. So the motivation just increases because you can almost touch the goal... I really like being here compared to on a campus because I just feel as if I’m in a different environment and anything can happen. I feel in touch with the workplace. You know, like the possibility of me becoming a nurse, you can imagine it even more when you’re here because you’re in a hospital. So I think the goal to become a nurse is more within your grasp because you see it. You know, it’s a goal that you’re living every day.

BB (Focus Group): Some days you think “oh my goodness, I’m so swamped with work, why am I doing this?” and then you walk out and you see the patients and they’re having lunch with their families and you think “oh, that’s nice that they can do that”. And then it gives you like “oh, I remember why I’m doing this”. And you see the RN rushing around grabbing coffee and eating lunch quickly. It’s like “oh, that’s why I’m doing this. I wanna be them one day.” Whereas at uni...it’s so separate.
In their own words, participants felt ‘connected’, at ‘home’ in the hospital, and have developed ‘confidence’ in who they are able to identify as when they were here. The realism that the environment provided made students astute in the awareness of professional boundaries and identities; something participants would often refer to as “the mindset” of being a nurse. Mindset for these participants is also adjustment to the responsibility that entry into a health care profession requires. The nature of the profession is stressful. But situated, prolonged exposure meant that for these students, they were not completely separated from that reality. Mindset was mental preparedness, which the extended time of exposure had afforded these students. Instead of being distracted or unsettled by the dynamic surroundings and stressful situations, they were prepared to focus on developing their learning foundations from university. This self-assuredness in professional identity and trajectory across the different boundaries and spaces arose from experienced familiarity and perceived belongingness over time. Notably, perceptions of hospital environment-associated anxiety were self-reported by participants to decrease over time and experience, expediting the process of adjustment and orientation to the hospital setting and the clinical environments therein.

AA (Individual interview): I think anxiety plays a big role because nursing, you’re working with patients...You’re working with people who are vulnerable...that’s why it’s [the hospital environment] so overwhelming and we’re not really sure what to do, where to go, who to ask and those kinds of things. I feel like learning here at the hospital it kind of feels like a second home. There are certain fears and misconceptions that you've got about hospitals that are kind of eliminated because you're there all the time and you see it. Things like hearing the sirens and looking at the helicopters that come in, all those kinds of things... I think if I were to learn [at the main university campus] and then come I wouldn’t be as mentally prepared for it. I think I'd be a lot more anxious coming because I really don’t know anything about the hospital...I think, if you weren’t constantly exposed to the environment, that anxiety does increase...

BB (individual interview): I think that being in a hospital is important for new nurses because it gets you familiar with the sights and the sounds and the smells, especially the smells, and the dynamics of the wards and everything so that when you do come to your clinical placements or when you do become a new grad nurse, you’re not so shocked.

CC (Focus group): There’s...a reduced anxiety. Knowing that you’re going to [this hospital] for your placement. You sort of know the policies and procedures. You’ve got a good sense of understanding of how things work. Once you get into a ward, maybe the things that you want to learn are like “where’s the pan room?” “where’s the drug room?”... there’s always that sense of security. That look – “at least I know how things are in this place”...if you are one
moment you’re in this hospital, and the next you are thrown to the next hospital, you don’t know what to expect and how things work...

Walker, Costa, Foster, and de Bruin (2016) conducted a systematic review of 13 qualitative research studies on the experiences of Australian newly graduated nurses. It was concluded that in the early months of adjustment to workplace expectations, the new level of responsibility is stressful for these novice nurses. Known as ‘transition shock’ or ‘reality shock’ (Kramer, 1974), this period of transition from ‘university student’ status, to ‘registered nurse’ is complex because of the changing expectations and responsibilities (Walker et al., 2016). However, this experience can be alleviated through effective organisational support, orientation periods, welcoming environments and mentoring relationships.

Heightened relevance awareness

Through the prolonged environmental exposure, participants experienced an appreciation for practical applications of their theoretical lessons and furthered their motivation to continue progressing in their studies. Further to this, was the integration of the three professional apprenticeships – ‘cognitive’, ‘practice’, and ‘formation and ethical comportment’ (Benner, 2015; Benner et al., 2010) (ref. pg. 30). Gradually, an understanding of how and why students situated within a hospital as their learning environment would grow to develop an identity, which meant associating themselves with the health precinct as a place, community and culture.

BB (Individual interview): It [the situated hospital learning environment] makes you put your learning into practice...for example, when we learnt hand hygiene, we’re in a hospital, we’re really aware of diseases and patients...So I remember I washed my hands like crazy after that...I make sure I do my hand hygiene. Now, if I was on the campus, no way...everyone is healthy, everyone is young....it wouldn’t be in the forefront of my mind. But since I’m in a hospital...I treat it like a hospital. I think it’s [the situated hospital learning environment] been a really important part, to be honest. I think it makes me be more serious about my work...I don’t know, this feels more real to me than [the main university campus].
AAVPM 6 of 12 (p.130): I wanted to capture that photo because to us, it’s really important. Every time I walk through these doors I always do my hand hygiene and feel like I’ve done something for I guess the public, I’ve done a public service.

CC (Individual interview): I think it’s [hospital situated learning environment] very important in the sense that, sometimes when you’re at uni, especially when it gets challenging - because there are times when you’ve got so many assignments, and you’re questioning, “Can I do this?” And then you walk out there, and you see RN’s doing what you want to do, and you see patients, and it’s a grounding in reality. It’s saying, “This is what I’m working towards.” It motivates you in times when things get very challenging. It’s something for you to say, “This is where I need to be. This is where I want to go.” And seeing a reflection of yourself in somebody who is passing through, just makes it a lot easier to push through the really difficult moments.

It appeared from the responses that familiarity and a sense of belonging with their surrounds aided in transition to professional practice. Students had that sense of belonging and connection and consistent exposure paralleled with their university teaching and learning. It should be noted that there were assumptions made about their student counterparts located at the main university campus. These were participant perceptions only, and it was not within the scope of this research to interview the main campus students.

CC (Individual interview): I think if you’re a [main university campus] student, you wouldn’t feel that sense of connection that I have with [this hospital]... Because, having done all my placements here, I almost feel like I work [here]. I have that sense of - I connect with the place, and I identify with the culture of the place, and the expectations that come with this. I don’t know what [main campus] students feel, but I think if I was being sent to [hospital name withheld] one day, [a different hospital name] the next day, then I wouldn’t have that sense of a connection. And there’s no sense of continuity in that, because you don’t know where you’re going to be at the end of the day. And you don’t know what the expectation is, when you move into a different place.

Participants felt part of the local hospital community; the environment. The sights, sounds and surroundings could dictate their identity and mindset, causing them to behave according to what was deemed appropriate. They felt a shifting of identities through constant and consistent environmental exposure being paralleled with their pre-registration lessons. These combined, helped to prepare them for their transition to professional practice. This does illustrate a laying of
foundations for a better understanding of the application of professional standards and codes of practice for the health precinct situated students. They perceive the local hospital staff as being who they would like to become one day, and could relate to them. It was ultimately about people and places, people in places, and the enterprises that the people in places are working towards achieving. The question raised is whether those who choose their site of program delivery to be within the health precinct are already highly motivated prior to commencement, or if that motivation increases over time as a direct result of the environmental influence.

Focus group excerpt:

CC: I feel I more relate to [the health precinct] than [the university]... don't get me wrong. I am proud to be part of the [university] community. But when you get into [the hospital] there is that sense that [the] hospital is more on the forefront of your mind and in terms of I see RNs walking around and I sort of like see them more as well I'm more looking into the future saying like "this is where I want to be, this is what I want to be" when I see them passing by. So I guess I more relate to being part of the [health precinct] community rather than being the university community in that sense.

ME: How did that come about? Identifying more as [a health precinct student]...

BB: it’s just the fact that you’re in a building that’s a hospital...it just registers in your mind “I am part of [this] hospital.”

When asked about physical spaces around the hospital in relation to identities, students spoke about how these were formed by location or by shared experience:

BB (Individual interview): I would say it’s almost entirely dictated by the environment. So in the rooms I’m a student. In the common room, I’m a student of the university. When I go to get my coffee...I feel a part of the hospital - I think because I see nurses and doctors lining up and I think I’ve got to be professional. And then when I cross the line here [BBVPM 1 of 15 p.129]...I just see myself as a professional-to-be, like a nurse-to-be. And the labs [CSLs] are training me to be that.

BB (Individual interview): I think when you enter a hospital, it’s not necessarily a happy, joyful place where you should be having fun. It’s more the serious, professional place where you need to be kind and compassionate. It’s about humans looking after humans, to me... So when I walk into the hospital in that sense, I become part of the staff in terms of if someone needed help, I would go straight to them and do everything I can.

AAVPM 3 of 12 (p.131): this is the way that a couple of friends and I go to go to class...this is very important because when we walk through here we...always see staff around having breakfast or patients. When we see the patients it reminds us ‘this is why we're here, we're here to learn’. We're here to learn so that we can get from point A to point B. It just kind of
puts us in...nursing mode like, yes, ‘this is what we’re going to do today’. You just really appreciate why you’re here walking through here.

BB: this is more to do with identities (BBVPM 15 of 15 p.125)...in [this hospital], I identify as a student and a nurse. There’s differences between what I feel as a student and a nurse...as a student, I am just part of the university community...Whereas out here, I’m in the hospital community. In terms of that responsibility, the student in the lectures, it’s myself, I’m the one who passes the assignment or fails. Whereas on clinical placement, it’s others. I’m responsible for other people. So it shifts...I feel like shifting through those identities is important because you’re going to become one of those identities in the future.

From the data collected, many participant responses were centred around learning for a sense of salience, and the ultimate practical applications of theoretical underpinnings. This may have been influenced by their initial expectations of associating learning within a hospital with the historical approach to nursing hospital training, or by the heightened sense of awareness experienced because of the authentic hospital surroundings.

BB (Focus Group): I think they [the nursing school] needed more practical ways that we can enforce...concepts. You know it’s great to learn it, but what’s the point - if you can’t use it?

AA (Individual interview): So they [the nursing school] give you examples of what's wrong and, you know, the things that you’ve got to be wary of but they don’t give you the solutions or strategies on how to communicate those issues and address them...in real-life situations.

DD (Focus Group): I expected that because it is in a hospital... they will teach us the same like the med students. So maybe “study for a month or two weeks” “so this is the things, let’s go to the wards now. This is the patient; you do these assessments”. I thought it would be more the old ways, you know? ...the hospital based...But then I realised “no, actually you have to wait the whole semester”. Then when placements come, then you can start consolidating whatever you have learned the whole semester.

It is clear from the findings that due to the reality of the hospital environment and dynamics, there was a heightened awareness of the relevance that theory directly has to practice. Subsequently, and perhaps significantly, there was a passionate case made by participants in the focus group for there to be more practical applications of theoretical underpinnings integrated into their program. It was clear from this research, that translation of what is learned in the academic settings into productive knowledge for application in the workplace was a significant process for these students. Without supporting a reconciliation of different learning expectations and outcomes between academia and...
their chosen profession, this can lead to a greater perceived disconnect and disassociation between experiences in the two areas than what already exists.

Focus group excerpt:

LH: There’s lots more opportunity to integrate the two a lot more. We could go get the CNSs to teach that specific, whatever they’re specialising in. We could get them to come down and teach use that so that we could learn it directly. We could have integration with the SiLECT [hospital simulation education] team...learning Advanced Life Support from them...It’s a lot more relevant to practice...cause those practical skills and practical knowledge is not really gained in the curriculum. It’s gained when you are on placement. I feel like I was kind of struggling my way through those kinds of things during placement. We weren’t really taught for that.

AA: I agree with LH. I also thought it was more integrated with the hospital. So..could be something possible in the future.

LH: ...My friend studies medicine here...their tutors take them up once they’ve already interacted with the patient that they know has the disease they’re about to study, they take their tutorial class up and they all go interact with this patient. They let them palpate, or whatever it is for that whatever that person’s disease is. And I feel that would be really valued by us.

DD: Exactly. And we did out Clinical Performance Appraisal [CPA, a practical examination] on abdominal assessment...and we didn’t have a real abdomen to do all the palpation, percussion all those steps...

XI: I agree with that. If we’re going to have a course in the hospital, why not utilise the hospital more ?

AA: Yeah.

XI: We’ve got the patients here, we’ve got real-life subjects here. We should utilise them.

CC: you tend to feel it’s like a wasted opportunity. If, for instance, say we’re dealing with things like broken bones. It almost feels like such a sad pity that you can’t go at the end of the class to the orthopaedic [ward]. Maybe that might actually help with understanding the theoretical underpinnings.
Chapter 5 - Discussion and conclusions

This study was designed to answer the following questions:

What is the pedagogical value of a situated learning environment in relation to the delivery of a pre-registration nursing degree from within a teaching hospital, and the wider health precinct?

Subset research questions were:

1. How do student nurses enrolled in this GEM degree perceive their experiences in the learning spaces within an authentic clinical teaching environment?

2. What do these student nurses describe as integral events in their professional learning across the different spaces in this environment?

Overall, the pedagogical value of a situated learning environment for these pre-registration nurses lies in the familiarisation of their surroundings and perceived connection with the CoP. There is a willingness to foster local culture, values and practices and to demonstrate or prove their affiliation to reciprocate those feelings of acceptance. This current model resulted in a self-identification that has helped to bridge gaps concerned with graduate preparedness and transition to professional practice as a newly registered nurse. All elements of their surrounds, paralleled with the proximal course delivery acts the reification of the very career aspirations they work towards. Despite the significance of this, there is further development needed, as overwhelmingly expressed by participants. A greater integration and collaboration between university and the hospital in which the course is delivered in, for these situated students. Having said this, this requires a further understanding and defining of what nursing is, and what nursing work entails, as well as the implications for curriculum development.
The findings of this study provide an understanding of the pedagogical value that a health care environment as a situated learning environment has for pre-registration nursing students. This research has depicted the health precinct as an embodiment of a ‘landscape of practice’, a term developed from the Wenger (1998) work on ‘communities of practice’. The term ‘landscape of practice’ is used to express the notion that “as communities of practice differentiate themselves and also interlock with each other, they constitute a complex social landscape of shared practices, boundaries, peripheries, overlaps, connections, and encounters” (p. 118). In reporting their experiences of forming identities and affiliations, students have corresponded with the Wenger-Trayner et al. (2015) statement:

As a trajectory through a social landscape, learning is not merely the acquisition of knowledge. It is the becoming of a person who inhabits the landscape with an identity whose dynamic construction reflects our trajectory through that landscape. This journey within and across practices shapes who we are. Over time it accumulates memories, competencies, key formative events, stories, and relationships to people and places. It also provides material for directions, aspirations, and projected images of ourselves that guide the shaping of our trajectory going forward. In other words, the journey incorporates the past and the future into our experience of identity in the present. (p.20.)

The theoretical underpinnings based on participant responses is best supported by the Wenger-Trayner et al. (2015) three modes of identification, used to make sense of one’s position in a given landscape:

1. Engagement: engaging in practice, doing things, working on issues, talking, using and producing artefacts, debating, and reflecting together.
2. Imagination: as we journey through a landscape we are also constructing an image of the landscape that helps us understand who we are in it.
3. Alignment: our engagement in practice is rarely effective without some degree of alignment with the context – making sure that activities are coordinated, that laws are followed, or that intentions are implemented. Enabling alignment around your design across the landscape is part of your identity as a professional.
Student nurse learning experiences and perceptions of undertaking their pre-registration degree within the situated hospital environment has been a valuable method of engagement with the CoP within the health precinct as a landscape of practice. The findings from this research suggest that a more integrated, sociocultural approach to learning and teaching for student nurses across landscapes of practice creates meaningful learning experiences that can aid in transition to professional practice. As discussed in the literature review (ref. pg. 30), it is through being placed within and learning within a particular situation, that abstract concepts can then be fully understood (Lave & Wenger, 1991). Identifying with the hospital more so than the school responsible for the delivery of their program came down to a matter of location - where they learn and the perceived legitimacy that this learning environment has over the traditional university campus setting. The hospital environment, dynamics, culture, people and even artefacts held significant memories of their situated learning experiences. Students are able to see their learning journey, their progress, their growth. Their surrounds are continually offering a glimpse of what their future may hold. Being surrounded by both past and possibility prompted a meaningful engagement with their learning.

Levett-Jones et al. (2007) reported on the qualitative phase of a mixed-methods study which explored nursing students’ experience of belongingness while on clinical placements. Eighteen interview participants in this study from Australia or the United Kingdom provided a range of perspectives on belongingness and how it influenced their placement experience.

*Belongingness is a deeply personal and contextually mediated experience that evolves in response to the degree to which an individual feels (a) secure, accepted, included, valued and respected by a defined group, (b) connected with or integral to the group, and (c) that their professional and/or personal values are in harmony with those of the group. The experience of belongingness may evolve passively in response to the actions of the group to which one aspires to belong and/or actively through the actions initiated by the individual. (p. 104)*
As discussed in the literature review (ref. pgs. 28-29), the importance of a consolidated period of practice for students to settle in and establish collegial relationships is acknowledged as a significant influence on their sense of belonging (Levett-Jones et al., 2008). There are feelings of vulnerability, stress and anxiety associated with starting in a new social and professional context (Donnelly & Wiechula, 2012; Levett-Jones et al., 2009; Levett-Jones et al., 2007). Some of these are due to the problems that any newcomer would face, such as not knowing where things are located, unfamiliarity with locally established routines, having to interact with a number of strangers, and these are often compounded by the lack of perceived competence which is characteristic of novices (Cope et al., 2000). In the Levett-Jones et al. (2007) study, participants strongly held the belief that belonging is a necessary precursor for clinical learning. Feelings of safety, comfort, satisfaction and happiness were reported as outcomes of a placement that facilitated belongingness. Students in this study felt more empowered and enabled to engage in any available learning opportunities when they felt they had a legitimate place in the nursing team, and they were often more self-directed and independent in their learning. Students who were secure in the knowledge that the nurses they worked with were receptive to and supportive of their learning focused their attention and energy on learning rather than trying to fit in.

The findings of this current study resonate with that of Levett-Jones et al. (2007). In their own words, participants felt ‘connected’, at ‘home’ in the hospital, and have developed ‘confidence’ in who they are able to identify as when they are here. The realism that the environment holds provides makes students astute in the awareness of professional boundaries and identities; something participants would often refer to as “the mindset” of being a nurse. This self-assuredness in professional identity and trajectory across the different boundaries and spaces arose from experienced familiarity and perceived belongingness over time. Notably, perceptions of hospital environment-associated anxiety were self-reported by participants to decrease over time and
experience, expediting the process of adjustment and orientation to the hospital setting and the clinical environments therein. Through the sense of connection and continuity, participants transitioned from feelings of being overwhelmed to feelings suggestive of ownership.

The wider question provoked by this study is why sociocultural learning theories which involve a combination of situated cognition, cognitive apprenticeships, and communities or landscapes of practice have not been further tested for their application to nursing pre-registration education. As discussed in the literature review (ref. pgs. 31-32, 40), after the transfer for nursing education from hospital trained to university educated, responsibility for novice nurse education then laid with tertiary education providers as a key stakeholder. This arrangement created a distancing of the health care system from being involved in the decision and processes of clinical education for the nurses who would eventually be employed within it, creating a lack of industry investment and ownership of nurse education (Brown et al., 2006; Elliot, 2002; Fetherstonhaugh et al., 2008). The resultant rift between “nurses in service”, and “nurses in education” (Andrew et al., 2008) saw an ideological shift from ‘training’ to ‘education’ (Forber et al., 2015). Andrew et al. (2008) attribute this perceived divide due to the separation of where and how ‘practitioners’ and ‘academics’ operate; that unfortunately, this predicament created conditions for disconnected experiences (Forber et al., 2015). There still remains a resultant disconnect between learning contexts, nature of learning, and facilitators of learning, creating a large and complex “gap”, and as such, is a main subject of nursing education perennial debate (Greenwood, 2000).

The direct influence of the context of learning in the current study is multifaceted. Due to the reality of the hospital environment and dynamics, there is a heightened awareness of the relevance that theory directly has to practice. Subsequently, and perhaps significantly, there was a passionate case made by participants in the focus group for there to be more practical applications of theoretical
underpinnings integrated into their program. Translation of what is learned in the academic setting into applicable knowledge in the clinical setting was found to be a significant process for these students. As Wenger-Trayner et al. (2015) acknowledge – “such formally acquired knowledge needs to be learned in such a way as to ensure it is readily translatable from the academic context into multiple, messy, complex contexts of practice.” (p.61). Components of university courses provide students with work-ready skills in order to maximise graduate employability. They are often designed with the aim to bridge academia and future intended workplace by differentiating between the specialised setting practices for greater preparedness. However, without supporting such reconciliation of different expectations, this can lead to a greater perceived disconnect between experiences in the two areas than what already exists.

With the current industry concerns around belongingness, graduate preparedness, and clinical learning environment suitability, there is large potential for sociocultural learning theory application to further efforts to close the theory-practice and practice-education gaps (ref. pg. 26). However, it must be re-iterated that effective ‘academic-service partnerships’ between tertiary education and health care sectors are a necessary precursor to such applications and testing. Without these being established, foundations for greater theory-practice integration with an outlook for sustainability into the future would be unable to be firmly established. As discussed in the literature review (ref. pg. 32), it is now a matter of the best way to create an appropriate “bridge” so that students no longer see the classroom and clinical practice teaching as separate parts during their education (Jeppesen et al., 2017). In fact, simply requiring more education will not be sufficient to bridge the established and significant gap. The quality of nursing education must be at a higher standard (Benner et al., 2010). Putting these two together – improving the quality of teaching and learning, will provide strength and durability to the bridge. I propose that the model of study is a type of bridge, as it is about situated learning as part of a partnership model, bringing the two key education
providers together. However, there is a need to transform teaching strategies so that student nurses
do not experience classroom and clinical practice teaching as separate parts during their education
(Jeppesen et al., 2017).

The strength of using the VPM were that memories became more vivid and emotions evoked. These
memories and emotions were associated with the photographic depictions of their learning
experiences within the situated environment. The reflective exercise paired with photography can
be valuable when investigating the role of places in people’s journeys. Insights can be gained from
viewing the world as they see it, from their perspective. For example, when students were choosing
what they should take photographs of, even which photographs they would reflect on, and which
photographs should then be included in this study. As demonstrated through transcripts,
photographic depictions and the accompanied reflections, discussions were more in-depth and
insightful than what this researcher believes to have been possible without its use. In the qualitative
study conducted by Burke and Evans (2011), oncology and palliative care nurses were asked to think
about what spirituality meant to them and then take photographs that represented these concepts.
Similar to this current study, photographs were used to guide the follow up semi-structured
interview, and authors asserted that the photography exercise was a useful tool for self-reflection,
as the process of taking photographs afforded participants time to reflect and think about how they
want to convey meaning in a photograph.

Through spoken and written words, through photographic representation, no participant recalled
“bad” or negative memories or emotions in regards to their situated learning environment. This is
potentially a result of the activity of walking around the hospital, taking photographs and the overall
reflective nature of this activity provided. However, it remains that participant memories combined
with reflection, shows an undeniable growth – they see how far they have come and there is a sense
of satisfaction rather than negativity. There is a direct, constantly visible link from where they started, to where they are currently in their degree, to where they are working in the future. There is less fear, less negativity, and an increase in learning satisfaction because of the direct projections of relevance. The reflective nature of this exercise made clear that situated learning within this workplace of industry bridges gaps; both that of progressing towards implementing practice as a registered nurse and that of forming a professional identity. For these students, their learning environment is proximally located to hospital wards; the clinical setting. As they learn, they are immersed within the hospital setting. The environment allows them to participate peripherally, and this is valued by students as part of their learning and professional development. The nature of exposure here eliminated a lot of “fear of the unknown”. Students can see their futures here. Seeing patients in this dynamic environment is their motivation and career affirmation. They are on the cusp of workplace reality and surrounded by the very manifestation of their learning and professional trajectories.

Limitations

This study has been primarily concerned with the participant descriptions of their learning experiences and perceptions. The analysis concentrated on the manifest content of collected data. The findings of this study are restricted to this particular setting only, as it is representative of the model of education delivery, student participant group and situated learning context at the time of study. Only 3 students from the initial focus group of 8 volunteered to continue with the VPM and individual semi-structured follow up interview. While this may be considered a low recruitment rate for this stage of the study, steps to establish rigour through ensuring trustworthiness of the study have been outlined (ref. pg. 46). At the data collection stage, this inaugural group of students had completed three out of four semesters of their degree, and would have spent the majority of their time in acute care settings for their clinical placements, as practiced in the hospital in which they
were situated. Therefore, their exposure to other clinical settings to gain experience in other various nursing practice areas, was limited in this way.

This study has addressed the question of pedagogical value of a situated learning environment only for the students located within it. Therefore, the limitations of this study are clear in that it lacks a comparative sample of those students undertaking the same degree at the main university campus. The resulting volunteer participants did not complete the intended maximum variation sampling, meaning that two of the possible groupings could not be represented. Notwithstanding these limitations, the strength of this study lies with the high level of rigour demonstrated through the multiple methods of data collection. The data triangulation accommodated for not being able to follow the initial maximum variation sampling plan.

**Recommendations**

Further study should seek to explore, in greater depths the current model of study. This current project was intended to be a small-scale trial of methods and methodology, in order to progress into a larger scale project. With participants perceiving a heightened sense of awareness regarding the practical applications of gained theoretical knowledge, future research should seek to explore the potential influence of a prolonged and consistent exposure to a situated learning environment on levels of student clinical reasoning. Ideally, data collection would expand into mixed-methodology, using validated ‘belongingness’ and ‘clinical reasoning’ scales (Levett-Jones et al., 2009; Liaw et al., 2017) and sampling could be potentially expanded to compare the situated health precinct students with their main campus student counterparts who complete periodic clinical placements within the health precinct. Qualitative data analysis would delve into thematic analysis of both manifest and latent content, requiring a higher level of interpretation than what was conducted in this current
study. It would also be good to further develop the research design by exploring this population of students as new graduate nurses to reflect on their transition experiences within the same environment where they undertook their studies. Exploration into the opinions of more experienced, senior nursing staff who believe that their way of training (e.g. hospital based) was best would also be a consideration for further research into a wider project.

Translation of what is learned in the academic setting into applicable knowledge in the clinical setting was found to be a significant process for these students. Students have a perceived need to engage in this process, and it is based on this finding that I recommend exploring methods within situated learning frameworks to better support the inverse translations between theory and practice.

For the students situated within the health precinct, the geographical disconnect was furthered by perceived differences in community, culture and enterprise. This led to participants disassociating themselves from the school, and instead preferring to align themselves with the community, culture and enterprise of the hospital. It is based on this finding that I recommend to use student experiences to support identity development in the preparation for professional practice and provide students with frameworks and ways of thinking about work challenges which can be translated practically in the workplace setting.

Conclusion

The authentic hospital environment reassures students of the choice to pursue nursing and the relevance of their concurrent learning. In this way, there is a constant visible source of ongoing motivation. Ongoing motivation was provided by the direct link their learning environment had to their future career, and to their current studies, reassuring them of the relevance of their degree content and trajectory. Identifying themselves as “health precinct nursing students” was
a way to begin aligning themselves with their future professional identity and local CoP. In this way, it bridges the divide of transition to practice. But still, a gap between what is taught at university and what is implemented on site remains. The “bridge” of transition to practice in this situation has two aspects made prominent by this research: professional identity formation and the ‘theory-practice’, or ‘practice-education gap’ (ref. pg. 26). The gap that remains with this student cohort is more so the latter, obvious to participants of this study as expressed through their plea for more integration within the partnership between the hospital and the nursing school.

Complex demands of contemporary healthcare practice places nursing education in a position of responsibility to both innovate and improve. A partnership between the health and education sectors has provided the opportunity to address evolving needs in both areas. It is important to discern factors that have the potential to facilitate student learning with the introduction of any new model of teaching, therefore the aim of this study was to gain an understanding of GE student nurse experiences and perceptions of their learning experiences in relation to the hospital as their situated learning environment. Expanding research and evidence about the potential pedagogical value, the influence or the role of the situated hospital learning environment for these novice nurses has provided insight into modifiable factors that may influence specific learning outcomes, in particular, those which align with professional standards and codes of practice.
References


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## Appendix A - Operationalisation through data collection – content of strategies

<table>
<thead>
<tr>
<th>Key concept</th>
<th>Table - Operationalisation through data collection – content of strategies</th>
<th>Individual photo elicitation &amp; photo feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Interview questions (focus group &amp; semi-structured, individual)</strong></td>
<td>Example theme: ‘Motivation to learn’</td>
</tr>
<tr>
<td><strong>‘GEM’</strong></td>
<td>General feedback on course experience.</td>
<td></td>
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<td></td>
<td>Undergraduate degree</td>
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<tr>
<td></td>
<td>Impact of undergraduate degree on current degree (approach to learning)</td>
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<tr>
<td></td>
<td>Motivation to pursue nursing</td>
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<td></td>
<td>Motivation to continue with and complete the course</td>
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</tr>
<tr>
<td><strong>Contemporary nursing pedagogy</strong></td>
<td>Perceived differences and similarities between traditional University campus and tertiary referral hospital / health precinct setting</td>
<td>Example themes: ‘How I like to learn’; ‘what helps me to learn’;</td>
</tr>
<tr>
<td></td>
<td>Learning preferences re. environment / conditions / learning and teaching styles</td>
<td></td>
</tr>
<tr>
<td><strong>Situated learning</strong></td>
<td>Reasons for selecting the health precinct</td>
<td>Example theme: ‘Who I identify as when I am here’; “Challenges I faced”</td>
</tr>
<tr>
<td></td>
<td>Perceptions of social, professional environment + culture of the health precinct</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Self-identification. E.g. as a health precinct student or as a nursing school student. How this came about.</td>
<td></td>
</tr>
<tr>
<td>Environment</td>
<td>Locale for clinical placements (i.e. within WSLHD or rural placements). Learning experience as a student</td>
<td></td>
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<tr>
<td></td>
<td>Use of the different learning spaces located within the Precinct. Nature of the relationship with the other situated health disciplines within the health precinct. Use of technology provided in the spaces. What makes a learning environment effective (generally) Learning within the current learning environment / educational facilities provided.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Example themes: ‘My typical day at the health precinct; ‘The Common room experience’</td>
<td></td>
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<table>
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<tr>
<th>Pedagogical value (meaningful engagement)</th>
<th>Characteristics of peer group of students Learning experiences within the health precinct with peers. Significance of particular memory. Factors considered to be conducive / a hindrance to learning.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Example theme: “What the health precinct is to me”</td>
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Appendix B - Guidelines for participants in the two visual participatory methods

The pedagogical value of a situated learning environment: Delivery of a pre-registration nursing degree within a health precinct

GUIDELINES FOR VISUAL PARTICIPATORY METHODS:

1. ‘photo elicitation’ (photographs provided by you); and
2. ‘photo feedback’ (the accompanying reflective captions for each photograph)

The purpose of taking photographs as part of this study is to capture images which you believe can best represent aspects of your learning experience in relation to the situated environment (The Precinct).

Participants must be accompanied by the researcher when taking photographs for this study. This is to ensure compliance with these set guidelines, as well as ethics approval granted by the Local Health District and the university. Please contact me via email (Charmaine.bonus@sydney.edu.au) to arrange a suitable date and time to complete this activity.

This researcher has been advised by the Western Sydney Local Health District (WSLHD) Human Research Ethics Committee Executive Officer (Kellie Hansen, kellie.hansen@health.nsw.gov.au) and the WSLHD Research Governance Officer (Maggie Piper, margaret.piper@health.nsw.gov.au) to supply WSLHD media consent forms. This must be signed prior to any images of students, staff, patients or visitors being taken, should the need arise.

Ultimately, it is your personal decision to select images that best capture your situated learning experiences as you understand it.

Collection of photographic images must be relevant to the purpose of this research, and must not be unreasonably intrusive when taken in any educational environment context which the photograph is intended to capture. Furthermore, images are to be considerate of the principles behind practicing cultural sensitivity. For example, to many Aboriginal and/or Torres Strait Islander communities it is distressful and offensive to
depict persons who have died. Images of those deceased is considered to be culturally inappropriate, not related to the focus of this study and therefore must not be taken.

This is in compliance with such policies, documents and professional standards as:

- The NSW Ministry of Health ‘Privacy manual for health information’;
- The NSW Ministry of Health ‘Code of Conduct’;
- The AHPRA National Board policy for registered health practitioners ‘Social Media Policy’; and
- The Royal Australian College of General Practitioners (RACGP) document - ‘An introduction to Aboriginal and Torres Strait Islander health cultural protocols and perspectives’

Photographs will be taken on a facility-owned, dedicated device. Personal devices must not be used for photography. I will then print out the photographs for you to complete the reflective captioning process, and you can return these to me when we next meet for the follow-up, individual interview (within 5-7 days later). After the conclusion of this final follow-up interview, all hardcopy / printed photographs will be destroyed by this researcher in a confidential waste bin.

The collection of photographs will be as a supplement, not as a replacement, of other methods of data collection as part of this research:

- the initial focus group interview;
- the reflective captioning of photographs (photo feedback); or
- the follow-up individual interview.

Some example themes of what could be chosen to represent in the photographs are:

- “My motivation to learn”;
- “What helps me to learn”;
- “My typical day at [ ];”
- “How I like to learn”;”
- ‘Who I identify as when I am here’;
- “Challenges I faced”
- “The Common room experience”
- “What the [ ] Precinct is to me”

(Example images on following page)
For the reflective captions to accompany each photograph submitted, you can use the following reflective process to guide the construction of the captions. This structured reflection is intended to facilitate the processing of an experience, and can allow for any learning that may occur to be both meaningful and memorable.
| **The learning experience** – *describe what is happening in the photograph* |
| **Reflecting on the experience** – *what thoughts, feelings or memories does this image evoke for you?* |
| **Analyse the experience** – *what kind of learning resulted from the experience depicted?* |
| **Looking ahead** – *How can I put what I learned into action in the future?* |

Photographs and their associated reflective captions must be submitted back to the researcher at the follow up individual interview (within 5-7 days after the photographs have been taken). The follow-up individual interview questions will be similar to those asked during the focus group. Questioning at this stage will provide an opportunity for further discussion and sharing of views based on the photographs and reflective captions which you, the participant, have provided for this study.

Thank you for your participation.
Appendix C – Example reflective cycles

Gibbs (1988) reflective cycle

Driscoll (2007) ‘the what model of structured reflection’
Appendix D – Interview Protocols for the Focus group and the Individual follow-up interviews

Focus Group Interview Questions

1. How are you finding the course / program so far?
2. What has been the most enjoyable part of your course?
3. ...And the most challenging?
4. What are your undergraduate degrees and have these impacted on your learning experience for this current course? If yes/no please elaborate on your answer.
5. What made you decide to pursue nursing?
6. What made you apply for this program, specifically being at hospital?
7. In what ways does having a degree delivered within a hospital differ from the traditional University campus setting?
8. How would you describe or identify yourself when studying here?
   a. Probe: For example, would you identify yourself more as a University student, a Nursing School student or as a Precinct Nursing student? Is it a combination of these or completely different?
   b. How did this identification come about?
9. I’d like to understand how you use different learning spaces located within the hospital. – Walk me through a typical day, here at as a nursing student.
10. Tell me about sharing the common room with medical and dental pre-registration students. – How has that been?
11. What about the technology that is currently provided in the spaces – what are you experiences with the technology from a student perspective?
12. What in the environment influences you to learn here?
13. As a nursing student, what do you think makes a learning environment effective? (Generally)
14. How do you think the schools could better support health students build a culture of interdisciplinary, learning?
15. Is there anything else that you would like to add?
Follow up individual interview questions

1. How are you finding the course / program so far?
2. What has been the most enjoyable part of your course?
3. ...And the most challenging?
4. What is your undergraduate degree, and has this impacted on your learning experience for this current course? If yes/no please elaborate on your answer.
5. What made you decide to pursue nursing?
6. What made you apply for this program, specifically being at [HOSPITAL] hospital?
7. In what ways does having a degree delivered within a hospital differ from the traditional University campus setting?
8. How did you find the exercise of taking photographs which you believe to represent your learning experience in relation to this learning environment [PRECINCT]?
9. Tell me about how you approached this exercise.
   a. Probe: Did you consider the ‘example themes’ at all? Or did you come up with your own?
   b. Probe: Did you pre-plan what kind of experiences you wanted to capture in a photograph? Or was it more spontaneous?
10. I’d like to understand more about the photographs you took and the captions you provided for each of them.
    a. Can we take a look at them together and talk about what they each represent?
11. Overall, does this environment influence you to learn? If yes/no, please elaborate on your answer.
12. As a nursing student, what do you think makes a learning environment effective? (Generally)
13. Is there anything else that you would like to add?
Using this data management software enabled me to manage the coding of the data and condense these into a smaller amount. I also used this software during the iterative process of QDA to go back through reading and viewing the data to make reflective memos and annotations. Returning back to the data as an iterative process was both valuable, recommended an expected part of the QDA process (Creswell, 2014). Some areas that I was able to condense were ‘fuel source – food drink’, ‘challenge’, and ‘long days of classes’ into ‘the course’, as these terms or allusions were in reference to the actual course structure and content. Other examples were ‘determination’ ‘nervous anxiety’ into ‘emotions’. Or, ‘westmead peer group’, ‘appreciating peers’ and ‘shared experiences’ into ‘peer group’. The abstraction process enabled me to re-think about the condensed data about the best way of organising the ideas. I placed these into NVivo through creating ‘tree nodes’. Examples of this were placing the nodes ‘mindset’ and ‘motivation’ under a parent node labelled ‘Perception’; and placing the nodes ‘memory’, ‘emotion’ and ‘expectations’ under ‘Memories’. The formation of ‘relationships’ between the nodes was necessary, as some tree and parent nodes were interrelated. For example, the child nodes ‘hospital environment vs. university campus’, ‘lecture theatre’ and ‘seminar room for tutorials’ were all placed under the parent node of ‘place’, but these also had a large amount of shared areas of content with such child nodes as ‘the course’, ‘learning experiences’ and ‘facilitates learning’ under the parent node of ‘learning’. The shared areas of coded content were easily visualised using features of the NVivo software such as ‘comparison diagram’ or through conducting node queries.
Describe what is happening in the photo

This is a photo outside the main lecture theatre room where we study our lectures. Students gather here to catch up from the weekend and nights before entering the room.

What are your thoughts feelings, or memories

This photo reminds me of orientation day. It was my first time going to [BLANK] hospital that day, everything was new, strange and unknown. I remember it was quite dark and mysterious the lighting was dim. I saw purple [BLANK] bags on the chairs, I was both excited and nervous to start my Nursing degree, I didn’t know what to expect. I thought it was cool that they had a theatre within the hospital. The first friend I made was sitting on the third chair; we immediately became friends because we remembered each other from the group interviews. We watched as unfamiliar faces began to line outside the theatre waiting to go inside. Little did we know, it was the beginning of great friendships and a challenging yet rewarding degree. Looking at this photo also reminds me of the second cohort of Nursing students gathered outside of the lecture on their first day. The looks on their faces felt familiar.

What kind of learning resulted from the image depicted?

I learnt that the feelings and thoughts that students have before commencing this course is somewhat similar, excitement, nervousness, curiosity, confusion, timidity and more.

How can I put what I learnt into action in the future?

Welcoming and talking to new students about my experience as a student nurse can help relieve some of the feelings and thoughts they might have. I think by providing in depth information about the course and structure will give them reassurance and a sense of security.
Parent, support, wisdom, the student in search of help

WHAT HELPS ME TO LEARN & OVERCOME CHALLENGES

1. The photo is of the nursing & midwifery faculty which functioned as a major support network during my time as a uni student.

2. Memories of support during hard times

3. I learnt that it is always important to have a support network, professionally and socially

4. I learnt from the experience that it is important to go to someone if I need help or I’m struggling in regards to work. In the future, as a grad RN, I know that it will be important to reach out when I need help.
1. Learning social space
   - Being a social space
   - Socializing, being yourself, being happy

2. Friends
   - Connecting
   - Networking
   - Making new friends

3. Study
   - Posting
   - Studying

4. Being a labor
   - Important
   - Essential

5. My typical day at "The Common Room Experience"

   1. A photo of an area of the common room where I would usually sit with my friends.

   2. Moments of collaborative learning, socializing, de-stressing and sharing the journey with others.

   3. In the common room, I was exposed to medical students and I got to understand how their degree is set out and what academic journey they must go through in order to become a doctor. The experience allowed me to connect with people beyond nursing and allowed me to appreciate the different roles people have in the hospital.

   4. In the future, I will foster professional relationships with my workmates which can facilitate further understanding of the hospital environment.
Describe what is happening in the photo

This is a photo of the ping pong table that is in the student common room on level 1. The common room is shared amongst medical, nursing and dentistry students. Although, this area is mainly used by the nursing and medical students. Every day walking into the common room you always see medical and nursing students playing ping pong!

What are your thoughts, feelings, or memories

Looking at this image makes me smile, I think of ping pong balls flying across the room, the noise of the ping pong balls and the loud students playing. I see friends and other students gathered around watching tournaments and getting along with one another. The ping pong table is well loved and brings students together. Overall, the common room is an area that we enjoy being in because it’s a safe place were we can relax and have some fun.

What kind of learning resulted from the image depicted?

I learnt that positive learning experiences requires a well balanced ratio between work and fun. Its important for students to have a space for themselves and be given privacy.

How can I put what I learnt into action in the future?

Talking with students about what they like about the common room can give insight into what is important in order to provide relaxing, comfortable and safe student spaces. Student-initiated/Student involvement.
Group work meetings coming up with ideas

Social determinants of Health

Interacting with medical students and other university staff members
Remember going on placements
Coming back to the common room for breaks

I remember many an assignment
Long nights and the breaks that ping pong helped us.
I remember us trying to imagine how we would do on our first placements.

This is where we sat to have first year happy memories long lunches and discussions about our great future as nurses.
Fear, knowledge, responsibility, need to know, patients, nurse, reality

1. People (educational)
   fear, reason to staff
   to be constantly alert

2. Fear, the need to know, gain knowledge,
you are responsible

3. From the experience,
   if made one aware of
   how you need to always
   be up to date

4. Be constantly up
date, they only up
   of research, allied
to acute, the
   learn, learn
   learn

MY MOTIVATION TO LEARN

1. This is a photo of an educational poster regarding Sepsis. It is a typical example of educational posters I would see around the hospital.

2. This image brings on feelings of fear and responsibility. Fear of not knowing enough to prevent life-threatening complications and the responsibility I will have as an RN in regards to taking care of my patients.

3. Learning experience gained from the poster is related to how I need to be constantly learning as a RN, especially a Graduate RN, in order to provide the best care possible.

4. This photo reminds me that in the future I must continually keep updated and
   remain on top of medical research in order to provide the best care
   for my patients.
Comfort, understanding, kindness, and possibility.
Late, lunch, tea, Clinical placement, EII, medication, start of shift, end of shift
The passage of day, familiar scenes of words, comfort the nurse, responsibility
1. This is an image of how I conceptualise my identity when I am a university student and on clinical placement.

2. There are a number of thoughts and feelings that this image evokes. In particular, it addresses how my identity continually shifts within the hospital and how essentially I'm playing two different roles in the hospital.

3. From this experience, it has taught me how to balance my life as a student and a professional.

4. I will...
Describe what is happening in the photo

This is a picture of a hospital ward at [hospital name] hospital. It was the first ward I went to on my first clinical placement. This photo is an image of what I saw in a student's eyes.

What are your thoughts, feelings, or memories

Going to your first placement is quite an experience. At first you feel a rollercoaster of emotions, nervous, scared, excited, eager, determined, nauseous, worried etc. You don't know what to expect especially if you have never been in a hospital / hospital ward. Going into the ward you see a lot of movement, noises on machines, phones ringing, trolleys moving, monitors going off and more. I remember in my head I would say what's that? what does that do?, how does that work?, who is that person? so many questions already! As a newbie student nurse on placement, it can be quite overwhelming. Its like you are used to your little bubble and suddenly your being forced out of that bubble into the real world. Our clinical facilitators drop us off and off we go. It kind of feels like we are the little chicks and our mother hen is abandoning us to survive haha. At the end of placement though, you laugh and wonder why you ever worried in the first place. Placement is such an invaluable experience and is unique to every student. No one placement is the same. The thing that makes placement the most rewarding experience is the wonderful staff and the patients. Staff are an important part to achieving your goals and enjoying your time on the ward. This photo reminds me of the values and principles that wards have; team work, respect, equality, understanding, kindness, and a passion to continue learning to be the best you can be to deliver quality and safe work. Learning is forever whether you’re a student or an RN.

What kind of learning resulted from the image depicted?

I learnt that clinical placement is critical to a student's learning experience. There are many things you learn on placement that you won’t be able to learn from a textbook or through lectures. Sometimes it really is a “you have to experience it to know it and understand it” process.

How can I put what I learnt into action in the future?

Always make goals when you are on placement because every placement is distinct in its own way. Keep a diary of everything you do so you can see how much you've learnt and progressed. Participate in open discussions about introducing more placements to the learning syllabus.
2. These are the seminar rooms where most tutorials were held. It also represents one of the major areas I would visit during my day at [BLANK]

2. The photo evokes memories of class where you had to actively participate and had the opportunity to explore others' viewpoints on nursing or issues surrounding learning content.

3. Unlike practical skills this represents a combination of active and passive learning. This type of learning was much more simplified around group activities so there was a lot of teamwork and exploration of people's thoughts, feelings and beliefs regarding nursing.

4. Tutorials made you aware of how others other people work and perceived things differently. It allowed me to recognise that working as a team is regards to nursing is best often better than working alone so there will always be differing perspectives. I will take this attitude into my new grad year.
Describe what is happening in the photo

This is a photo of A & B block, it is one of my sections at [blank] hospital. This area is very busy with patients, families, doctors, nurses, porters and many other staff members walking by and coming in and out of elevators.

What are your thoughts feelings, or memories

The A & B block is a place I pass by often. The first time I came here, I was on my first clinical placement. I remember how big the sign was and seeing so many people waiting at the elevators and walking by, it is such a busy area. I was nervous, excited, scared, confused, I didn’t know what to expect up there. Whilst on placement I have shared this elevator with many staff members especially porters, patients and families. I remember waiting at the elevators making small talk with them, holding doors, helping them inside and more. I also remember helping people who were lost and just as confused as I was when I first came here. It feels great to help and interact with people outside of university because you feel that’s you are a part of the community. It’s a great feeling to help people especially those who may be distressed, confused or anxious. No matter how small the help it is one thing less they have to worry about.

What kind of learning resulted from the image depicted?

I learnt that students need to interact with others outside the university environment to increase their communication and interpersonal skills. There are two worlds that students live in, the university world and the outside world. Transitioning from university to the outside world can often be challenging. Being exposed to a hospital everyday provides students the opportunity to practice communication and interpersonal skills and go outside their comfort zone.

How can I put what I learnt into action in the future

Continue talking to patients, visitors and staff to make the most of your learning experience.
Boundary crossing, adult or student? race, knowledge, hallway of transition

THE BOUNDARY BETWEEN two identities

1. This image represents how my identity shifts between student and nurse when I enter different parts of the building. This image is the hallway towards the labs where I do my clinical practice.

2. This image evokes memories about university and my time as a student nurse. It reminds me how university is training me to become an RN and the responsibility I will carry as an RN when I graduate.

3. The type of learning is similar to the Labs. See No. 3
Describe what is happening in the photo

This is a photo of the hand-wash station. It is a big station placed at the front entrance of the hospital. Unfortunately, many people walk past this station and walk through the automatic doors.

What are your thoughts feelings, or memories

When I see this image I think of early morning starts, I see people walking past, sitting on the chairs, children talking to their parents, people on the phone, the buggy driving people around the hospital etc. It is very busy! Through all the commotion I see very few people using the wash station. Before I walk through the doors, I walk slowly towards the wash station, hoping people would see that its there to be used. I take one pump and rub my hands together, through the crevasses of my fingers etc. I do this because we have all learnt the importance of hand hygiene, its good practice and I feel that I have done good deed for myself and others. Although I walk to class as a student I still carry the principles and standards as a student nurse or future nurse.

What kind of learning resulted from the image depicted?

I learnt that being exposed to the hospital environment prompts you to practice your basic skills and knowledge. It reminds you what is expected of you as both a student and future nurse. I also learnt that there is a need to educate visitors about hand hygiene. The sign is big and says visitors wash station but it doesn’t say why we use the wash station.

How can I put what I learnt into action in the future

Talking with [BLANK] staff about putting more signs and educational information about hand hygiene may increase participation and compliance.
Describe what is happening in the photo

Every morning I walk through here to go to class. Around this area there are many staff members eating breakfast and patients and families sitting down and talking etc

What are your thoughts, feelings, or memories

Everyday I pass this sign and wonder what I am going to learn today, it’s always something new! It’s very refreshing to see patients and their families before going to class. It reminds you that life is fragile and that it is a new day. It makes you appreciate life so much more! It motivates you to be the best you can be in everything you do and make the most of what you have. It puts in a nursing mindset, keeps you determined and motivates you to continue learning through the hardest of times. The feelings that being around patients and families evoke is very unique, it is something that cannot be replicated or imitated in a normal university setting. There will always be days when you don’t want to get out of bed because it’s too cold or too early but when you arrive here your whole mindset changes. It has helped mentally and physically prepare myself for the day ahead. Once I see the big education block sign I am ready to study and learn and eager to go to class.

What kind of learning resulted from the image depicted?

I learnt that studying in a hospital setting keeps you grounded, it reminds you of the world that exists outside university and study life. I also learnt that studying at Westmead allows you to grow both as a person and nursing student. Interacting and seeing patients and families from day to day can challenge your beliefs, values, morals as well as teach you things that cannot be learnt from a textbook. Doing so moulds you as a person.

How can I put what I learnt into action in the future

When you feel drained or unmotivated, take a step back, breathe and look at what is around you. Practice mindfulness.
Appendix G - Data Analysis Summary Table (Exemplar only)

‘Content area’ organisation of the four interviews and data pertaining to the visual participatory methods (VPM) as ‘Units of Analysis’ – actual interview transcript excerpts and individual VPM data

<table>
<thead>
<tr>
<th>Research aim, primary and secondary questions</th>
<th>Organisation of Codes</th>
<th>BB</th>
<th>CC</th>
<th>Focus Group Interview</th>
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<tr>
<td>How student nurses perceive their experiences in the learning spaces within this authentic clinical teaching environment</td>
<td>Influence of realism</td>
<td>Indiv. Interview Excerpts</td>
<td>VPM extracts +/- Image comment from individ. interview</td>
<td>Indiv. Interview Excerpts</td>
</tr>
</tbody>
</table>
| In the labs, I love labs, that’s where I learn the most I think other than placement because I can put all the theory into practice. If I really don’t understand it, I can ask. I feel it’s my safe place because I can make mistakes and I know I can make mistakes whereas in placement you kind of, you know, really don’t want to be making mistakes in placement because you’re working with real patients. Most enjoyable? Placement. Yeah, I think it’s (CSL sessions) important so that because on placement you kind of have an idea of what you’re getting into. Whereas if, you know, you go on placement and you don’t you have to start from all the way to the bottom and guess, okay, what’s this light for, what’s this for and it’ll just take a lot of time. Yeah, I think this is great. And the sounds as well, so when you press the call button and the emergency button, it’s good to know what it kind of sounds like so you know what you’re looking out for. ... There’s so many things that now you think nothing of it but it really is you don’t know what it is if you’ve never seen it. A good example is this, actually. It makes you put your learning into practice. So, for example, when we learn hand hygiene, we’re in a hospital, we’re really award of diseases and patients are coming and they’re touching. So I remember I washed my hands like crazy after that. And consciously, I make sure I do my hand hygiene. Now, if I was on the campus, no way. Interviewer: Everyone is healthy. Yeah, everyone is healthy, everyone is young. You know, like, I wouldn’t not overthink it, but it wouldn’t be in the forefront of my mind. But since I’m in a hospital, it is, and I treat it like a hospital. I think it’s been a really important part, to be honest. I think it makes me be more serious about my work, I think. I think it definitely helps my work a lot more and makes me take on a lot more responsibility than I think I should. For me, personally, it’s good, in the sense that you know what you’re going to get. You don’t spend a lot of time wondering, and imagining worst possible scenarios. But, also, having worked in a hospital, I had a little bit of an expectation of what I was getting into, in that sense. But, mainly, I think it helps you focus more, in the sense that you tend to see the patients that you’re going to be dealing with, and interacting with in the future, maybe, on a daily basis. Sometimes you even interact with them when they ask for directions, and all those things. I think it’s (hospital situated learning environment) very important in the sense that, sometimes when you’re at uni, especially when it gets challenging - because there are times when you’ve got so many assignments, and you’re questioning, "Can I do this?" And then you walk out there, and you see RN’s doing what you want to do, and you see patients, and it’s like a grounding in reality. It’s saying, “This is what I’m working towards.” It motivates you in times when things get very challenging. It’s something for you to say, "This is where I need to be."

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<tr>
<th>AAVPM 7 of 12</th>
<th>BBVPM 3 of 15</th>
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<td>AAVPM 8 of 15</td>
<td>BBVPM 5 of 15</td>
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| I think it’s (hospital situated learning environment) very important in the sense that, sometimes when you’re at uni, especially when it gets challenging - because there are times when you’ve got so many assignments, and you’re questioning, “Can I do this?” And then you walk out there, and you see RN’s doing what you want to do, and you see patients, and it’s like a grounding in reality. It’s saying, “This is what I’m working towards.” It motivates you in times when things get very challenging. It’s something for you to say, “This is where I need to be."

| BBVPM 12 of 15 |
| TB: It sort of prepares you mentally as well. In the fact that as they were saying that we’re gonna be working in the hospital one day, rather than... because when you go to uni it sort of um the uni environment I guess? But here you come in and the thing is as soon as you walk in the hospital door, we see patients who are outside and it sort of drills in your head that you’re studying nursing and you’re gonna be looking after patients one day |
| AA: It makes it feel more real. Whereas when you’re at university it’s kind of like “oh i’m gonna study go home.”... Study and go home... You don’t really think about the big picture whereas when you’re here it’s your face constantly. So it’s a reminder constantly reminds you “yes – this is real. This is the real deal. This is what happens. This is how it is” and what you know your future will be like if you were here or in another hospital. |
| PG: For me, it’s atmosphere. The Uni atmosphere is a lot more casual and easy going. At the uni it’s like you are in a little holiday away from the rest of the world. The uni has its own environment, its own rules. And you are sort of like you are taking a step away from the reality of life. And when you’re in the hospital, it’s different because like everyone is saying, you walk in, you see patients, you see people walking around with drip stands, you see people who are amputated...there’s a certain reality to it and you’re seeing ambulances rushing in and out. The atmosphere is very different in the sense that you don’t have.. the other thing with being at uni is that you have sort of like an imagination of how you’re... |
patients you don’t always see, you’ve got distressed families. It can be quite overwhelming. would if I was just at Main campus. I don’t know, this feels more real to me than Main campus. This is where I want to go.” And seeing a reflection of yourself in somebody who is passing through, just makes it a lot easier to push through the really difficult moments. Future employment will turn out to be like. Which in some situations, might not be real (laughter). It might actually be way off. But in the sense, when you’re in (hospital name withheld) hospital you’re actually sort of like see the real patients that you’ll be dealing with, the families that you get to interact with when you’re out there. So there’s that very …there’s a more sense of a connection between what you’re doing now and where you’re going in a sense. So there’s almost that link. You don’t have to go too far to imagine what it’s going to be like.

The pedagogical value of a situated learning environment in relation to the delivery of a pre-registration nursing degree from within a teaching hospital, and the wider health precinct.

Familiarity, sense of belonging aids in transition to professional practice. I think being at the hospital and being there every day it kind of, you know, mentally prepares you. It mentally prepares you when you see it every day and so you kind of think “okay it’s not so bad” or it’s not this or it’s not that. The kind of questions that you have in your head they kind of get answered as you’re there. Because you’re seeing everything layout, you know.

Even if it’s seeing - say, for example, before I didn’t know that patients who had the IV lines and they carry them, I thought they were very, extremely sick, I had no idea. Now when I see them just having lunch with their family I know they’re okay and just by assessing.

But I think, if you weren’t constantly exposed to the environment, that anxiety does increase because you do know that you’re working with patients and it’s a lot of interaction with different people every day, and the turn over and those kind of things. It is big, like every hospital is big. The layout’s quite the same in every ward but we don’t know that

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AAVPM 6 of 12

I wanted to capture that photo because to us it’s really important. Every time I walk through these doors I always do my hand hygiene and feel like I’ve done something for I guess the public, I’ve done a public service.

I think when you enter a hospital, it’s not necessarily a happy, joyful place where you should be having fun. It’s more the serious, professional place where you need to be kind and compassionate. It’s about humans looking after humans, to me. And I think that mentality came about from this degree mostly. So when I walk into the hospital in that sense, I become part of the staff in terms of if someone needed help, I would go straight to them and do everything I can. Whereas maybe if I was on the street and they were across the road and they fell over and I see someone walking towards them, I’m like okay, they’re fine.

Let’s just say I go to another hospital that’s not (hospital name withheld). I’m not familiar with the surroundings, I’m not familiar with anything. I think my reaction would be slower and I would be more preoccupied with trying to get a sense of where I am, what I’m doing here. Whereas in (hospital name withheld), I’m

AAVPM 6 of 15

This is about time management and how, on clinical placement, I break-up my clinical placement based on time. So it’s like lunch, tea, clinical, meet the clinical facilitator, BSLs, medications. Timing and nursing. So every single nurse that I’ve talked to, they’re like get a timesheet, get a timesheet. So this clock is just representative of that. And also that clock is everywhere at (hospital name withheld). So

I think if you’re a Main campus student, you wouldn’t feel that sense of connection that I have with (hospital name withheld), in a sense. Because, having done all my placements here, I almost feel like I work at (hospital name withheld). I have that sense of - I connect with the place, and I identify with the culture of the place, and the expectations that come with this. I don’t know what Main campus students feel, but I think if I was being sent to (Hospital name withheld) one day, (Hospital name withheld) the next day, then I wouldn’t have that sense of a connection. And there’s no sense of continuity in that, because you don’t know where you’re going to be at the end of the day. And you don’t know what the expectation is, when you move into a different place.

You are in a hospital, working towards becoming a nurse. There’s that sense that you’ve got a very strong connection with your future career. And for somebody who really wants to learn, or study, the space, and opportunity is there for you to actually engage in that

AA: I identify as someone who will eventually be employed as a nurse whether it’s at (hospital name withheld) or somewhere else but I take pride in being a student nurse. So even though I’m not wearing my student nurse uniform, when I walk in the doors and I see patients if they need help, or need a chair or anything, I kind of scan the place and feel I’m gonna be part of this community or this environment. So it’s a nice feeling. Even though we can’t really do much as student nurses but it prepares us for the future. I think we’ve got that in the back of our heads …subconsciously. I think for me anyway that’s when I’m walking in there – I’m a student I’m here to learn you know, I wanna be this or do this or do that.
at the time. I think all of those things are quite daunting.

I would hope that I'm going to be a part of (hospital name withheld) because I want to work at (hospital name withheld). (Being here)... it reminds me I'm going to be part of this environment as in working as a nurse in a hospital with these people and these patients.

I think in a job you've got to like the environment that you work in. Because you're working with patients you have to like working with patients. You have to like talking to patients, interacting with them, understanding them, those types of things. As well as being with supportive staff and that kind of thing. I think the culture here at (hospital name withheld) is great. It's very supportive. Teamwork is great here, I think personally anyway.

Every day you see, even research, people in research you see doctors, you see physios they're all talking with each other in the hallways or in elevators and things like that. I think seeing that constantly it just makes the standard for you like this is where I want to work, this is what I want.

so orientated that I don't need to think about all that stuff and so I can focus on other people. So when Main campus people come here for clinical placement, I guess it would be like they're still trying to adjust. Whereas I'm like I know this, I know this, I can help patients, I know where this ward is... If a patient is having a problem, I can be like "go up there." So I don't need to adjust.

Like, you know where the policies are, you know how the internet works, mostly you know things like who to call for bed cleaning. So you know all the procedures and policies and stuff, which makes clinical placement easier. I don't know if it would necessarily give you an advantage because every hospital is different and you have to relearn everything anyway usually. But I guess it makes it easier to focus on your learning rather than trying to figure out where everything is.

whatever ward I go to, I feel right at home when I have that clock because it's like I know my clock.

sense. So, I think it does encourage learning. Absolutely.
### Appendix H – Consistency table of analytical findings and interpretations (Exemplar only)

<table>
<thead>
<tr>
<th>Research aim, primary and secondary questions</th>
<th>Category</th>
<th>Key data excerpt</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>How student nurses perceive their experiences in the learning spaces within this authentic clinical teaching environment</td>
<td>Influence of realism</td>
<td>BB (Individual interview): It (the situated hospital learning environment) makes you put your learning into practice. So, for example, when we learn hand hygiene, we’re in a hospital, we’re really aware of diseases and patients are coming and they’re touching. So I remember I washed my hands like crazy after that. And consciously, I make sure I do my hand hygiene. Now, if I was on the campus, no way…everyone is healthy, everyone is young… it wouldn’t be in the forefront of my mind. But since I’m in a hospital, it is, and I treat it like a hospital. I think it’s (the situated hospital learning environment) been a really important part, to be honest. I think it makes me be more serious about my work, I think. I think it definitely works my work a lot more and makes me take on a lot more responsibility than I think I would if I was just at Main campus. I don’t know, this feels more real to me than Main campus.</td>
<td>Reality exposure – students can appreciate the practical applications of their theoretical lessons. The environment allows them to participate peripherally, and this is valued by students as part of their learning and professional development. The nature of exposure here eliminated a lot of “fear of the unknown”. Students can see their futures here. Seeing patients in this dynamic environment is their motivation and career affirmations.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CC (Individual interview): For me, personally, it’s (hospital situated learning environment) good, in the sense that you know what you’re going to get. You don’t spend a lot of time wondering, and imagining worst possible scenarios…mainly, I think it helps you focus more, in the sense that you tend to see the patients that you’re going to be dealing with, and interacting with in the future, maybe, on a daily basis. Sometimes you even interact with them when they ask for directions, and all those things.</td>
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<td></td>
<td></td>
<td>CC (Individual interview): I think it’s (hospital situated learning environment) very important in the sense that, sometimes when you’re at uni, especially when it gets challenging - because there are times when you've got so many assignments, and you’re questioning, &quot;Can I do this?&quot; And then you walk out there, and you see RN’s doing what you want to do, and you see patients, and it’s like a grounding in reality. It’s saying, &quot;This is what I'm working towards.&quot; It motivates you in times when things get very challenging. It’s something for you to say, &quot;This is where I need to be. This is where I want to go.&quot; And seeing a reflection of yourself in somebody who is passing through, just makes it a lot easier to push through the really difficult moments.</td>
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<tr>
<td></td>
<td></td>
<td>CC (Individual interview): When you’re at uni, you spend a lot of time - well, I spent a lot of time - imagining what my future career would be like. But, being at (hospital name withheld), you’d see patients, you’d see people in wheelchairs, you’d see ambulances rushing in and out. And you get to see doctors, and nursing, and you get to see all those professionals, pretty much, within this environment. And there’s more of a realistic sense of expectation, at least, as in, what you’re going to get at the end of your programme.</td>
<td></td>
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<tr>
<td>The pedagogical value of a situated learning environment in relation to the delivery of a pre-registration nursing degree from within a teaching hospital, and the wider health precinct.</td>
<td>Emphasis on practical application of theoretical principles</td>
<td>BB (Individual interview): I really like being here compared to on a campus because I just feel as if I’m in a different environment and anything can happen. I feel in touch with the workplace. You know, like the possibility of me becoming a nurse, you can imagine it even more when you’re here because you’re in a hospital. So I think the goal to become a nurse is more within your grasp because you see it. You know, it’s a goal that you’re living every day.</td>
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<td></td>
<td></td>
<td>CC (Individual interview): The other enjoyable aspect, I guess, is when you’re out there on placement, and when some of the things that you learned at uni that you were wondering, &quot;Where the hell does this fit in?&quot; And you actually get to see it all play a part. I guess, when you're putting it all together, is when you being to realise, &quot;Oh my God, I can actually be, totally, a nurse one day.&quot;</td>
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<td></td>
<td></td>
<td>CC (Focus group): you tend to feel it’s like a wasted opportunity. If, for instance, say we’re dealing with things like broken bones. It almost feels like such a sad pity that you can’t go at the end of the class to the orthopaedic ward. Maybe that might actually help with understanding the theoretical underpinnings.</td>
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<td></td>
<td>LH (Focus group): There’s lots more opportunity to integrate the two a lot more. We could get the CNSs to teach that specific, whatever they’re specialising in. We could get them to come down and teach us that so that we could learn it directly.</td>
<td></td>
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<td></td>
<td></td>
<td>BB (Focus group): I think they needed more practical ways that we can enforce…concepts. You know it’s great to learn it, but what’s the point - if you can’t use it? You know? So what’s that I’m talking about – the theory – it’s so unbalanced.</td>
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<td>LH (Focus group): …My friend studies medicine here and she’s part of the (hospital name withheld) cohort. And I know their tutors take them up once they’ve already interacted with the patient that they know has the disease they’re about to study, they take their tutorial class up and they all go interact with this patient. They let them palpate, or whatever it is for that whatever that person’s disease is. And I feel that would be really valued by us.</td>
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<td></td>
<td></td>
<td>DD (Focus group): Exactly. And we did our CPA on abdominal assessment for this semester and we didn’t have a real abdomen to do all the palpation, percussion all those steps. Even we don’t get that one in our placements because every nurse has got a different way of doing. Whether listening to the chest or it’s the abdomen or all those physical assessment, I personally feel I am still not confident. Theoretically, I am confident how to do it but physically when I do it on a patient, I doubt myself that which sound is this one? Which part I am doing it?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>XI (Focus group): I agree with that. If we’re going to have a course in the hospital, why not utilise the hospital more?</td>
<td></td>
</tr>
</tbody>
</table>
| Familiarity, sense of belonging aids in transition to professional practice | AA (Individual interview): I think being at the hospital and being there every day it kind of, you know, mentally prepares you... Every day you see, even research, people in research you see doctors, you see physios they're all talking with each other in the hallways or in elevators and things like that. I think seeing that constantly it just makes the standard for you like this is where I want to work, this is what I want.  
BB (Individual interview): when I walk into the hospital in that sense, I become part of the staff in terms of if someone needed help, I would go straight to them and do everything I can.  
CC (Individual interview): having done all my placements here, I almost feel like I work at (hospital name withheld). I have that sense of - I connect with the place, and I identify with the culture of the place, and the expectations that come with this. | Students have that sense of belonging and connection and consistent exposure paralleled with their University teaching and learning. |
Appendix I – Concept Map of findings

Perceived disconnect: Hospital – University campus. Reality has relevance.

Interprofessional

Learning settings

Common room

Overall satisfaction

Experiences

Geographical disconnect: Market St, Camino and Westmead Health Precinct

Delivery intensity

Obvious to students that there should be greater integration incorporated into the partnership

Hold a University degree already. Appreciate that practical applications of knowledge is has relevance for workplace functioning after graduation

The hospital as a situated learning environment. Delivery of a pre-registration nursing degree within a health precinct

The pedagogical value of a situated learning environment. Delivery of a pre-registration nursing degree within a health precinct

Familiarisation, belongingness and connection

Mindset

Reality

Bridging gaps

Associations and affiliations

Constant and consistent exposure parallelled with their University degree delivery

Identify and boundaries

Authenticity of environment. Emphasis on practicality of pre-registration applying evidence informed best practice

Theory-Practice

Transition to professional practice assessed

Growth

Decreased anxiety

Environment

Profession

**Terms/descriptors related to the method, and my quick reference guide**

<table>
<thead>
<tr>
<th>Numerical ordering</th>
<th>Term / descriptor</th>
<th>Meaning</th>
<th>Additional assoc. detail</th>
<th>Initial organisation of my application (to demonstrate decision trail)</th>
<th>NVivo application notes (Bazeley, 2007)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Decide</td>
<td>Manifest Content</td>
<td>What the text says – Describes the visible/obvious components</td>
<td>Both involve interpretation, but varies in levels of abstraction and depth</td>
<td>Choice: Stay within the descriptive domain. i.e. the manifest content. Do not want to go into an interpretation of the underlying meaning (latent content) in order to develop themes. Aim of this study is to gain an understanding. Remaining at a descriptive level of manifest content interpretation at this stage of the research is appropriate given the limitation of a 20,000-word Master’s level dissertation. Repeating the study with an exploratory level of latent content interpretation as the aim could be an area for potential expansion into a doctor of philosophy theses in the future.</td>
<td>Read through data collected several times, ‘immersing’ myself in the data to get a ‘sense of the whole’. Suspect that this helps to determine an overall or general focus or direction.</td>
</tr>
<tr>
<td></td>
<td>OR Latent Content</td>
<td>What the text talks about; relationships aspect; interpretation of underlying meaning</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 2. Select          | Unit of Analysis (UOA) | A large variety of possibilities e.g. a person, program, community, interviews, parts of text abstracted or coded, even every word or phrase | Suggested most suitable UOA is whole interviews large enough to be considered a whole, and small enough to be possible to keep in mind as a context for the meaning unit | My UOAs:  
- 4 interviews (X1 focus group, x3 follow up individual interviews)  
- 36 photographs (photo elicitation) with their associated reflective captions (photo feedback) and the corresponding individual interview responses pertaining to the visual participatory methods in stage 2 (refer to table in Appendix G for depiction of UOA based on organisation of content areas) | Once have imported the data in it’s various forms (i.e. interview transcripts and photographs with the associated reflective captions), considered in NVivo as an ‘internal source’. |
Choice: not to consider the reflective captions as separate UOAs, as this would detract from the meaning of the photograph taken by each individual participant.

Choice: not to consider each of the 3 main participants (who undertook both stages of the data collection process) as 3 separate UOAs, as I did not want the context of the meaning units to be restricted to each individual. In this way, meaning units could be shared across any of each of the participant’s contributions (their individual interview, their photographs, their associated reflective captions for each photograph).

<table>
<thead>
<tr>
<th>3. Organisation of Content Area</th>
<th>Parts of a text dealing with or shedding light on a specific explicit area of content identified, with minimal interpretation</th>
<th>E.g. Can be parts of the text based on theoretical assumptions from the literature, or content which addresses a specific topic in an interview</th>
<th>Based on my identified key concepts (refer to table in Appendix G for depiction of UOA based on organisation of content areas)</th>
</tr>
</thead>
</table>

While reading, add annotations, similar to what I would place in the borders of tangible or printed documents.

Enter my organised content areas into NVivo as individual ‘free nodes’

<table>
<thead>
<tr>
<th>4. Use content areas to create MUs and UOAs as a context for Meaning Unit (MU)</th>
<th>Constellation of words, statements, sentences, paragraphs containing aspects (content, context) related to each other through central meaning</th>
<th>Can fit into more than one theme. ('Themes’ applicable if choosing to analyse latent content)</th>
<th>(refer to table in Appendix H for depiction of UOA based on organisation of content areas. This table also includes the subsequent formation of ‘meaning units’ based on the latter established components).</th>
</tr>
</thead>
</table>

Go through data as ‘internal sources’, line by line analysis to which I will then apply the appropriate “free node”.

| (Note: For the table, the table data as presented in the image is not legible. The text is not readable enough to be accurately transcribed.) | (Note: For the table, the table data as presented in the image is not legible. The text is not readable enough to be accurately transcribed.) | (Note: For the table, the table data as presented in the image is not legible. The text is not readable enough to be accurately transcribed.) | (Note: For the table, the table data as presented in the image is not legible. The text is not readable enough to be accurately transcribed.) |
5. Undertake the process of Condensing the MUs

Decreasing the amount of text while preserving the quality of what remains

Condense the meaning units into descriptions and close to the text and the manifest content

Choice: Stay within the descriptive domain. i.e. the manifest content. Do not want to go into an interpretation of the underlying meaning (latent content) in order to develop themes.

Aim of this study is to gain an understanding. Remaining at a descriptive level of manifest content interpretation at this stage of the research is appropriate given the limitation of a 20,000-word Master’s level dissertation. Repeating the study with an exploratory level of latent content interpretation as the aim could be an area for potential expansion into a doctor of philosophy theses in the future.

Where ‘free nodes’ can be grouped, place into ‘child’ and ‘parent’ nodes

6. Condensed text / MUs are then Abstracted

Group together under higher order headings, whilst emphasising description and interpretations on a higher logical level

E.g. creating codes, categories and themes of various levels

Condensed MUs were abstracted and labelled with a -> Code.

7. Label the MUs with a Code

Allows the data to be thought about in new and different ways, and should be understood in terms of context

E.g. A code can be assigned to discrete objects, events and other phenomena. Can fit into more than one theme. (‘Themes’ applicable if choosing to analyse latent content)

Codes compared based on similarities and differences

Aggregate the child nodes to the parent nodes based to merge the categories that are still representative of an idea in terms of the research question and focus
### 8. Create Categories

A group of content that shares a commonality. Refers mainly to a **descriptive** level of content - can be seen as an expression of the **manifest** content of the text. Thread throughout codes. Mainly descriptive level of content.

A core feature of qualitative content analysis. Categories can fit into more than one theme. (‘Themes’ applicable if choosing to analyse latent content)

Codes then sorted into categories and sub-categories

---

### 9. Categories often include

**Sub-categories**

At varying levels of abstraction

Sub-categories can be sorted and abstracted into a category, or the category can be divided into sub-categories

---

### 10. Link underlying meanings by creating Themes

A thread of underlying meaning through condensed meaning units, codes or categories. An interpretive level of expressing latent content.

As all data has multiple meanings, themes are not mutually exclusive.

Again, choice to: Stay within the descriptive domain. i.e. the manifest content. Do not want to go into an interpretation of the underlying meaning (latent content) in order to develop themes.

Aim of this study is to gain an **understanding**. Remaining at a descriptive level of manifest content interpretation at this stage of the research is appropriate given the limitation of a 20,000-word Master’s level dissertation. Repeating the study with an exploratory level of latent content interpretation as the aim could be an area for potential expansion into a doctor of philosophy theses in the future.

Included this row and part of the analysis for my own holistic understanding.
Appendix K – Ethics Approval Letter

The University of Sydney

Research Integrity & Ethics Administration
Human Research Ethics Committee

Thursday, 6 April 2017

Prof Frances Waugh
Fac Ed & Soc Wk - Research; Faculty of Education & Social Work
Email: fran.waugh@sydney.edu.au

Dear Frances

The University of Sydney Human Research Ethics Committee (HREC) has considered your application.

After consideration of your response to the comments raised your project has been approved.

Approval is granted for a period of four years from 06 April 2017 to 06 April 2021

Project title: The pedagogical value of a situated learning environment: Delivery of a pre-registration nursing degree within a health precinct

Project no.: 2017/113

First Annual Report due: 06 April 2018

Authorised Personnel: Waugh Frances; Bonus Charmaine; Da Silva Kimberly;

Documents Approved:

<table>
<thead>
<tr>
<th>Date Uploaded</th>
<th>Version number</th>
<th>Document Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>24/03/2017</td>
<td>Version 2</td>
<td>Visual Participatory Methods Guidelines (Clean copy)</td>
</tr>
<tr>
<td>01/02/2017</td>
<td>Version 2</td>
<td>PIS</td>
</tr>
<tr>
<td>01/02/2017</td>
<td>Version 2</td>
<td>Consent Form</td>
</tr>
<tr>
<td>31/01/2017</td>
<td>Version 1</td>
<td>Email invitation to participate</td>
</tr>
<tr>
<td>31/01/2017</td>
<td>Version 1</td>
<td>Guidelines for the two visual participatory methods</td>
</tr>
<tr>
<td>31/01/2017</td>
<td>Version 1</td>
<td>Interview Questions (Focus group and Individual Follow-up)</td>
</tr>
</tbody>
</table>

Conditions of Approval

- Research must be conducted according to the approved proposal.
- An annual progress report must be submitted to the Ethics Office on or before the anniversary of approval and on completion of the project.
- You must report as soon as practicable anything that might warrant review of ethical approval of the project including:
  - Serious or unexpected adverse events (which should be reported within 72 hours).
  - Unforeseen events that might affect continued ethical acceptability of the project.
- Any changes to the proposal must be approved prior to their implementation (except where an amendment is undertaken to eliminate immediate risk to participants).
• Personnel working on this project must be sufficiently qualified by education, training and experience for their role, or adequately supervised. Changes to personnel must be reported and approved.

• Personnel must disclose any actual or potential conflicts of interest, including any financial or other interest or affiliation, as relevant to this project.

• Data and primary materials must be retained and stored in accordance with the relevant legislation and University guidelines.

• Ethics approval is dependent upon ongoing compliance of the research with the National Statement on Ethical Conduct in Human Research, the Australian Code for the Responsible Conduct of Research, applicable legal requirements, and with University policies, procedures and governance requirements.

• The Ethics Office may conduct audits on approved projects.

• The Chief Investigator has ultimate responsibility for the conduct of the research and is responsible for ensuring all others involved will conduct the research in accordance with the above.

This letter constitutes ethical approval only.

Please contact the Ethics Office should you require further information or clarification.

Sincerely

[Signature]

Professor Glen Davis
Chair
Human Research Ethics Committee

The University of Sydney HRECs are constituted and operate in accordance with the National Health and Medical Research Council's (NHMRC) National Statement on Ethical Conduct in Human Research (2007) and the NHMRC's Australian Code for the Responsible Conduct of Research (2007).
Appendix L – Participant Information Statement

The pedagogical value of a situated learning environment: Delivery of a pre-registration nursing degree within a health precinct

PARTICIPANT INFORMATION STATEMENT

(1) What is this study about?

You are invited to take part in a research study about the educational value of delivering a pre-registration nursing degree within the Westmead Precinct.

You have been invited to participate in this study because you will have completed at least one year as a full time student undertaking your nursing studies within the Westmead Precinct as part of your education at The University of Sydney. This Participant Information Statement tells you about the research study. Knowing what is involved will help you decide if you want to take part in the study. Please read this sheet carefully and ask questions about anything that you don’t understand or want to know more about.

Participation in this research study is voluntary.

By giving consent to take part in this study you are telling us that you:
✓ Understand what you have read.
✓ Agree to take part in the research study as outlined below.
✓ Agree to the use of your personal information as described.
You will be given a copy of this Participant Information Statement to keep.

(2) **Who is running the study?**

The study is being carried out by the following researchers:
- Mrs Charmaine Bonus (Associate Lecturer, Sydney Nursing School, The University of Sydney)

Charmaine is conducting this study as the basis for the degree of the Master of Education (Research) at The University of Sydney. This will take place under the supervision of Dr. Frances Waugh, Associate Dean (International) and Professor in Social Work, Sydney School of Education and Social Work, The Faculty of Arts and Social Sciences, The University of Sydney. At the Westmead Precinct site, research will be supervised under a Local Health District assigned Chief and Principal Investigator, Kimberly Da Silva, Acting Manager Nursing and Midwifery Education, WSLHD.

The researchers do not have any potential or actual conflicts of interest to declare.

(3) **What will the study involve for me?**

You will be asked to participate in a one-hour audio-recorded focus group. You will then be invited to take part in the next activity, requiring you to take photographs of your learning environment. Photographs must be taken on a facility owned, dedicated camera, and the researcher will provide you with guidelines for this activity. This activity will also involve providing accompanying captions for the photographs to be submitted back to the researcher. Finally, a 45-minute audio-recorded individual interview will be conducted as a follow-up on the previous activities.

(4) **How much of my time will the study take?**

Focus group will take approximately one hour. The photograph and accompanying captioning activity will take approximately 90 minutes. The individual interview will take approximately 45 minutes. The total expected time that this study will take is three hours and 30 minutes over 2 weeks. These activities will take place outside of usual class time.

(5) **Do I have to be in the study? Can I withdraw from the study once I’ve started?**

Being in this study is completely voluntary and you do not have to take part. Your decision whether to participate will not affect your current or future relationship with the researchers or anyone else at the University of Sydney or any institutions within the Western Sydney Local Health District (WSLHD), of which the Westmead Precinct is a part of. Your decision whether or not to participate will also not have any implication/effect on your marks or assessments in any manner, shape or form.

You will be asked to complete a consent form if you participate in the focus group, photograph and accompanying captioning activity, as well as for the follow-up individual interview components of this study. If you take part in any of these activities, you are free to stop participating at any stage and can refuse to answer any of the questions. However, it will not be possible to withdraw your individual comments from our records once the focus group has started, as it is a group discussion.
For the individual interview, you are free to stop the interview at any time. Unless you say that you want me to keep them, any recordings will be erased and the information you have provided will not be included in the study results. You may also refuse to answer any questions that you do not wish to answer during the individual interview.

If you decide to take part in the study and then change your mind later, you are free to withdraw at any time. You can do this by emailing Mrs Charmaine Bonus (Charmaine.bonus@sydney.edu.au) and requesting that your individual responses and submissions be removed. There are no consequences to you requesting removal of your responses and submissions.

(6) **Are there any risks or costs associated with being in the study?**

Aside from giving up your time, we do not expect that there will be any risks or costs associated with taking part in this study.

(7) **Are there any benefits associated with being in the study?**

We cannot guarantee that you will receive any direct benefits from being in the study.

(8) **What will happen to information about me that is collected during the study?**

By providing your consent, you are agreeing to us collecting personal information about you for the purposes of this research study. Your information will only be used for the purposes outlined in this Participant Information Statement, unless you consent otherwise.

I wish to collect your views and experiences regarding the delivery of a pre-registration nursing degree within the Westmead Precinct environment. This information will be collected through audio recording of the focus group, participant-supplied photographs with accompanying textual captions, and an audio-recorded follow-up individual interview. The audio recorded data will be transcribed by this researcher and analysed electronically.

All data collected will be kept confidential and only I, or the assigned research supervisors will have access to data collected. Identifiers collected will only be used for research purposes only. Electronic data will be password protected and any hard copy data will be kept in a locked cabinet in a secured university office used by this researcher and transferred to archives on study completion and kept for 5 years. After this time period all the data will be destroyed.

Your information will be stored securely and your identity/information will be kept strictly confidential, except as required by law. Study findings may be published, but you will only be identifiable in these publications if you indicate so on the consent form.

We will keep the information we collect for this study, and we may use it in future projects. By providing your consent you are allowing us to use your information in future projects. We don’t know at this stage what these other projects will involve. We will seek ethical approval before using the information in these future projects.
(9) **Can I tell other people about the study?**

Yes, you are welcome to tell other people about the study.

(10) **What if I would like further information about the study?**

When you have read this information, Mrs Charmaine Bonus will be available to discuss it with you further and answer any questions you may have. If you would like to know more at any stage during the study, please feel free to contact Mrs Charmaine Bonus, Associate Lecturer – Clinical Education Specialist via email: Charmaine.Bonus@Sydney.edu.au.

(11) **Will I be told the results of the study?**

You have a right to receive feedback about the overall results of this study. You can tell us that you wish to receive feedback by emailing Mrs Charmaine Bonus (Charmaine.bonus@Sydney.edu.au). This feedback will be in the form of a one page lay summary. You will receive this feedback after the study is finished.

(12) **What if I have a complaint or any concerns about the study?**

Research involving humans in Australia is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). The ethical aspects of this study have been approved by the HREC of the University of Sydney [INSERT protocol number once approval is obtained]. As part of this process, we have agreed to carry out the study according to the *National Statement on Ethical Conduct in Human Research (2007)*. This statement has been developed to protect people who agree to take part in research studies.

If you are concerned about the way this study is being conducted or you wish to make a complaint to someone independent from the study, please contact the university using the details outlined below. Please quote the study title and protocol number.

The Manager, Ethics Administration, University of Sydney:

- **Telephone:** +61 2 8627 8176
- **Email:** human.ethics@sydney.edu.au
- **Fax:** +61 2 8627 8177 (Facsimile)

_This information sheet is for you to keep_
Appendix M – Participant Consent Form

The pedagogical value of a situated learning environment: Delivery of a pre-registration nursing degree within a health precinct

PARTICIPANT CONSENT FORM

I, ......................................................... [PRINT NAME], agree to take part in this research study.

In giving my consent I state that:

✓ I understand that the researcher will conduct this study in a manner conforming to ethical and scientific principles set out by the National Health and Medical Research Council of Australia.

✓ I understand the purpose of the study, what I will be asked to do, and any risks/benefits involved.

✓ I have read the Participant Information Statement and have been able to discuss my involvement in the study with the researchers if I wished to do so.

✓ The researchers have answered any questions that I had about the study and I am happy with the answers.

✓ I understand that being in this study is completely voluntary and I do not have to take part. My decision whether to be in the study will not affect my relationship with the researchers or anyone else at the University of Sydney, Western Sydney Local Health District, and The Westmead Precinct now or in the future.

✓ I understand that I can withdraw from the study at any time.
✓ I acknowledge that this research has been approved by the Western Sydney Local Health District Human Research Ethics Committee.

✓ I acknowledge that I have received a copy of this form and the Participant Information Sheet.

✓ I understand that I am free to stop participating at any stage.

✓ I understand that I may stop the individual interview at any time if I do not wish to continue, and that unless I indicate otherwise, any recordings will be erased and the information provided will not be included in the study. I also understand that I may refuse to answer any questions I don’t wish to answer.

✓ I understand that I may leave the focus group at any time if I do not wish to continue, and can refuse to answer any of the questions. I also understand that it will not be possible to withdraw my individual comments once the group has started as it is a group discussion.

✓ I understand that personal information about me that is collected over the course of this project will be stored securely and will only be used for purposes that I have agreed to. The study researchers will keep the information we collect for this study, and we may use it in future projects. By providing your consent you are allowing us to use your information in future projects. We don’t know at this stage what these other projects will involve. We will seek ethical approval before using the information in these future projects.

✓ I understand that information about me will only be told to others with my permission, except as required by law.

✓ I understand that the results of this study may be published, but these publications will not contain my name or any identifiable information about me unless I consent to being identified using the “Yes” checkbox below.

☐ Yes, I am happy to be identified.

☐ No, I don’t want to be identified. Please keep my identity anonymous.

I consent to:

- Audio-recording YES ☐ NO ☐

- Photographs YES ☐ NO ☐

- Reviewing transcripts YES ☐ NO ☐

- Being contacted about the next stage of this study YES ☐ NO ☐

Would you like to receive feedback about the overall results of this study?

YES ☐ NO ☐

If you answered YES, feedback will be in the form of a one page lay summary. You will receive this feedback after the study is finished.