School of Nursing

Faculty of Health Sciences

An exploration of midwifery students' perceptions of clinical facilitators and experiences of clinical facilitation during midwifery clinical placements in Perth, Western Australia

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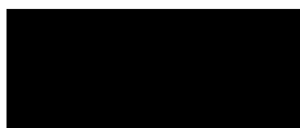
Declaration

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgment has been made.

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

The research presented and reported in this thesis was conducted in accordance with the National Health and Medical Research Council National Statement on Ethical Conduct in Human Research (2007) – updated March 2014. The proposed research study received human research ethics approval from the Curtin University Human Research Ethics Committee (EC00262), Approval Number HRE2017-0585.

Signed:  Date: 28 January 2022

Attribution Statement

ATTRIBUTION STATEMENT

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Abstract

Background

Clinical facilitation is a model of supervision for students during professional practice experiences which aims to promote the integration of theoretical and practical teaching and, the connection between health services and education providers. Midwifery clinical facilitation is an important aspect of midwifery education in preparing graduate midwives for the workplace. There is limited midwifery-specific research, however, in nursing, clinical facilitation has been identified as beneficial to student development. While midwifery students may face similar situations to nursing students in the professional practice environment it is important to examine the concept as it relates to midwifery and develop the midwifery body of knowledge as a distinct profession. Midwifery students' perceptions and experiences of clinical facilitation are under-investigated. Adding the student voice to this phenomenon allows educators to examine the existing implementation of clinical facilitation and tailor the program to meet the unique needs of the midwifery student. This qualitative study aimed to explore midwifery students' perceptions of the role of the Clinical Facilitator (CF) and describe their experiences of clinical facilitation during midwifery clinical placements in Western Australia (WA) to identify strengths and areas for improvement.

Methodology

A qualitative descriptive exploratory approach was used to develop knowledge and understanding of midwifery students' experiences with midwifery clinical facilitation. The target population was WA undergraduate

midwifery students who had attended clinical placement that included clinical facilitation. Purposive sampling was used to achieve a maximum variation sample, capturing students across several stages of undergraduate midwifery programs at two universities. Ten interviews were completed and transcribed. Data analysis was conducted simultaneously using thematic analysis to identify themes and sub-themes.

Findings

The major themes that emerged from the data were identified as *the role of midwifery clinical facilitation* and *engaging with midwifery clinical facilitation*. The first major theme, *the role of midwifery clinical facilitation*, had two linked sub-themes, namely *understanding of midwifery clinical facilitation* and *factors affecting midwifery clinical facilitation*. This theme highlighted that midwifery students had a clear understanding of midwifery clinical facilitation, it was highly valuable to their learning and development, and it was not fulfilled by other influential roles in their education and professional practice experiences. The second major theme, *engaging with midwifery clinical facilitation*, had three sub-themes, labelled *supportive midwifery clinical facilitation*, *unsupportive midwifery clinical facilitation* and, *recommendations for improvements*. Concepts from this theme impacted midwifery student experiences with clinical facilitation. The themes and sub-themes were used to reveal an understanding of the students' perception of the process of midwifery clinical facilitation and their description of experiences that affect engagement with midwifery clinical facilitation.

Conclusion

Midwifery clinical facilitation is highly valued by midwifery students in supporting them to become midwives. They appreciate the midwifery facilitator being an independent, trusted representative of the university in the clinical environment and found the process was improved when there was continuity. Midwifery students' experiences were impacted by inconsistencies that came from the model of employment and role operationalisation. It is important to recognise midwifery clinical facilitation as an educational process and, strengthen the alignment of the role to education providers. The study presented by this thesis has provided an early understanding of the student experience of midwifery clinical facilitation. Further investigation is needed to examine the experiences of midwifery CFs, comparing the hospital-based and university-based models of employment. It would also be useful to clarify the expectations of midwifery clinical facilitation with both education providers and health services.

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Acknowledgement of Country

We acknowledge that Curtin University works across hundreds of traditional lands and custodial groups in Australia, and with First Nations people around the globe. We wish to pay our deepest respects to their ancestors and members of their communities, past, present, and to their emerging leaders. Our passion and commitment to work with all Australians and peoples from across the world, including our First Nations peoples are at the core of the work we do, reflective of our institutions' values and commitment to our role as leaders in the Reconciliation space in Australia

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Glossary of Abbreviations

Abbreviation	Term
AHPRA	Australian Health Practitioner Regulation Agency
ANMAC	Australian Nursing and Midwifery Accreditation Council
CCE	Continuity of Care Experience
CF	Clinical Facilitator
Curtin	Curtin University
ECU	Edith Cowan University
EMHS	East Metropolitan Health Service
MGP	Midwifery Group Practice
Notre Dame	University of Notre Dame
RN	Registered Nurse
WA	Western Australia

Chapter 1

Introduction

Clinical facilitation is a model of clinical supervision for students on clinical placements, which aims to bridge the theory to practice gap and provide a link between the university and industry. As a practice-based profession, clinical education is an integral aspect of midwifery programs in Australia and clinical facilitation should promote a positive learning environment for students undertaking the required professional practice experiences (Andrews & Ford, 2013; McKellar et al., 2018; McKellar & Graham, 2016). A CF is employed to support midwifery students during professional practice experiences and facilitate their integration into the clinical environment. Midwifery students come into contact with and are influenced by many health professionals who contribute to their learning and provide supervision throughout their course of study. The role of the CF is different from other student clinical supervisory roles in that the student is the main focus of the role. In addition, the CF also provides a university presence in the clinical area. CFs play a major role in the student experience of clinical placements and therefore are influential in the development and professional growth of students (Franklin, 2013; Griffiths et al., 2021; Jayasekara et al., 2018; McKellar et al., 2018; McKellar & Graham, 2016; Needham et al., 2016; Ryan & McAllister, 2019). By ensuring clinical facilitation is beneficial to students, universities, industry, and the profession promotes student satisfaction and enhances the university profile while developing confident graduate midwives (Griffiths et al., 2021; Jayasekara et

al., 2018; McKellar et al., 2018; McKellar & Graham, 2016; Needham et al., 2016).

This study aimed to explore midwifery students' perceptions of the role of the CF and describe their experiences of clinical facilitation during midwifery clinical placements in WA to identify strengths and areas for improvement. This chapter presents the background and significance of the study including the aim and objectives. In doing so, it provides an overview of the existing literature related to clinical facilitation of midwifery students and highlights the importance of this aspect of education to the profession of midwifery. It identifies the gap in knowledge and explains the implications for practice and the importance of exploring and developing the collective understanding of clinical education of midwifery students. The positionality statement explains the researcher's interest in and experience with this area of midwifery clinical education, allowing insight into the perspective which the researcher brings.

1.1 Background

1.1.1 History of the Regulation of Midwifery

Traditionally, childbirth and midwifery were the realms of women (Callaghan, 2001; Davison, 2020; Jones, 2012). Midwives were women who learned through apprenticeship and experience, how to provide care for women and their families during pregnancy, birth and, the postpartum period (Callaghan, 2001; Fahy, 2007; Jones, 2012). Prior to the western colonisation of Australia, Aboriginal-led midwifery care supported women to birth safely (Callaghan, 2001; Ireland et al., 2015). It was widely accepted in Aboriginal cultures, that women had the knowledge needed to provide care,

reduce fear and support one another during this time and they developed into skilled practitioners through experience (Callaghan, 2001; Ireland et al., 2015; Jones, 2012). Traditional Aboriginal birth practices vary greatly between the different cultural groups but the land is essential to the rituals and methods of supporting the woman and her baby (Callaghan, 2001). After western colonisation occurred, colonial midwives independently provided most of the maternity care for the settlers until the 1880s (Fahy, 2007). These colonial midwives were also trained through apprenticeship and experience. A lack of colonial midwives in more remote locations meant that traditional Aboriginal midwives also attended to childbearing settler women and shared their expertise with the colonial nurses (Jones, 2012). A formal midwifery training program was commenced in 1888, but only nurses were allowed to enrol, and the Aboriginal and colonial midwives were excluded (Best & Gorman, 2016; Fahy, 2007).

Regulation of midwives by state legislation started in 1901 in Tasmania. It was then implemented by the other states over the next two decades as biomedical management of maternity care overtook the traditional model (Bogossian, 1998; Kurz et al., 2020). From this point on midwifery was gradually subsumed as a branch of nursing and by the 1940s only midwives who were state registered nurses (RNs) with additional education in midwifery could provide midwifery care and they were governed by nursing regulations (Bogossian, 1998; Fahy, 2007). During this period, Aboriginal-led midwifery care was also displaced in favour of western biomedical approaches (Ireland et al., 2015). Aboriginal midwives were replaced by Aboriginal birth assistants who worked under the supervision and direction of

mission nuns with formal nursing and midwifery training, with the gradual removal of culture from birthing and birth services from remote settings (Best & Gorman, 2016; Ireland et al., 2015; Jones, 2012). The opportunity to access formal training as a nurse or midwife was not available to most Aboriginal women until the 1950s due to protectionism and segregation policies (Best & Bunda, 2020; Best & Gorman, 2016).

The result of these events was that midwifery in Australia was viewed as a specialty of nursing with a biomedical philosophy and it was assumed that all midwives were RNs first (Bogossian, 1998). The assimilation of midwifery into the profession of nursing with its different philosophy, values and, scope of practice has caused a variety of issues for midwifery and midwives. There has been a degradation of midwifery professional identity and skills, philosophical conflict and, a loss of autonomy. For example, as recently as 1992, midwives in some states of Australia required the supervision of a medical practitioner, who may or may not have been experienced in maternity care (Bogossian, 1998).

In the 1980s concerns with the appropriateness of nursing regulation of midwifery began to arise (Leap et al., 2017). The need to address the projected shortage of midwives and to recognise international midwives without nursing qualifications for registration was identified (Bogossian, 1998; Gray, 2019; Leap et al., 2017). Also, each state and territory had its own board which accredited education programs creating disparity of education requirements and registration standards (Bogossian, 1998; Gray, 2019; Leap et al., 2017). Consumers, midwifery leaders and, the government began calling for midwifery models of care. However, education programs at the

time were not preparing graduates for midwifery clinical models (Leap et al., 2017; McKellar et al., 2020). There was increasing pressure to standardise midwifery education which would prepare students for the full scope of midwifery practice and separate midwifery from nursing with an undergraduate midwifery program and a midwifery-specific professional practice framework (Leap et al., 2017). The 1990s and 2000s was a period of action for midwifery leaders, educators and, researchers in reviewing midwifery education and regulation, promoting midwifery unity and, arguing and preparing for the separation of midwifery from nursing as a distinct profession (Gray, 2019; Leap et al., 2017). In 2002 the first Bachelor of Midwifery programs commenced in Australia but due to the lack of standardisation across the nation, registration processes ranged from difficult, at best, to impossible as in the case of Queensland (Gray, 2019). In 2010 the states and territories came together, and each introduced the *Health Practitioner Regulation National Law Act* in their state jurisdiction. In WA, this was the *Health Practitioner Regulation National Law (WA) Act 2010*. This created the National Registration and Accreditation Scheme, the Australian Health Practitioner Regulation Agency (AHPRA) and the national health professional boards (Berglund, 2019; Staunton & Chiarella, 2020). Midwifery was recognised in its own right as a distinct health care profession, separating it from nursing, albeit with a combined national board (Gray, 2019).

Following on from midwifery being legitimately acknowledged as independent from nursing, midwives had to re-form themselves. In a system where most maternity care occurs in a biomedical model, midwives needed

to develop the role and identity of midwifery separate from nursing (McKellar et al., 2020). Gray (2019) interviewed midwives who had been registered pre- and post-national standardisation of regulations and found that the separation of midwifery from nursing had been received positively by them. When asked about the required recency of practice to maintain both their midwifery and their nursing registrations, participants categorised clinical practices to be either nursing, midwifery or overlapping depending on the type of person they were caring for, the setting and the type of activity. Interestingly the participants felt that when working in a nursing setting, they perceived that there are no nursing practices that could be included under a midwifery philosophy. For practices to be included as midwifery-specific they needed to involve midwifery philosophy (Gray, 2019). From this study it was clear that there were similarities between nursing and midwifery care activities, however, with its distinct philosophy, scope of practice and, specific skills, midwifery is different from nursing. The transferability of nursing literature to midwifery has been assumed in many areas due to the history and underlying acceptance of midwifery as a discipline of nursing. As midwifery continues to re-establish itself independent of nursing, developing the midwifery-specific body of knowledge is imperative to this process.

1.1.2 Evolution of Midwifery and Nursing Education in Australia

Midwifery and nursing education in Australia transitioned from hospital-based training into universities over a period of ten years, from 1985 to 1994 (Grealish & Smale, 2011). With the historical view of midwifery being a specialty of nursing, midwifery has previously been offered only as a postgraduate course with students first attaining a nursing undergraduate

qualification as part of the entry to practice requirement into midwifery. The introduction of direct-entry midwifery programs in Australia in 2002 (Licqurish & Seibold, 2008; Licqurish et al., 2013; McKellar et al., 2018; McKenna & Rolls, 2007) has allowed for students to study midwifery without being an RN first. WA introduced a direct-entry midwifery program in 2008 (Licqurish et al., 2013), existing alongside the more traditional postgraduate approach. In WA midwifery education is currently offered by three universities, Curtin University (Curtin), Edith Cowan University (ECU) and, the University of Notre Dame (Notre Dame). The traditional model of educating RNs to become midwives is offered by all three in the form of a graduate diploma program at Curtin and Notre Dame and a coursework masters degree at ECU. Curtin and ECU also offer direct-entry to practice midwifery programs. At ECU this is in the form of a double degree, where students complete a Bachelor of Nursing and a Bachelor of Midwifery concurrently. Curtin offered a Bachelor of Midwifery from 2008 until 2019. This was replaced in July 2020, when the Master of Midwifery program was introduced. This graduate entry course allows students who have completed a relevant degree, not necessarily nursing, to become a midwife. It is important to recognise that in this evolving context of separation from nursing, student midwives come from a variety of backgrounds. Not all student midwives have previous clinical experience related to health and students in such graduate entry to practice midwifery programs may require different support in the clinical setting than previous approaches to midwifery education have offered.

Since the implementation of the *Health Practitioner Regulation National Law Act* all education providers of health care programs that prepare

students for registration with AHPRA must be accredited (Staunton & Chiarella, 2020). The Australian Nursing and Midwifery Accreditation Council (ANMAC) is responsible for ensuring that midwifery and nursing education programs meet the accreditation standards and appropriately prepare graduates for each profession (Australian Nursing and Midwifery Accreditation Council [ANMAC], 2016). Quality clinical education within accredited education programs has a positive influence on the development of competence and workplace readiness of midwifery students (Griffiths et al., 2021; Lazarus, 2016; McKellar et al., 2018; McKellar & Graham, 2016).

Nursing education programs are required by ANMAC to include a minimum of 800 hours of professional practice experience (ANMAC, 2019), whereas the ANMAC requirement for current midwifery programs is that universities provide a program that includes 50% theory and 50% professional practice experience (ANMAC, 2014). Midwifery education programs must also provide clinical placements that allow students to meet minimum midwifery practice requirements (ANMAC, 2014). The ANMAC accreditation standards for midwifery have recently been reviewed and this requirement has been changed, only stipulating that students attend professional practice experiences to meet the minimum midwifery practice requirements (ANMAC, 2021). All education programs accredited at the time of conduct of the study reported in this thesis had to meet the 2014 requirements of 50% theory and 50% professional practice experience (ANMAC, 2014). For the ECU double degree students, this equated to at least 840 hours of midwifery professional practice experience, on top of their 800 nursing clinical placement hours. The previous Curtin Bachelor of

Midwifery students were required to complete a minimum of 1500 hours of clinical experiences and the current Master of Midwifery students will complete a minimum of 1000 hours of midwifery practice in a maternity setting. The minimum clinical hours for each course have been included in Table 1 (below).

Table 1

Accredited Hours for WA Entry to Practice Courses

Entry to Practice Course	Minimum Clinical Hours
Nursing	800 hours
ECU Bachelor of Midwifery & Bachelor of Nursing	1640 hours
Curtin Bachelor of Midwifery	1500 hours
Curtin Master of Midwifery	1000 hours

In the case of midwifery courses, education providers have worked out what is needed to enable students to meet minimum practice requirements. The hours presented in Table 1 in relation to midwifery courses therefore indicate the hours anticipated to complete these requirements and show that midwifery students will spend a considerable time in the clinical setting and with the midwifery CFs. Student midwives may even need more than the stipulated clinical hours to meet the required minimum midwifery practice experiences dependent on actual circumstances within the clinical setting at the time of professional practice experiences. A study in the United Kingdom where, similar to the Australian system, students spent up to 50% of the program in the clinical setting, identified that role models play a critical part in

helping midwifery students to learn the role of the midwife. Given the amount of time students spend in the clinical environment, the researchers determined that it was important that clinical role models are a positive influence (Bluff & Holloway, 2008). Furthermore, achieving the required midwifery professional practice experiences can be impacted by the clinical placement environment and learning culture and, individual student personality. Advocacy from midwifery clinical facilitation is important in assisting midwifery students to achieve the required minimum midwifery practice experiences (Griffiths et al., 2021; McKellar et al., 2018; Wood et al., 2011). Hence, the different professional practice requirements for midwifery students should be considered in the transferability of nursing literature to midwifery. Further reiterating the value of developing the body of knowledge specific to the clinical education of midwifery students.

1.1.3 Clinical Supervision

Since the transition of midwifery and nursing education programs into the university system there have been concerns about the integration of theory and practice and, developing workplace readiness (Department of Health, 2013; Grealish & Smale, 2011; Hall-Lord et al., 2013; Jayasekara et al., 2018; McKellar et al., 2018; Milton-Wildey et al., 2014). In practice-based professions, clinical education forms a vital aspect in preparing competent practitioners with strong professional identities and much of this is achieved during professional practice experience (Griffiths et al., 2021; Lazarus, 2016; McAllister et al., 2014; Needham et al., 2016). The literature is concordant in that quality clinical supervision is instrumental to creating a positive learning environment in the clinical placement setting which enhances the student

experience and development (Carolan-Olah & Kruger, 2014; Griffiths et al., 2021; Hauck et al., 2016; Hauck et al., 2017; Lazarus, 2016; McAllister et al., 2014; Milton-Wildey et al., 2014; Needham et al., 2016; Nieuwenhuijze et al., 2020).

In recognition of the importance of clinical supervision to the education and development of health professionals in Australia, Health Workforce Australia developed the National Clinical Supervision Competency Resource (2013). Here, they define clinical supervision as involving;

> … the oversight – either direct or indirect – by a clinical supervisor of professional procedures and/or processes performed by a learner or group of learners within a clinical placement for the purpose of guiding, providing feedback on, and assessing personal, professional and educational development in the context of each learner's experience of providing safe, appropriate and high-quality patient-client care. (Health Workforce Australia, 2013, p.22)

This resource was designed to support clinical supervisors in maintaining competence, understanding requirements of the role and, developing quality health professionals (Health Workforce Australia, 2013). They define a clinical supervisor as:

> An appropriately qualified and recognised professional who guides learners' education and training during clinical placements. The clinical supervisor's role may encompass educational, support and organisational functions. The clinical supervisor is responsible for ensuring safe, appropriate and high-quality patient-client care. (Health Workforce Australia, 2013, p.22)

In the WA health care system, clinical supervision may be provided by preceptors or CFs, defined in the next sections. Franklin (2013) identified the "facilitation/preceptor model" in nursing education where the student is allocated to an RN, the preceptor, for clinical placement shifts and is part of a group being supervised by the nursing CF (p.36). Entry to practice midwifery students most often experience a similar approach to clinical supervision,

where the midwifery student is allocated to a preceptor midwife on a shift-by-shift basis and is part of a group being supervised by a midwifery CF.

1.1.3.1 Midwifery Preceptors. Midwifery preceptors are the midwives that work alongside the student during professional practice experiences providing direct midwifery care, this may be for one shift, several shifts or for the whole placement (Chenery-Morris, 2014; Griffiths et al., 2021; Hallam & Choucri, 2019; Hauck et al., 2016; Jayasekara et al., 2018; Licqurish et al., 2013; McKellar & Graham, 2016; Walker et al., 2013). In international literature, the preceptor is also called the mentor (Barnett et al., 2010; Chenery-Morris, 2014; Hallam & Choucri, 2019; Wood et al., 2011). However in Australia, a mentor is a trusted, more experienced practitioner or role model, generally chosen by the student or graduate, to provide indirect support over a long-term period (Franklin, 2013). Midwifery students in WA rarely have mentors assigned. The benefits of student midwives working with a positive midwife preceptor have been identified in the literature (Hauck et al., 2017; Lazarus, 2016; Licqurish & Seibold, 2008; Licqurish et al., 2013; Nieuwenhuijze et al., 2020). When able, midwifery students seek out midwifery preceptors whose practice and philosophy they admire in order to develop their own competence and confidence (Licqurish & Seibold, 2008; Licqurish et al., 2013; Nieuwenhuijze et al., 2020). While evaluating a preceptor training program, Hauck et al. (2017) identified that midwifery students valued continuity of preceptors, who were willing, understanding and, provided constructive feedback. The importance of continuity and positive preceptor attitude in clinical supervision to undergraduate midwifery students was supported in the literature review by Hallam and Choucri

(2019), where student midwives felt these aspects improved their learning and placement experience. It can be difficult for clinical placements to provide continuity of preceptor and ensure a receptive attitude for students, however, this can be mitigated by clinical facilitation (Courtney-Pratt et al., 2012; Henderson & Tyler, 2011; McAllister et al., 2014; Ryan & McAllister, 2019; Sanderson & Lea, 2012; Walker et al., 2013). The study presented in this thesis explored midwifery students' experiences with clinical facilitation and their perceptions of how it impacted learning in the clinical environment.

It has been identified that preceptors often feel ill-prepared for their role in supervising students while on clinical placement and feel they need more support (Barnett et al., 2010; Courtney-Pratt et al., 2012). Although it is considered part of the role of both midwives and RNs (Nursing and Midwifery Board of Australia, 2016, 2018), preceptors do not necessarily possess the skills or the desire to teach students (Hall-Lord et al., 2013). More often than not, preceptors do not receive any compensation in workload allocation and therefore are torn between their duty to care for clients and their duty to teach students (Barnett et al., 2010; Brown et al., 2012; Courtney-Pratt et al., 2012). Preceptors and students alike report difficulties related to the role due to being time-poor and overburdened (Brown et al., 2012; Courtney-Pratt et al., 2012; Croxon & Maginnis, 2009; Hall-Lord et al., 2013). However, nursing CFs are seen to provide valuable support to both students and preceptors (Courtney-Pratt et al., 2012; Henderson & Tyler, 2011; O'Brien et al., 2008). In a mixed-methods study encompassing midwifery students from two South Australian universities across five clinical placement sites, preceptor midwives identified the need for more support from CFs (McKellar

et al., 2018). The study highlighted the need for further research to understand the role of midwifery clinical facilitation. This thesis provides an exploration of midwifery clinical facilitation from the perspective of students in the WA context.

1.1.3.2 Clinical Facilitators. ANMAC (2019) stipulates that universities are required to provide well-defined models of facilitation and assessment, with appropriately prepared academics and midwives supporting students during professional practice experiences and regular evaluation of this role by students, as well as other sources. In 2016, the WA universities that provide midwifery education, namely ECU, Notre Dame and, Curtin developed the following description of the CF:

> The Clinical Facilitator (CF) is the link person between industry and the universities. Their role is to support midwifery students in the clinical area and this is best achieved when the CF is not allocated a patient load but able to focus fully on the individual student requirements. This will ensure that students meet their objectives and are supported to reach their full potential. (Midwifery Education Western Australia, 2016)

Curtin further defined the role of the midwifery CF as the person who assists "students to apply knowledge of midwifery practice over the continuum of midwifery care" (p. 20) by working with them at times during clinical placements, as well as promoting a positive learning environment, acting as a role model, providing feedback, debriefing and reflection and, completing formal assessments (Curtin University, 2020). Several international and Australian studies across different health care services and universities have considered different models of clinical facilitation for nursing students however the relevance of their findings to the midwifery context remains uncertain given the difference in philosophies that support care

provision. In particular, there is very limited research regarding midwifery clinical facilitation in WA, necessitating this study.

The development of the understanding of clinical facilitation in nursing has revealed some emerging themes for best practice and some challenges to be addressed (Brown et al., 2012; Courtney-Pratt et al., 2012; McAllister et al., 2014; Needham et al., 2016; Ryan & McAllister, 2019; Sanderson & Lea, 2012). Notably, it has been identified that an essential aspect of the role of the CF is supporting preceptors as well as students (Courtney-Pratt et al., 2012; Henderson & Tyler, 2011; McKellar et al., 2018; O'Brien et al., 2008). This element is overlooked in the descriptions of midwifery clinical facilitation, suggesting that it is not formally recognised in the understanding of the role. With the relative recency of the regulation of midwifery being returned to midwives and the separation from nursing, the need to develop the midwifery-specific body of knowledge is more crucial than ever. This study adds to the understanding of clinical facilitation in midwifery.

In WA, entry to practice midwifery students are allocated one hour of clinical facilitation per shift. Midwifery CFs organise for this time to be provided throughout each week of the professional practice experience. This time may be used in various ways, including, but not limited to, direct clinical supervision, reviewing the student’s portfolio, discussion and debriefing, completing clinical assessments, consultation with staff, facilitating learning opportunities and, organising rosters. CFs may be employed by the respective university as a sessional academic (university-based), or by the hospital where students attend clinical placement (hospital-based). University-based midwifery CFs are not required to have been previously

employed as a midwife at the site where they are providing clinical facilitation. University-based midwifery CFs may also provide facilitation across more than one clinical placement site to students from the same university or course. Hospital-based midwifery CFs are stationed at one clinical placement site and may facilitate students from different universities at this site. They have generally been employed by the health care service provider as a midwife before moving to the CF role.

In 2016, the WA government reorganised the management of public health throughout the state. Health Service Providers were created to be responsible for the public health services of their local areas and communities (Department of Health, 2021; East Metropolitan Health Service [EMHS], 2018). The six different Health Service Providers are governed separately by their own board to ensure services are tailored to local requirements (Department of Health, 2021). While Health Service Providers need to meet minimum requirements for clinical placements for students, individual Health Service Providers have their own practices regarding clinical supervision of students during professional practice experiences (Department of Health, 2021). These are often verbal agreements between CFs and unit managers within the health care facility, rather than official policies, which determine student supervision practices. While the universities support midwifery CFs to work clinically with students, anecdotal evidence indicates that this practice is restricted by some Health Service Providers in WA. Hospitals have differing approaches to the presence of CFs in the clinical areas with students. At some sites, CFs can work with

students to the full scope of practice, while other sites only allow CFs to practice in some clinical areas in specific circumstances with students.

As an example, the *Nursing and Midwifery Student Clinical Placement Manual* for the East Metropolitan Health Service (EMHS) states that nursing CFs should support students providing patient care and supervise clinical skills and procedures in collaboration with the ward staff (2018). Midwifery CFs can work clinically with students in the postnatal ward. They are only permitted to work clinically with students in the birth suite and assessment unit if they are concurrently employed in the maternity department by EMHS. Those CFs without concurrent employment with EMHS “can visit the site, meet with students, review the necessary equipment, provide theoretical teachings and complete students’ progress reports” (EMHS, 2018, p. 12). Midwifery CFs are not permitted in clinical areas other than the postnatal ward, except to discuss feedback provided by staff with the student when there are concerns about practice (EMHS, 2018). Having to know the different expectations of different Health Service Providers is an added challenge to the role of the CF which also affects the way the CF operationalises the role and the support they can provide to the students and the staff. Clinical facilitation should form an integral aspect of the clinical experiences of midwifery students and provide a link for students between the university and the health service (Needham et al., 2016). The study presented in this thesis provides insight into how CFs are operationalising the role to meet the different requirements of the clinical placement settings and the impact on the student experience.

The CF provides learning support in a supernumerary capacity to one or more students, is employed by the university or the Health Service Provider, and is responsible for the student's overall clinical learning and development during professional practice experiences (Andrews & Ford, 2013; EMHS, 2018; McKellar et al., 2018; Ryan & McAllister, 2019; Sanderson & Lea, 2012; Walker et al., 2013). There is a lack of unity amongst authors, particularly internationally, in the terms used for clinical supervisory roles which may create difficulties for transferability of findings to the WA clinical midwifery context. Incongruence in the literature regarding the definition and operational implementation of clinical facilitation suggests that the role is complex and diverse and may be interpreted to fit local requirements furthering the need to explore the midwifery CF role in WA (Jayasekara et al., 2018; McKellar et al., 2018; O'Brien et al., 2014; Ryan & McAllister, 2019). The CF role is different from other clinical supervision roles fulfilled by midwives in the clinical area and plays a vital part in the growth and development of students during professional practice experiences (Franklin, 2013; Jayasekara et al., 2018; McAllister et al., 2014; McKellar et al., 2018; McKellar & Graham, 2016; Needham et al., 2016). It is important to develop an understanding of how the role is interpreted locally and in midwifery.

There is a growing body of research regarding clinical facilitation for nursing students, however, midwifery students are not well represented. International literature has identified that student nurses benefit from a clinical supervisor that is independent of existing hospital or university personnel (Hall-Lord et al., 2013; Lambert & Glacken, 2005, 2006). A

supernumerary clinical supervisor whose sole purpose is to enhance clinical education and decrease the theory-practice gap better supports the goals of nursing education and student learning (Hall-Lord et al., 2013; Lambert & Glacken, 2005, 2006). Australian literature supports that nursing clinical facilitation enhances students' experiential learning and developing competency during professional practice experiences (Brown et al., 2012; Courtney-Pratt et al., 2012; Franklin, 2013; Jayasekara et al., 2018; Needham et al., 2016; Ryan & McAllister, 2019). The complexity of the role of the nursing CF has been explored from the perspective of students, clinicians and, facilitators to enhance the comprehension of the role, its operationalisation and, the influence it has in promoting positive clinical learning environments (Milton-Wildey et al., 2014; Needham et al., 2016; Ryan & McAllister, 2019; Sanderson & Lea, 2012; Walker et al., 2013). This thesis describes an exploration of the student perceptions and experiences of clinical facilitation in midwifery.

Penney (2016) comments that teaching and midwifery share many of the same skills. The ultimate function of both is to develop a supportive, person-centred relationship that leads to positive outcomes, transformation and, empowerment (Penney, 2016). It is important to recognise that clinical facilitation is an educational role. Acknowledging midwifery as its own profession, separate from nursing, and the importance of clinical education in the development of workplace-ready graduate midwives points to the need to investigate clinical supervision in midwifery further. Exploring the clinical supervisory roles and establishing best-practice principles for clinical supervision of midwifery students is essential given the significant portion of

their course of study which is spent undertaking professional practice experiences. Clinical facilitation is a required aspect of midwifery clinical education and effective clinical facilitation is fundamental to the quality of clinical placements and therefore the development of students and future graduate midwives.

1.1.3.3 Student Perceptions. Ensuring student satisfaction with the support they receive during professional practice experiences will improve learning and decrease attrition rates of student and graduate midwives (Franklin, 2013; Griffiths et al., 2021; McKellar & Graham, 2016). Despite philosophical differences, there are similarities in some midwifery clinical activities with nursing and therefore there will be some similarities in clinical education requirements between the two professions (Gray, 2019). Midwifery and nursing students may be impacted by similar issues whilst in the clinical placement area, and the body of nursing research related to clinical supervision should be considered, however, it is timely to specifically examine clinical supervision of midwifery students independently (McKellar et al., 2018; McKellar & Graham, 2016). The study reported in this thesis seeks to give a voice to WA midwifery students and describe their experiences and perceptions of midwifery clinical facilitation.

It is important to note that the different clinical supervision needs of undergraduate and postgraduate students receive little consideration in the literature. A study examining the perceptions of role models, of 35 Dutch direct-entry and nine Icelandic postgraduate midwifery students, did not address the potential impact of previous clinical experience on the clinical needs of students (Nieuwenhuijze et al., 2020). Researchers determined

that positive role models are valued by all students (Nieuwenhuijze et al., 2020). An Irish study explored the concept of clinical facilitation from the perspective of CFs and postgraduate student nurses completing a paediatric qualification. While the postgraduate qualification in this study was a specialty of nursing and, not a different profession, and the geographical context is different to Australia, the student respondents identified the need for a role to provide them with clinical support, despite their previous qualifications and clinical experience. The authors found that a supernumerary clinical supervisory role was important in the integration of theory with practice for postgraduate student nurses (Lambert & Glacken, 2006). In a study of undergraduate nursing students from a large school of nursing in regional New South Wales, Australia, it was identified that younger students without previous clinical experience valued moral support from clinical supervisors more than their more mature peers (Lee et al., 2002). While it is unclear whether this is related to age or lack of clinical experience, it is worthy of examination when considering clinical education. As midwifery further emerges as separate to nursing, students with and without previous clinical nursing experience will require support to apply the midwifery philosophy to the unique challenges and environments of the midwifery profession. Investigation into the potential for different support requirements of students is warranted in the geographical context of WA, now that midwifery education programs include direct-entry to practice undergraduate and postgraduate courses. This study provides some insight into the perceptions of students without previous clinical experience of midwifery clinical facilitation.

Education providers are responsible for developing competent work-ready graduates, and a major aspect of this is providing quality clinical education with positive clinical supervision. Midwifery students are potentially more impacted by factors affecting clinical education due to their increased professional practice experience requirements. Students encounter a variety of clinical supervisors during professional practice experiences who influence the development of their midwifery identity, philosophy and, skills (Griffiths et al., 2021; McAllister et al., 2014; Needham et al., 2016; Severinsson & Sand, 2010). They spend the most time with midwifery preceptors, however, this time is not always quality learning time due to the impacts of the preceptors' conflicting responsibilities and, preparedness and support for the role (Hall-Lord et al., 2013; Hauck et al., 2017; McKellar et al., 2018; McKellar & Graham, 2016; O'Brien et al., 2014). Universities are required to provide midwifery clinical facilitation to support students in the clinical placement environment in recognition of the positive impact it has on clinical learning and development (Penney, 2016). Developing an understanding of best practice in midwifery clinical facilitation in the WA context is valuable to both students and the profession.

1.2 Research Problem

There is no doubt that clinical experience is an essential part of midwifery education (Griffiths et al., 2021; McKellar et al., 2018; McKellar & Graham, 2016), and undergraduate midwifery students feel concerned about the development of their clinical skills and being prepared for the workplace (Carolan-Olah & Kruger, 2014; McIntosh et al., 2013; Sheehy et al., 2021). In Australia, midwifery students may be exposed to several different models

used to support them during professional practice experiences (McKellar & Graham, 2016). The literature has highlighted that clinical facilitation is likely tailored to meet local requirements, making it important to consider midwifery clinical facilitation in the WA context. There is more to midwifery clinical facilitation than being a university representative and completing student assessments. It is essential to ensure that midwifery clinical facilitation in WA is beneficial to students, universities, industry and, the profession of midwifery (Franklin, 2013; Griffiths et al., 2021; Jayasekara et al., 2018; McKellar & Graham, 2016).

The limited existing midwifery literature and emerging nursing literature recognise the role of the CF as multifaceted, calling for further research to develop an understanding of the role and exploring student perceptions of clinical facilitation (Barnett et al., 2010; Bourgeois et al., 2011; Brown et al., 2012; Croxon & Maginnis, 2009; McKellar & Graham, 2016). Works by Andrews and Ford (2013) and McKellar et al. (2018) have begun to explore midwifery clinical facilitation in Australia and identify the need for further research to enhance this important role that is influential in preparing competent, safe, woman-centred graduate midwives. As midwifery is its own profession with unique conditions and challenges furthering the body of literature specific to midwifery is imperative. Evaluating midwifery-specific models of clinical supervision to ensure the emergence of confident graduate midwives who are ready for practice and strong in their identity as a midwife is crucial for the profession (Griffiths et al., 2021; McKellar et al., 2018; McKellar & Graham, 2016).

The purpose of this study was to offer the WA student perspective of midwifery clinical facilitation, gauging how clinical facilitation is experienced by midwifery students. Their perception and experience of the midwifery CF role offered feedback to CFs and universities and, identified aspects unique to the midwifery context. Graduate midwives are under huge pressure to be work-ready on completion of their courses (Sheehy et al., 2021). The preparedness of graduate midwives is dependent on many things but is largely influenced by quality clinical education (Griffiths et al., 2021; McKellar et al., 2018; McKellar & Graham, 2016), which is enhanced with quality clinical facilitation.

1.3 Aims and Objectives

The aim of this study was to explore undergraduate midwifery students' perceptions of the role of the CF and their experiences of clinical facilitation during midwifery clinical placements in WA. In keeping with this broad aim, the study planned to address the following specific objectives:

1. To describe midwifery students' experiences with clinical facilitation.
2. To identify from midwifery students' experiences perceived supportive clinical facilitation.
3. To identify from midwifery students' experiences perceived unsupportive clinical facilitation.
4. To explore midwifery students' perceptions of the role of the CF.
5. To determine from midwifery students' perspectives how clinical facilitation may be improved.

1.4 Study Significance

This study hoped to clarify the role of the midwifery CF by understanding it as perceived by the students. Defining the role more clearly strengthens knowledge to support education providers and industry partners to deliver quality clinical facilitation and ensure that midwifery education goals are being achieved. Exploring the student perspective allows education providers to determine the expectations of students, identify if their needs are being met, or realign student expectations with the purpose of clinical facilitation. Clinical facilitation should enhance the student's professional practice experiences and provide a link for both students and industry to the university. It was, therefore, important to assess to what degree this was being achieved and identify opportunities for improvement.

A supportive clinical environment enhances clinical learning for students and this study helps to assess how clinical facilitation supports the provision of such an environment. Assessing the experiences students have with clinical facilitation allows for evaluation of the education and support being provided to midwifery students (Griffiths et al., 2021; McKellar et al., 2018; McKellar & Graham, 2016). This reflection on student needs during professional practice experiences has implications for recruitment and responsibilities of CFs and guides educators on students' preparation for clinical placement.

Universities are responsible for providing education programs that prepare graduates to meet the standards for professional practice and above all, promote public safety. Quality clinical education and supervision are crucial in developing graduate midwives that are competent, confident and,

ready for the workplace (Griffiths et al., 2021; McKellar et al., 2018; McKellar & Graham, 2016). The ultimate goal is for students to graduate as safe practitioners that enhance the health outcomes of clients. Exploring midwifery students' perspective of clinical facilitation and its role in their clinical education can assist in identifying any gaps or improvements needed that may enhance workplace readiness and safety of practice. This information also informs CFs and universities on how to strengthen the support provided to midwifery students via the CF role and to determine how it aligns with educational objectives, potentially identifying gaps that may need to be addressed.

Clinical facilitation also has a role in ensuring the client experience is not negatively impacted by midwifery students during professional practice experiences. Supporting clinicians in supervising students has been identified in the literature as an important element of the role (Courtney-Pratt et al., 2012; Henderson & Tyler, 2011; McKellar et al., 2018). Collaboration with clinicians and role modelling positive education strategies can improve the clinical learning environment and promote a culture of learning. Exploring the student experiences of midwifery clinical facilitation in WA helps to identify if the students perceive the support provided to preceptors as a valuable part of the process. This is not currently recognised in the WA definitions of a midwifery CF as part of the role.

Examining the existing model of midwifery clinical facilitation employed in WA from the students' perspective assists in assessing its appropriateness and identifying if policy changes are warranted. In many instances, CFs are no longer able to work clinically with students. This change has been

implemented by some industry partners and this study can help understand how this is experienced by the students and whether further changes to policy are required.

Finally, in the interest of developing the body of knowledge that is specific to the profession of midwifery, this research will allow clinical facilitation to be considered in the midwifery setting from the students' perspectives. This may reveal issues or needs that are unique to midwifery students and their professional practice experiences allowing educators to examine the existing implementation of clinical facilitation and appropriately tailor clinical education programs as required.

1.5 Researcher Positionality Statement

Qualitative research explores a phenomenon through the experiences of individuals and values descriptions of lived experiences (Bourke, 2014). The research process is impacted by the researcher's beliefs and background, the relationship between researcher and participant and, the interpretations made. It is important for researchers to acknowledge the subjective nature of the qualitative research process whereby the researcher is the instrument and seeks to be objective (Bourke, 2014). The researcher's positionality statement helps to demonstrate reflexivity, trustworthiness and, transparency by demonstrating their recognition of where they are situated in the research problem (Berger, 2013).

I am an RN and a midwife. I completed a Bachelor of Science (Nursing) degree, and then, close to 10 years later, a Graduate Diploma in Midwifery. I attended clinical placement as a student midwife in an employment model, that is, I was employed as a student midwife by the

clinical placement site, and I was allocated a hospital-based CF, also employed by the clinical placement site, as opposed to the university. Consequently, while I do have some personal experience with the hospital-based model of midwifery clinical facilitation as a postgraduate student, I do not have personal experience with midwifery clinical facilitation as an undergraduate student midwife or by a university-based CF.

At the end of my time as a student midwife, I was amazed to be awarded the clinical prize by my university because I had never worked clinically with my midwifery CF, and I wondered how this appraisal of my clinical practice could have been made from afar. This provided some of the motivation for me to work as a midwifery CF myself. I have provided clinical facilitation for both undergraduate and postgraduate midwifery students from Curtin since 2014 at secondary and tertiary, public and private hospitals in WA.

My midwifery philosophy is woman-focussed and holistic. I entered the profession, from a nursing background, at a time of great change for midwifery in Australia, however, my true understanding of midwifery commenced during time spent working as an RN in Canada. There I saw midwifery working as its own discrete profession, with autonomous midwives providing care to the full scope of their practice in equal collaboration with other maternity care providers. I believe being a midwife is about combining evidence-based knowledge, experience and, intuition to promote women's health and social status. Empowerment is at the core of midwifery and supporting the profound transformation of women through pregnancy, childbirth and mothering is important for women, their families and, society as

a whole. My approach to midwifery education is similar. I see myself as the midwife for neophyte midwives, supporting students through their transition into midwives. This process is holistic, student-focussed and, individual and, results in the birth of an empowered midwife. I believe in respecting students as individuals and acknowledging their life experiences while providing support and guidance as they develop. Acknowledging that their journey is impacted by emotional, cultural and personal beliefs and promoting the achievement of individual aspirations encourages students to take control of their education. These philosophies shape my approach to clinical facilitation of midwifery students.

While working in clinical facilitation I noticed that the needs of postgraduate and undergraduate students differed. Postgraduate students ranged from experienced RNs to newly graduated, but either way, they generally required less direct clinical supervision. Having already practiced as RNs, these students often had experience with many of the clinical care activities, were familiar with hospital systems and ward processes and, had already developed their self-advocacy skills. However, frequently their motivation for entering midwifery was related to career options or as something they had always wanted to do, not necessarily driven by a passion for midwifery. In my experience, postgraduate students often demonstrated a lack of understanding of midwifery philosophy, which meant that they needed more support from me in integrating this new way of thinking into their practice and separating from the biomedical model that they were used to. Undergraduate students often entered midwifery full of passion and with an innate understanding of the philosophy of being ‘with woman’, which at

times rivalled my own. However, their need was for me to assist them in mastering clinical skills and merging their ideals of midwifery into the current system. I received feedback during my time as a CF from the undergraduate students related to the varying methods of midwifery clinical facilitation they experienced across different clinical sites and CFs. I became interested in the way clinical facilitation was operationalised differently and the impact that could have on student experiences and learning outcomes.

In recent times there has been a move by the healthcare industry to remove university-based CFs from the clinical area, not allowing them to directly supervise students. Despite having a pre-existing relationship with the hospital where I provide clinical facilitation, I worked there before I moved into education, I was no longer able to provide clinical care with students. There was the option to maintain a casual position with them, but this involved committing to a minimum number of shifts which was not feasible with my academic and personal commitments. This has resulted in a change in the way I provide clinical facilitation, from mostly direct clinical care to an increase in observation, discussion, and simulation. Having always believed in the importance of working with students in the clinical area, I still try to be clinically present as a third person wherever appropriate. This change of policy led me to question the value students placed on this aspect of the role and how important the ability to work clinically with students was to their development.

I also work as an academic at Curtin and have been the unit coordinator for one of the clinical units in the postgraduate midwifery course, for RNs becoming midwives. In this role I worked in conjunction with both hospital-

based and university-based midwifery CFs, supporting students in their clinical learning. Through this experience, I developed a broader understanding of the importance of this role from the perspective of midwifery educator and the varied ways clinical facilitation is experienced by students. I also became more aware of the apparent dichotomy of having sessional or seconded staff provide such an important role in the development of students. The CF is a representative of the university in the clinical environment and has a large role to play in the creation of the future workforce, yet they are not permanent university staff. CFs come from a variety of backgrounds with no standard requirements for recruitment and their employment arrangements are often ad hoc. This lack of permanency and recognition implies that the role is not as important as others and it can be performed by anyone, which in my experience was not the case. Over time I developed the view that clinical facilitation did affect the student's journey and the way the role was operationalised, the model of clinical facilitation, and the individual attitudes and characteristics of the CF could impact student experiences.

I wanted to understand midwifery clinical facilitation from the perspective of the undergraduate midwifery student, their experiences with midwifery clinical facilitation, and their perception of the role. I bring my experiences as a student nurse, RN, student midwife, midwife, midwifery CF, and midwifery academic to this body of work. Having shared experiences with the participants can lead to a better understanding of their perceptions (Berger, 2013). However, it was important to ensure that it was the participant's story being told and not my own. My supervisors helped me to

separate my assumptions and experiences from what emerged from the participants.

Going into the study, I hoped that students valued midwifery clinical facilitation. I believed that clinical facilitation was operationalised differently by each individual CF and that this would impact student experiences. Finally, I assumed that working clinically with students would be considered an essential aspect of clinical facilitation. The results of this study have confirmed most of my assumptions regarding clinical facilitation, with the exception of the need to work clinically with students. What emerged was that students found working clinically with the CF useful, but not essential to supportive clinical facilitation. Furthermore, the students recognised and equally valued the other aspects of the role, such as debriefing, advocacy and, feedback, and prioritised the importance of an independent university representative over the ability to work clinically with the CF.

1.6 Definition of Terms

The following terms have been defined to assist with understanding how they were applied within this study and across the thesis.

Midwifery clinical facilitation – the process of providing support to students during professional practice experiences to enhance learning and development and, provide a link to the university while in the clinical setting.

Midwifery CF – a midwife employed to support students in a supernumerary capacity in the clinical placement environment.

Hospital-based midwifery CF – midwifery CF employed by the hospital that hosts students permanently or on an as-needed basis, may facilitate students from different universities.

University-based midwifery CF – midwifery CF employed on a sessional basis by the university that the student attends, may facilitate students in different clinical settings.

Midwife preceptor – midwife paired with the student to provide supervision and support in the clinical setting, may be an ongoing relationship or on a shift-by-shift basis.

Clinical placement site – an off-campus clinical setting that hosts students for professional practice experiences.

Professional practice experience – off-campus practical experiences attended by students as part of their clinical education, also 'clinical placement'.

Direct-entry midwife – a midwife who has completed an entry to practice midwifery education program without needing to complete a nursing qualification first.

1.7 Thesis Organisation

This thesis consists of five chapters and is laid out as follows:

- Chapter 1 (Introduction) establishes the importance of midwifery clinical facilitation to midwifery and midwifery education. The background and significance of the problem have been clearly described, identifying the gap in the literature that requires additional investigation. The aims and objectives of this study have been introduced.
- Chapter 2 (Literature Review) provides a summary of the literature relevant to clinical supervision in midwifery and nursing, linking it to the proposed study.

- Chapter 3 (Methodology) presents the methodology selected, justifying the chosen research paradigm and design, sampling, data collection, and data analysis, and discusses ethical considerations and trustworthiness.
- Chapter 4 (Findings) describes the students' responses regarding their experiences with and perceptions of midwifery clinical facilitation by presenting the themes and sub-themes as they emerged from data analysis.
- Chapter 5 (Discussion) discusses how the findings relate to the relevant literature and suggests recommendations for further research and implications for midwifery education.

1.8 Conclusion

Midwifery clinical facilitation is an important aspect of midwifery education in preparing graduate midwives for practice. In the body of literature regarding nursing clinical facilitation, the role has been identified as a beneficial aspect of clinical supervision which is challenging, complex, and often adapted to local needs. However, there has been limited exploration of the concept of clinical facilitation specific to midwifery. While midwifery students may face similar situations to nursing students, it is important to examine the concept as it relates to midwifery and develop the midwifery body of knowledge as its own distinct profession. The next chapter, Chapter 2 (Literature Review), will discuss the existing literature and previous research on clinical facilitation in more detail.

Chapter 2

Literature Review

This chapter presents the literature review to establish what is known about clinical facilitation of undergraduate midwifery students and identify gaps in knowledge relevant to the study reported in this thesis. Given the relative recency of midwifery being re-established as a separate profession from nursing and the previous and ongoing similarities in clinical education, both nursing, and midwifery literature have been considered and are presented together, as they relate to the theme identified in the literature. However, it is important to recognise the requirement of education providers to place a strong emphasis on professional practice experiences in midwifery and the extended period midwifery students spend in the clinical environment as a result. This intensifies the importance of clinical supervision for midwifery students, which is already well documented for nursing students and indicates the need for midwifery-specific evidence to support clinical facilitation. Models of clinical supervision revealed in the literature are varied and often modified to local requirements. Different naming conventions of roles can make comparison difficult. Factors affecting quality clinical supervision can impact the student experience and there is agreement amongst many authors that the support of a CF can alleviate challenges for both students and clinicians. Despite this obvious benefit, the role of the CF remains somewhat enigmatic due to the autonomous nature of the position and the individualistic, flexible approach that is employed. The uniqueness of the CF role does create some challenges which require continued attention if

clinical facilitation is to remain the model of choice for clinical supervision of midwifery students in the professional practice environment.

The purpose of a literature review is to present what is known about a topic and acknowledge the work that has already been done, thereby assisting the reader to become more familiar with the topic. Understanding what is known about a phenomenon reveals where there are gaps in the existing body of knowledge and establishes the significance of the study being presented (Holloway & Wheeler, 2010; Streubert, 2011). This literature review was commenced using the databases and journal collections available through Curtin Library and Google Scholar, such as CINAHL, Ovid, PubMed Central, BioMed Central, ProQuest, Scopus, Science Direct, Wiley Online Library, Medline, and Informit. The keywords used in a variety of combinations via Boolean operators were “clinical facilitation”, “clinical supervisor”, “clinical placement”, “preceptor”, “mentor”, “clinical education”, “clinical teacher”, “midwifery student”, “nursing student”, “midwifery” and “nursing”. The articles were read, generally several times, and analysed to determine their quality and relevance to the topic being explored. Further sources were followed from the reference lists of those papers determined to be appropriate and appraised for inclusion. This process started during the research proposal stage and then re-commenced after data collection and analysis were completed to reduce the opportunity for influence over emerging findings. This literature review presents an analysis of the included papers and what is known about midwifery clinical facilitation and provides context for the study introduced in Chapter 1 (Introduction) of this thesis.

2.1 Importance of Clinical Supervision

Midwifery and nursing are practice-based professions meaning practical skills are an essential component of the necessary learning for midwifery and nursing students. These practical skills can initially be learnt theoretically and then practiced in the laboratory and simulation settings, but professional practice experiences are vital to consolidate what has been learnt in the classroom environment (Griffiths et al., 2021; Griffiths et al., 2020; Needham et al., 2016; Taylor et al., 2015). Professional practice experiences also assist students to develop an understanding of the role and the profession they are entering and build their own identity within their new profession (Griffiths et al., 2021; Griffiths et al., 2020; Needham et al., 2016; Taylor et al., 2015). Clinical supervision during professional practice experiences allows students to be assessed, mentored, and given feedback on their application of knowledge and skill development to ensure safe, evidence-based care is promoted (Health Workforce Australia, 2013). Students should be supervised, directly or indirectly, while in the professional practice environment, by “an appropriately qualified and recognised professional who guides learners’ education and training” (Health Workforce Australia, 2013, p. 22). Positive clinical supervision during professional practice experiences is paramount in facilitating students on their journey towards competence and professionalism, ensuring the development of excellent practitioners for the future (Griffiths et al., 2021; Griffiths et al., 2020; Needham et al., 2016; Nieuwenhuijze et al., 2020; Severinsson & Sand, 2010).

Midwifery students spend a significant amount of time in the professional practice environment due to requirements of course

accreditation and minimum numbers of midwifery practice for eligibility for registration (ANMAC, 2014). In the future this requirement will change with the revised ANMAC standards (ANMAC, 2021). However, anecdotal evidence of student midwives in previously accredited programs indicates requiring the full amount of clinical time to achieve the minimum midwifery practice experiences. It is therefore anticipated that the time spent in the professional practice environment under the new accreditation standards will not be significantly different. As a result, clinical supervision, currently and in the future, forms a notable proportion of midwifery education programs and clinical supervisors directly impact the development of the future workforce.

2.1.1 Clinical and Cognitive Skills

Research has found that both midwifery and nursing students highly value time spent in the professional practice environment but are not always aware of the full range of development opportunities their professional practice experiences offer (Carolan-Olah & Kruger, 2014; Chenery-Morris, 2014; McIntosh et al., 2013; Milton-Wildey et al., 2014). Students see professional practice experiences as providing the opportunity to learn, develop and practice the clinical skills that prepare them for the workforce and may not be cognisant of the other benefits, such as critical thinking and problem-solving skills (Carolan-Olah & Kruger, 2014; Chenery-Morris, 2014; McIntosh et al., 2013). In the historical literature review presented in Chapter 1 (Introduction) examining the transfer of Australian nursing education from the hospital-based model to tertiary education, it was identified that the priorities of clinical education had shifted. The change to a university program of study led to the importance of developing cognitive skills

overtaking the previous focus on clinical skill acquisition (Grealish & Smale, 2011). However, the literature suggests that midwifery and nursing students continue to see these soft skills, such as communication, research, critical reflection, and evaluation, as abstract and less important (Carolan-Olah & Kruger, 2014; Chenery-Morris, 2014; McIntosh et al., 2013; Milton-Wildey et al., 2014).

Midwifery students are very focussed on learning the clinical skills they deem necessary to become a midwife, with limited value being placed on theoretical and interprofessional units of study (Carolan-Olah & Kruger, 2014; Chenery-Morris, 2014; McIntosh et al., 2013). Students perceive that there is a definable body of midwifery knowledge to be mastered. On completion of the education program, students believe they will have attained all of the knowledge needed to be prepared for the unpredictable nature of the clinical environment (Carolan-Olah & Kruger, 2014; McIntosh et al., 2013). Student attitudes, from six British universities, toward learning to be a midwife were assessed as part of a larger-scale national study (McIntosh et al., 2013). Researchers identified that student-centred education pedagogy left students feeling anxious as opposed to empowered as they doubted their ability as adult learners to learn what was needed to become a competent practitioner. Students were externally motivated to learn by fear related to the uncertainty of the clinical environment. They wanted to be given the correct information and skills to be competent practitioners and they generally saw this as a set body of knowledge they needed to know which would prepare them for all uncertainties (McIntosh et al., 2013). In a smaller qualitative study exploring the assessment of undergraduate midwifery student practice in the clinical

area, British students again placed the highest importance on developing the clinical skills that they saw as essential for their future midwifery practice. The students viewed softer skills, such as communication, as over-assessed and as either present or not present and, not something that needed to be developed (Chenery-Morris, 2014). While further research in the Australian context is warranted to confirm transferability, Australian literature has also reported students prioritising clinical education over theoretical content (Carolan-Olah & Kruger, 2014; Milton-Wildey et al., 2014). The proportion of time spent completing professional practice experiences is similar for British and Australian midwifery students and this may translate to a similar focus.

Students can be single-minded in the importance of clinical skills, often valuing and prioritising them above all other aspects of their education, particularly the more theoretical content (Carolan-Olah & Kruger, 2014; Chenery-Morris, 2014; McIntosh et al., 2013; Milton-Wildey et al., 2014). Professional practice experiences offer students more than just the opportunity to perfect their practical skills, it allows them to learn and develop the cognitive skills and professional behaviours, which are equally important in current midwifery and nursing practice (Carolan-Olah & Kruger, 2014; Griffiths et al., 2021; Griffiths et al., 2020; Hauck et al., 2016; McIntosh et al., 2013). The development of cognitive skills, such as critical thinking and problem-solving are important aspects, not only of university education but also, of an autonomous, evidence-based practitioner (Carolan-Olah & Kruger, 2014; Milton-Wildey et al., 2014). The intense focus on clinical skills by students could be detrimental to the development of these important cognitive skills and suggests that students need greater support to enable the

development of both (Carolan-Olah & Kruger, 2014). This creates concern around how the health sector may be affected in the future if critical thinking and reflective skills are not seen to be an important part of the clinician's role (Milton-Wildey et al., 2014). Communication, problem-solving, critical thinking, reflection, evaluation, and decision-making skills enhance student competence, increase workplace readiness, and promote excellence in practice (Carolan-Olah & Kruger, 2014; Griffiths et al., 2021; Griffiths et al., 2020; Hauck et al., 2016). Quality clinical supervision of students can promote the development of students' understanding of the importance of the broad range of skills needed to be workplace-ready independent health professionals (Carolan-Olah & Kruger, 2014; Milton-Wildey et al., 2014).

In recognition of the demographic change in midwifery students that occurred as a result of the introduction of the direct-entry program, a phenomenological study explored the concerns of Australian third-year undergraduate midwifery students at Victoria University. Preparation for emergencies and professional practice experiences were identified as the most vital aspect of midwifery education (Carolan-Olah & Kruger, 2014). Although this study focussed on only one institute, similar findings have also been reported in nursing. A mixed-methods study of 530 Australian nursing students from two different universities revealed that students perceived practical nursing skills to be more valuable than theoretical skills in preparing them for the workplace. While the total participants for this study represented 18% of enrolled students, it still highlighted the importance of quality clinical education to students and the need for a student-focussed approach to clinical education. Furthermore, it was identified that older nursing students

were generally less satisfied with their clinical education and how it prepared them for the workplace and the potential for students to have differing needs at different stages of their education (Milton-Wildey et al., 2014) This difference in satisfaction could be explained by different previous clinical experiences or life experiences of older students. Additionally, younger Australian nursing students, who were less likely to have previous clinical experience, have revealed that they valued moral support during professional practice experiences over clinical competence. This reiterates the importance of clinical supervisors providing individualised teaching strategies (Lee et al., 2002). This is of note because direct-entry midwifery students are now older, with potentially no nursing or recent student experience. The age range of the participants in the phenomenological study was higher than the midwifery student population which may mean the findings are not representative, however, further investigation is warranted (Carolan-Olah & Kruger, 2014). These studies indicate that Australian midwifery and nursing students place high importance on professional practice experiences and their perceptions may be impacted by age or previous experiences.

It is suggested that novice practitioners initially prioritise mastery of clinical skills to cope with the workload of an RN and then progress to developing their understanding of the importance of the theoretical skills (Milton-Wildey et al., 2014). The development of cognitive skills with experience and time is supported by a study of newly graduated postgraduate midwives in WA (Hauck et al., 2016). These respondents had previously completed an undergraduate nursing program and identified education on communication skills as a vital component of the university

programs. They recommended that this aspect could be increased to better prepare students for autonomous practice, implying that the understanding of the broader skills needed in midwifery is developed further following registration (Hauck et al., 2016). In contrast, British postgraduate midwifery students suggested that their undergraduate counterparts would benefit from education and development of their theoretical skills, which as RNs they felt that they had already mastered. Additionally, this study revealed that students perceived teachers of practical skills, in both the classroom and clinical environments, as having the highest levels of midwifery knowledge. In which case, clinical supervisors are well placed to reinforce the importance of developing cognitive skills to enhance practical skills and assist students in feeling more confident in dealing with the uncertainties of autonomous practice (McIntosh et al., 2013). It is therefore important to understand how midwifery students perceive the role of the CF in the development of cognitive skills in the Australian context.

Despite the common perception of students that cognitive skills have limited relevance to their clinical practice, clinical supervisors appear to understand the importance. An Australian study revealed that nursing students who had a CF were more likely to report that broader skills, such as problem-solving, reflection, and critical thinking, were encouraged (Walker et al., 2013). Additional investigation into this aspect of clinical facilitation is warranted as the response rate for this study represented 38% of the possible sample. Participants in this study were supervised individually by an RN preceptor or in a group model where a CF provided supervision to a group of students who were individually allocated to an RN for each shift.

However, 76% of the respondents were in the clinical facilitation model which may have skewed the result. Moreover, the authors acknowledged that the survey tool could be further developed to ensure the accuracy of results (Walker et al., 2013). However, these findings did replicate earlier Australian nursing research where the clinical teacher has been acknowledged as vital in supporting students' socialisation into nursing. Clinical supervisors act as role models to assist in the development and reinforcement of professional behaviours and values which include critical thinking and problem-solving skills (Brown et al., 2012; Sanderson & Lea, 2012). Clinical supervisors assist students with more than gaining new skills, developing existing skills, and integrating knowledge with clinical practice. They are also pivotal in nursing students' acquisition of professional values and behaviours, such as critical thinking and decision making (Brown et al., 2012; Sanderson & Lea, 2012; Walker et al., 2013).

In midwifery, the importance of cognitive skills was supported by a study evaluating a WA training workshop for midwife preceptors. The preceptors reported significant improvement in their performance of the role due to, among other skills, increased confidence in assisting and challenging students to develop and use problem-solving and critical thinking skills (Hauck et al., 2017). Quality clinical education allows students to expand their cognitive skills as well as their practical skills. Supporting students to recognise the value of clinical reasoning skills is an important element of clinical supervision.

Professional practice experiences are a critical aspect of education programs in preparing students for midwifery and nursing. The development

of midwifery and nursing students is greatly impacted by the experiences they have in the professional practice environment. The emphasis which is placed on professional practice experiences results in students having the perception that the acquisition of practical skills is the priority over all other skills. Quality clinical supervision can help students to see the value in developing their cognitive skills, which will, in turn, enhance their practical skills and build confidence and independence. Clinical facilitation aims to promote the integration of theory and practice by enhancing the development of clinical and cognitive skills. It is important to explore students' perceptions of the role of clinical facilitation in midwifery. Further research into student perceptions of clinical education is needed to ensure transferability across different age groups and backgrounds within WA midwifery student populations. The study presented in this thesis aimed to further develop the understanding of midwifery students' experiences of clinical education.

2.2 Factors Affecting Clinical Supervision

Several different models of clinical supervision are explored throughout the literature suggesting that there is no one perfect model for all settings, let alone for both midwifery and nursing. Quality clinical supervision has a positive effect on student learning, development of competence, and preparedness for practice (Griffiths et al., 2021; Griffiths et al., 2020; Hauck et al., 2016; Hauck et al., 2017; Jayasekara et al., 2018; Lazarus, 2016; McKellar et al., 2018; McKellar & Graham, 2016; Needham et al., 2016; Nieuwenhuijze et al., 2020; Ryan & McAllister, 2019). It is, therefore, important that models of clinical supervision are sustainable, promote pedagogic goals for education and create workplace readiness, while being

manageable for health care settings and providing support for students and clinical staff involved in their learning (Barnett et al., 2010; Bourgeois et al., 2011; Franklin, 2013; Jayasekara et al., 2018). From the health care services' perspective delivering positive professional practice experiences is important for future recruitment of students as staff (Barnett et al., 2010; Bourgeois et al., 2011). Successful professional practice experiences are a team effort between education providers and health care service staff, and it is unlikely that there is one model to suit everyone's needs. Understanding the principles that work well can lead to improvement in clinical supervision of students in all professional practice settings. The study presented in this thesis reports on midwifery students' experiences of midwifery clinical facilitation, one of the models of clinical supervision in WA.

The most common forms of clinical supervision for midwifery and nursing students in WA are preceptorship and clinical facilitation. Commonly a combination of the facilitator and preceptor model is utilised, whereby the student is assigned to a preceptor for each shift and a CF provides overarching supervision and support to a group of students and the preceptors they work with (Franklin, 2013). Models of clinical supervision are adjusted to fit the needs of different clinical specialities, health care services, education providers, and students. Hence, supporting the individuals that work with students is emerging as an important aspect of successful clinical supervision models. Understanding the student experience of the different models of supervision is paramount to ensuring that clinical education goals are being met. It is important to further explore the desired characteristics and best model of practice that enables clinical facilitation to not only

complement but enhance student learning in the professional practice environment (Franklin, 2013; Jayasekara et al., 2018).

Providing quality clinical supervision to students during professional practice experiences is essential to the development of safe and competent beginning-level practitioners (Courtney-Pratt et al., 2012; Griffiths et al., 2021; Licqurish et al., 2013; McIntosh et al., 2013). The review of the literature regarding factors affecting quality clinical supervision has revealed four themes: continuity in clinical supervision, characteristics of clinical supervisors, preparation and support for the role of clinical supervisor, and the impact on workload for preceptors. This section will use the themes identified from the literature to discuss the factors affecting clinical supervision.

2.2.1 Continuity in Clinical Supervision

There is discussion throughout the literature about the value of continuity of clinical supervisor for both midwifery and nursing students during professional practice experiences Whereby students are overseen during their clinical placements by the same clinical supervisor (Barnett et al., 2010; Courtney-Pratt et al., 2012; Hallam & Choucri, 2019; Hauck et al., 2017). Both clinical supervisors and students value continuity in this process as it allows for a relationship to be established which leads to enhanced learning opportunities and improved development of the student (Barnett et al., 2010; Courtney-Pratt et al., 2012; Hallam & Choucri, 2019; Hauck et al., 2017). While the argument remains that there are benefits in observing different approaches to practice, in general continuity of clinical supervision is

perceived as more advantageous (Barnett et al., 2010; Courtney-Pratt et al., 2012; Hallam & Choucri, 2019; Hauck et al., 2017).

Continuity of clinical supervisor for both midwifery and nursing students has been identified in the literature to be valuable and have a positive effect on clinical experiences (Barnett et al., 2010; Chenery-Morris, 2014; Courtney-Pratt et al., 2012; Hallam & Choucri, 2019; Hauck et al., 2017; McIntosh et al., 2013). Twenty participants were interviewed for the qualitative aspect of a WA mixed-methods study to gauge their perceptions of the support they received from midwife preceptors. The students in this study revealed that they valued developing a relationship with one preceptor as this allowed them to establish their current level and learning needs once and removed the feeling of needing to convince new preceptors of their abilities each time. A familiar relationship with a preceptor also meant that students felt more at ease in asking questions and promoted the constructive feedback process (Hauck et al., 2017). Midwifery students in England reiterated the value of continuity of clinical supervisor and having a familiar relationship with their preceptor. In an exploration of 11 midwifery students' perceptions of being assessed during professional practice experiences, participants reported that different expectations and teaching styles of different preceptors negatively influenced their performance (Chenery-Morris, 2014). The value of continuity of clinical supervisor was further supported in a literature review focussing on undergraduate midwifery students in the United Kingdom (UK). It was revealed that the clinical supervisor-student relationship was improved by continuity which led to enhanced learning experiences and development of midwifery skills for students (Hallam &

Choucri, 2019). The ease of working with someone they know allows students to feel comfortable and develop as a midwife. Further exploration in the Australian context would add to the body of knowledge. It is important to further examine midwifery students' experiences in WA professional practice settings to determine their perceptions of continuity in quality clinical supervision.

The importance of continuity of clinical supervisor may fluctuate at different stages of student development. Continuity of clinical supervisor was particularly important to midwifery students during initial professional practice experiences, although this was more challenging for the supervisors. Senior midwifery students still valued a continuity relationship with a clinical supervisor, particularly when being assessed. However, they also appreciated working with a variety of clinicians, including from other health professions, to experience different styles and approaches to care (Hallam & Choucri, 2019). In contrast, senior midwifery students in Australia and the UK, have expressed frustration at working with different midwives who do things differently. They found continuity of preceptor allowed them to amplify their learning experiences due to a well-developed student-preceptor relationship and a good understanding of learning needs (Licqurish & Seibold, 2008; McIntosh et al., 2013). Developing the midwifery-specific knowledge base of best practice in clinical supervision is important for education program success and student satisfaction and confidence.

In the UK it is a requirement of the regulating body for midwifery students to receive continuity of preceptor for 40% of their professional practice experience. However, a review of the literature revealed that not all

students were receiving this opportunity and most students felt that they needed more. Continuity of clinical supervisor should be encouraged for midwifery students to enhance their sense of belonging and connectedness to the professional practice setting and the profession, leading to heightened learning and development (Hallam & Choucri, 2019). In contrast, Australian nursing studies have reported that high-quality professional practice placements can be achieved without the continuity of a clinical supervisor. Organisational and contextual constraints can affect opportunities for maintaining continuity of clinical supervision, which may negatively affect professional practice experiences for both students and clinical supervisors (Courtney-Pratt et al., 2012; Hallam & Choucri, 2019). However, an Australian mixed-methods project exploring the quality of professional practice experiences and a WA study of an alternative preceptorship model to reduce preceptor burnout found that high-quality professional practice experiences could be achieved without continuity of clinical supervisor (Courtney-Pratt et al., 2012; Russell et al., 2010). While the benefits of continuity of clinical supervisor were removed, lack of continuity could, at least in part, be made up for with a positive culture of education at the placement site (Courtney-Pratt et al., 2012; Russell et al., 2010).

Continuity of clinical supervision is appreciated by students and health professionals alike, as it makes the process easier and the relationship that develops enhances learning. It is not always possible to provide continuity of clinical supervisor, there are benefits to working with different clinicians and professional practice placement can be successful without it. However, professional practice experiences and learning are optimised when continuity

of clinical supervision is engaged. Understanding midwifery students' experiences with continuity of clinical supervision in WA is important in ensuring the development of workplace-ready practitioners.

2.2.2 Characteristics of Clinical Supervisors

Individual characteristics of a clinical supervisor impact the learning environment and the effectiveness of the relationship, which in turn influences the development of student competence and confidence (Courtney-Pratt et al., 2012; Franklin, 2013; Grealish & Smale, 2011; Griffiths et al., 2021; Hallam & Choucri, 2019; Hauck et al., 2017; Licqurish et al., 2013; Severinsson & Sand, 2010). Students need a clinical supervision relationship that is supportive and student-focused with a trusted role model. The impact of individual preceptor qualities on student learning experiences in the clinical environment was revealed in an Australian grounded theory study (Licqurish & Seibold, 2008). Final year undergraduate midwifery students categorised preceptors as helpful or unhelpful depending on their interpersonal, therapeutic, and clinical attributes. Helpful preceptors were described as caring, helpful, and prepared to share knowledge. The ability to give constructive feedback and an enjoyment of teaching were also identified as important characteristics. Helpful preceptors were perceived by students as those with whom they were philosophically aligned, who role modelled the type of midwife they wanted to be. Students reported they felt competent when they were given opportunities to be responsible and accountable for planning and implementing care under supportive supervision. More recently these findings were reiterated, whereby additional Australian midwifery students acknowledged the positive effect of dedicated preceptors on their

learning and development as midwives (Griffiths et al., 2021; Hauck et al., 2017). Engaged preceptors enhanced critical thinking, integration of theory with practice and learning experiences, and thereby the development of competence (Griffiths et al., 2021; Hauck et al., 2017; Licqurish & Seibold, 2008).

Students are more likely to develop a positive relationship with midwives they perceive to have desirable qualities, and this in turn positively affects the student's learning (Griffiths et al., 2021; Hallam & Choucri, 2019; Hauck et al., 2017). Additionally, self-awareness of the impact of a positive preceptor on student experiences is important (Hauck et al., 2017). WA midwifery students have disclosed that midwife preceptors should be aware that they are role models. Students learn by watching midwives and what they see reinforces the practice they wish to emulate (Bluff & Holloway, 2008; Hauck et al., 2017; Licqurish & Seibold, 2008). Given the amount of time students spend with clinical supervisors, and the understanding of how students change their practice to conform with their clinical supervisor, it is important that clinical role models are a positive influence. Clinical supervisors are responsible for helping students to develop their understanding of the role of the midwife and their philosophy of midwifery care (Bluff & Holloway, 2008; Hauck et al., 2017; Licqurish & Seibold, 2008; Licqurish et al., 2013).

The impact of a positive preceptor is also reported in a grounded theory exploration of the influence of midwifery role models on undergraduate and postgraduate midwifery students in a variety of clinical environments in the UK (Bluff & Holloway, 2008). This study has significance due to the similarity

between Australian and UK midwifery education programs in relation to clinical requirements and therefore attention to role modelling is critical to ensure appropriate behaviours are learned. As with the Australian studies (Griffiths et al., 2021; Hauck et al., 2017; Licqurish & Seibold, 2008), the authors identified that student midwives experienced two types of preceptors during professional practice experiences, namely helpful and unhelpful. Helpful role model midwives were those who demonstrated woman-centred, evidence-based care and an ability to interpret and individualise policies. Students hoped to practice in this way themselves once they were registered. Positive role models were more open in their practice, allowing students to decide which practices they wish to incorporate, develop their own style and learn how to become autonomous practitioners (Bluff & Holloway, 2008). Helpful role models have a positive influence on the development of student midwives as professional practitioners and the midwifery care they will provide (Bluff & Holloway, 2008; Griffiths et al., 2021; Hallam & Choucri, 2019; Hauck et al., 2017; Licqurish & Seibold, 2008).

Although helpful role models were preferred, students have revealed that they modified their practice to match that of the midwife that they were paired with, irrespective of whether this aligned with their own values and beliefs (Bluff & Holloway, 2008; Licqurish & Seibold, 2008; Licqurish et al., 2013). In the UK, midwifery students perceived themselves to be in a position of low status within the hierarchy of midwifery. They sometimes felt the need to imitate their preceptor midwives to avoid conflict and ensure a positive assessment of their performance. It was important to avoid humiliation from unhelpful preceptors and secure the advocacy needed to

meet the clinical requirements of their placement. Participants described unhelpful role models as those midwives who strictly adhered to policies and practice in a medicalised way as opposed to providing flexible, individualised care (Bluff & Holloway, 2008). This was supported by midwifery students in other studies, who reported unhelpful preceptors were inconsistent in their advice, philosophy, and midwifery practice and who felt having a student was a burden on their workload (Grealish & Smale, 2011; Hallam & Choucri, 2019; Hauck et al., 2017; Licqurish & Seibold, 2008). Students also identified more specific characteristics of unhelpful preceptors, such as those who showed a lack of support, interest, communication, and encouragement (Licqurish & Seibold, 2008; Ranse & Grealish, 2007). Unhelpful preceptors are poor role models for students (Bluff & Holloway, 2008; Licqurish & Seibold, 2008). Developing a positive relationship with a positive midwife clinical supervisor is crucial to student learning and is greatly impacted by the clinical supervisor's individual qualities (Bluff & Holloway, 2008; Grealish & Smale, 2011; Hallam & Choucri, 2019; Hauck et al., 2017; Licqurish & Seibold, 2008).

The importance of the relationship between preceptee and preceptor has also been identified in studies exploring undergraduate nursing student experiences (Courtney-Pratt et al., 2012; Dickson et al., 2006; Grealish & Smale, 2011; Vallant & Neville, 2006). The Nursing Clinical Teacher Effectiveness Inventory was employed with 104 second-year undergraduate nursing students and 17 clinical educators from an Australian regional university to explore the characteristics of effective clinical educators. Skills such as active listening, promoting mutual respect, and providing support and

encouragement as well as characteristics like being a positive role model and enjoying nursing were highly valued (Lee et al., 2002). This was supported by undergraduate nursing students in New Zealand who appreciated feeling like they belonged and being recognised as more than just a student. These students expressed frustration and hurt when supervisors made them feel invisible or ignored. Revealing that a negative attitude towards students during professional practice experiences stalled their learning (Vallant & Neville, 2006).

An Australian mixed-method study also confirmed that a positive student-supervisor relationship can build student confidence, while an unsupportive relationship can increase feelings of anxiety and incompetence (Courtney-Pratt et al., 2012). Distinctive to this study was the finding that both student nurses and clinical supervisors appreciate similar qualities in the other in this relationship. Students and preceptors want the person that they are paired with to be ‘supportive, friendly, enthusiastic, welcoming, confident and comfortable’ (Courtney-Pratt et al., 2012, p. 1386). The importance of student attitude on the relationship has been further developed whereby clinicians reported some students expected to be passive recipients of knowledge, similar to what can occur in traditional classroom settings (Grealish & Smale, 2011). The focus group interviews with 11 graduating undergraduate nursing students in New Zealand revealed that students recognised the reciprocity of their relationship with the preceptor. These students agreed that the enthusiasm and interest displayed by their preceptor increased their motivation to learn, however they did believe that there were some RNs who did not respond, despite the motivation shown towards

learning by the student (Vallant & Neville, 2006). Furthermore, a positive preceptorship relationship is beneficial to the knowledge and skills of both the preceptor and the student, as supervising students results in the growth and development of RNs as well (Courtney-Pratt et al., 2012). These studies demonstrate the reciprocity of the relationship between students and clinical supervisors and the potential for mutual benefit as well as the influence of individual characteristics.

The relationship between student and clinical supervisor and the impact it can have on students' learning and development has been acknowledged in both the midwifery and nursing literature. An important aspect of successful professional practice experiences is students being made to feel that they belong and being seen as a member of the team. Clinical supervisors are pivotal at creating an atmosphere where students feel valued and their ability to do this is greatly impacted by their individual qualities and characteristics. The relationship is reciprocal, with student attitude also important. Where clinical supervisors display helpful, supportive, and flexible characteristics, students are more likely to feel positive about their learning and develop confidence in their professional identity and clinical practice.

2.2.3 Preparation and Support for the Role

The literature positions clinical supervision as a vitally important component of clinical education, yet it is also clear from the literature that further consideration to the preparation for and support of this role is required (Courtney-Pratt et al., 2012; Hall-Lord et al., 2013; Hauck et al., 2017; Jayasekara et al., 2018; McKellar et al., 2018; McKellar & Graham, 2016; O'Brien et al., 2014). Preceptors fundamentally enjoy their role supervising

students however those supported by a CF and those who had completed preceptor training feel more satisfied (McKellar et al., 2018; O'Brien et al., 2014). Clinical supervisors have reported that they do not feel prepared or supported to supervise students during professional practice experiences and standardised training is recommended (Hall-Lord et al., 2013; Hauck et al., 2017; McKellar et al., 2018; McKellar & Graham, 2016; O'Brien et al., 2014).

Critical thinking and reflective practice skills are an expectation of a university education program preparing a professional for practice, however, clinicians may not be equipped to teach this to students. The literature has raised concerns as to whether bedside clinicians are appropriately qualified to provide students with the standard of teaching expected of a university education (Hall-Lord et al., 2013; McKellar & Graham, 2016; O'Brien et al., 2014). A quantitative, cross-sectional design was used to survey 337 midwives, RNs, and enrolled nurses from nine Australian public acute care hospitals regarding their role as a preceptor to undergraduate midwifery and nursing students (O'Brien et al., 2014). Fifty-four percent of the preceptors had been qualified for more than ten years, however, only 27.4% had a postgraduate level of education. Thirty-six percent of preceptors had completed a training workshop for preceptorship and seven had education qualifications, four vocational and three at a postgraduate level. In this study, 61% worked in a model that included a university-based CF. The support of a CF and preparation for the role improved the confidence and role satisfaction of clinical supervisors (O'Brien et al., 2014). However, the

findings of this study potentially suggest that preceptors may not be qualified to the standard expected of university education providers.

A cross-sectional study of 294 nursing student supervisors in Sweden found that preceptors mostly focused on the practical aspects of nursing in their supervision of students and did not encourage higher levels of thinking promoted in university-based nursing education programs (Hall-Lord et al., 2013). The authors reported that the preceptor role should be restricted to daily supervision of clinical skills and role-modelling for student nurses and, suggested that a CF role would better support the goals of nursing education due to higher pedagogic competence and supernumerary position. Despite the different geographical context of this study, similarities were noted suggesting that this finding may also be relevant in Australia. The pedagogical approach to nursing, the challenges faced by preceptors, and the concerns regarding collaboration between the clinical setting and the education provider described in the Swedish system appear to be like the Australian experience. This supports the concerns raised in Australian studies that bedside clinicians are not necessarily qualified to teach students some of the broader aspects of the role beyond practical skills (Hauck et al., 2017; McKellar & Graham, 2016; O'Brien et al., 2014). Further preparation and support for those who supervise students in the clinical area are needed to ensure educational goals are being achieved and establish satisfaction in the role (Hauck et al., 2017; McKellar & Graham, 2016; O'Brien et al., 2014). Clinical facilitation can assist preceptors in supporting students in the clinical area and promote critical thinking and reflective practice skills expected of university education programs.

An important aspect of providing clinical supervision is understanding the expectations and educational goals of the student and the education provider. Preceptors have revealed that the student's scope of practice is not always clear, and they are unsure of their role (Barnett et al., 2010; Hauck et al., 2017; McKellar et al., 2018; O'Brien et al., 2014). Preceptor midwives and RNs in an Australian study evaluating their role in clinical education revealed that they were not sure of what students needed or expected of them (O'Brien et al., 2014). This was supported by another Australian study where preceptor midwives felt unsure of what the university expected of midwifery students and were concerned about the students' ability to actively participate in professional practice experiences. They identified that the student's scope of practice and learning needs were unclear to the midwife preceptors. Additionally, the preceptor midwives wanted further support from CFs in providing constructive feedback for students and completing student assessments (McKellar et al., 2018). Australian midwifery students concur with the importance of preceptors understanding and being prepared for their role (Griffiths et al., 2021; Hauck et al., 2017; McKellar et al., 2018).

In the qualitative aspect of a mixed-methods study, it was specifically revealed that preceptors often were not comfortable in documenting constructive feedback which students found to be more useful and desired than generalised, benign feedback (Hauck et al., 2017). Furthermore, an earlier Australian study highlighted that some RNs did not consider clinical supervision of students as a part of their role and felt unwilling to have their practice questioned by students which affected the student experience (O'Brien et al., 2008). Feeling unprepared, unsupported, and not confident in

supervising students in the clinical area may contribute to preceptors being perceived by students as unhelpful role models. This has the potential to negatively impact student learning and development during professional practice experiences.

The literature reports that ongoing support and preparation for clinical supervisors improves confidence and satisfaction in the role (Barnett et al., 2010; Courtney-Pratt et al., 2012; Hauck et al., 2017; Severinsson & Sand, 2010). In WA, it has been identified that specific training can assist in preparing and supporting midwife preceptors and that there was an increase in preceptor confidence in performing the role after a training program was completed. Midwife preceptors reported improved knowledge and ability to carry out the role, an increased ability to promote the integration of theory with practice and balance the demands of supervising a student with the existing workload as a result of this training program. They felt better prepared to adapt to the learning needs of students, support the development of problem-solving and critical thinking skills, and provide constructive verbal and written feedback. The authors noted that there was not a significant improvement in preceptor confidence when dealing with conflict and suggested that this was a skill that required more than one education session (Hauck et al., 2017). It should not be assumed that all midwives possess the appropriate skills to supervise students during professional practice experiences. Adequately preparing midwives for clinical supervision will ensure that they are helpful role models for midwifery students with positive impacts in learning and development in the clinical area. Providing the

support of clinical facilitation can promote the pedagogic goals expected of university education.

The importance of preparing preceptors for their role to enhance the clinical learning environment and student experience has been acknowledged in nursing literature in Australia and abroad (Barnett et al., 2010; Courtney-Pratt et al., 2012; Jayasekara et al., 2018; Severinsson & Sand, 2010). In regional Australia, a supportive preceptorship model was found to be an important aspect in improving professional practice experiences for nursing students (Barnett et al., 2010). The RN preceptors attended a training program which led to them expressing enjoyment in providing preceptorship. They received support from a CF and regular debriefing meetings and uniquely were also recognised with certificates and opportunities of credit towards formal post-graduate studies (Barnett et al., 2010). It has been acknowledged that it is difficult to ensure that all supervising practitioners have received training due to the large numbers needed to support the increasing number of nursing students during professional practice experiences (Courtney-Pratt et al., 2012). Despite this, providing feedback, support, and recognition to supervising clinicians is important to affirm their valuable role (Barnett et al., 2010; Courtney-Pratt et al., 2012; Hauck et al., 2017; Severinsson & Sand, 2010).

Quality improvement projects designed to enhance the clinical learning environment for student nurses from regional Australia (Taylor et al., 2015) and WA (Russell et al., 2010) sought the opinions of the RN preceptors at study sites to determine their perceptions of the role. The authors of these papers reported that preceptor RNs felt abandoned, stressed, and

dissatisfied. The feedback indicated that changes were needed to assist preceptors to better support students in the professional practice environment. These studies recognised that when clinical supervisors feel undervalued, unprepared, and unsupported it impacts the experience of students in the professional practice setting (Russell et al., 2010; Taylor et al., 2015). In the systematic review by Jayasekara et al. (2018) examining the effectiveness of different models of clinical supervision for nursing students, the authors suggested that health care services rely on the preceptor model to develop their future workforce into competent practitioners. Therefore, it is important to ensure that support and development opportunities are available to those willing to provide clinical supervision to midwifery and nursing students in the professional practice area (Jayasekara et al., 2018). Clinical supervisors play a crucial role in student development during professional practice experiences, assisting them in developing competence for beginning-level practice (Courtney-Pratt et al., 2012; Hall-Lord et al., 2013; Hauck et al., 2017; Licqurish et al., 2013; McKellar et al., 2018; McKellar & Graham, 2016; O'Brien et al., 2014). Preparing clinical supervisors for the role and providing recognition and ongoing support promotes a positive clinical learning environment for students. CFs can assist in both the preparation and support of preceptors in the professional practice environment, further enhancing the learning experiences for students. The study reported in this thesis further explores midwifery student experiences of clinical supervision and their perception of clinical facilitation in WA.

2.2.4 Impact on Workload for Preceptors

Possibly the greatest challenge for preceptors providing clinical supervision of students in the clinical area is the need to balance their workload and continue to provide quality patient care with little to no recognition or compensation (Courtney-Pratt et al., 2012; Franklin, 2013; McKellar et al., 2018; McKellar & Graham, 2016; O'Brien et al., 2014). The priority of the preceptor must be patient care, and this can impact learning opportunities and experiences for students. Midwifery literature has identified that the role of clinical supervisor can be undervalued, and students are often seen as an extra workload for the clinician (Hauck et al., 2017; McKellar et al., 2018; McKellar & Graham, 2016). Moreover, the quality of the supervision is largely affected by clinical conditions, staffing levels, and the blend of skills (McKellar & Graham, 2016). Clinical supervisors are expected to manage the standard workload, with minimal protected time to spend with students (Courtney-Pratt et al., 2012; Franklin, 2013; McKellar et al., 2018; McKellar & Graham, 2016; O'Brien et al., 2014).

A collaborative project involving an Australian regional university and hospital revealed that nursing students were seen as an encumbrance and staff were disinclined to be preceptors. Despite students being generally satisfied with their professional practice experiences, the findings from the 409 quantitative surveys revealed the students were made to feel unwelcome and treated as a burden by staff (Taylor et al., 2015). This experience has also been reported by graduating nursing students in New Zealand, where students acknowledged that the preceptor's patient care load affects the student's opportunities for learning and the preceptor's attitude to the student

(Vallant & Neville, 2006). The literature clearly identifies that the impact of clinical supervision on the workload of the clinical supervisor does not receive appropriate recognition and compensation, and this may lead to role dissatisfaction and negatively impact student learning.

Different models of clinical supervision of undergraduate nursing students are explored in the literature that takes into account the impact of preceptorship on the workload of the preceptor RNs (Barnett et al., 2010; Bourgeois et al., 2011). It has been identified that preceptor RNs did not feel confident in their skills to supervise students when they first began. Support from CFs, particularly when their ability to give time to a student was impacted by time constraints and workload, allowed for quality clinical supervision to be provided (Courtney-Pratt et al., 2012). Different approaches have been trialled to improve the experiences of clinical supervisors. Rotating preceptors was one such method and has successfully been implemented in Australian studies in an attempt to prevent burnout and dissatisfaction (Barnett et al., 2010; Bourgeois et al., 2011; Russell et al., 2010). Preceptors have also identified experiencing greater satisfaction with the role when they were supported by a university-based CF. They reported that they were conflicted because being a preceptor takes time away from direct patient care, especially with difficult students (O'Brien et al., 2014). The literature highlights that clinical supervisors need to be given support to balance their workload priorities of providing care and supervising students, with CFs assisting them to achieve this (Courtney-Pratt et al., 2012; Franklin, 2013; McKellar et al., 2018; McKellar & Graham, 2016; O'Brien et al., 2014).

Students are generally aware of the impact their presence has on the clinical supervisor’s workload and that there is a reluctance by clinicians to take on the role (Bluff & Holloway, 2008; Hauck et al., 2017; Licqurish & Seibold, 2008; Taylor et al., 2015). Furthermore, in an Australian grounded theory research study looking at the impact of midwife preceptors on student learning, midwifery students sometimes felt exploited (Licqurish & Seibold, 2008). The students revealed that they were made to feel that they were working ‘for’ the preceptor rather than ‘with’ them. This was seen by students as detrimental to their learning and negatively impacted the professional practice experience (Licqurish & Seibold, 2008). The biggest challenges to the preceptorship model of clinical supervision are the competing commitments for RNs of patient care and supporting students, coupled with the lack of teaching expertise (Franklin, 2013; Jayasekara et al., 2018). This can lead to the use of the student to assist in the management of the workload, rather than being provided with opportunities to learn (Franklin, 2013). Interestingly, this experience was reported by nursing students in the evaluation of the Dedicated Education Unit model of clinical supervision where students felt they were used as workers when there were not enough qualified staff (Ranse & Grealish, 2007). Furthermore, it has been suggested that this was part of the reason for the move in Australia toward using CFs who can focus on the needs of students (Franklin, 2013). CFs in rural Australia acknowledged this issue for preceptors and actively worked with students in the clinical area. They found that by structuring clinical facilitation to ensure time was spent working alongside students, assisting with procedures, and debriefing, the burden on preceptors was reduced. This in

turn improved the relationship between clinical staff and students and created a more favourable learning environment overall (Sanderson & Lea, 2012).

Students feel it is important that midwives accept preceptorship as part of their role in assisting with the development of others and suggest that workloads should be adjusted for preceptors to acknowledge the extra duties, they are completing (Hauck et al., 2017). Providing education continues to be part of the role of midwives and RNs but in the interest of encouraging positive learning environments for students and staff, preceptors need to be valued and recognised. CF support for preceptors and students can mitigate the impact on workload for preceptors and help develop their confidence in supervising students. Thereby, improving satisfaction with the role and the quality of the supervision. This thesis presents a study that explores midwifery students' experiences with clinical facilitation and their perception of the role.

2.3 The Role of the Clinical Facilitator

The clinical facilitation model uses a health professional employed by the university or health service in the role of CF to provide supervision and assessment of a group of students in a supernumerary capacity in the professional practice environment (Courtney-Pratt et al., 2012; Franklin, 2013; Ryan & McAllister, 2019; Sanderson & Lea, 2012). There is a lack of consensus in the literature of the definition of clinical facilitation and the process seems to be operationalised according to local, individualised needs. Essentially, the role is to enhance and support the integration of theory and clinical practice. This involves teaching practical skills and encouraging the development of cognitive skills in line with university educational goals, such

as self-directed, life-long learning, critical thinking, reflection, and research. It also includes supporting preceptors to supervise students and to develop teaching and assessing skills (Andrews & Ford, 2013; Courtney-Pratt et al., 2012; Jayasekara et al., 2018; McKellar et al., 2018; Needham et al., 2016; Ryan & McAllister, 2019; Sanderson & Lea, 2012; Walker et al., 2013). Historically, when existing personnel, such as clinicians or lecturers, attempted to include clinical supervision in their role, the quality and quantity of their clinical teaching were hindered due to conflicting demands (Lambert & Glacken, 2005). The benefit of having a supernumerary clinical role with the sole purpose being clinical education and decreasing the theory-practice gap is identified in the literature with calls for more research (Jayasekara et al., 2018; McKellar et al., 2018; O'Brien et al., 2014; Ryan & McAllister, 2019). The study presented in this thesis aims to further define both the concept of clinical facilitation and the role of the CF in midwifery.

Both students and preceptors alike value the support of a CF during professional practice experiences. Australian undergraduate nursing students expressed that learning is enhanced when a CF is involved in their professional practice experiences (Courtney-Pratt et al., 2012; Henderson & Tyler, 2011; Sanderson & Lea, 2012). In Tasmania, Australia, both students and preceptors reported that nursing students received the highest level of support from CFs. A modified tool, established to be valid, was used to collect quantitative and qualitative data on two occasions from second-year undergraduate nursing students. Findings revealed that students particularly valued the reflective sessions with the CF as a way of sharing experiences and debriefing (Courtney-Pratt et al., 2012). Furthermore, in the mental

health context, the clinical facilitation model was rated positively by students, preceptors, and CFs. A significant increase in student nurse interest in mental health nursing was also attributed to the introduction of clinical facilitation (O'Brien et al., 2008). This benefit has been reported in an Australian rural health setting as well. CFs were credited with promoting a positive learning experience which promoted greater consideration of rural nursing as a future career pathway by students (Sanderson & Lea, 2012). These studies reinforce the idea that quality clinical facilitation of nursing students can enhance professional practice experiences and affect how students view different specialties. Further investigation of midwifery clinical facilitation is needed to develop the understanding of the midwifery student experience.

Clinical facilitation supports preceptors who supervise students as well. The literature has identified that preceptors benefit from clinical facilitation through the development of their own clinical or teaching skills and the opportunity for respite from teaching to manage their clinical workload (Barnett et al., 2010; Courtney-Pratt et al., 2012; Henderson & Tyler, 2011; Needham et al., 2016; Taylor et al., 2015). Australian RN preceptors in one study identified that they felt relieved when the CF could take over a teachable moment and directly supervise the student for an episode of care allowing them the time to complete other clinical duties. The CFs in the same study reported that assistance was most often requested when the preceptor and/or the student was unfamiliar with a skill. The authors suggest further consideration is needed on how to enhance the role of teaching within nursing as this is the point of most frequent contact for the student during

professional practice experiences. They also recognised the importance of preceptors being acknowledged for their contribution (Henderson & Tyler, 2011). This issue has been addressed collaboratively by education and health service providers in Victoria and Queensland, Australia, reported by Barnett et al. (2010) and Taylor et al. (2015) respectively. A CF role was introduced or re-defined to support both preceptors and students during professional practice experiences. This involved working with unit managers, hospital-based educators, and university academics to organise learning experiences for students and preceptors, provide problem-solving and mediation, and promote a positive clinical learning environment. The support was well-received and there was an increase in satisfaction with the preceptor role by students and clinicians. While further evaluation of this collaborative approach is ongoing, Barnett et al. (2010) and Taylor et al. (2015) suggested that other health care services and education providers could consider aspects of this model to address the ongoing need to provide quality, supported clinical learning for students while not overly burdening clinicians.

The ‘cluster’ model is a clinical facilitation model of clinical supervision that has been rated positively in the literature. It was implemented in different health care services in New South Wales, Australia, whereby RNs were seconded to the role of CF to supervise undergraduate nursing students during professional practice experiences (Bourgeois et al., 2011; Croxon & Maginnis, 2009; O'Brien et al., 2008). Clinical facilitation was found to be a success and the preferred model of clinical supervision by nursing students (Bourgeois et al., 2011; Croxon & Maginnis, 2009; O'Brien

et al., 2008). Again, students valued having a role that was dedicated to them, so their learning experiences were not dependent on different preceptors' enthusiasm, skill, and time. The CFs had a vested interest in student learning, were knowledgeable regarding the student scope of practice, and their constant presence allowed for greater facilitation of learning. Additionally, these trials identified the importance of the CF being comfortable in the professional practice environment as this added to the students' experiences of feeling welcomed (Bourgeois et al., 2011; Croxon & Maginnis, 2009; O'Brien et al., 2008). The biggest challenge identified for this model of clinical facilitation was the need to accommodate eight students and the CF at one time. Work around strategies were implemented, such as using the cafeteria for breaks instead of the staff room on the ward, however, a viable solution for handover was not found. Therefore, reducing the group size was recommended by the authors whilst recognising the impact this would have on the funding required for this model (Bourgeois et al., 2011; Croxon & Maginnis, 2009). Despite this, Bourgeois et al. (2011) report that the 'cluster' model of supervision continued at the initial health care service, trialled with two universities using the model jointly and other health facilities also showing interest in utilising this model for undergraduate nursing student supervision during professional practice experiences.

Clinical facilitation is commonly utilised in clinical supervision models for Australian midwifery and nursing students during professional practice experiences, however, there is a limited midwifery-specific body of knowledge. Students and clinicians alike value the clinical facilitation model which allows for the presence of a dedicated teacher for students during

professional practice experiences, a link to the education provider, support for the preceptor and student, and enhanced learning which promotes a positive learning environment and further improves student development. A CF is a registered professional employed to support a group of students during professional practice experiences in a supernumerary capacity. How this role is operationalised and what responsibilities are included varies, depending on the model of supervision, the clinical setting, and the individual CF in the role. There is no doubt that students and preceptors value the support of a CF, and that clinical facilitation enhances professional practice experiences. It is beneficial if the CF is familiar with the clinical setting and staff, and their knowledge of pedagogic techniques combined with clinical skill further encourages the integration of theoretical knowledge with professional practice. The role of the CF has been described in the literature as rewarding yet challenging, important yet undervalued and, practical yet theoretical (Courtney-Pratt et al., 2012; Henderson & Tyler, 2011; Needham et al., 2016; Sanderson & Lea, 2012; Taylor et al., 2015). It is certainly autonomous and varied in the way it is enacted by the CFs, despite this the nursing literature reveals many similarities in how CFs complete their role and the challenges they face which are discussed below.

2.3.1 Knowing Self within the Professional Context

CFs identify in the literature that an important aspect of the role is knowing themselves, their strengths, their scope of practice, and their development needs. Best practice in undergraduate nursing clinical facilitation was explored using concept mapping, focus groups, and individual interviews to collect data from 11 Australian CFs with more than five years'

experience. The CFs in the study identified that as part of their role they also assess themselves to determine if their knowledge base can meet the needs of students in the designated clinical area (Needham et al., 2016). These CFs reflected that some of the main features of best practice in clinical facilitation were maintaining a current knowledge base of nursing and education, including research, policies, curriculum, and procedures (Needham et al., 2016). ‘Knowing your own limitations’ emerged in another Australian study to describe how CFs promoted a collaborative clinical learning environment (Dickson et al., 2006). CFs were interviewed with the aim of developing an understanding of how CFs complete their role on a day-to-day basis. Participants had an average length of employment as a CF of twelve semesters and data saturation was achieved after five interviews. The participants again described the importance of knowing their own scope of practice and then identified the further step of ensuring that the most appropriate resources and people were used in assisting the student to develop their knowledge and skills (Dickson et al., 2006). Additionally, CFs recognise that facilitating students helps them to realise their own knowledge and skill, leading to an increase in confidence in their own practice and the recognition by other staff of their expertise (O'Brien et al., 2008). CFs demonstrated that while it was important that they maintain excellent skills, the role of the CF is not necessarily to know everything and teach everything but instead to facilitate appropriate experiences with appropriate supervision. Knowing self within the professional context has been identified as an important aspect of nursing clinical facilitation. Exploring clinical facilitation in

the midwifery context is crucial to developing the understanding of what is best practice in midwifery clinical facilitation.

2.3.2 Knowing Students

Nursing students report that the input of their CF is vital to their learning and development during professional practice experiences (Ryan & McAllister, 2019). One study identified the 'notion of stepping in or stepping back' to describe the skills used by the CF to determine when it was appropriate to observe and allow the student to direct the learning, or intervene, because of the potential risks of a situation (Dickson et al., 2006). Another qualitative research study included eleven CFs with at least two years' experience working in regional and metropolitan health care services across Australia. These facilitators identified that a student-centred approach was vital to building a trusting relationship and determining the clinical learning needs of each student. CFs got to know the students individually by providing orientation, working clinically together, and allocating daily one-to-one sessions (Ryan & McAllister, 2019). This was re-iterated by more Australian CFs who identified the importance of getting to know students particularly to assess their current level, learning needs, and goals for development (Needham et al., 2016). In rural Australia, CFs identified that providing orientation was one of the first steps in getting to know students, along with discussions regarding expectations and learning needs, and working clinically together. In this study the CFs also needed consider the impact of a rural professional practice experience on the student and reported that this broadened the pastoral care aspect of their role (Sanderson & Lea, 2012). Knowing the students allows the CF to tailor the learning

experiences to ensure they are appropriate, safe, and promote student development (Needham et al., 2016). Building a trusting relationship with students is central to the role of the CF and allows for student-centred learning and the accomplishment of goals. These studies have reported the importance of 'knowing students' in nursing clinical facilitation, it is therefore timely, to develop an understanding of clinical facilitation specific to midwifery.

2.3.3 Behind the Scenes Work

The literature has revealed that preceptors appreciate the support of a CF to assist in the clinical supervision of students (Courtney-Pratt et al., 2012; Henderson & Tyler, 2011; McKellar et al., 2018). Studies exploring the role of the CF demonstrate that CFs are aware of the importance of developing positive relationships with clinicians and preparing the clinical environment for students (Needham et al., 2016; Ryan & McAllister, 2019; Sanderson & Lea, 2012). CFs report that this behind-the-scenes element of their role is extremely important in encouraging staff to be welcoming and allowing CFs access to students and clinical learning opportunities during the professional practice experiences (Dickson et al., 2006; Lambert & Glacken, 2006; Ryan & McAllister, 2019). CFs also assess the professional practice environment to determine the types of learning opportunities available and match them to student needs (Needham et al., 2016). This finding is supported by Sanderson and Lea (2012) who interviewed eight CFs supporting students in several health care services in rural New South Wales, Australia. The CFs reported that preparing clinical staff for the arrival of students was an essential aspect of their role to ensure the success of

professional placement experiences, particularly for health care services in remote areas from the university (Sanderson & Lea, 2012).

CFs dedicate a lot of time and effort to developing relationships and collaborating with clinical staff to improve the learning opportunities for students and build partnerships between health care service and education providers (Dickson et al., 2006; Ryan & McAllister, 2019; Sanderson & Lea, 2012). Interpersonal and communication skills were identified by CFs as vital, to guide relationships between students and staff, and enhance the learning environment (Dickson et al., 2006; Needham et al., 2016). The flow-on effect from the positive relationships with ward staff is a cultural change towards successful teaching and learning in clinical areas, benefitting students and staff alike, promoting safe, evidence-based care, and providing positive professional practice experiences (Ryan & McAllister, 2019). Building relationships with clinical staff may go unnoticed or be considered not important by others, but it is an essential part of the CFs' role that allows for collaboration and promotes a positive learning culture. CFs are allocated a set number of hours per student and how this is operationalised is individualised to the needs of the specific setting and student. Further insight into clinical facilitation may clarify whether this aspect of the role is being completed outside of the assigned hours or only when time allows within the allocated hours.

2.3.4 Sharing the Journey

CFs illustrate the experience of clinical facilitation as a shared journey between themselves and the student (Dickson et al., 2006; Needham et al., 2016; Ryan & McAllister, 2019). They describe the relationship as mutually

beneficial. CFs feel proud to be involved in the development of students and report being energised by the process (Ryan & McAllister, 2019). CFs find it rewarding to assist students as they achieve their goals and transition into autonomous practitioners and feel privileged to guide students as they enter the profession (Needham et al., 2016; Ryan & McAllister, 2019). Understanding this aspect of the role in the midwifery context may assist in the preparation and support provided to midwifery CFs to ensure quality relationships with midwifery students and improve job satisfaction.

2.3.5 Facilitating Positive Professional Practice Experiences

The end goal of the role of the CF is to facilitate positive professional practice experiences for students. This is achieved when the other aspects of the role come together. Knowing self, building a relationship with the student, developing a student-centred plan for learning, and collaborating with clinicians allows CFs to facilitate appropriate experiences and learning opportunities for students and to assess their competency and receive feedback (Dickson et al., 2006; Needham et al., 2016; Ryan & McAllister, 2019; Sanderson & Lea, 2012). Australian CFs have highlighted that a positive preceptor is crucial to the nursing student experience as that is who the student spends the most time with during professional practice experiences. This is one of the benefits of having a relationship with the ward staff which allows the CF to identify and develop appropriate preceptors, leading to enhanced professional practice experiences (Dickson et al., 2006).

Conversely, rural CFs felt it was imperative to work clinically alongside students to give them the opportunity to work within the student scope of

practice and maximise their learning. The CFs determined that this assisted clinicians, by allowing them to focus on patient care, and further enhanced the attitude of clinical staff to students. Additionally, they identified that working clinically with students ensured that learning opportunities were not affected by workload and time constraints of preceptors and allowed for ongoing assessment of learning. Immersing students in the reality of nursing and assisting them to develop their cognitive nursing skills as well as the practical skills enhanced the professional practice experience for nursing students (Sanderson & Lea, 2012). The ultimate objective of clinical facilitation is to make the clinical education process of students seamless, creating a positive professional practice environment that promotes student learning and development. Nursing CFs maintain a flexible approach to their role to ensure they meet the needs of the student, the education provider, and the health care service. Further understanding of midwifery clinical facilitation is needed to clarify the role and ensure it is meeting the needs of stakeholders.

2.3.6 Teaching Professional Values and Behaviour

Clinical teachers and graduate RNs were interviewed as part of a large mixed-methods Australian study that aimed to understand the role of the clinical teacher in student nurse professional socialisation (Brown et al., 2012). The term clinical teacher was used by the authors to describe those individuals who supervised student nurses as representatives of the university during professional practice experiences, which fits with the general understanding of a CF in other Australian literature. The qualitative aspect of this study concluded that the role was instrumental in student

nurses developing their own professional identity and understanding the culture and profession of nursing. There was more to this role than meets the eye, in that the clinical teacher acted as a professional role model, facilitated learning opportunities, encouraged the development of nursing values and behaviours, and supported the cognitive evolution of what it is to be an RN (Brown et al., 2012).

This theme emerged from another study in rural Australia, whereby CFs perceived that an important aspect of their role was to assist nursing students to expand their understanding of and reinforce professional behaviours and values (Sanderson & Lea, 2012). This was achieved through role-modelling and the immersion of students in the realities of nursing practice by supervising them to manage an appropriate caseload during professional practice experiences. Furthermore, debriefing was identified as a major aspect of the role of the CF promoting professional reflection and providing support (Sanderson & Lea, 2012). One study suggested that CFs supported other clinical supervision staff in assisting students on their professional socialisation journey (Brown et al., 2012). This study acknowledged that understanding the full impact of clinical facilitation on socialisation was beyond the scope of the study and the effect of other key players in the students' journeys was not assessed, therefore further research was required. However, the authors did believe that the influence of CFs on the development of students' professional identity justified clinical facilitation as valuable for student nurses. Moreover, they recommended every effort to ensure the role is ongoing and sustainable and is beneficial to student nurses and the profession (Brown et al., 2012).

The role of the CF needs to be flexible to meet the needs of the varied stakeholders involved in the clinical education process of students. Ultimately the role of the CF is supportive and there is a developing body of evidence describing best-practice in nursing clinical facilitation that includes knowing self, knowing students, behind the scenes work in the professional practice settings, teaching professional values, facilitating positive and appropriate experiences, and sharing the journey with the student. As the role is individualised to local needs it is important to explore midwifery clinical facilitation in the WA context to develop an understanding of the process.

2.3.7 Challenges

As the body of knowledge regarding the role of the nursing CF increases, challenges have been revealed. While a challenging role can be rewarding, it is important to understand what the demands are and provide support to CFs to ensure the role remains viable and continues to meet the needs of universities, health care services, students, clinicians, and the profession.

2.3.7.1 Emotional Support for Students. Identifying and managing the differing needs of students is part of the challenge of clinical facilitation. CFs acknowledge that providing emotional support for students can be testing and this is intensified when students are unprofessional, unsafe, or struggling (Andrews & Ford, 2013; Ryan & McAllister, 2019; Taylor et al., 2015). Specifically, an exploratory study examining the lived experience of Australian nursing CFs identified that students needed assistance managing the demands of professional practice experiences with ongoing academic workload (Ryan & McAllister, 2019). The autonomous nature of the role can

be perceived as a negative feature when CFs feel alone in the responsibility of making student assessment decisions and the effect this may have on the student's progression through their course and on their emotional well-being (Andrews & Ford, 2013; Needham et al., 2016; Ryan & McAllister, 2019; Taylor et al., 2015). On these grounds, more formal support from colleagues and professional development would be useful for CFs (Needham et al., 2016; Ryan & McAllister, 2019; Taylor et al., 2015). Developing strategies to ensure that CFs feel supported in managing students' emotional needs can lessen this challenge of clinical facilitation.

2.3.7.2 Preparing for and Developing in the Role. One of the concerns about a preceptor-only model of clinical supervision is that bedside clinicians may not be qualified to teach students to the level expected of university education programs. The assumption is that a CF would be more knowledgeable in pedagogical techniques; however, this may not be the case. One Australian study revealed that 27% of nursing CFs had completed postgraduate level education (Ryan & McAllister, 2019), which is similar to the level of postgraduate education, reported by O'Brien et al. (2014), in preceptors. Moreover, it is unknown whether the postgraduate study completed by CFs was focussed on education and prepared them for clinical facilitation. Regardless of the level of education, most CFs did not feel prepared to provide clinical facilitation to students (Ryan & McAllister, 2019).

Nursing CFs are experienced RNs, generally with a bachelor-level of education (Needham et al., 2016; Ryan & McAllister, 2019). They commence their role as CFs with limited knowledge, understanding. and guidance (Andrews & Ford, 2013; Needham et al., 2016). Overall, CFs are

reported to enjoy the autonomy and flexibility of this rewarding position but were initially unsure of how to get started, feeling isolated and stressed (Andrews & Ford, 2013). CFs report that an interest in and enjoyment of teaching draws them to the role but, they do not necessarily feel prepared for the role (Andrews & Ford, 2013; Needham et al., 2016). They suggest that a preparation course could be beneficial, but they also acknowledge that there is no way to be fully prepared for the role of CF (Andrews & Ford, 2013; Needham et al., 2016). The amount of time from being notified that they had been given a CF position to commencing in the position was also associated with feelings of unpreparedness. CFs in an Australian study reported that the arrangements were often made last minute, and this led to feelings of being overwhelmed and unprepared (Andrews & Ford, 2013). Ultimately the CFs learnt about the role once they were in it, using their own experience, ongoing experiential learning, and the experiences of others to develop in the role (Andrews & Ford, 2013; Needham et al., 2016). For this reason, they found having access to more experienced CFs and support from the university critical (Andrews & Ford, 2013; Needham et al., 2016).

The need for peer support and ongoing professional development for CFs to alleviate the challenges of isolation and stress is acknowledged throughout the literature (Andrews & Ford, 2013; Needham et al., 2016; Ryan & McAllister, 2019). Developing a further understanding of the educational qualifications of CFs and how this affects preparedness for the role and operationalisation is important in ensuring that the role meets the pedagogic goals expected. CFs play an instrumental teaching role in clinical education;

it is, therefore, vital, that they are appropriately qualified and prepared for the position.

2.3.7.3 Feedback and Support. CFs feel that they could be better assisted by receiving formal feedback and support from the universities (Andrews & Ford, 2013; Needham et al., 2016). Given the autonomous nature and the ongoing experiential development of the role, coupled with the professed importance of the role with no requirement for formal education, CFs want to know how they are doing, not just from the students but from the university (Andrews & Ford, 2013; Needham et al., 2016). The lack of formal feedback and recognition for CFs increased the feeling of not belonging, as they are not a part of the ward staff, but they also do not truly feel part of the university academic team (Needham et al., 2016).

Ongoing support from the more experienced CFs or the university is vital for best-practice clinical facilitation (Andrews & Ford, 2013; Needham et al., 2016; Taylor et al., 2015). This ensures that the standard of clinical facilitation being provided is maintained and is particularly needed for CFs who are just commencing in the role (Needham et al., 2016). Furthermore, CFs have noted that support from the university or colleagues was important in the management of challenging students (Taylor et al., 2015). Networking or mentoring would be valuable to discuss student issues and provide guidance in unfamiliar or difficult situations, but also to share ideas and experiences, continue their professional development, and remind them that they are part of a team and, not alone (Andrews & Ford, 2013). The process of development for a CF has been likened to the way students develop from novice to beginning level practitioners. Education providers are unable to

fully prepare them for everything they will experience along the way and so, must provide ongoing support and mentoring to guide them through the journey. As a result of this finding, the University of Tasmania developed a Lead Facilitator role and a community of practice to provide support and mentoring for the CFs, recognising the value of CFs working as a team and the contribution CFs make to the education and competence of nursing students (Andrews & Ford, 2013). Understanding how CFs can be better supported is essential in maintaining quality clinical facilitation and the development of the future workforce.

2.3.7.4 The Clinical Facilitator as a Sessional. CFs are deployed on an as-needed basis, dictated by student placement and numbers. For this reason, the role is casual and filled by a sessional academic as either, a clinician seconded to the position or a shared facilitator that works for the placement site with students from multiple universities. The literature suggests that students favour the seconded CF due to the benefits of the facilitator being employed by, and therefore familiar with, the health care service (Bourgeois et al., 2011; Croxon & Maginnis, 2009; Franklin, 2013; Jayasekara et al., 2018) and this has led to the recommendation of reviewing the use of sessional CFs (Franklin, 2013). It would be ideal if the CF could maintain employment in both the academic and health care settings however that generally is not practical (Jayasekara et al., 2018). It is proposed that sessional CFs can provide a more cohesive link to the university and are better qualified than bedside clinicians to provide the expected level of clinical teaching (Jayasekara et al., 2018).

It has been suggested that the existing clinical facilitation model is not sustainable due to the expense of employing sessional CFs and the difficulty in recruiting and retaining as a result of the sessional nature of the work (Mannix et al., 2006). CFs themselves report that this aspect of the role is challenging to them. Recruitment and retention of quality CFs may be affected by the limited opportunities for career progression in a sessional position (Franklin, 2013). The casual employment model means that it can be difficult for CFs to plan their work because they often receive minimal notice of this employment opportunity, and being a casual staff member enhances the isolation of the role because they are not connected to or present for extended periods on a specific ward (Andrews & Ford, 2013; Needham et al., 2016). A literature review highlighted that the casual nature of the position may mean that the CF is not familiar with the healthcare service where they are allocated students, impacting their ability to provide quality clinical supervision (Franklin, 2013). It has been identified that in midwifery, CFs that are not known to the professional practice area find it difficult to work alongside students and midwives, affecting the ability of the CF to provide direct supervision and education (McKellar et al., 2018). The suggestion is that CFs should be sent to the same healthcare service to allow for familiarity, the development of relationships with staff, and the benefits to student professional practice experiences that come from this (Dickson et al., 2006). Additionally, attention should be given to formalising the role and providing supportive ongoing professional development and career progression pathways, given the important role the CF has in supporting

students, enhancing learning, and developing the future workforce (Courtney-Pratt et al., 2012).

2.3.7.5 Conflicting Demands of the Role. CFs can be challenged by the conflicting demands of this role and the sense of not belonging and being undervalued. They are in the unique position of being accountable to the student and the university, but also the patient and the health service provider and ultimately the profession (Dickson et al., 2006; Lambert & Glacken, 2006; Needham et al., 2016). This can lead to conflicting role expectations or role confusion and even the perception that the role is easy or that the CF has limited responsibilities (Needham et al., 2016). This has been demonstrated in the literature by CFs describing experiences where they are asked to take a patient load due to staff shortages, confirming such perceptions of their CF role (Ryan & McAllister, 2019).

CFs are aware that due to the mostly sessional basis of their employment, the role is costly for universities and feel that this can sometimes be of greater concern than the impact the support of a CF can have on the student experience (Ryan & McAllister, 2019). They report being told that their role is important but admit that this message is contradicted by the lack of preparation, support, feedback, and sense of not belonging (Mannix et al., 2006; Needham et al., 2016). This feeling of being undervalued is deepened by the perceived lack of research into the provision of midwifery and nursing education by CFs (Needham et al., 2016). Despite this, nursing students appear to understand the role well and value the positive impact the support of a CF has on their clinical learning (Lambert & Glacken, 2006). As most of the current understanding comes from nursing

students, the study reported in this thesis is needed to ensure the perspective of midwifery students is explored.

As the comprehension of the role continues to develop, CFs report that the attitudes of clinicians are improving. Further research can assist in clarifying the role of the CF. Recognition of clinical facilitation as an educational role is vital and regular evaluation is a requirement of accreditation. Aligning the role to education would increase the sense of belonging to a team, provide networking opportunities and access to ongoing professional development and feedback (Needham et al., 2016). Consideration of other models of employment within the university could also address university and CF concerns regarding the sessional nature of the role and ensure appropriate monitoring and improvement strategies are applied. CFs do contribute greatly to the development of midwifery and nursing students and thereby the professions, understanding the challenges and developing solutions is essential in continuing to provide quality professional practice experiences.

2.4 Clinical Facilitation in Midwifery

There is limited research regarding clinical facilitation in midwifery. A recent review of the literature explored different types of clinical supervision and noted that there was a lack of research that specifically addressed the needs of midwifery students alone (McKellar & Graham, 2016). Australian midwifery students have expressed frustration and disappointment with the perceived disconnect of the professional practice environment from the midwifery philosophy and theory of their education (Griffiths et al., 2020; Licqurish et al., 2013). A grounded theory study described the experiences

of the first cohorts of Australian undergraduate midwifery students as part of exploring their process of assimilation (Licqurish et al., 2013). The final year students involved in this study moved from recognising the conflict between the theory they were taught and the reality of practice in the clinical environment to adapting their practice to emulate the system and the midwife they were working with in order to be assessed as competent and pass. The study identified that students felt frustrated and disappointed by the need to assimilate into a system of varying degrees of medical dominance, which did not match the theory contained in the course. This draws attention to the importance of quality clinical supervision and professional practice experiences in midwifery. Students appreciate the continuity of support through the process of assimilation that occurs during the development of competence. Clinical facilitation can provide an ongoing link to the university to assist in the development of professional identity and promote the interpretation of experiences through the lens of midwifery philosophy (Licqurish et al., 2013). More recently, midwifery students in South Australia re-identified an ongoing mismatch with the theory that is taught and what is experienced in the professional practice environment (Griffiths et al., 2020). While this phenomenon has been reported previously in midwifery literature (Bluff & Holloway, 2008; Licqurish & Seibold, 2008; Licqurish et al., 2013), it has not been identified in the nursing literature reviewed in support of the study in this thesis. This suggests it is unique to midwifery and warrants further exploration.

Midwifery clinical facilitation is not well researched, with only two publications available to review for the study reported in this thesis. A

sequential mixed-method evaluation research design was used to compare three models of midwifery clinical facilitation for midwifery students from two different universities attending professional practice experiences at five hospitals in South Australia. The authors labelled the models of clinical facilitation according to the mode by which the facilitator was employed (McKellar et al., 2018). The shared model described CFs employed by one hospital in a position funded by both universities, meaning the CF supervised students from both universities. The seconded model was used to label CFs who were seconded from their continuing midwifery clinical position to supervise students and the CFs from the contracted models were midwives employed by the university on a sessional contract to facilitate students, both having their allocated hours dictated by student numbers. Overall, it was concluded that these models of clinical facilitation all provided high-quality support to midwifery students during professional practice experiences. This positively impacted student experiences and the development of skills and competence (McKellar et al., 2018).

The model of employment was noted to affect role operationalisation although this did not impact the student experience. One aspect of this was that not all CFs were able to work clinically with students to the same degree. It was noted that the CFs that were unable to work clinically with students focussed more time on debriefing and support which was highly valued by students. Shared CFs had a closer working relationship with preceptors as they were a part of the hospital staff, which led to improved preceptor preparation and support. Students also appreciated the support available for continuity of care experiences (CCE) when it was provided, although it was

not officially part of the role (McKellar et al., 2018). The CCE is a registration requirement unique to midwifery and, therefore, not an expectation of nursing students. Understanding the role of the CF in supporting midwifery students during this experience is important as they are the person of contact in the professional practice environment.

In this study, students demonstrated a preference for the contracted and seconded models, however, the authors deduced that the shared model of midwifery clinical facilitation could become best practice with further development due to its focus on preparing successful midwife preceptors (McKellar et al., 2018). The authors concluded that shared CFs focussed on education and supporting preceptor midwives to supervise students effectively and recommended that this was an aspect of clinical facilitation that needed further development (McKellar et al., 2018). The value of preceptor support from a CF and preceptor preparation, assistance, and recognition has been identified throughout the literature as important in improving professional practice experiences and clinical supervision for students. Further research could clarify what aspects of the role are important to students and how support for preceptors can be developed in the model of clinical facilitation preferred by students. Given the widespread perception that clinicians may not be qualified to embed cognitive skills in bedside teaching of students, continuing to develop and understand the role of the midwifery CF is important.

The role of Clinical Practice Facilitator was introduced into some London hospitals and universities in 2009. It was created to support student midwives and preceptor midwives to continue to provide safe care for women

and babies, and participate in high-quality learning opportunities in the wake of increasing numbers of students (Wood et al., 2011). It seems that the role is similar to that of the shared model CF described by McKellar et al. (2018), in that the Clinical Practice Facilitator worked for both the universities and the hospital to support students and midwives (Wood et al., 2011). The duties were adapted to the needs of the hospital, the students, and the midwife preceptors, but generally included working clinically with students and midwives, supporting preceptor midwives in developing effective teaching skills, ensuring students were linked with preceptors, and being a professional role model. Furthermore, an important element of the position was maintaining strong links to the education provider. The authors identified the potential for role confusion due to conflicting expectations as the Clinical Practice Facilitators reported to a hospital manager and an education provider manager (Wood et al., 2011). This issue would be worthy of further investigation in the Australian shared model of midwifery clinical facilitation. The position within the UK context achieved what it was designed to do by relieving the demands on the midwives in the clinical area. It also reported benefits such as earlier identification of and collaboration with students needing extra support, open lines of communication between the professional practice settings and the education providers and, an improved understanding of each setting's processes and challenges. The authors acknowledged that formal evaluation of this position was needed but it was hoped that hospitals would recognise the value of this role and include it permanently to support their staff and assist in the development of competent beginning level midwives, as has been done in nursing (Wood et al., 2011).

As this report is now ten years old and no formal evaluation was completed it is timely to investigate the CF role in the current model of midwifery education.

Clinical facilitation in midwifery needs further research to determine if it is meeting the needs of midwifery students, universities, healthcare services, and the profession. The current literature emphasises the importance of CFs providing support for midwife preceptors, and this has been identified in the nursing literature as the behind-the-scenes work of CFs, an important aspect of the role. It is becoming more difficult for midwifery CFs to work clinically with students, so further investigation into how midwifery CFs operationalise the role and how that is perceived by students is relevant. Developing a best practice model of supervision for midwifery students during professional practice experiences is crucial to ensure that education programs prepare competent midwifery graduates. This should include a collaborative approach between industry partners, education providers, CFs and students, the defining of supervision roles and, clear and coordinated communication between education and health service providers. Additionally, consideration is needed to clinical supervision during CCEs, a significant aspect of clinical education that is unique to midwifery (McKellar & Graham, 2016). The study reported in this thesis adds to the currently scant available evidence related to midwifery clinical facilitation.

2.5 Conclusion

In this chapter, the literature has been reviewed to determine the current knowledge and understanding of clinical facilitation of undergraduate midwifery students. The combination of preceptor and clinical facilitation has

been identified as a supportive model of clinical supervision for students during professional practice experiences. Clinical facilitation is valued by students and clinicians alike and, in combination with preceptors can enhance student learning and professional development. Best practice for clinical facilitation in nursing is beginning to emerge from the literature but there is minimal research that is specific to midwifery clinical education, clinical supervision, and students. While some of the skills needed in midwifery are similar to nursing, midwifery is a separate profession, with its own skills and practice, philosophy, professional values, and identity. It is important to develop midwifery-specific knowledge and understanding to ensure best educational practice for midwifery students and the profession.

Chapter 3 (Methodology) will discuss the methodology of the research project presented in this thesis. It will provide an overview of the different approaches to research and describe the common research designs, sampling and recruitment, data collection, and data analysis. It will then detail the research approach and methods that were used in the study reported in this thesis and the quality enhancement strategies employed to demonstrate integrity and allow for the assessment of quality by the reader.

Chapter 3

Methodology

It is well recognised that research plays an important role in the modern professions of midwifery and nursing (Polit & Beck, 2017; Richardson-Tench et al., 2018; Schneider & Whitehead, 2014). To ensure evidence-based practice, it is important that midwives and RNs have a good understanding of research. While they may engage with research in different ways, what is certain is that midwives and RNs will be involved in research-related activities within the clinical care setting. They may contribute as research participants, provide information to clients about research, be consumers of research or produce evidence through research. All these different roles require knowledge of research processes and the ability to critically appraise research. Methodically investigating problems within the professions develops knowledge and understanding, and improves outcomes for clients, clinicians, and health service providers. Ensuring that research is well conducted, rigorous, and trustworthy is vital to furthering the professions of midwifery and nursing (Polit & Beck, 2017; Richardson-Tench et al., 2018; Schneider & Whitehead, 2014). The study presented in this thesis aimed to develop knowledge and understanding of midwifery students' experience with midwifery clinical facilitation using descriptive exploratory methodology. These findings will inform midwifery clinical education and improve outcomes for students, clinicians, clients, health services, and education providers. By contributing to the body of knowledge, the research reported in this thesis can help to identify and promote evidence-based practice in relation to midwifery clinical education. This chapter provides an overview of the

research paradigms relevant to midwifery and nursing research. This is followed by a detailed explanation of the methodology used for the study presented by this thesis with supporting rationale.

3.1 Research Paradigms

Midwifery and nursing research has traditionally been approached from two paradigms, namely, positivism and constructivism (Polit & Beck, 2017). The decision of which paradigm to use is influenced by the research questions being posed, the profession, and the theoretical and philosophical positions of the researcher (Frances et al., 2014; Polit & Beck, 2017). It is important that the research design fits with the purpose of the research, the experience of the researcher, and the nature of the problem. The inquiry may be approached from the positivist paradigm using quantitative research methods, the constructivist paradigm using qualitative research methods, or sometimes both paradigms may be brought together in one study, known as mixed-methods research. Different research paradigms or combinations of approaches allow multiple perspectives of problems to be revealed, resulting in enhanced understanding. Using different research paradigms to approach phenomena in midwifery and nursing allows for improved practice (Frances et al., 2014; Polit & Beck, 2017). The positivist paradigm and quantitative research will be discussed in more detail first, followed by the constructivist paradigm and qualitative research, then mixed-methods research.

3.1.1 Positivism

The positivist paradigm has been and continues to be, the main approach used in midwifery and nursing research (Frances et al., 2014; Polit & Beck, 2017; Richardson-Tench et al., 2018). Positivism is a traditional

scientific approach to research where objectivity is valued, and reality is understood as fixed. The researcher attempts to explain phenomena using cause-and-effect with strict controls of the research situation. The goal for the researcher is total objectivity, or as close as possible. Positivist research methods approach problems in an orderly and structured manner to obtain measured information that can be widely generalised (Frances et al., 2014; Polit & Beck, 2017; Richardson-Tench et al., 2018).

Quantitative research is closely associated with positivism (Frances et al., 2014; Polit & Beck, 2017; Richardson-Tench et al., 2018). It uses the traditional scientific methods of objective observation and analysis to test cause-and-effect relationships in a measured way. Researchers must be systematic, use control strategies and collect empirical evidence that is quantitative to produce findings that are generalizable to individuals who have not participated in the study (Frances et al., 2014; Polit & Beck, 2017; Richardson-Tench et al., 2018). There are two major types of quantitative research design, namely experimental and non-experimental. Experimental research designs are considered the gold standard in determining cause-and-effect; however, it is not always ethically or technically possible to conduct research using such an approach. Most experimental designs involve the researcher manipulating one variable while controlling the others and assigning participants randomly to either the control or experimental group (Frances et al., 2014; Polit & Beck, 2017; Richardson-Tench et al., 2018). A quasi-experimental design is often more practical and may be more acceptable to a broader range of participants. This design still aims to test cause-and-effect relationships but does not match the standards for a true

experimental design due to a lack of control or randomisation. Whilst the quasi-experimental design can threaten the internal and external validity of a study, it is more adaptable and feasible in clinical settings (Frances et al., 2014; Polit & Beck, 2017; Richardson-Tench et al., 2018). Despite this, many research problems cannot be addressed experimentally. Quantitative researchers use non-experimental studies when they cannot, or should not, manipulate the variable/s of study. In midwifery and nursing research, non-experimental designs are most commonly used due to human beings being study participants (Polit & Beck, 2017; Richardson-Tench et al., 2018; Shields & Smyth, 2014).

A sampling plan is developed in quantitative research to ensure the inquiry achieves statistical conclusion validity and is generalizable (Fisher & Fethney, 2014; Polit & Beck, 2017; Richardson-Tench et al., 2018). It is, therefore, important that the sample is representative of the population and large enough to test for group differences especially when causality is being determined. Eligibility criteria are used to define the population and will affect the interpretation and generalizability of the results. The two types of sampling design used in quantitative research are probability and non-probability samples (Fisher & Fethney, 2014; Polit & Beck, 2017; Richardson-Tench et al., 2018). Quantitative researchers aim to reduce sampling bias by attempting to reflect variation in the population with variation in the sample. This helps to prevent inaccurate results and allows for generalization. Non-probability samples are most commonly used in midwifery and nursing research (Fisher & Fethney, 2014; Polit & Beck, 2017; Richardson-Tench et al., 2018). While this is less likely to create representative samples, it is

more practical, requires fewer resources, and complies with the ethical expectations of conducting research with human subjects. Also, strategies can be employed to build representativeness into a design using a non-probability sample. Sample size is important in quantitative research to achieve statistical conclusion validity but can be affected by limitations of time and resources (Fisher & Fethney, 2014; Polit & Beck, 2017; Richardson-Tench et al., 2018). Utilising an appropriate sampling plan allows the researcher to generalize findings to the accessible population. Describing the sampling strategies allows a reviewer to determine the generalizability of a study to a larger population (Fisher & Fethney, 2014; Polit & Beck, 2017; Richardson-Tench et al., 2018).

The aim of data collection in quantitative research is to systematically and consistently measure or assign a numerical value to objective data (Da Costa & Schneider, 2014). Choosing the right data collection method is imperative to ensure the data is accurate and complete. Data collection decisions are mostly dependent on the types of data needed, but also influenced by ethical considerations, budget, and resources (Polit & Beck, 2017). The five most common methods of data collection in quantitative research are biological measurements, observation, interviews, questionnaires, and existing data sources (Da Costa & Schneider, 2014). Statistical procedures are used to analyse quantitative data and enable researchers to interpret and communicate findings (Fisher & Fethney, 2014; Polit & Beck, 2017; Richardson-Tench et al., 2018). To ensure quantitative research is of a high standard it is important that the research design, sampling, and data collection are chosen to enhance the internal and

external validity of the findings. This allows the credibility, dependability, and generalisability of the findings to be determined and ensures that theory and practice can be shaped (Da Costa & Schneider, 2014; Taylor et al., 2006).

Quantitative analysis converts the raw numbers, collected as data, into statistics which provide a numerical summary to answer the research problem (Fisher & Fethney, 2014; Polit & Beck, 2017; Richardson-Tench et al., 2018). This process aims to allow the researcher to be able to describe the characteristics of the group, with descriptive statistics, and generalise the results to the population, with inference statistics. The reliability of the process of statistical inference is dependent on good sampling and good measurement. Inferential statistics are based on random samples from a population, which through hypothesis testing can allow researchers to generalise their findings to the population (Fisher & Fethney, 2014; Polit & Beck, 2017; Richardson-Tench et al., 2018). Researchers complete a variety of different statistical tests of significance to test the hypothesis, often using statistical computer software packages. Depending on the type of data, hypothesis, and variables, these tests may be parametric or non-parametric and the resultant statistics will be used to determine if the null hypothesis will be accepted or rejected. Parametric tests, such as t-tests, ANOVA, and Pearson's r, are considered to be more robust than non-parametric tests, for example, Wilcoxon rank-sum tests, u-tests, and chi-square tests (Fisher & Fethney, 2014; Polit & Beck, 2017; Richardson-Tench et al., 2018). However, not all data can meet the assumptions required for parametric testing. Statistical tests are designed to test for differences between means,

differences in proportions, and the presence of relationships (Fisher & Fethney, 2014; Polit & Beck, 2017; Richardson-Tench et al., 2018).

In quantitative inquiry, researchers are looking to discover whether a causal relationship exists between variables (Polit & Beck, 2017; Richardson-Tench et al., 2018; Schneider, 2014). The independent variable is the intervention, treatment, or attribute that is proposed to influence an outcome, the dependent variable. A quantitative study will be designed to investigate how variation of the independent variable affects the dependent variable and determine the presence or absence of a cause-and-effect relationship between the variables (Polit & Beck, 2017; Richardson-Tench et al., 2018; Shields & Smyth, 2014). A hypothesis is the statement of the relationship between variables. The research hypothesis is the statement made by researchers of the predicted or expected relationship between the independent and dependent variables. The null hypothesis is the statement that says the independent variable does not affect the dependent variable. Hypothesis testing using statistical analysis allows researchers to determine the probability that the null hypothesis is incorrect and thereby accept or reject their research hypothesis (Polit & Beck, 2017; Richardson-Tench et al., 2018; Schneider, 2014).

When testing a hypothesis to determine causal relationships between variables two types of error may occur (Fisher & Fethney, 2014; Polit & Beck, 2017; Richardson-Tench et al., 2018). Type I errors occur when the result is actually due to chance, but the null hypothesis is wrongly rejected. A type II error is when the null hypothesis is accepted, and a significant cause-and-effect relationship is missed. These errors are generally related to sampling

bias and size (Fisher & Fethney, 2014; Polit & Beck, 2017; Richardson-Tench et al., 2018). Power analysis is a statistical procedure implemented to control for errors by determining the appropriate sample size to achieve statistical significance. Type I errors can be controlled by setting significance levels (p values or α level). Usually, the minimum accepted level of significance is $p < 0.05$, meaning that there is a less than five percent chance that the null hypothesis has been rejected in error. While significant p values demonstrate statistical significance, the effect size is used to determine clinical significance (Fisher & Fethney, 2014; Polit & Beck, 2017; Richardson-Tench et al., 2018). Effect size is described as small, medium, or large, and clinically significant effect size needs to be nominated before the research is conducted. There is an inverse relationship between effect size and sample size, through which a large effect size requires a small sample size as the relationship or impact is easier to observe. Small effect size is common in midwifery and nursing whereby the impact or relationship is only detected statistically (Fisher & Fethney, 2014; Polit & Beck, 2017; Richardson-Tench et al., 2018). Setting power levels allows for control of type II errors. Power calculations determine if the sample size is large enough for statistically significant findings. The commonly accepted power value is 0.80 or better, which indicates that there is an 80 percent probability of not making an error. This translates to a 20 percent chance that the null hypothesis has been accepted in error and, therefore, a cause-and-effect relationship has been missed (Fisher & Fethney, 2014; Polit & Beck, 2017; Richardson-Tench et al., 2018). When inferential statistics are reported, the power analysis used to determine sample size must be included so that the readers can ascertain

the quality of the research and the clinical and statistical significance. Research findings should be related to the relevant theoretical framework and previous findings, considered for implications, and then, conclusions and recommendations should be developed (Fisher & Fethney, 2014; Polit & Beck, 2017; Richardson-Tench et al., 2018). The discussion will now move on to the constructivist paradigm and a summary of qualitative research methods.

3.1.2 Constructivism

The constructivist paradigm began as an attempt to find an alternative to balance the positivist tradition (Frances et al., 2014; Polit & Beck, 2017). Constructivism accepts that individuals interpret reality differently from one another. Thereby, reality is flexible and constructed by individuals in response to events. Based on this, constructivism seeks to present the voice of the study participants and recognises that the researcher cannot be separated from the process (Frances et al., 2014; Polit & Beck, 2017; Richardson-Tench et al., 2018; Whitehead & Whitehead, 2014). As indicated earlier, there is no one right approach to research as there is not one research design that will answer all research questions. Constructivism and positivism can work synergistically to explore phenomena and develop knowledge and understanding by completing different studies based on different paradigms. Constructivist inquiry is often chosen when there is little known about the phenomenon of interest, as a starting point to discover and grow an understanding. Positivist research studies can then build on the existing information and develop the body of knowledge further (Polit & Beck, 2017).

Qualitative research methods are most often associated with the constructivist paradigm (Frances et al., 2014; Polit & Beck, 2017; Whitehead et al., 2014). The process of completing qualitative research is typically more flexible than quantitative. It aims to be holistic and reveal the lived experiences of participants. Researchers need to become immersed in the study and data is analysed continuously permitting adjustments in the process and determination of completeness (Frances et al., 2014; Polit & Beck, 2017; Whitehead et al., 2014). Qualitative research planning is generally broad, allowing for contingencies while providing overall direction for the study. In contrast to quantitative inquiry, whereby the research design is developed before data collection begins, the design of qualitative studies emerges as the research is conducted. This flexible design allows the researcher to adjust as needed to the information being received during data collection to ensure the inquiry meets the ultimate aim of qualitative research, namely, to describe, explore and understand phenomena, and reveal multiple realities. This can be approached in a variety of ways and is often categorised according to disciplinary traditions (Frances et al., 2014; Polit & Beck, 2017; Whitehead et al., 2014).

Traditional approaches to qualitative research have generally developed from the disciplines of psychology, anthropology, and sociology (Polit & Beck, 2017). Phenomenology focusses on the meaning of the participants' lived experiences and is grounded in psychology and philosophy. The researcher aims to understand the experience of the phenomena as a whole. Within phenomenology there are different philosophical approaches and interpretations that affect the research

processes and, therefore, the findings (Polit & Beck, 2017; Whitehead et al., 2014). Ethnography originates from anthropology, whereby it aims to describe and interpret cultures and social groups (Polit & Beck, 2017; Whitehead et al., 2014). Grounded theory is a widely utilised qualitative method in midwifery and nursing research, characterised by the use of data to develop theory and create hypotheses for further research. As with phenomenology, there are different versions of grounded theory which generally demonstrate different approaches to data analysis, and in turn affect the findings and outcomes (Polit & Beck, 2017; Whitehead et al., 2014). Additionally, qualitative research can represent an ideologic perspective, such as critical theory, feminist research, and participatory action research. These approaches are designed to highlight social problems or the needs of certain groups that lead to improvement and change (Polit & Beck, 2017). Some methods of qualitative research are not associated with a distinct discipline or ideology. These include case studies, an intensive analysis of a particular unit, and narrative analyses, where stories are examined to understand a phenomenon (Polit & Beck, 2017; Whitehead et al., 2014). Finally, descriptive qualitative research aims to generate a new understanding of the phenomenon of interest. As it is not linked to a particular ideology or discipline, the design is eclectic and chosen to suit the research problem (Polit & Beck, 2017; Whitehead et al., 2014). In qualitative research design, the appropriate methodological strategies are chosen based on the traditions of the discipline, the ideology of the researcher, or the nature of the area of interest (Polit & Beck, 2017).

As the purpose of qualitative research is different from quantitative research, so too are the sampling strategies. Qualitative research uses different considerations in selecting participants and sampling decisions are not focussed on ensuring generalisability, but rather the data participants can provide (Polit & Beck, 2017; Whitehead & Whitehead, 2014). This generally results in a smaller, non-random sample. The type of sample sought out by qualitative researchers is dependent on the conceptual requirements of the study. Researchers seek participants that can help them describe and understand the phenomenon, that is, people who are good informants. Eligibility criteria can be used to assist reviewers in determining transferability, but for researchers, it ensures individuals have had experience with the phenomenon. Sample size in qualitative research is guided by data saturation and the information needs of the study (Polit & Beck, 2017; Whitehead & Whitehead, 2014). This can be affected by the scope of the study, the quality of the data obtained, and the skill and experience of the researcher. Thorough descriptions of sampling are crucial to allow potential readers to establish the transferability of a study's findings. A detailed description of the sample allows the reader to determine the context of the study and if it is similar to their own, thereby permitting them to decide if the findings apply to their setting (Polit & Beck, 2017; Whitehead & Whitehead, 2014).

Data collection in qualitative studies is also influenced by the different discipline traditions. Generally, qualitative data collection approaches are less structured than in positivist research and new strategies may emerge during the process (Polit & Beck, 2017; Whitehead & Whitehead, 2014).

Interviews and observations are the main methods of data collection, making the development and maintenance of a trusting relationship with participants a critical element of the data collection process. Due to the required immersion of the researcher into the study, researchers must practice reflexivity by being aware of themselves and their potential to affect the data. In qualitative research, data collection and data analysis often occur simultaneously, allowing researchers to adjust strategies as appropriate and determine when informational needs have been met (Polit & Beck, 2017; Whitehead & Whitehead, 2014). The data collected is narrative, as opposed to numerical in quantitative inquiry, and there are no standard procedures of data analysis for the researcher to follow. Qualitative researchers analyse the data by studying it intensely looking for meaning (Polit & Beck, 2017; Whitehead & Whitehead, 2014). As insights emerge, researchers are able to reduce the vast amount of narrative data into themes and concepts to allow the development of meaningful conceptual patterns. Interpretation occurs concurrently with data collection. Minimising the distance between participants and the researcher, creativity, time, and reflexivity affect interpretation and, therefore the implications of the study findings (Polit & Beck, 2017; Whitehead & Whitehead, 2014).

How the rigour of qualitative research is evaluated is debateable and influenced by philosophical and methodological perspectives (Polit & Beck, 2017; Richardson-Tench et al., 2018; Streubert, 2011). Most commonly, qualitative researchers aim to establish trustworthiness as described in the framework by Lincoln and Guba (1985). This framework initially identified the four criteria of credibility, dependability, confirmability, and transferability,

which aligned with the criteria used in quantitative research to determine quality (Lincoln & Guba, 1985). A fifth criterion, namely authenticity, was added on review of the framework by the original authors (Guba & Lincoln, 1994). Dependability describes the reliability of the data and whether findings are able to be replicated (Colorafi & Evans, 2016; Lincoln & Guba, 1985; Polit & Beck, 2017). This forms a part of achieving credibility, which establishes the believability of and confidence in the findings (Colorafi & Evans, 2016; Harding & Whitehead, 2014; Lincoln & Guba, 1985; Polit & Beck, 2017). Confirmability is the degree to which others would agree with the interpretations made by the researcher, creating the need for qualitative researchers to make certain that the findings reflect the participants' views and not their own (Colorafi & Evans, 2016; Lincoln & Guba, 1985; Polit & Beck, 2017). Transferability is the capacity for findings to be applied in other settings (Colorafi & Evans, 2016; Lincoln & Guba, 1985; Polit & Beck, 2017). The qualitative researcher is responsible for providing descriptive data of the participants and their experiences, research context and processes so that transferability can be determined by the reader. Finally, authenticity is the degree to which the experience being explored is described so that the reader also feels immersed (Polit & Beck, 2017). Strategies to enhance the rigour of qualitative inquiries are employed throughout the different phases of the study. The credibility of the researcher is also an important factor in the trustworthiness of qualitative research as they are the data collection tool. Findings may be impacted by the experience and ability of the researcher; therefore, it is crucial that qualitative researchers are committed to maintaining quality processes (Colorafi & Evans, 2016; Lincoln & Guba,

1985; Polit & Beck, 2017). The next section will explain mixed-methods research, where qualitative and quantitative research methods are combined into one study design.

3.1.3 Mixed-methods Research

Mixed-methods research is the incorporation of both qualitative and quantitative data to produce findings. Wide acceptance of this approach to research is emerging and many are growing to believe it can lead to enhanced inquiry (Mertens, 2014; Molina-Azorin & Fetters, 2019; Polit & Beck, 2017; Richardson-Tench et al., 2018; Sandelowski, 2014; Whitehead & Day, 2014). When the two seemingly opposed paradigms are complementarily integrated limitations can be reduced, phenomena can be further explored within one study than would be possible using one research paradigm and validity can be enhanced. Research questions in mixed-methods studies generally require more than one type of data. Quantitative and qualitative data may be collected either sequentially or concurrently and often, one approach is given dominant status. The integration of the approaches during data collection, data analysis, or interpretation of findings is important for a mixed-methods study to achieve the inherent capacity for enhanced inquiry (Polit & Beck, 2017; Richardson-Tench et al., 2018; Whitehead & Day, 2014). Sampling and data collection strategies in mixed-methods research are selected appropriately for each branch of the study and can be chosen to balance the weaknesses of the other strand. Decisions regarding data analysis for mixed-methods studies are dependent on the primary purpose of the research, when and how the integration of data will occur, and if comparisons between data will be made (Polit & Beck, 2017;

Richardson-Tench et al., 2018; Whitehead & Day, 2014). Quality criteria for mixed-methods research are still emerging. The qualitative and quantitative strands must meet the trustworthiness standards and reliability and validity criteria, respectively. Despite the lack of consensus on quality criteria for mixed-methods research, quality research processes must continue to be demonstrated after the integration of the qualitative and quantitative strands, regardless of whether that occurs during data collection, data analysis, or interpretation of findings, to ensure the entire investigation can be assessed for quality (Polit & Beck, 2017; Richardson-Tench et al., 2018; Whitehead & Day, 2014).

The first section of this chapter has summarised the three approaches to research by describing the common research designs, sampling and recruitment, data collection, and data analysis associated with quantitative, qualitative, and mixed-methods research. The next sections will focus on the study reported in this thesis and describe the research approach adopted and the methods that were used linked to this approach.

3.2 Research Design

The study presented in this thesis has used the constructivist paradigm. Qualitative research is designed to provide insight and understanding of a phenomenon by exploring the way it is experienced by participants (Whitehead et al., 2014). This approach was appropriate as the research aimed to explore the perceptions and experiences of undergraduate midwifery students in WA in relation to midwifery clinical facilitation (Polit & Beck, 2017; Whitehead et al., 2014). Clinical facilitation in the midwifery context is not well understood making a qualitative design well suited as it

provides rich descriptions to generate understanding of a topic (Whitehead et al., 2014). The study planned to discover, describe, and understand midwifery clinical facilitation from the perspective of WA midwifery students. The researcher wanted to understand the phenomena from the participants' viewpoint, and this is not necessarily quantifiable (Colorafi & Evans, 2016; Neergaard et al., 2009). A qualitative design allowed what is important to student midwives regarding midwifery clinical facilitation across the different stages of undergraduate midwifery courses in WA to be revealed.

A descriptive exploratory method was chosen as the purpose of the research was to describe a phenomenon that, thus far, has been minimally addressed in the literature. Descriptive methodology is a qualitative approach that focusses on providing a factual, low-inference description of the phenomenon (Colorafi & Evans, 2016; Neergaard et al., 2009; Sandelowski, 2010; Willis et al., 2016). The descriptive exploratory method allows the researcher to present the perceptions and experiences as interpreted by the participants and this, in turn, is interpreted by the researcher throughout the research process. It does not require the researcher to make research decisions based on a specific theoretical or disciplinary framework. Descriptive methodology allows the researcher to stay close to the data and provide a summary of the participants' experiences with the phenomenon, making it different from the more traditional qualitative methodologies such as phenomenology, ethnography, and grounded theory (Colorafi & Evans, 2016; Polit & Beck, 2017; Whitehead et al., 2014; Willis et al., 2016). This methodology developed from the need to simplify the research process and make it more accessible to clinicians. Rich narrative

data is collected from small sample populations and thematically analysed using general qualitative principles (Colorafi & Evans, 2016; Whitehead et al., 2014; Willis et al., 2016). According Colorafi and Evans (2016) the qualitative descriptive method is useful in healthcare environments for highlighting the experiences of using a service or function. This type of research has been used to capture people's experiences of services and functions and identify elements that impact engagement with those services and functions. This aligns with this study's objectives because CFs provide a service, namely supporting students in the clinical placement environment. The study presented in this thesis was designed to explore the student experience of clinical facilitation and describe the barriers and enablers to the relationship from the student perspective. This methodology was deemed appropriate because it was in keeping with achieving the study objectives and is suited to candidacy requirements for a Master of Philosophy (MPhil) higher degree by research study. As clinical facilitation in the midwifery context has not received much attention in the literature, a descriptive exploratory design was relevant. Descriptive research can only yield a description of the phenomenon; however, this is important in developing future theory-based research (Neergaard et al., 2009; Sandelowski, 2010). It, therefore, aligned with the purpose of the study presented in this thesis which was to describe the perceptions of and experiences with midwifery clinical facilitation from student midwives' perspectives using a cross-sectional approach to capture a broad picture of this phenomenon.

3.3 Sampling and Recruitment

The target population for the study presented in this thesis was WA undergraduate midwifery students who had attended at least one professional practice experience with a CF. The aim of qualitative sampling is to select suitable participants who can assist the researcher in developing an understanding of the phenomena. Appropriate sampling is crucial in qualitative research design as it influences the dependability of the findings. Purposive sampling is designed to recruit informants that have had the experiences being researched (Polit & Beck, 2017; Whitehead & Whitehead, 2014). For the study being presented in this thesis, undergraduate midwifery students who had completed at least one clinical placement were sought, with the exclusion criteria of any previous contact with the researcher, who had worked as a CF within the WA midwifery context. Purposive sampling was used to ensure that a maximum variation sample was achieved. Participants were chosen so that data was captured from students attending the two universities in WA that offered undergraduate midwifery programs, namely Curtin's Bachelor of Science (Midwifery) and ECU's Bachelor of Science (Nursing)/Bachelor of Science (Midwifery) and from across the several stages of each of the courses. This allowed for consideration of the varying dimensions of the experience of midwifery clinical facilitation and suggests that common findings are representative of the broad midwifery student experience. This sampling technique fits well with qualitative descriptive research where the aim is to develop wide-ranging insights into the phenomena being described (Colorafi & Evans, 2016; Polit & Beck, 2017; Whitehead & Whitehead, 2014). Using this maximum variation sampling

approach allowed data to be collected from the full spectrum of undergraduate midwifery students in WA, ensuring person and space triangulation, enhancing the transferability of the study.

Students were recruited as participants for the study on a voluntary basis from the university campus that they attended or clinical placement site. Voluntary participants are more likely to be willing and able to articulate their experiences (Holloway & Wheeler, 2010). To ensure students did not feel coerced they were not recruited by unit coordinators, lecturers, or CFs. The educator responsible for each cohort provided an introduction to the researcher, who then conducted a study briefing to interested midwifery students. Only study information was provided during the initial meeting and students were aware that participation was voluntary and in no way connected to their university grades. Students who then contacted the researcher to volunteer to participate were provided with written participant information (Appendix A), the consent form (Appendix B) and, afforded an opportunity to ask questions and given time to consider if they wished to participate. A meeting was arranged at a time and place convenient to those who decided to participate, and the consent was confirmed before the interview began. The researcher worked as a midwifery CF within WA, hence as mentioned previously, the exclusion criterion for this study was previous contact with the researcher in her capacity as midwife or CF. This approach was selected to reduce participants feeling obligated to participate and to ensure authentic data collection.

Generally qualitative inquiries involve a smaller sample size studied comprehensively and determined by the data collected (Holloway & Wheeler,

2010; Polit & Beck, 2017; Willis et al., 2016). The quality of the data collected is more important than the number of participants, with the common range of qualitative sample size being eight to twenty participants. There are no criteria to determine whether a sample size is large enough for a study and the researcher does not always begin with a predetermined sample size (Polit & Beck, 2017; Whitehead & Whitehead, 2014). Data saturation is used as the guiding principle. This is when researchers determine that enough in-depth data has been collected to allow for an understanding of the phenomena being studied because informants are no longer providing new information (Polit & Beck, 2017; Whitehead & Whitehead, 2014). In this case, before recruitment began it was estimated that a sample size of sixteen to twenty participants would be needed to fulfill the information needs of this study. Data saturation was suspected after eight participants were interviewed and two further interviews were completed to confirm this. Therefore, the final sample size for the study presented in this thesis was ten participants, with data saturation indicating to the research team that the information needs of the study had been met.

3.4 Data collection

Interviews are the main method of data collection used in qualitative research (Polit & Beck, 2017; Whitehead & Whitehead, 2014). For the study reported in this thesis, data was collected by the researcher using semi-structured one to one, in-person interviews, as per the participants' preference and availability. These interviews were guided by the research objectives and conducted over a period of ten months. Semi-structured interviews allow for participants to talk freely about the phenomenon whilst

also enabling the interviewer to guide the conversation to ensure that specific topics are covered (Colorafi & Evans, 2016; Richardson-Tench et al., 2018; Willis et al., 2016). The researcher developed and used an interview question guide (Appendix C) to facilitate the discussion and allow consistency of data collection (Colorafi & Evans, 2016; Goodell et al., 2016; Polit & Beck, 2017; Whitehead & Whitehead, 2014). Interview questions revolved around the participant's experiences with midwifery clinical facilitation and their perception of the role of the midwifery CF. The benefit of qualitative data collection is the relationship that develops between researcher and informant which allows for the collection of rich, meaningful data and assists the researcher to become immersed in the participant's world. However, this is impacted by the skills of the researcher. It is important to acknowledge that despite all efforts at bracketing, findings will be influenced by the researcher. Body language, the choice of words used, and the personality of the interviewer will affect participant responses (Goodell et al., 2016; Whitehead & Whitehead, 2014). In an attempt to mitigate this effect in the study reported in this thesis, research supervisors reviewed the first five interview transcripts. They provided feedback and guidance on the interview technique used to ensure the influence on participants was minimal and data were credible, dependable, and confirmable.

The researcher collected basic demographic data with the first question of the interview to allow for a description of the population and as a way of commencing rapport building. Questions were asked in a clear and balanced way ensuring a congenial environment was generated and maintained and the researcher was careful to avoid leading questions or influencing the

participant. The researcher adopted active listening strategies and employed probing and paraphrasing techniques to assist with understanding and to encourage storytelling (Goodell et al., 2016; Richardson-Tench et al., 2018; Whitehead & Whitehead, 2014). Interviews were arranged at a time and place convenient and comfortable for the participant to further assist in the development of the relationship between the researcher and the informant, and to increase participant comfort levels and encourage them to reveal information (Polit & Beck, 2017; Streubert, 2011; Whitehead & Whitehead, 2014).

Interviews were allowed to run their natural course ensuring participants were able to provide their complete stories (Whitehead & Whitehead, 2014). On average the interviews lasted 37 minutes, allowing for rapport to be established and for significant data to be uncovered. Participant validation was employed at the end of each interview to confirm the researcher understood the essence of the conversation. Audio recording of interviews was utilised with consent to allow the researcher to concentrate wholly on listening and guiding the conversation. This also ensured that participant responses were recorded accurately and not influenced by the researcher's memory or bias (Holloway & Wheeler, 2010; Polit & Beck, 2017). As mentioned earlier, the interviews were completed over a period of ten months, allowing for immersion in the world of the participants and sensitivity to the data, which assisted to minimise the gap between participants and researcher (Polit & Beck, 2017).

3.5 Data analysis

The aim of qualitative data analysis is to bring forth meaning from the narrative data collected and develop findings that can be communicated. It generally occurs simultaneously to data collection which allows interviews to develop into more precise conversations (Colorafi & Evans, 2016; Goodell et al., 2016; Polit & Beck, 2017; Willis et al., 2016). The method of data analysis chosen is dependent on the researcher's philosophical approach and the research design and context, however, there are no universal rules to guide the process of qualitative data analysis. Researchers need to be purposeful, yet also creative and conceptual to elicit findings that reflect the perspectives of the participants (Polit & Beck, 2017). In descriptive exploratory research, different aspects of a variety of qualitative analysis processes may be used by the researcher to fit the needs of the study. The aim of descriptive exploratory research is to describe the participants' experiences with a phenomenon and increase understanding, therefore the analysis of the data usually produces themes that are often narratively described (Colorafi & Evans, 2016; Harding & Whitehead, 2014; Willis et al., 2016).

Thematic analysis is a general qualitative strategy to data analysis, which is appropriate in descriptive exploratory studies, whereby the researcher identifies themes emerging from the data set (Harding & Whitehead, 2014; Polit & Beck, 2017; Richardson-Tench et al., 2018; Willis et al., 2016). The researcher develops an overall understanding of the whole data and searches for themes and patterns that help to describe the informants' experiences. This process requires the researcher to be familiar

with the data which is achieved by moving back and forth over the data. The researcher needs to read and re-read the data, take time to refine insights and develop themes and then re-read the data again with those themes in mind. This process continues until the themes have been honed to reflect the perspectives of the participants. Identifying the pervasive ideas from the data allows for experiences and perspectives to be described and understood (Harding & Whitehead, 2014; Polit & Beck, 2017; Richardson-Tench et al., 2018; Willis et al., 2016).

In the study presented in this thesis, the researcher listened to the audio recordings of the interviews soon after the interviews were completed. This ensured that the recording was audible and complete, but also allowed the researcher to refine their technique for future interviews (Polit & Beck, 2017; Willis et al., 2016). The data were transcribed verbatim into text to maintain its richness (Holloway & Wheeler, 2010). The text was checked for accuracy, then read and re-read to develop an overall understanding of its meaning and allow for further reflection by the researcher (Harding & Whitehead, 2014; Polit & Beck, 2017; Richardson-Tench et al., 2018; Willis et al., 2016). The researcher became familiar with the data by reading and re-reading the transcriptions searching for meaning units. The researcher took time during data analysis to reflect on emerging meaning units, to identify those that were similar and remove those that were different. Similar meaning units were clustered to form sub-themes and further reviewed to determine their fit under the sub-theme and nominate appropriate labelling. Sub-themes were then examined to group under major themes. Transcripts were shared among the research team initially for independent analysis and

then this was discussed by the research team to ensure agreement in interpretations. This form of investigator triangulation was utilised to refine the identified themes and ensure they accurately represented the experience of the participants (Polit & Beck, 2017). The final themes and linked sub-themes have been presented in Chapter 4 (Findings) using rich descriptions of the data and participant quotes to demonstrate for the reader how analytical decisions were made. Comparisons to the existing literature in Chapter 5 (Discussion), help to portray the relevance of the findings from this study.

3.6 Ethical Considerations

To ensure the rights of individuals are respected and protected consideration of potential ethical issues is a profoundly important aspect of conducting research (Polit & Beck, 2017; Richardson-Tench et al., 2018; Woods & Lakeman, 2014). Historically, concerns regarding unethical biomedical research prompted international and national efforts to define and provide advice on ethical conduct in research. Principles identified in the *Universal Declaration on Bioethics and Human Rights* (United Nations Educational Scientific and Cultural Organisation, 2005) guide Australian human research ethics committees, and those of many other countries, and reflect the bioethical principles of autonomy, beneficence, non-maleficence and justice.

The principle of autonomy recognises each individual's right to self-determination, that is their right to have their own views and make their own decisions (Staunton & Chiarella, 2020; Woods & Lakeman, 2014). Researchers demonstrate respect for autonomy by ensuring the consent

process is informed and participants have the right to refuse. The participants have the right to make an informed, voluntary choice to join the study or not (Polit & Beck, 2017; Richardson-Tench et al., 2018; Woods & Lakeman, 2014). The researcher has the responsibility to ensure that the participant is competent and fully understands the research, that information is provided in plain language and that there is no element of coercion. Respecting participant privacy and maintaining confidentiality also relates to the bioethical principle of autonomy (Polit & Beck, 2017; Richardson-Tench et al., 2018; Woods & Lakeman, 2014). The researcher must inform the participants if anyone else, such as a transcriber or co-researcher, will have access to the data at the time of consent, and of the measures that will be employed to protect participant privacy throughout the research process (Polit & Beck, 2017; Richardson-Tench et al., 2018; Woods & Lakeman, 2014). Beneficence is defined as doing good, and non-maleficence means to do no harm (Polit & Beck, 2017; Staunton & Chiarella, 2020). The purpose of research should be to benefit others and researchers must consider the potential for harm and take steps to prevent it. Harm may be physical or psychological and the potential for harm should be discussed with participants. Researchers need to be sensitive to participants and respect their personal integrity, particularly those that are vulnerable (Polit & Beck, 2017; Richardson-Tench et al., 2018; Woods & Lakeman, 2014). Justice is the right to be treated fairly (Polit & Beck, 2017; Staunton & Chiarella, 2020). In quantitative research, this can be achieved through randomising participants in a controlled trial so that each person has an equal chance of risk or benefit. In qualitative research, respect for justice includes selecting

participants based on inclusion criteria, not convenience, as well as providing clear information to participants regarding the study, what is expected of them and the researcher's role (Polit & Beck, 2017; Richardson-Tench et al., 2018; Woods & Lakeman, 2014).

Ethical approval was sought and granted for the study described in this thesis from the Curtin University Human Research Ethics Committee. The need for reciprocal ethical approval from ECU was investigated and deemed not necessary. No changes were made to the research procedures after ethics approval (Woods & Lakeman, 2014). Interested students were provided with a printed information sheet (Appendix A) and the opportunity to have their questions answered before agreeing to participate and signing a consent form (Appendix B). The information was expressed in plain language ensuring that the participant understood what they were agreeing to and what to expect (Woods & Lakeman, 2014). The researcher's position as a CF did not include any role in allocating student placements or CFs. In addition, students who had contact with the researcher in any role previously were not included in the study. These measures were taken to minimise any actual or potential power imbalance between the researcher and study participants and ensure that they were selected because they met the criteria for the study (Woods & Lakeman, 2014).

Participants were informed that involvement in the study was entirely voluntary and that they were free to withdraw at any time without negative consequences (Holloway & Wheeler, 2010; Streubert, 2011; Williams et al., 2010; Woods & Lakeman, 2014). They acknowledged that anonymity could not be guaranteed but that confidentiality would be maintained. Informants

were notified of the processes to protect their privacy and were asked not to identify the CF they were discussing, to also protect the privacy of the CF. They were made aware that the de-identified transcripts would also be viewed by the other members of the research team (Woods & Lakeman, 2014). Participants were also informed of their right to contact the researcher regarding the study. The researcher ensured that consent was given and that the participant agreed to audio recording of the interview prior to its commencement. The data was de-identified during transcription to ensure participant and CF confidentiality.

It was recognised that participants who have had negative experiences with midwifery clinical facilitation or their clinical placement may experience distress when recounting events during interviews. An adverse events protocol was put in place to manage such situations if they occurred whereby the researcher would stop the interview and recording device immediately and allow the participant some time to regain their composure. An assessment would then have been made to determine the appropriateness of continuing with the interview depending on the participant's level of distress and desire to continue with the process. If the participant reported unethical or unprofessional conduct by a CF, the researcher would have directed the student to share this information with the relevant course coordinator at their university. All participants were provided with the contact details of their university counselling services in the event they needed to seek assistance with managing feelings of discomfort after the interview. None of the ten participants expressed feelings of or exhibited behaviour indicating distress during the interviews and no interview had to be halted.

3.6.1 Data Storage

A Data Management Plan (Appendix D) was created to ensure that the data was handled appropriately and details how the study data was managed and stored. Research data will be retained for a minimum of seven years and then destroyed as per the *Western Australian University Sector Disposal Authority* (State Records Commission, 2013). As this study was for an MPhil higher degree by research project, the data was shared with the researcher's supervisors, and this was addressed in the participant consent process. Audio recordings were transferred to the Curtin central research data storage (R drive) as soon as possible, which is set up according to standard Curtin Information Technology Services security and safeguarding protocols. Interviews were de-identified during transcription. Files were only transferred to a personal password-protected computer when they were being actively worked on. When work was completed, they were transferred to the Curtin R drive and deleted from the personal computer. Files were named using a numbered title and date. Hardcopies of the participant consent forms were stored in a locked drawer in a locked office at Curtin. This data management plan protects the privacy of the participants and ensures the study presented in this thesis meets the ethical and university requirements.

3.7 Trustworthiness

It is important that researchers strive for excellence when conducting qualitative research. However, there is much debate about how the rigour of qualitative research should be determined while recognising it as different to, but as equally valuable as quantitative research (Harding & Whitehead, 2014; Polit & Beck, 2017). Determining rigour, through the assessment of reliability

and validity, is used in the positivist paradigm to evaluate the quality of the research. It has been argued that given the fundamental differences between the paradigms, rigour is not an appropriate criterion for assessing the quality of qualitative research (Guba & Lincoln, 1994; Harding & Whitehead, 2014; Lincoln & Guba, 1985; Polit & Beck, 2017). There is little consensus on what terms should be used to describe quality criteria in qualitative research but the framework by Lincoln and Guba (1985) is referred to most commonly. In this framework, trustworthiness is used to describe the rigour or integrity of a study and is assessed using the five criteria of credibility, dependability, confirmability, transferability, and authenticity (Guba & Lincoln, 1994; Harding & Whitehead, 2014; Lincoln & Guba, 1985; Polit & Beck, 2017). By describing how these quality criteria have been addressed in their work, researchers make it possible for external audiences to judge the trustworthiness, or quality, of the study (Polit & Beck, 2017; Streubert, 2011).

3.7.1 Credibility

Credibility in qualitative research is related to validity in quantitative research and it is achieved when participants and external audiences recognise lived experiences in the research akin to their own (Colorafi & Evans, 2016; Harding & Whitehead, 2014; Lincoln & Guba, 1985; Polit & Beck, 2017). It allows readers to trust that the findings represent the truth (Colorafi & Evans, 2016; Polit & Beck, 2017).

The researcher completed interviews over a period of ten months, during which data analysis was concurrently occurring. As mentioned earlier, this allowed the researcher to refine the interview technique and ensure rich,

relevant data was collected. The length of individual interviews ranged from 19 minutes to 62 minutes, with an average of 37 minutes, during which the interviewer used active listening strategies. During interviews, there was adequate time to develop rapport and allow participants to tell their stories. The audio recording and verbatim transcription ensured the participants' voices were depicted accurately. Paraphrasing and probing questions were used to confirm understanding with the participants and ensure the participant felt that the researcher accurately understood their experience (Holloway & Wheeler, 2010; Polit & Beck, 2017; Streubert, 2011). Data triangulation is the use of multiple data sources to evaluate the effect of different perspectives on the data. Person and space triangulation was utilised by interviewing students from different universities and different stages in their education (Colorafi & Evans, 2016; Polit & Beck, 2017; Streubert, 2011). This allowed the researcher to determine if the experience was impacted by these variables, further enhancing the credibility of the findings. Finally, confirming data saturation with two subsequent interviews after it was suspected, ensures that the experiences and perspectives of the midwifery students described in this thesis are a reliable representation of this population (Polit & Beck, 2017).

Investigator triangulation allows for the collaboration of researchers to reduce the impact of biased interpretations. Regular supervision meetings and supervisory reviews were used to ensure that data analysis resulted in plausible and trustworthy conclusions. This also functioned as a reflexivity strategy (Goodell et al., 2016; Polit & Beck, 2017; Willis et al., 2016). The researcher for this study was a CF and has provided a position statement in

Chapter 1 (Introduction) disclosing relevant background and influences. As the researcher is the key instrument in data collection and analysis in qualitative inquiry it is important to the credibility of the study that this is recognised and reflexivity strategies are implemented (Goodell et al., 2016; Polit & Beck, 2017; Sorsa et al., 2015). The researcher was able to identify their own perspective and suspend preconceptions through discussions with the supervisors so that the findings were a representation of the participants' views, and not that of the researcher (Polit & Beck, 2017; Sorsa et al., 2015). Peer review was also used to enhance the credibility of the inquiry presented in this thesis. As part of the higher degree by research program, the student was required to present a summary of the research at several points through the process. This provided the opportunity for reviewers to consider the various aspects of the research and decision-making processes and provide feedback for enhancing quality (Polit & Beck, 2017).

Reporting findings using rich, descriptive text and participant quotes is a hallmark aspect of qualitative research (Colorafi & Evans, 2016; Polit & Beck, 2017). This helps to develop the credibility of the inquiry by demonstrating the data analysis decision-making. In turn, allowing the external audience to have confidence in the truth of the researchers' interpretations. All interpretations have been supported by participant quotes in Chapter 4 (Findings) demonstrating credibility in the data analysis process. Additionally, in Chapter 5 (Discussion), the findings are discussed in the context of existing relevant literature. This provided the opportunity for the researcher to confirm the accuracy and explanations and assists to increase confidence in the meaning as it has been deduced (Colorafi & Evans, 2016;

Polit & Beck, 2017). The strategies described have been deliberately employed to strengthen the credibility of this research and promote its trustworthiness and integrity.

3.7.2 Dependability

Dependability is required for credibility to be achieved. It is associated with reliability, which is used in quantitative research to evaluate the degree to which the research instrument will produce repeatable results (Colorafi & Evans, 2016; Lincoln & Guba, 1985; Polit & Beck, 2017). As the researcher is the research tool in qualitative inquiry it is acknowledged that the researcher will impact the results. Therefore, dependability refers to the likelihood that another researcher would reach the same conclusions being presented (Colorafi & Evans, 2016; Lincoln & Guba, 1985; Polit & Beck, 2017). Dependability is enhanced through the use of an interview guide and the consistency of the interviewer and data analysis by the research team (Colorafi & Evans, 2016). Triangulation of data was used to help capture a more complete understanding of the phenomena and assisted in achieving dependability (Polit & Beck, 2017). Finally, document versions have been saved separately to help demonstrate the decision-making that has occurred throughout the inquiry, creating an audit trail. These strategies combine with the approaches to enhance credibility to ensure dependable results have been produced (Polit & Beck, 2017; Streubert, 2011).

3.7.3 Confirmability

To achieve confirmability the researcher must ensure that the findings portray the experiences and perspectives of the participants and not the researcher. This is accomplished when the reader can be confident that the

researcher has attempted to maintain objectivity and acknowledged their own subjectivity (Colorafi & Evans, 2016; Lincoln & Guba, 1985; Polit & Beck, 2017). Confirmability can be demonstrated by the use of participant quotes to support the researcher's interpretations of the data, investigator triangulation, peer review, comparisons to the literature and maintaining documentation that shows the progression of data analysis decisions (Colorafi & Evans, 2016; Polit & Beck, 2017; Willis et al., 2016). As the research reported here is part of an MPhil higher degree by research project, investigator triangulation and peer review were achieved with regular supervision meetings and supervisory reviews and summary presentations to university reviewers. Participant quotes have been embedded throughout the description of the findings to demonstrate the decision-making in data analysis and these results have been compared to the literature as part of the discussion. Documentation has been maintained to ensure that the decision-making process is clear. This evidence allows the reader to determine the confirmability of the inquiry reported in this thesis (Colorafi & Evans, 2016; Polit & Beck, 2017; Willis et al., 2016).

3.7.4 Transferability

Transferability is used in qualitative inquiry instead of generalisability, which is used in quantitative studies (Colorafi & Evans, 2016; Holloway & Wheeler, 2010; Lincoln & Guba, 1985). Not all qualitative research aims to accomplish generalisability and constructivist researchers aim to identify patterns and contribute to the body of knowledge (Colorafi & Evans, 2016; Streubert, 2011). Transferability, therefore, is the degree to which the interpretations of the research will have meaning in another similar setting.

This can only be decided by the reader, and it is the responsibility of the researcher to provide enough information for this to be determined. Documenting quality enhancement strategies, as has been done here, is important as this allows the reader to interpret the quality of the study, understand the phenomena and ascertain if the findings are applicable to their setting (Colorafi & Evans, 2016; Polit & Beck, 2017). In this study, the researcher has enhanced the potential user's ability to make the determination of transferability by providing rich descriptions of the setting, participants and findings, ensuring data saturation and supplying a comparison to the existing body of knowledge (Colorafi & Evans, 2016; Polit & Beck, 2017). The reader will then be able to establish if this study and its findings apply to their setting.

3.7.5 Authenticity

As a quality criterion, authenticity was added to Lincoln and Guba's framework following their own review and in response to criticism that the framework did not address the uniqueness of the constructivist paradigm (Guba & Lincoln, 1994; Polit & Beck, 2017). Authenticity refers to the feelings and emotions from the participants that the researcher is able to pass on to the reader and the recognition of multiple realities (Neergaard et al., 2009; Polit & Beck, 2017). It is demonstrated with reflexivity, prolonged engagement, audio recording and verbatim transcription, rich descriptions, and compelling writing (Neergaard et al., 2009; Polit & Beck, 2017). This thesis aims to authentically portray the experiences and perspectives of WA undergraduate midwifery students with midwifery clinical facilitation and enhance the reader's understanding of their lived experience.

3.8 Conclusion

This chapter has described the methodology used for the inquiry presented in this thesis and the rationale for decisions regarding the research design. The descriptive qualitative exploratory design was well suited to this study and enabled the experiences and perspectives of undergraduate midwifery students in WA with midwifery clinical facilitation to be described. Quality enhancement strategies have been discussed to demonstrate integrity and allow for the assessment of quality by the reader. A maximum variation sample allowed data to be collected via semi-structured interviews from the full spectrum of undergraduate midwifery students in WA and thematic analysis was used to identify themes and their linked sub-themes.

The following chapter (Chapter 4, Findings) will present the findings of this study by describing the participant demographics and the major themes, sub-themes, and related concepts. Rich description and participant quotes are used to maintain the presence of the participant in the written text and demonstrate how meaning was elicited. The findings represent the participants' experiences and provide insight into their perspectives

Chapter 4

Findings

The purpose of this study was to explore midwifery students' perceptions of the role of the CF and their experiences of clinical facilitation during midwifery clinical placements in WA. A qualitative descriptive cross-sectional approach was employed for the study utilising purposive sampling to ensure that data was captured from the two universities in WA that offered undergraduate midwifery programs and from students across several stages of the courses at a single point in time. This maximum variation sample allowed data to be collected from the full spectrum of undergraduate midwifery students in WA, ensuring person and space triangulation, and amplifying the transferability of the study. The researcher worked as a midwifery CF within WA, hence, the exclusion criterion for this study was previous contact with the researcher in their capacity as midwife or CF. Data analysis occurred simultaneously with data collection. Thematic analysis was used to identify themes and sub-themes, to extract meaning from the data and allow the students' perspective to be described.

4.1 Participant Demographics

The target population for this study was undergraduate midwifery students who had attended a professional practice experience. Purposive sampling was used. Undergraduate midwifery students were recruited as participants for the study on a voluntary basis from the university campus that they attended or clinical placement environment. To ensure students did not feel coerced they were not recruited directly by their university contact. The researcher was introduced to potential participants by their educator on

campus or their CF on clinical placement and then provided the study information. This approach was selected to reduce participants feeling obligated to participate and to ensure authentic data collection.

Data was collected by the researcher during one to one, in-person interviews. The researcher used an Interview Question Guide (Appendix C) to collect basic demographic data and facilitate the discussion. Interviews lasted approximately 37 minutes on average, with a range from 19 to 62 minutes. Data saturation was suspected after eight interviews, with two further interviews conducted to confirm data saturation.

Ten students were recruited for this study from the two available undergraduate midwifery programs, six students from Curtin's Bachelor of Science (Midwifery) and four students from ECU's Bachelor of Science (Nursing)/Bachelor of Science (Midwifery). All the participants were female, six were mature age students, and had studied and/or been employed before commencing their midwifery course and four students commenced their midwifery course as high school graduates. The mean age of the participants was 25 years old, and the median age was 24.5 years old, with a range of 19 – 35 years old. Participants were from a variety of stages of their course and had differing opportunities for clinical placements. The duration and quantity of clinical placements are arranged for students to meet the requirement of clinical hours for their course and competency for registration. All the participants had completed at least one clinical placement in midwifery aligned to the study's focus. Students in both courses did not have a midwifery CF in their first year, therefore all participants were in at least the second year of their course. The midwifery course offered at Curtin was a

three-year course, while at ECU it was four years, as it is a double degree. For the purpose of comparison, the researcher calculated students' progress across their course as a percentage of their course completed value. Participants ranged from having completed 37% of their course to 83%. The demographic data of the participants of this study is displayed in Table 2.

Table 2

Patient Demographics

Participant	Age	University	Year	Semester	% Course completed	Midwifery Placements
1	33	Curtin	3	6	83	8
2	35	Curtin	3	6	83	8+
3	19	Curtin	2	4	50	4/5
4	26	ECU	2	4	37	2
5	19	Curtin	2	4	50	4
6	26	ECU	3	6	62	4
7	23	Curtin	2	5	66	7
8	29	ECU	2	5	40	4
9	21	ECU	4	7	75	6/7
10	19	Curtin	2	4	50	3

4.2 Findings

The major themes that emerged were the *role of midwifery clinical facilitation,* which encompasses what students understood about the role and what they thought affected the role, and *engaging with midwifery clinical facilitation,* which describes students' experiences and engagement with the process. The major themes with their linked sub-themes are indicated in Table 3 (below).

Table 3

Major Themes and Related Sub-themes

Major Themes	Linked sub-theme
1. The role of midwifery clinical facilitation	a) Understanding of midwifery clinical facilitation b) Factors affecting midwifery clinical facilitation
2. Engaging with midwifery clinical facilitation	a) Supportive midwifery clinical facilitation b) Unsupportive midwifery clinical facilitation c) Suggestions for improvement

The following sections provide a more detailed description of each sub-theme and its linked concepts which are captured in Tables 4 and 5 (below). Participant quotes have been provided to support interpretations and assist with confirmability. Participant quotes have not been amended for grammar but italicised in quotation marks and left verbatim as spoken by the participant to maintain their presence within the written text.

Table 4

Sub-themes and Related Concepts for Theme 1

Theme 1 The role of midwifery clinical facilitation	
Sub-themes	Concepts
a) Understanding of midwifery clinical facilitation	Value in the role Integration of theory to practice Role distinction
b) Factors affecting midwifery clinical facilitation	Role operationalisation Models of employment Qualities of the midwifery CF

Table 5

Sub-themes and Related Concepts for Theme 2

Theme 2 Engaging with midwifery clinical facilitation	
Sub-themes	Concepts
a) Supportive midwifery clinical facilitation	Knowledge of clinical site Consolidated clinical time Constructive feedback Portfolio feedback Clinical continuity Debrief Student advocate Pastoral care
b) Unsupportive midwifery clinical facilitation	Unbalanced role operationalisation No presence
c) Suggestions for improvement	Unify approach to clinical facilitation Balance role operationalisation Create a plan with the student Mechanisms for anonymous feedback Regular communication/contact Time

4.2.1 The Role of Midwifery Clinical Facilitation

The midwifery students interviewed were resolute that the role of midwifery clinical facilitation was to support students through their clinical experiences. They identified the role of midwifery clinical facilitation as distinct from other professional influences, valuable and essential for the integration of theory with practice. The participants acknowledged that midwifery clinical facilitation was not delivered uniformly but that flexibility was needed in how the role was operationalisation for it to be perceived as

supportive. The model of employment and the individual qualities of the midwifery CF also affected midwifery clinical facilitation. The sub-themes, *understanding of midwifery clinical facilitation* and *factors affecting midwifery clinical facilitation*, which have emerged from the data will be explained further below.

4.2.1.1 Understanding of Midwifery Clinical Facilitation. The participants presented a clear understanding of midwifery clinical facilitation. They unanimously recognised the value of the role and the unique benefits provided by midwifery clinical facilitation. Overwhelmingly, participants appreciated the specific role of the midwifery CF, providing support not found elsewhere and bridging the gap between university education and clinical experiences. The concepts of value in the role, integration of theory with practice and role distinction were identified in this sub-theme.

4.2.1.1.1 Value in the Role. All the students interviewed highly valued the role of the midwifery CF. One participant stated, "*It helps with the transition into hospital placement I think overall it is really valuable to the students to have a clinical facilitator*" (P3). It was agreed by all participants, that having midwifery clinical facilitation whilst on clinical placement enhanced student learning and development and provided emotional and practical support. Participant 6 reflected that "*clinical facilitation helps support you through that placement … I definitely think it's better having it than not. I think it helps, and prac would be a lot harder without facilitation*". Participants felt that the role of the CF provided support and guidance. They indicated that they were not able to find a similar role with its support elsewhere and emphasised that they could not do without it.

> "*I think the facilitators play a very underrated but extremely important role in making people into midwives, turning students into midwives … And a facilitator is the only person in the hospital who you know has your back … There's lots of midwives around who you can go to … But you know your facilitator will back you up. And you can't do it without that. You couldn't be a student midwife without that.*" (P2)

Participant 7 further confirmed the value of midwifery clinical facilitation, indicating that *"when you have a really supportive facilitator that makes all of the difference"*. The students valued the role of midwifery clinical facilitation. They found it beneficial to their learning and development as a midwife, but also supportive personally. Participants described midwifery clinical facilitation as irreplaceable.

4.2.1.1.2 Integration of Theory with Practice. Participants broadly understood midwifery clinical facilitation to assist in the integration of theory with practice.

> "*I think a clinical facilitator is there to kind of help guide you … linking the theory to that practical experience, because when you are doing the practical work … you're so focused on getting that right that you're not actually thinking of how this all links until after".* (P10)

They identified that this role needed to change with the needs of the student, "she was always checking on my work weekly, and guiding me on where I should be, and it has prepared me for my reflections, for applying for jobs" (P7). Students recognised that sometimes practice in clinical areas did not appear to match what was taught in the classroom and that midwifery clinical facilitation assisted them to bridge the gap between what was taught and what was experienced or observed. One student reflected, "You'd learn one way at uni and then you go out and practice and everyone is using different equipment" (P2). Another student acknowledged that, "uni very much teaches us the way it should be, and then you go on placement and it's not

… that real contrast between what midwifery should be, and what it often is" (P6). Midwifery clinical facilitation assisted students to understand and reconcile these apparent differences, helping them make sense of clinical placement and events that take place, as this student summarised, "they're there to help understand sometimes why things are different in practice" (P6).

The integration of theory with practice was often achieved through debriefing and discussion. Participants found that while students frequently discussed and debriefed with each other, the process was enhanced when a midwifery CF with understanding and experience of the clinical environment was involved. This participant reflected, *"As a group of students you do that* [debrief] *a lot with each other anyway, but it's good also having that facilitator who knows the other side"* (P6). The students valued their group of fellow students for understanding their unique situation and providing personal support but recognised that professional debriefing was more effective when led by the midwifery CF.

Midwifery clinical facilitation assisted students to bring everything they learn together in a meaningful way. This allowed students to, not only develop their theoretical knowledge and clinical skills, but also facilitated clinical reasoning, professional communication, and leadership skills. The integration of theory with practice allowed students to move from actively participating in care to planning and leading the care.

4.2.1.1.3 Role Distinction. Participants identified that the role of the midwifery CF was unique from other influences in their development as a midwife. They often reported that the clinical placement sites did not know what was expected of the student midwives or what the universities expected

from the students. Students felt that the CF created this link, "*They are our only constant link to the University when we are on placement*" (P1). Another midwifery student expanded on the distinctiveness of the role:

> "*It's good to have someone who knows about the uni and all the uni needs … I feel like they're like* [the university's] *people who are helping us through the* [university] *side of it, … what we should be doing, what we should be aiming for.*" (P5)

Furthermore, it was identified that the role was specific to the clinical area and therefore not necessarily fulfilled by the university lecturer. Midwifery clinical facilitation was named as a separate role providing support in the clinical area, as this student describes:

> "*It is quite difficult to tell your tutor because she is mainly focused on your university work. So, having a clinical facilitator for your clinical work is nice. And I felt really supported in that way because I could talk and debrief with her.*" (P3)

Participants recognised the need for the specific role of the midwifery CF, "*the support in the classroom needs to extend to that environment* [the professional practice setting] *as well and that is where the clinical facilitator comes in*" (P2). The students appreciated a dedicated person in the clinical placement environment as their link to the university.

The midwifery students valued having a dedicated presence in the professional practice environment while on midwifery clinical practice rotations, *"she's there with you as a student, her job is to support you as a student"* (P6). They felt that the clinical demands on midwives made it difficult, sometimes impossible, for preceptor midwives to provide the time and opportunities that were needed for learning, *"sometimes the preceptor is a just bit busy and don't have the time to do things slowly"* (P4). The students recognised that the primary purpose for midwives was providing

care for women and that educating students would always be secondary to that. They felt that the primary purpose for the midwifery CF was students, and this made them more comfortable learning with them:

> "*They help link all that together, as well as provide opportunities for you to do things, because as I said some preceptors, they don't really allow students to do much, or they don't really want to teach or don't want to let you take up opportunities. So, I think facilitators are there to help with that and to help make sure you do get as much opportunity to do things as you possibly can.*" (P10)

Midwifery students distinguished the role of the midwifery CF from the role of the preceptor midwife. The participants acknowledged feelings of concern discussing events or clinical practices with preceptor midwives who they felt may not have up to date evidence or due to a perceived lack of objectivity.

> "*If anything's come up in the area, it's kind of hard to talk to the midwives in the hospital about it, cos they were there too, so it's nicer having a facilitator to talk to them about it.*" (P5)

Another participant highlighted this distinct aspect of the role of the midwifery CF being independent and objective, *"you don't know whether you can, I guess trust, the preceptors that are there because they all have such different opinions"* (P10). The students revealed that it was important to them to have a credible and neutral role model to discuss and debrief clinical events with.

Overall participants described the role of the midwifery CF as separate and distinct from their university lecturers/tutors and their preceptor or mentor midwives. They felt that this role created a much-needed bridge between the university and the clinical placement site and provided unique support that enhanced their learning experiences.

4.2.1.2 Factors Affecting Midwifery Clinical Facilitation. Midwifery students reported that midwifery clinical facilitation was enacted in varying

ways. Role operationalisation, the model of employment and the qualities of the individual midwifery CF affect the student perception and experience of midwifery clinical facilitation. These concepts are described in more detail below to demonstrate their effect on perceived supportive midwifery clinical facilitation.

4.2.1.2.1 Role Operationalisation. Participants observed that midwifery CFs approached the role in a variety of ways. They reported that flexible role operationalisation allowed for facilitation that was tailored to the individual student's needs and the placement environment. Flexibility of role operationalisation was demonstrated by the availability, the individualistic approach to support and student-centred focus of the midwifery CF.

Students identified that it was important for midwifery CFs to be adaptable in their availability. They described the contact schedule flexibility that is needed, *"there are times when they do come in on the weekends or will organise their shifts so they're there into the night so they can work with students who are on night shift that week"* (P6). Being flexible allowed the midwifery CF to meet the differing needs of students, *"I don't think I necessarily need to see them every day. Text message is fine … help with paperwork, and maybe a check-in once a week in-person"* (P9). The participants appreciated that the midwifery CF went out of their way to be available to their students both face to face and from a distance. Students felt reassured when midwifery clinical facilitation was accessible, *"I can message her if something, about a problem … if we needed help, she would come in and work with us"* (P4). This flexible approach allowed the midwifery

CF to meet the individual needs of students and provide support as needed in the clinical placement environment.

Individualisation of the role allowed the midwifery CF to meet the needs of all students. The participants reported that at each stage of the course the midwifery clinical facilitation they needed was different, *“going from that supportive guiding role to somebody who’s pushed me to stand on my own two feet”* (P1). They also recognised that different students needed different things. Providing a personalised approach to midwifery clinical facilitation allowed students to receive the support they needed, in particular, *“there are some students who really, I think, need a lot more of that support. I think inevitably, a lot of the facilitators actually end up spending more time with the students than what they’re allotted”* (P4). Adaptability and flexibility in the way the role was operationalised allowed the needs of students to be met, even where more support was required than expected, at the varying stages of their education.

The midwifery students valued student-centred midwifery clinical facilitation. They found it beneficial to be consulted on how the midwifery clinical facilitation could support them best, how the role could be operationalised to promote their learning and development.

> “*She gave you the choice, it was student-directed, which was great. It was very flexible in how the student learned, which I thought was great because one size doesn't fit all and you have to be flexible, so that was really good.*” (P7)

This flexible approach encouraged the student to reflect on their own learning needs and style and to be an active participant in their education.

> “*She really made us choose how we want to be taught. ‘What’s your style, do you want me to come work with you, do you want me to just look at your [portfolio], what is it you want me to do?’*” (P10)

Participants perceived student-centred midwifery clinical facilitation as part of the flexibility needed to provide support to them as students.

Flexible role operationalisation was identified as an important aspect of midwifery clinical facilitation. Participants found it allowed for personalised midwifery clinical facilitation, which addressed individual learning needs and provided the required support.

4.2.1.2.2 Models of Employment. The model used to employ midwifery CFs influenced the participants' experience of midwifery clinical facilitation. Midwifery students found that there were advantages and disadvantages to both models of employment, hospital or university-based. Participant 3 (below) described their experience of where the same midwifery CF provided hospital-based facilitation in the first instance and then again, at another placement site where the facilitator was in the university-based model. The participant found it beneficial to their learning experience when the midwifery CF was hospital-based, stating *"I felt like she was more involved, if she was employed by the hospital"* (P3). The student then goes on to describe what it is like when that same facilitator is not employed by the hospital.

> *"I felt that she couldn't, I guess, go into the room with me. She was more, in between. If I had a break, she would talk to me. So, I found that not as useful compared to if she was employed [by the hospital] and known by the staff and was able to help with hands-on learning."* (P3)

The midwifery CF could work alongside the student and provide clinical care as they knew the staff and the site. This was echoed by other respondents who described the knowledge of the staff and site as advantageous when the midwifery CF was hospital-based, as this allowed them to work with students

clinically in all areas. "*For me I like it when the facilitators actually work with us in whatever place we are"* (P10). Participants felt that midwifery CFs that were employed by the hospital were able to take advantage of their knowledge and comfort with the clinical placement site when providing midwifery clinical facilitation.

The disadvantages students noted with the hospital-based employment model of midwifery clinical facilitation involved lack of recourse for perceived unsupportive midwifery clinical facilitation. Participant 8 described a negative experience with a hospital-based midwifery CF that demonstrated bias to one particular university programme over the others. The midwifery CF was, *"very negative of our uni, not keen on the* [university programme]*, very disparaging of the whole* [university programme] *and particularly uni and any students that she's ever had"* (P8). Other participants did not voice similar experiences; however, students did express concern regarding the reporting of perceived unsupportive midwifery clinical facilitation in the hospital-based model. They generally felt limited in providing feedback regarding perceived negative experiences because there was no anonymous feedback process and their university had little power over improving the situation, *"I did make a complaint to the university but there was nothing I could do because they were a hospital-employed facilitator, not a university-employed facilitator"* (P7). The midwifery students also felt that they were unable to provide feedback regarding hospital-based midwifery CFs because it may affect their own clinical placement or that of students that come after them. The student experience was affected by the connection of the hospital-based midwifery CF to the clinical placement site and the perceived lack of university control.

All the participants perceived the university-based model of midwifery clinical facilitation to be more supportive to them in their student role. The students identified that while they enjoyed the benefits when the midwifery CF was known to the clinical placement site, this was also possible to achieve with a university-based facilitator and it came with the further advantage of independent and trusted support. Participants felt that it was important that the midwifery CF was a representative of the university. When discussing experiences with a CF in the hospital-based model, this participant stated:

> "*Definitely represented the hospital more than the uni … she very much represents that hospital and that hospital's interests … I don't think they should be employed by the hospital; they should be independent of that through the uni, cos you're supposed to be representing the uni.*" (P8)

Having a representative of the university with them on clinical placement was seen to be important. Students recognised the benefit of having access to an independent resource person with a broad range of experiences.

> "*She works with the uni, but she goes there* [a hospital] *and to a number of the other hospitals and has worked at numerous hospitals in Perth. And hearing that she had experience from all the hospitals, and all the birth centres and that was really nice.*" (P8)

The idea of an independent, trusted role model was also related to the model of employment of midwifery CF. It was identified that a university-based midwifery CF was trusted to be unbiased.

> "*I like having a facilitator who doesn't work at the hospital because sometimes you feel a little bit awkward when you want to say … 'I don't agree with what your hospital is doing,' it's easier to bounce that off someone who doesn't* [work there] *or doesn't even work with those midwives … I definitely prefer that in some ways.*" (P6)

Some participants described university-based facilitators to be more present and engaged, and demonstrated more enthusiasm for education, *"the three*

facilitators I've had that were employed by the university went above and beyond and they just stood out" (P7). They found that hospital-based midwifery CFs tended to be based in an office which had the effect of removing them from the students' experiences, *"the two that have been employed by the hospital are obviously office-based, and don't come into the wards at all, and the two that were uni-bound or whatever saw us a lot"* (P8). University-based midwifery clinical facilitation was described as supportive because the students viewed it as a link to their university and the independence of the midwifery CF from the clinical site or healthcare facility was valued.

The main concern the interviews revealed regarding the university-based employment model of midwifery clinical facilitation was the potential for limited opportunities to work clinically with their midwifery CF. When the university-based midwifery CF was not concurrently employed by the placement site, it sometimes affected what clinical care they could be involved with or which care areas they could participate in. *"I didn't actually get to work with her in a clinical capacity only because … they're not allowing clinical facilitators to work with students on birth suite or in assessment unit"* (P1). Not all students valued or had experienced a midwifery CF that worked with them clinically; therefore, they found this possibility for limited direct clinical supervision from the midwifery CF less of an issue.

Participants reported mixed experiences with the university-based and hospital-based models of employment for midwifery clinical facilitation and many of them had experienced advantages and disadvantages of both models. The majority of participants prioritised the importance of an

independent university representative and therefore rated their experiences with university-based midwifery clinical facilitation as more supportive.

4.2.1.2.3 Qualities of the Midwifery Clinical Facilitator. The midwifery students consistently described the qualities and skills needed for midwifery clinical facilitation as, "*kind of like being a midwife*" (P2) or "*just like our little mum*" (P4). Participants saw the midwifery CF not only as their teacher, but also, a maternal figure, their advocate, and their support person. Figure 1 provides a visualisation of the words students used when discussing the qualities and skills that they valued in a midwifery CF. They likened the qualities of the midwifery CF to those valued in midwives caring for women.

Figure 1
Qualities and Skills of the Midwifery Clinical Facilitator

Demeanour was consistently identified as an important feature of the midwifery CF. Students appreciated, *"Someone that is open and relaxed"* (P1), *"they need to be nice and not intimidating"* (P4) and *"happy … approachable and relatable"* (P8). Participants valued good interpersonal

and communication skills and identified that the midwifery CF should be, *"interested … they're open, they have good body language, they ask open-ended questions, they encourage discussion"* (P7) and willing to give constructive feedback, *"someone that is supportive and can give you feedback that is constructive or that you can use to improve"* (P3). Patience was also considered a very important personality trait for the midwifery CF. Students revealed that the pressure of time affected their learning, *"you don't feel like you're rushed … I think they definitely need to make you feel like they're putting time for you and that they care about your learning"* (P10). The manner of the CF influenced the rapport between student and CF and subsequent experience of midwifery clinical facilitation.

"Kindness more than anything" (P1), was considered by participants to be, an extremely important personality trait for the midwifery CF. Students sought reassurance and comfort from the midwifery CF because they often felt stressed, even scared, and challenged in the clinical placement environment.

> "*She would give me some reassurance. And I felt that was really comforting because it is hard to, when you are on placement … someone that you can confide to, debrief about scenarios and then, they can give you their opinion that's, sort of, constructive as well.*" (P3)

This compassionate nature allowed the midwifery students to feel supported and comfortable to debrief their experiences.

Enthusiasm and passion were identified as noteworthy qualities of the midwifery CF. These qualities affect the student experience of both the midwifery clinical facilitation and the clinical placement.

> "*They're passionate about midwifery, they're passionate about education … they have good rapport with the staff of the hospitals …*

> *they know the obstetricians, they know the physios, they've got good connections with the multi-disciplinary environment, they're keen to get their hands-on with the students, they're keen to make the plan with the coordinators, they're keen to make things happen, they advocate for the students, and they really speak up for the students.*" (P7)

Participants also described the significance of the midwifery CF being experienced and knowledgeable, *"clinical knowledge has to be exceptional because there are so many questions all the time"* (P2). Students wanted the midwifery CF to be a role model, in particular, someone who demonstrates the continual nature of professional learning.

> "*A clinical facilitator that lets you* [see] *their weaknesses as well, so you can learn from them … Seeing the other clinical facilitators that take learning opportunities as well … 'I haven't done this in ages. I haven't done this in six months myself, let's go look at the guidelines.' That's really good.*" (P1)

These qualities allowed students to trust the midwifery CF to guide them in their clinical experiences and support them in their learning, development, and reflection.

The students respected their midwifery CFs as role models, "*I admire facilitators*" (P1), and often saw them as the epitome of midwives, "*Oh my God. They just know so much*" (P2). They likened the relationship between the student and the midwifery CF as being the same as the relationship between the woman and the midwife. Therefore, the qualities of the midwifery CF, as described by the midwifery students, are similar to the qualities that the students identified as estimable in midwives. Participants valued and felt supported by midwifery CFs that they perceived to have the qualities of a good midwife.

4.2.2 Engaging with Midwifery Clinical Facilitation

The second major theme revealed from the data was *engaging with midwifery clinical facilitation*. The midwifery students described their experiences with midwifery clinical facilitation and what they believed affected their engagement with this process. The sub-themes, *supportive midwifery clinical facilitation*, *unsupportive midwifery clinical facilitation* and *recommendations for improving midwifery clinical facilitation* were identified.

4.2.2.1 Supportive Midwifery Clinical Facilitation. Supportive midwifery clinical facilitation was perceived by the participants to be the aspects of the role that enhanced their learning, maximised their clinical placement experiences and assisted their development as midwives. The midwifery students demonstrated a clear understanding of what they perceived to be supportive midwifery clinical facilitation. From this sub-theme emerged the concepts of knowledge of the clinical site, consolidated clinical time, constructive feedback, portfolio feedback, clinical continuity, debrief, student advocate and pastoral care, which will be discussed further below.

4.2.2.1.1 Knowledge of the Clinical Site. Participants identified that knowledge of the clinical placement site enhanced the student perception of midwifery clinical facilitation. They felt that a pre-existing relationship between the clinical placement site staff and the midwifery CF allowed for supportive facilitation, "*it's nice to know that everyone knows what everyone's role is and everyone's well-orientated to each other ... that was really helpful*" (P7). Students described that it was beneficial to their experience when the midwifery CF was familiar with the clinical placement environment, staff, culture, and policies. They felt having access to some inside information

about the clinical placement site allowed both the student and the midwifery CF to be more prepared for and comfortable with the placement. Being known to the clinical placement site also reportedly resulted in the increased ability of the midwifery CF to work directly with the student in clinical areas as it was often associated with the hospital-based model of employment.

> "*She knew all the staff, knew what was happening, all the procedures and things like that, … she got to work with me in* [the Assessment Unit] *and in the post-natal ward as well and a bit on labour and birth too.*" (P10)

Knowledge of the clinical site was linked to increased satisfaction with midwifery clinical facilitation by students. Students felt better supported because the midwifery CF was comfortable in the environment, and it often resulted in increased clinical time with their midwifery CF.

4.2.2.1.2 Consolidated Clinical Time. At some clinical placement sites, midwifery CFs were able to work directly with students in the clinical areas. The participants reported a variety of situations where they worked directly with their midwifery CF, which ranged from completing a skill to completing a whole shift, with the student and CF being the primary carers. Those interviewed who had experienced this type of midwifery clinical facilitation found it helpful, "*I did find it good having the facilitator working clinically with me in birth suite… I definitely felt there was a benefit having her work clinically with us*" (P6). This sentiment was repeated, "*I just think most people do benefit from a good CF who does help you with your learning when you are actually in a clinical setting doing clinical things*" (P10). Consolidated clinical time with the midwifery CF was perceived by students as supportive.

Participants identified that consolidated clinical time with the midwifery CF promoted a less pressured environment for them as students to develop their skills, knowledge and understanding. They acknowledged that this allowed them the time they needed as a student to complete tasks and learn in the clinical environment.

> "*We could take our time. When it needed to be done, we prioritise care, but it was an opportunity for me to ask more questions. And ask questions in a safe way, not feeling like you have someone looking at you.*" (P2)

The students recognised that because the midwifery CF was not included in the staffing numbers and thereby, was not allocated a workload, this allowed them to participate in clinical care at a rate appropriate to the student. This separated the role from the midwifery preceptor, who was described by participants as primarily present for the woman and her family*, "sometimes the preceptor is just a bit busy and don't have the time to do things slowly, so having someone who can do it slowly and talk along the way, it would be good"* (P4). The dedicated presence of the midwifery CF was perceived by students to maximise their learning experiences, "*we got to go through the whole thing step-by-step and we got to do it slowly while the midwife did everything else, so that was good"* (P5). Students felt that midwifery CFs were there specifically to teach them and had the time to allow an unhurried learning environment. This was perceived by participants as supportive midwifery clinical facilitation.

The importance of role modelling when consolidated clinical time is included in midwifery clinical facilitation was also identified in the data. Consolidated clinical time with a midwifery CF allowed students to

experience and participate in what they perceived to be exemplary care in the clinical environment.

> "*It's good cos they'll tell you exactly what you should be doing, and all the little things the midwives have kind of been slack with. Especially when it comes to when we're getting near skills assessment time, they'll be like, 'this is the correct way to do it'.*" (P5)

The participants enjoyed the opportunity to observe how the midwifery CF provided care and approached challenges and felt this enhanced their learning and development as a midwife. Midwifery CFs also identified and attended to student needs in relation to the university requirements and assessments.

The students appreciated the opportunity to have consolidated, student-focussed clinical time with the midwifery CF. They recognised that midwifery CFs had an investment in the professional growth and development of the student and therefore the time spent together was perceived as quality time. Students described the benefits of having the time and atmosphere to learn and a trusted role model to learn from. Consolidated clinical time with a student-focussed approach was perceived as supportive midwifery clinical facilitation.

4.2.2.1.3 Constructive Feedback. The midwifery students viewed constructive feedback from midwifery CFs as supportive. They identified that effective feedback promoted learning and development, *"she does push you and question you, but I think that really helped the learning"* (P10). The participants reflected that their midwifery preceptors were less likely to provide constructive comments and they particularly appreciated feedback from the midwifery CF following clinical experiences together, *"you got feedback on it after which was good as well… They're more willing to say*

what we did wrong. Midwives would just be, 'oh that was good'. It's good cos we've learnt from it" (P5). Participants trusted the feedback from the midwifery CF more than from other midwives, they felt it would be a truer reflection of their performance. The students recognised that constructive feedback was essential to their development as a midwife and perceived it as a supportive aspect of midwifery clinical facilitation.

4.2.2.1.4 Portfolio Feedback. All the participants identified the student portfolio as an important element of the midwifery course. They found portfolio feedback to be a valuable component of midwifery clinical facilitation, "*It's good when they go through* [the portfolio] *and put comments in through the semester as well, so we can see as we go*" (P5). This notion was repeated, "*Going through my paperwork, which is pretty helpful, being involved in my portfolio*" (P2). The students recognised that midwifery CFs could support learning and development by reviewing the portfolio, as this is a way of reviewing the care the student is providing and giving feedback.

> "*The facilitators who take that extra time to question why you've written this, and that, 'you need to put in this because', and 'evidence says this' and 'you shouldn't be writing this' and 'you should be saying this instead', and just questioning your management and your documentation helps the learning process.*" (P7)

Participants also felt that as the portfolio is a university-specific requirement the midwifery CF was the appropriate person to provide feedback, *"the uni paperwork, and what they want from reflections and portfolio, and having that understanding of the uni requirements is beneficial as well"* (P6). The students appreciated the formative feedback throughout the semester to ensure they were progressing as expected, *"we don't really know if we are doing it right or not until we get to the end of semester and we get our*

marks." (P10). Contemporaneous, constructive portfolio feedback was associated with supportive midwifery clinical facilitation by the participants.

4.2.2.1.5 Clinical Continuity. The midwifery students identified that continuity of midwifery CF was instrumental in supportive midwifery clinical facilitation. Participants felt comforted having a known midwifery CF, "*I had one clinical facilitator for a few different hospitals. So, she was sort of like a familiar face … which was reassuring and nice … I think that's what makes it less scary*" (P3). Feeling less afraid allowed students to engage more fully in the educational opportunities presented through the clinical placements. They described a sense of relief when they had the support of a known midwifery CF who was familiar with their skills and needs as a student.

> "*Just being with a new person, new midwife every day, and having to explain where I'm at and what I can do, what I'd like to do, it's just a bit tiring. So, I feel like I missed out on opportunities where an emergency came up, and I was more than capable of doing it, but I wasn't confident, because I felt like I had to explain where I was every day.*" (P7)

Student midwives experienced reassurance when paired with a known midwifery CF. Continuity of midwifery CF allowed students to feel more at ease in the clinical placement environment and make the most of the learning opportunities.

Participants appreciated that midwifery clinical facilitation could be more individualised with continuity of midwifery CF. The students believed that clinical continuity with a midwifery CF placed the CF in the best position to give feedback and assist with developing goals.

> "*I think that the facilitator knows me a bit better* [than the midwife]*. They know my strengths and weaknesses. They might know something that I have set as an objective that my midwife in the room might not be aware of.*" (P2)

They described that an existing relationship with the midwifery CF allowed for recognition of progression and development as a student, *“the one that I had in semester three, I had her again semester five. So, she could really see the difference in me”* (P2).

Student midwives also recognised that it took time to develop a productive relationship with a midwifery CF. They felt that each time they had to start with a new midwifery CF the process of developing the relationship potentially led to reduced learning time in the clinical placement setting. Continuity of midwifery CF allowed for the student and the CF to pick up their relationship where they left off and continue with student-focussed professional growth and development.

> “*I think it is good if we have the same facilitators over and over again. Because I do find that you learn more the second time with a facilitator than I do the first time. Because the first time we are kind of getting to know each other and then you’ve picked up all the skills that they’ve taught you and then you go on and you progress from there.*” (P1)

Students valued a pre-existing and ongoing relationship with the midwifery CF, and they perceived that continuity of midwifery CF allowed for sustained development of skills and recognition of progression. Clinical continuity provided students with reassurance and a sense of an ongoing relationship that they perceived as being supportive and beneficial to their overall development as a midwife.

4.2.2.1.6 Opportunity to Debrief. All the participants valued debriefing as an essential part of supportive midwifery clinical facilitation to assist them to process events and learn from experiences. They reported that they found being a midwifery student challenging and that there was little opportunity for debriefing within their courses.

> "*After I spoke to her I felt so much better … there's no other space to debrief in this course. Except with your friends, if you are lucky enough to have a good set of friends at uni, then you can … If you don't have someone who has that knowledge who can reassure you that the right thing happened, you ruminate on it for weeks. … You need to have somebody you can explain what's happened because it's scary. There's a lot of scary stuff happens, and you don't understand it.*" (P1)

The students revealed that they often debriefed with each other however, they were aware that this usually was not enough, *"I didn't have anyone to like, ask, apart from other students, who were all just as blind as me really"* (P2). It was recognised that debriefing with the midwifery CF allowed students to discuss situations that they have experienced with a knowledgeable advisor and develop their understanding of what happened and why.

> "*Sitting and debriefing with a facilitator, you can kind of reflect on it more … talking through a particular situation whether it's good or bad, and particularly in the early stages, you have no idea why some things have happened and it can help if someone kind of explains … it was nice to have that other person who, not always agrees with you, but you can get a second opinion.*" (P8)

Participants found debriefing with the midwifery CF provided them with clarity and reassurance, it provided *"… a different perspective in that moment when it is all fresh, rather than me stewing on it"* (P2). They appreciated debriefing as it assisted them to process their experiences and move forward, *"so I didn't feel that it was something that was at the back of my head. I could talk about it, so that was nice"* (P3). It was agreed that there was a great need for debriefing for midwifery students, they considered it a vital aspect of the role of the midwifery CF. Participants perceived that supportive midwifery clinical facilitation included time to debrief.

4.2.2.1.7 Student Advocate. Students identified that supportive midwifery clinical facilitation included the role of student advocate. The participants all reported improved learning opportunities and experiences when they had a midwifery CF who understood the needs of the student and spoke up for them.

> "*You need someone there to vouch for you basically … Because it is difficult to put yourself forward … If she* [the CF] *hadn't been there, I don't think they would have let me, because they didn't know me. It was my first ever placement there. It was important that she was able to say, 'Yeah, yeah, she's good'.*" (P1)

They established that it was important for the midwifery CF to be able to reassure clinical placement staff of the student's abilities, ensure that staff had appropriate expectations of the student role and that students were being included in care at the appropriate level. At its most basic level the participants perceived the student advocacy element of midwifery clinical facilitation to be all about making the most of their clinical placement, *"If there's something, a skill that we need to do or want to do, they can help find the opportunities to do it"* (P4). However, it was also acknowledged that students often felt overlooked in the clinical placement setting and supportive midwifery clinical facilitation allowed them to feel seen, *"they should help you have a voice as well because students are not really regarded as much, in clinical settings"* (P10). Participants identified that student advocacy enhanced their opportunities for learning while on placement and therefore they perceive it to be essential to supportive midwifery clinical facilitation.

4.2.2.1.8 Pastoral Care. Midwifery students also expressed appreciating the less clinical aspects of the role of midwifery clinical facilitation. Participant 1 highlighted the isolating nature of undertaking a

midwifery course through the following quote, *"This course is isolating. It isolates you from your family and your friends because, you can't take a day off."* (P1). They reported that as student midwives they require and benefit from midwifery clinical facilitation that is holistic and considerate of them as individuals. Midwifery CFs who provided pastoral care, emotional, spiritual and social care, were seen to be supportive, "*Just be that person that we can go to if we need, if we have a problem or need some help with something"* (P4). Participants generally found their courses and the professional practice environment to be stressful and they valued having a support person that understood their situation.

> "*She called me a week before just to see how I was travelling, if I needed anything, if I wanted to talk about anything, how I was feeling about the placement coming up … she just helped me in building my confidence.*" (P2)

Empathy for the student situation, understanding that their lives are affected by more than just midwifery, but also having an appreciation of the effect that midwifery has on their lives, allowed students to feel supported.

> "*So definitely well-rounded, definitely taking in the emotional needs of the students, cos it does get quite stressful. It's not just what do you need to achieve, it's how are you feeling, and how can we get you to a better place by the end of semester, and how can we cope better.*" (P7)

The students described the pastoral care from midwifery CFs as guidance and nurturing to support them to achieve their goal of becoming a midwife, while recognising them as an individual. Participants valued pastoral care as an essential part of supportive midwifery clinical facilitation.

4.2.2.2 Unsupportive Midwifery Clinical Facilitation. Most of the midwifery students had experienced unsupportive midwifery clinical facilitation, at some stage. Their responses within this sub-theme were

broken down into two concepts: unbalanced role operationalisation and no presence.

4.2.2.2.1 Unbalanced Role Operationalisation. It has been identified that midwifery CFs often operationalised their role differently from one another. Participants felt that this made it difficult for them as students to have a clear understanding of what the role was and what they should expect from their relationship with the midwifery CF, "*what a clinical facilitator wants may be different from another clinical facilitator. It is difficult in that sense*" (P3). The interviews also revealed that the participants perceived that different midwifery CFs had different expectations of them, "*the expectations are different which is sometimes a bit tricky but … on the first day you come in and have to like, sort of try and work out what they are like*" (P4). While this potential for initial disharmony was identified as an inconvenience, participants indicated that if the operationalisation of the role did not fit with their expectations this could lead to midwifery clinical facilitation that was perceived as unsupportive.

Participants reported that ideally there needed to be a balance between consolidated clinical time, debriefing, pastoral care and portfolio reviews, and that unsupportive midwifery clinical facilitation resulted from an unbalanced approach or an approach that did not meet the student's needs. Many of the students had experienced clinical facilitation that involved no consolidated clinical time, *"but you didn't see me. I didn't work with you. I didn't do a thing with you"* (P2). This experience made the participants concerned about the quality of feedback that the midwifery CF could provide regarding their

practice. Experiences that lacked consolidated clinical time, were often reportedly associated with excessive discussion time.

> "*It would have been better if she did more hands-on with me rather than just talking and asking how I am doing … because I feel like some* [CFs] *just want to talk, then that's it, and it would be better if it was mixed.*" (P3)

Midwifery students felt that they missed out on important learning opportunities because they were obliged to spend non-clinical time with the midwifery CF.

> "*If they're constantly pulling you out of something that's interesting in order to have a discussion, and you're like, 'but I'm not learning cos we're just discussing this now' … Cos you don't want to miss out on something really interesting to just go have a discussion.*" (P8)

Participants described that an extreme version of unbalanced role operationalisation occurred when there was limited contact in any way with the midwifery CF, *"she would pop in and just say 'hello' in a room and then just walk away, and I just thought she was someone from* [the University]*, just coming to say hello"* (P5). This created insecurity for the students, where they were unsure of what to expect from the role or what was expected from them.

> "*She used to pop her head down and say, 'Is there anything that you would like to do?' … I didn't know what was expected of me, and I felt I couldn't ask much of her because of the lack of contact.*" (P7)

The midwifery students perceived that midwifery clinical facilitation that prioritised one aspect of the role over the others was not ideal and did not create the experience that they desired.

Unbalanced role operationalisation created an experience for the participants that was perceived as unsupportive. The students described confusion regarding what to expect and what was expected of them which resulted in them not receiving the benefits of midwifery clinical facilitation.

4.2.2.2.2 No Presence. While some students reported experiencing midwifery CFs that went "*above and beyond*" (P7), they also reported experiencing what was perceived as unsupportive clinical facilitation because they felt the midwifery CF was not present. The lack of presence was described by students as a lack of physical presence or a lack of emotional presence. The lack of physical presence included the amount of time the midwifery CF spent with the student and their availability to the student. The ability of the midwifery CF to be present was affected by the role operationalisation and the type of clinical placement setting.

The participants reported a disparity between the amounts of time midwifery CFs spent with them. Many had experienced midwifery clinical facilitation where they had spent limited time with the facilitator, *"chatting with you 10 to 15 minutes and then they are gone and then you don't see them for, until the next week"* (P3). When students were in this situation, with a midwifery CF who chose to operationalise the role in a way where they did not spend much time with the student, the participants identified that the midwifery CF was not present, and they felt unsupported.

> "*I had a clinical facilitator for nine weeks last year that I saw for 15 minutes. I remember emailing her and calling her before I started just to introduce myself because that was the polite thing to do … Then I tried to call her because there was a problem with my roster … I didn't get a reply. And that just kinda made me close off to her a little bit.*" (P2)

Not being responsive and available to students was also interpreted as a lack of presence by midwifery CFs. The perceived lack of physical presence, due to a limited time investment or unavailability, was described as unsupportive midwifery clinical facilitation by participants.

Some clinical areas, such as Visiting Midwifery Services and Midwifery Group Practices (MGP), created a situation where it was difficult for midwifery clinical facilitation to occur, *"I didn't see the facilitator that much, cos I was with the MGP … She was kind of there but didn't really help that much"* (P5). When students were allocated these clinical placement environments, they were often offsite or practised according to the schedules of both the women and the midwives, which made it difficult to arrange time with the midwifery CF.

> "*It was the Visiting Midwife Service at* [Public Hospital in WA]*. So, I had three weeks there but, it was quite hard to get in contact with her because of the timing. Because you are offsite. So, when you come back it differs … so it is hard to meet up.*" (P3)

This geographical disconnect between the student and midwifery CF was only partially mitigated when the midwifery CF was proactive in the role operationalisation. While students understood the difficulty in providing midwifery clinical facilitation in these clinical placement environments, they reported that the process of midwifery clinical facilitation was less beneficial due to the lack of presence of the midwifery CF. Students described experiences with midwifery clinical facilitation in geographically removed clinical placement settings as unsupportive. The lack of emotional presence was described by students as the midwifery CF being disconnected from or not interested in the student learning journey. Often when students deemed there was a lack of physical presence, they also felt an emotional disconnect from the midwifery CF.

Emotional disconnection between the student and midwifery CF was also perceived as unsupportive by the participants. The data from the interviews demonstrated that the manner and demeanour of the midwifery

CF played an important role in how midwifery clinical facilitation was perceived. Midwifery students reported that when midwifery CFs lacked enthusiasm, they did not feel supported, *"Some of them have just been a bit sharp and not really interested in it, and so you can tell, and you're not as willing to ask for help from them"* (P5). They identified that this lack of connection also affected their learning and development as a midwife.

> "*An interest in students makes all the difference. Just rocking up because you have to be there, students can tell and it's really disheartening … I just felt that I was fending for myself the entire semester and that was awful.*" (P7)

A lack of emotional presence of the midwifery CF in the student journey affected the participant's experience with midwifery clinical facilitation and as a result the clinical placement. Sometimes students were not aware that they had missed out on a beneficial relationship until they experienced supportive midwifery clinical facilitation at a later date, and participants recognised that this was a missed opportunity for learning, development and support.

> "*The first facilitator I had, I didn't even know that I had a facilitator, and right at the end she was like 'I just need to meet with you to do an* [assessment]*,' and I was like 'I don't even know who you are'.*" (P5)

Midwifery clinical facilitation that was characterised by a lack of presence also made participants question the validity of the assessment process.

> "*I don't know how she honestly did that because she hadn't seen me in the clinical setting, and it just seemed false, her* [assessment]*, it was just very removed … Barely any contact, only for the* [assessment] *… and she probably dropped in once … a lack of availability, a lack of contact, lack of communication, lack of reflective practice and debriefing, lack of guidance, lack of support, lack of encouragement, just nothing. No presence."* (P7)

The lack of physical presence was often connected with a lack of emotional presence and was seen by participants as unsupportive and devalued the role to them.

An impression of no presence of midwifery clinical facilitation in the student experience created an unproductive relationship and a discouraging experience for student learning. The data depicted that lack of presence could be physical and emotional, with both creating experiences for students that were perceived as unsupportive midwifery clinical facilitation.

4.2.2.3 Suggestions for How to Improve Midwifery Clinical Facilitation. Participants generally appreciated and were satisfied with the midwifery clinical facilitation that they had experienced. The recommendations for improving midwifery clinical facilitation were related to the perception that every facilitator completed the role differently. This sub-theme is discussed using the concepts identified during data analysis, namely, to unify the approach to midwifery clinical facilitation, balance role operationalisation, create a plan with the student, maintain regular contact, provide time and mechanisms for anonymous feedback.

4.2.2.3.1 Unify Approach to Midwifery Clinical Facilitation. Participants felt overall that midwifery clinical facilitation could be improved with a more unified approach to the role. They identified that each midwifery CF approached the role differently and that this could cause confusion for them as student midwives in what was expected of them and what they could expect from their midwifery CF. A consistent approach was recommended by the data, "*I feel like maybe if there was more structure, cos each one does it so differently, if you got them together and gave them a guideline of what to do*" (P5). Participants also identified that this issue could also be resolved or prevented with continuity of midwifery CF, "*so we had each other for an entire semester which was great, over two hospitals. So it was good*" (P7).

The responses portrayed a desire for a more unified structure to the way midwifery clinical facilitation is operationalised.

4.2.2.3.2 Balance Role Operationalisation. One of the concepts related to a perception of unsupportive midwifery clinical facilitation was an unbalanced operationalisation of the role. When participants felt that too much emphasis was placed on one aspect of the role while others were neglected, midwifery clinical facilitation was not seen to be supportive. They valued midwifery clinical facilitation that allocated quality, student-focussed time to the student as they needed it, where the midwifery CF balanced the time spent working clinically, debriefing, providing pastoral care and reviewing portfolios. Participants recommended balancing role operationalisation as a way to improve midwifery clinical facilitation. Midwifery students particularly identified time spent in consolidated clinical time and conversation as an area where it was important to get the balance right, "*balancing the talking and hands* [-on] *teaching … I think it would be useful because mostly, you are telling the clinical facilitator what you are doing, but when she sees you do it, it is different*" (P3). They suggested reviewing the way midwifery CFs use their allocated time.

> "*Do like a couple hours, or like three hours say, doing clinical things with you dealing with women and checks and things like that. And then maybe an hour or less, or more, on portfolio as well, or just chatting about what you've done, about expanding knowledge and things like that.*" (P10)

The aspects of the role of the midwifery CF that students value have already been identified in the section of this chapter which focussed on supportive midwifery clinical facilitation. They suggested that balancing the way these

concepts were implemented with the learning needs and preferences of the student would improve midwifery clinical facilitation.

4.2.2.3.3 Create a Plan with the Student. The data from the interviews highlighted that creating a plan with students would enhance midwifery clinical facilitation. Participants felt that creating a plan was a good way to develop the relationship between the midwifery student and midwifery CF.

> "*By making a plan with the students of what we can do together in the time we have together. I guess making some goals or some learning objectives to work towards would be good, working together on a regular basis would work, and actually having the contact with the student*." (P7)

It allowed mutual expectations to be established and a student-focussed approach to the learning and development in the clinical placement area.

> "*I like when they, facilitators before have said, 'oh we'll meet once a week at this time' or something, so you know that you're getting constant guidance from them or feedback … So, if other facilitators used that too."* (P5)

Students appreciated being involved with and leading their learning and described that this was facilitated further when they had established a schedule for midwifery clinical facilitation.

4.2.2.3.4 Regular Contact. Participants felt well supported when they had regular communication or contact with the midwifery CF. Some students had experienced midwifery clinical facilitation where there had been limited communication or contact and they identified that this should be improved, "*a phone call to ask me how my placement is going would have been beneficial*" (P3). The data revealed that midwifery students appreciated communication that created rapport and a nurturing relationship, "*I like those kinds of messages beforehand, so you know that you're on their radar that they're*

thinking about what you need already before you even start" (P2). Regular communication and contact between the midwifery CF and student midwife added to the pastoral care aspect of the role and allowed the student to feel supported and was identified as a way to improve midwifery clinical facilitation.

4.2.2.3.5 Time. Flowing on from the benefits of regular communication and contact, participants expressed the desire for more time with the midwifery CF. Students identified that the amount of time spent with the midwifery CF was affected by the type of placement the student was on, the increased needs of other students, the workload of the midwifery CF and the way the role was operationalised.

> "*I lost a bit of time with her at the start because she was so preoccupied … that for the first three weeks of my first clinical hospital placement I didn't really have a clinical facilitator. Which was a bit scary*." (P1).

Of concern, several of the participants expressed that they had never received their full allotment of time with a midwifery CF, *"I probably wouldn't have ever got that time"* (P4). Students identified that it is important to receive their full allotment of time with the midwifery CF, even when they are coping well with the experiences, and for many of them an increase in allocated time was perceived as of benefit.

> "*It would be nice to have a whole shift that you work through with your facilitator, because they are a lot relying on feedback they're getting and the amount of time they can drop in to get a picture of how you're working and where you might be struggling and not struggling, so actually I think sort of having a bigger amount of time would be good.*" (P6)

Overall, the participants expressed that more time with the midwifery CF would improve the midwifery clinical facilitation.

4.2.2.3.6 Mechanisms For Anonymous Feedback. Midwifery students identified that providing feedback regarding midwifery clinical facilitation was not easy. They identified barriers to providing feedback, particularly negative feedback and suggested that mechanisms for anonymous feedback would improve midwifery clinical facilitation.

> "*Most of the hospitals I have been to have requested that the students complete feedback. I'm pretty sure the feedback almost goes directly back to the person it relates to at that time, right after your prac finishes. Like, I'm not going to give feedback, negative, if it's going back to them and it's going to be pretty obvious it's going to be one of the four students that just came in … feedback is generally pretty difficult when it's kind of obvious who it's going to be relating to."* (P8)

The data from the interviews suggested if students felt more comfortable in providing negative feedback without fear of consequences this would allow for universities to make a proper assessment of whether midwifery clinical facilitation had been effective.

> "*An opportunity at the end of semester for the students to be able to provide anonymous feedback in some sort of way … we all work on reflective practice so it should be applied to the teaching role, I mean for uni we reflect on the units, we reflect on the lecturer's or the tutor's performance, so how should that be different for clinical facilitation?*" (P7)

Participants suggested that providing a mechanism for anonymous feedback would strengthen students' ability to respond to requests for feedback and allow for improvements to the provision and quality of midwifery clinical facilitation.

4.3 Conclusion

The findings discussed represent the experiences and perceptions of midwifery clinical facilitation of the students interviewed. The themes and sub-themes have been discussed to reveal an understanding of the students' perception of the role of midwifery CF and their description of experiences

that affect engagement with midwifery clinical facilitation. The participants valued the role of the midwifery CF as a positive influence on their learning and development. From their perspective midwifery clinical facilitation provides a presence in the clinical environment dedicated solely to students providing them with unique support and assisting them to integrate theory with practice.

The student experience with clinical facilitation is impacted by role operationalisation, models of employment and the qualities of the individual CF. Students in this study found university-based midwifery clinical facilitation where the CF was familiar with the placement setting to be the most supportive. Continuity of CF was perceived by students to enhance the midwifery clinical facilitation process as they reported that allowing for a relationship to be established and developed over time provided them with reassurance. The participants perceived that continuity of midwifery CF allowed them to maximise the learning opportunities in the professional practice environment. Students appreciated midwifery CFs who were seen to be kind, enthusiastic educators and, passionate midwives with good communication skills and patience. They felt these qualities promoted the student-CF relationship and allowed for constructive feedback and honest debriefing.

Where midwifery clinical facilitation was seen to be unsupportive, students described a lack of physical or emotional presence or an unbalanced role operationalisation by the CF. Participants felt that unifying and balancing the approach to midwifery clinical facilitation, promoting continuity of midwifery CF and, establishing a plan for clinical facilitation with

students would ensure learning needs and preferences of individual students were met. Finally, students suggested that a mechanism for providing anonymous feedback without the risk of negative consequences would allow for improvements in the provision of midwifery clinical facilitation.

These descriptions of the student experiences and engagement with midwifery clinical facilitation are useful to understanding and further developing this educational support mechanism. The final chapter, Chapter 5 (Discussion) will discuss the findings from this study in the context of the relevant literature to identify implications for midwifery clinical education. Limitations of the present study and recommendations for practice will also be presented.

Chapter 5

Discussion

This study explored midwifery students' perceptions of the role of the CF during midwifery clinical placements in WA using a descriptive qualitative exploratory approach. Ten undergraduate midwifery students who had completed at least one professional practice experience that included clinical facilitation volunteered to participate and were interviewed. Thematic data analysis was used to identify themes and related sub-themes and concepts. The findings, detailed in Chapter 4, represent the experiences of midwifery clinical facilitation by undergraduate midwifery students in WA.

Findings revealed that participants valued the role of the midwifery CF and felt that it enhanced their learning and development as a midwife. Their descriptions of engagement with midwifery clinical facilitation provided useful insight into understanding and further developing this important aspect of clinical education. Discussing the findings in the context of the existing relevant literature assists in demonstrating the quality, credibility, and confirmability of the research. This chapter will compare the findings presented in this thesis to the existing body of knowledge, identifying across the discussion implications for midwifery clinical education and presenting recommendations for further research in this area. The discussion and recommendations have been structured using the themes and sub-themes identified in Chapter 4 (Findings). Limitations of this study are discussed, allowing for the quality and transferability of the research to be assessed.

5.1 The Role of Midwifery Clinical Facilitation

Midwifery students, that participated in the study reported in this thesis, perceived that the role of the midwifery CF was to support them during their professional practice experiences. This reinforces both the midwifery and nursing literature whereby clinical facilitation is seen as an essential component of successful professional practice experiences (Andrews & Ford, 2013; Brown et al., 2012; Courtney-Pratt et al., 2012; Griffiths et al., 2021; Ryan & McAllister, 2019; Sanderson & Lea, 2012). Nursing CFs have identified feeling an immense duty to provide students with positive professional practice experiences, acknowledging the importance of their role which can be both rewarding and challenging (Dickson et al., 2006; Ryan & McAllister, 2019).

Furthermore, the literature has recognised that CFs also support preceptors and staff that supervise students by assisting them to develop confidence in the teaching role and provide quality supervision that meets the needs of students and the requirements of the university (Brown et al., 2012; Courtney-Pratt et al., 2012; Griffiths et al., 2021; Lazarus, 2016; McKellar et al., 2018). In contrast, Griffiths et al. (2021) reported that not all midwifery students perceived that midwifery academics in the clinical area (a similar role to the midwifery CF) worked as a team with the midwifery preceptors to provide clinical supervision and that this required further research to ensure that universities and health services are working collaboratively. Midwifery students interviewed for the present study did not acknowledge preceptor support as being part of the role of the midwifery CF. They valued the role highly because from their perspective it provided a presence in the clinical

environment dedicated solely to students. It may be that the participants were unaware that the CF was providing this type of collegial support behind the scenes. This difference in perception might also be due to how clinical facilitation has been defined within the WA context, whereby preceptor support has not been identified as an element of clinical facilitation (Curtin University, 2020; Midwifery Education Western Australia, 2016).

Strong partnerships between health services and education providers promote positive professional practice experiences and student development (Barnett et al., 2010; Bourgeois et al., 2011; McKellar & Graham, 2016). Further investigation into the state of these relationships and best practice in clinical supervision of midwifery students is crucial to support the development of the future workforce (Griffiths et al., 2021; McKellar & Graham, 2016). This thesis presents an early understanding of the student perception of midwifery clinical facilitation. It is important to develop a comprehensive understanding of midwifery clinical facilitation from the perspectives of students, CFs, health services and education providers in WA to ensure that midwifery clinical education being provided is successful. Furthermore, investigating the support needs of midwife preceptors and how they work in tandem with CFs would assist in clarifying the CF role and identifying how best to support midwife preceptors.

5.1.1 Understanding of Midwifery Clinical Facilitation

This thesis reported that participants understood midwifery clinical facilitation as a unique and valuable role that helped to bridge the gap between theory and practice and acted as a link to the university. They also felt that midwifery CFs provided support that was not present in their

relationships with preceptors and academics. The literature has shown that midwifery students are concerned about being prepared for clinical practice and they generally prioritise the mastery of clinical skills over cognitive skills (Carolan-Olah & Kruger, 2014; Chenery-Morris, 2014; McIntosh et al., 2013; Milton-Wildey et al., 2014). Professional practice experiences that include quality clinical supervision allow the opportunity for students to develop the practical skills, that they are focussed on, but also the more cognitive skills, that they may not prioritise but that are essential for an autonomous, evidenced-based practitioner (Carolan-Olah & Kruger, 2014; Griffiths et al., 2021; Griffiths et al., 2020; Hauck et al., 2016; McIntosh et al., 2013; Milton-Wildey et al., 2014). The literature supports that quality clinical supervisors promote the growth of workplace-ready graduates by facilitating the development of critical thinking, reflection, evaluation, problem-solving and communication which enhances student confidence in the clinical area (Carolan-Olah & Kruger, 2014; Griffiths et al., 2021; Milton-Wildey et al., 2014; Needham et al., 2016; Nieuwenhuijze et al., 2020; Walker et al., 2013). In the present study, the participants observed that midwifery clinical facilitation promoted clinical reasoning, professional communication and leadership skills which allowed students to develop from actively participating in care to planning and leading the care.

As a supernumerary role, the CF is in a unique position to address cognitive skills in clinical education as their presence in the professional practice experience is dedicated to student development and it is reasonable that students would value the role that they perceive to be designed to support them. As previously stated, examining the support needs of midwife

preceptors would be valuable to determine whether their needs can be met separately to midwifery clinical facilitation. This would ensure that students are receiving the full benefit of clinical facilitation as well as quality clinical supervision when the CF is not present. Understanding how CFs operationalise the role and the expectations of clinical facilitation by the stakeholders is important for maximising clinical education in midwifery.

Theoretical and practical teaching are provided separately in midwifery education and the intent of professional practice experiences is to allow students to consolidate and connect this information in the clinical environment (Chenery-Morris, 2014; Courtney-Pratt et al., 2012; Grealish & Smale, 2011). It has been acknowledged that the unpredictable nature of the clinical environment makes it difficult to fully prepare students for what they may encounter during professional practice experiences (Grealish & Smale, 2011). While investigating the evolution of Australian nursing students to RNs, Edgecombe and Bowden (2009) reported nursing students felt insecure and uncomfortable while on clinical placement Nursing students identified that being in the professional practice environment highlighted the perceived gap between theoretical knowledge and clinical practice (Edgecombe & Bowden, 2009). Midwifery students specifically have expressed frustration and disappointment with the perceived disconnect between what they are taught and what they observe during professional practice experiences (Griffiths et al., 2021; Licqurish et al., 2013). This feeling was reiterated by the midwifery students included in the study presented by this thesis.

Support and guidance from a CF have been identified in the literature as leading to enhanced skills and capability, improved confidence, and

achievement of goals by midwifery and nursing students (Courtney-Pratt et al., 2012; Franklin, 2013; Griffiths et al., 2021; Walker et al., 2013). Clinical facilitation is well placed to relate what has been taught in the university environment to the experiences within the clinical setting as CFs should have more advanced pedagogical skills than preceptors, time to dedicate to students and an understanding of the university expectations and knowledge of the clinical areas (Griffiths et al., 2021; Milton-Wildey et al., 2014; Needham et al., 2016). The findings of the present study support the importance of clinical facilitation whereby midwifery students highly valued the role of the midwifery CF because they found it enhanced student learning and provided both emotional and practical support. Students reported that midwifery clinical facilitation assisted them to make sense of clinical placement experiences in terms of helping them to apply their theoretical learnings within the practice setting context. This process was often enhanced with professional debriefing led by a midwifery CF which promoted professional practice and cognitive skills development, as well as that of the student towards becoming an independent practitioner.

The midwifery students interviewed for this research, understood that midwifery clinical facilitation was able to assist with the integration of theoretical and practical knowledge because of the presence of an independent person in the clinical area dedicated to supporting students. The students identified the role of the midwifery CF as unique and fulfilling a different purpose than that of university lecturers and midwife preceptors or clinical staff. This sentiment correlates with findings from other studies reported in the literature whereby students enrolled in midwifery and nursing

courses will have a variety of educators with differing priorities which impact the quality and content of the teaching (Franklin, 2013; Lambert & Glacken, 2005). Lecturers and university staff prioritise academic teaching and research responsibilities. Preceptors and clinical staff on the other hand prioritise patient care and clinical activities and are not always aware of the university requirements. However, CFs are primarily present to support and teach students in the clinical area (Courtney-Pratt et al., 2012; Franklin, 2013; Griffiths et al., 2020). The CF role is dedicated to ensuring students have positive professional practice experiences by facilitating appropriate learning opportunities, promoting the integration of theory and encouraging reflective practice and critical thinking (Courtney-Pratt et al., 2012; Griffiths et al., 2021; Walker et al., 2013). The literature reports that both students and preceptors value the role of the CF and perceive that student learning and development is enhanced when clinical facilitation is incorporated into the professional practice experience (Courtney-Pratt et al., 2012; Needham et al., 2016; Sanderson & Lea, 2012; Taylor et al., 2015). These findings are aligned with the views of student participants reported in the present study, highlighting the value of the role and how important its operationalisation is to midwifery clinical education.

5.1.2 Factors Affecting Midwifery Clinical Facilitation

Midwifery students involved in the study presented in this thesis recognised that midwifery clinical facilitation was affected by several factors which influenced how midwifery clinical facilitation was enacted and experienced. The implementation of midwifery clinical facilitation was perceived by the students to be modified according to individual student

needs, specific clinical site requirements and the personal attributes and preferences of the midwifery CF. The literature has reported that clinicians with an interest in education are attracted to the role of CF but often have limited preparation for or support in the position (Andrews & Ford, 2013; Needham et al., 2016). Most CFs do not have a formal qualification in education and base their role on the facilitation that they experienced as a student or have observed (Andrews & Ford, 2013; Needham et al., 2016; Ryan & McAllister, 2019). This lack of preparation and support for CFs may affect how midwifery clinical facilitation is delivered and lead to varied experiences of midwifery students.

Examples of these varied experiences from the present study were addressed under the sub-themes of *supportive midwifery clinical facilitation* and *unsupportive midwifery clinical facilitation.* Some students identified that their CF had not worked clinically with them during certain professional practice experiences despite being allocated to the CF. An example of this was Participant 5 who recalled not realising that they were allocated a CF until after the placement was completed. The varied experiences dependent on individual midwifery CFs was confirmed by another student midwife's statement, *"When you have a really supportive facilitator that makes all of the difference"* (P7). It suggests that not all midwifery clinical facilitation is provided in the same way. Implementing preparation, monitoring and improvement strategies for CFs would ensure that midwifery clinical facilitation is more uniform and improve the experiences of midwifery students. Developing clarity of the role and expectations of midwifery clinical

facilitation will ensure programs for preparation and support are designed appropriately and will improve clinical education in midwifery.

Akin to the difficulty in preparing students for the clinical environment, the literature acknowledges that there is no way to be fully prepared for the role of CF (Andrews & Ford, 2013; Needham et al., 2016). CFs report enjoying the independent and flexible nature of the role, but initially find this challenging, feeling isolated and unsure of where to begin (Andrews & Ford, 2013). Despite this, flexibility in how clinical facilitation is operationalised is recognised as an essential element of the role, enabling the CF to provide a service that meets the needs of the student and the clinical area (Needham et al., 2016; Ryan & McAllister, 2019; Sanderson & Lea, 2012). Specific to midwifery, students from an Australian study perceived that midwifery clinical facilitation allowed for the achievement of individual goals during professional practice experiences (Griffiths et al., 2021). Flexible role operationalisation of midwifery CFs was also reported to be valuable by the participants of the study presented by this thesis, as this allowed the midwifery CF to meet the different needs of individual students.

Student-centred midwifery clinical facilitation provided the support students needed in the clinical area and encouraged students to be active participants in their own learning and development. A potential negative consequence of different styles of teaching could be that midwifery students do not know what to expect (Chenery-Morris, 2014). However, the students in the present study did not report this, perhaps because they described that teaching styles were adapted to them and therefore suited their learning needs. Ensuring alignment of expectations and, teaching and learning

approaches between student and CF should be actively addressed at the beginning of the professional practice experience (Chenery-Morris, 2014; Grealish & Smale, 2011; Needham et al., 2016; Sanderson & Lea, 2012). This would ensure that the benefits from the flexible operationalisation of clinical facilitation are maximised to promote student-centred clinical education, positive experiences, and student development.

More research has been suggested into the effect the model of employment has on the role of the CF and student learning experiences (Franklin, 2013). CFs employed within the healthcare service are familiar with the environment and staff and, may be more able to provide greater flexibility and work clinically with students, thereby impacting the professional practice experience (Franklin, 2013; McKellar & Graham, 2016; Milton-Wildey et al., 2014). It has been suggested that a best practice clinical supervision model for midwifery students in Australia should include hospital-based CFs due to the ease of role operationalisation within the familiar environment and the enhanced ability to prepare and support preceptors (McKellar & Graham, 2016). The research reported in this thesis revealed that midwifery students found that there were advantages and disadvantages to both hospital and university-based models of employment of midwifery CFs. Hospital-based midwifery clinical facilitation often allowed midwifery CFs to work with students clinically in all areas and students found the CFs' increased knowledge of and comfort within the clinical placement environment beneficial to their professional practice experience. However, the loyalty of the hospital-based midwifery CF to the clinical placement site and the perceived lack of university control, particularly when students found

midwifery clinical facilitation to be unsupportive, were identified by students as disadvantages of the hospital-based model of employment. Participants in the present study found that university-based CFs were often just as familiar with the clinical setting as hospital-based CFs. Further research is needed to understand midwifery clinical facilitation from the perspective of the preceptor and health service. This information would establish how important preceptor support is in midwifery clinical facilitation and assist in determining whether it needs to be incorporated into the role more officially. Understanding the importance of preceptor support as part of the role of the CF will contribute to the assessment of which model of employment is most appropriate in midwifery clinical facilitation.

All students in the present study reported the university-based model of midwifery clinical facilitation to be more supportive. Students identified that it was important that the midwifery CF represented the university and found it beneficial to have access to an independent resource person with experiences across the continuum of care and with different clinical sites. University-based midwifery CFs were seen to be more engaged in the education process and many were just as familiar with the clinical placement area as hospital-based CFs. The potential for the clinical placement site to limit the ability of a university-based CF to work clinically with students was a concern to some of the participants. Despite this, students rated their experiences with university-based midwifery clinical facilitation as more supportive. An alternative explanation for this differing perception of the operationalisation of midwifery clinical facilitation has been provided by one Australian study, whereby the CFs had protected workspace at some clinical

sites but at other sites, CFs attended based on the student's shift (Griffiths et al., 2021). Their midwifery student participants felt that the clinical teacher was not visible and accessible in the professional practice setting. The researchers suggested that the way the role was enacted could be dependent on the organisational support of the clinical setting. Potentially having a workspace impacted the way the CF engaged with the clinical environment, thereby impacting the student perception of the CF being present (Griffiths et al., 2021). This may correlate with the student experience in the study presented by this thesis, whereby some participants described university-based facilitators to be more present and engaged. While many hospital-based CFs have a dedicated workspace, generally university-based CFs do not. Certainly, it is clear from the literature and this study, that familiarity with the professional practice environment positively impacts the experience of clinical facilitation.

The literature has revealed that students learn by watching midwives. Students are more likely to develop positive relationships with midwives they perceive to have desirable qualities, and this has a positive impact on student learning in the professional practice environment (Griffiths et al., 2021; Hallam & Choucri, 2019; Hauck et al., 2017). While students prefer to work with positive role models, they will modify their practice to match the midwife that they are paired with, even if that practice does not align with their own values and beliefs (Bluff & Holloway, 2008; Licqurish et al., 2013). Individual characteristics of a clinical supervisor impact the effectiveness of the relationship that is developed (Franklin, 2013; Griffiths et al., 2021; Hallam & Choucri, 2019; Hauck et al., 2017; Licqurish et al., 2013). The midwifery

students included in the study reported in this thesis described that the qualities they valued in midwives when observing them caring for women, were also the desirable qualities for a midwifery CF.

Study participants in the present study perceived that a calm, approachable demeanour, good communication skills and patience were attributes in the CF that positively influenced their experiences with midwifery clinical facilitation. Midwifery CFs who were seen to be kind, compassionate and reassuring made students feel supported and promoted honest debriefing. Students also valued enthusiasm for education and passion for midwifery and, trusted the guidance and support provided by midwifery CFs who were perceived as knowledgeable and experienced. These findings resonate with existing literature whereby positive clinical role models are seen as helpful, caring, friendly, enthusiastic, confident, supportive and adaptive with good communication skills, a willingness to share knowledge and feedback and, the ability to give students the space to learn (Courtney-Pratt et al., 2012; Hallam & Choucri, 2019; Hauck et al., 2017; Needham et al., 2016; Nieuwenhuijze et al., 2020). In contrast to the findings presented by this thesis whereby midwifery students saw the midwifery CF as a maternal figure, Walker et al. (2013) found that nursing students had less positive attitudes towards the CF if they “mothered” them. Studies have also identified that students’ attitudes and characteristics are important in developing a positive and effective relationship (Courtney-Pratt et al., 2012; Vallant & Neville, 2006), which was not mentioned by the participants in the research presented in the thesis. This highlights an area for further research related to examining the roles and responsibilities of midwifery students in

ensuring that professional practice experiences are effective and maximising the benefits of clinical facilitation. Preparing CFs for their role in supporting students in the professional practice environment should include discussion around the factors affecting midwifery clinical facilitation and the expectations of stakeholders. This would ensure that the clinical education provided meets the needs of all concerned and promotes the development of a confident and capable future midwifery workforce. Education providers also need to consider how students are prepared for the professional practice experience and to receive clinical facilitation. A clear view of the roles of both parties in the student-CF dyad will ensure alignment with realistic expectations, maximising the professional practice experience for the student.

5.2 Engaging with Midwifery Clinical Facilitation

In the research presented in this thesis, midwifery students reported that their engagement with midwifery clinical facilitation was impacted by whether they perceived the midwifery clinical facilitation to be supportive or unsupportive and they provided some suggestions to improve the student experience of midwifery clinical facilitation. The literature suggests that CFs are poorly prepared and often lack support in their role (Andrews & Ford, 2013; Needham et al., 2016; Ryan & McAllister, 2019). Understanding the midwifery student perspective on how midwifery clinical facilitation is experienced is integral to ensuring that midwifery CFs are providing best practice clinical education.

5.2.1 Supportive Midwifery Clinical Facilitation

Supportive midwifery clinical facilitation was described, by students in this thesis, as the elements of the role seen to enhance their learning, support them to maximise opportunities during professional practice experiences and assist them to become independent practitioners. Students identified that a pre-existing relationship between the midwifery CF and the clinical staff was beneficial to both the student and the midwifery clinical facilitation process. When the midwifery CF felt comfortable in the clinical environment, the student also felt more comfortable and often the CF's knowledge of the clinical site resulted in increased clinical time together. Knowledge of the clinical site by CFs improves the student professional practice experience due to a rapport with clinicians which creates a positive learning environment as well as the practical benefits of being familiar with the setting (McKellar et al., 2018; Needham et al., 2016; Ryan & McAllister, 2019; Sanderson & Lea, 2012).

The literature suggests that creating a welcoming environment, where students feel a sense of belonging and safety to learn is a beneficial outcome of a CF who is familiar with the professional practice environment (Bourgeois et al., 2011; Brown et al., 2012; Courtney-Pratt et al., 2012). A supportive learning culture for students is developed when there is an established and effective relationship between the CF and the clinical area. This allows for improved access to resources, collaborative problem-solving and a well-facilitated transition of the student into the clinical area. Rapport between clinicians and CFs ensures a positive learning atmosphere whereby staff are prepared to receive students, understand the expectations, and feel

supported by the CF to supervise students. This, in turn, led to students feeling that they were a trusted part of the team and enhanced their learning, development, and confidence (Bourgeois et al., 2011; Brown et al., 2012; Courtney-Pratt et al., 2012). It has been suggested that feeling a sense of belonging and being supported during professional practice experiences may be more beneficial to student development than having theoretical knowledge, given the unpredictable nature of the clinical environment (Grealish & Smale, 2011). Ultimately, when professional practice experiences are facilitated by a CF who has a relationship with the clinical area, it strengthens the partnership between healthcare and education providers, improving the learning experiences for future students (Dickson et al., 2006; Sanderson & Lea, 2012).

When the CF is familiar with the clinical area and perceived to be part of the team, both students in the study reported here and, in the literature, describe greater satisfaction with clinical facilitation. Further to this, McKellar and Graham (2016) also recognised that midwifery CFs who are known to the clinical area were more likely to be able to work directly with midwifery students. This was also the experience of the midwifery students interviewed for the research presented here. Additionally, Carolan-Olah and Kruger (2014) suggested that midwifery students should be given the opportunity to become familiar with a specific clinical area by attending multiple professional practice experiences at the same site. This would enhance the sense of belonging the student feels and thereby maximise the benefits of the professional practice experience.

Consolidated clinical time with the midwifery CF was perceived by the participants in the current study as another element of supportive midwifery clinical facilitation. Not all students had experienced working clinically with the midwifery CF, however, those that had found it beneficial. Student-focussed time in the clinical area promoted a less pressured environment and allowed them to participate in clinical care at a pace appropriate to the individual student's learning. It also took the pressure off midwifery preceptors who were perceived by students as often too busy to focus on student learning. Additionally, consolidated clinical time with the midwifery CF was valued by participants in the study being reported as an opportunity to observe exemplary clinical care from a trusted role model.

The importance of clinical facilitation that includes working directly with the student is supported in the literature by clinicians and CFs (Courtney-Pratt et al., 2012; McKellar et al., 2018; O'Brien et al., 2014; Ryan & McAllister, 2019; Sanderson & Lea, 2012). There has been limited investigation into the student perspective, however, student nurses in Ireland were reported to value working clinically with the CF (Lambert & Glacken, 2006). The research presented in this thesis has added the midwifery student voice to this discussion. The literature has raised concerns on whether clinicians are appropriately prepared or capable of providing the clinical teaching expected of university programs (Hall-Lord et al., 2013; McKellar & Graham, 2016; O'Brien et al., 2014). It is hoped that CFs, in the role dedicated to supporting students, are better able to meet the pedagogical needs of students in the clinical area, however, it is understood that generally they are drawn to the role by personal interest and have not

had any further specific education (Andrews & Ford, 2013; Needham et al., 2016; Ryan & McAllister, 2019). Despite this, clinicians report feeling more satisfied when they are supervising students who are supported by a CF. When the CF works clinically alongside the student it provides some respite for the clinician from their educative workload, allowing them the opportunity to focus on their clinical workload (Courtney-Pratt et al., 2012; Henderson & Tyler, 2011; Needham et al., 2016; Taylor et al., 2015). CFs have also recognised this as an important element of their role, reducing the workload of preceptors by working alongside students also ensures that learning opportunities appropriate to individual students are maximised and professional practice can be role modelled (Brown et al., 2012; Sanderson & Lea, 2012).

The students that participated in this research recognised that constructive feedback was essential to their development into midwives. They found that midwifery CFs were more likely to provide effective feedback than midwife preceptors, and they trusted midwifery CF feedback as a true reflection of their performance designed to promote learning and development. This correlates with the literature, whereby students perceived that they received valuable, timely feedback from CFs and appreciated the guidance offered regarding learning objectives, development, and assessment (Courtney-Pratt et al., 2012; Croxon & Maginnis, 2009; Griffiths et al., 2021). Nursing CFs have acknowledged that they are well placed to provide feedback due to their relationship with the student and experience in clinical education (Ryan & McAllister, 2019). Portfolio feedback was seen to be an important component of midwifery clinical facilitation by the students in

the current study, as it was a way of reviewing the care the student was providing against unit/course expectations. Students reported that university-specific, formative feedback on their portfolios throughout the semester allowed them to feel confident that they were progressing as expected. Whilst the importance of written feedback has been highlighted in the current study, previous findings indicate that this is an area where midwife preceptors in WA require more education (Hauck et al., 2017). This finding aligns with midwifery students in the current study preferring to be assessed by CFs rather than midwife preceptors. Providing timely, constructive feedback is a skill expected of CFs, and midwifery students value the impact it has on their development as independent practitioners. This has implications for the preparation of CFs for the role and how clinical facilitation is operationalised.

Continuity of clinical supervisor has been identified in the literature as valuable by both the students and the supervisors (Courtney-Pratt et al., 2012; Hallam & Choucri, 2019; Hauck et al., 2017; McIntosh et al., 2013). Participants in the research reported in this thesis felt comforted, relieved, and reassured by having a known midwifery CF and they perceived that this allowed them to maximise the learning opportunities in the professional practice environment. This is supported by the perceptions of other students reported in the literature, of enhanced learning experiences with continuity of supervisor. Students in other studies reported feeling more confident and capable and being seen as a member of the team when they were supported by a known clinical supervisor (Chenery-Morris, 2014; Hallam & Choucri, 2019; Hauck et al., 2017; McIntosh et al., 2013). Furthermore, students

perceived that lack of continuity of clinical supervisor was detrimental to their professional practice experience and development (Chenery-Morris, 2014; Hallam & Choucri, 2019).

Preceptors and CFs also prefer a continuity relationship with students as it allows learning and development to progress across different professional practice experiences and not be interrupted by the ongoing need to develop new relationships. They reported that they felt better placed to provide feedback and complete assessments when there had been a pre-existing relationship with the student (Chenery-Morris, 2014; Dickson et al., 2006; Hallam & Choucri, 2019). Midwifery students in the present study agreed and believed that this positioned the midwifery CF as the most appropriate person to provide feedback, assist with creating goals and assess their ongoing midwifery growth and development. They identified that it took time to develop a student-facilitator relationship and continuing with an existing relationship allowed for sustained professional development and recognition of progression. Continuity of preceptor in the clinical environment is affected by organisational and contextual constraints (Courtney-Pratt et al., 2012; Hallam & Choucri, 2019; Russell et al., 2010), however, continuity of CF may be more easily attained. In the study presented by this thesis, clinical continuity with a midwifery CF was perceived as beneficial to a student's overall development as a midwife.

The findings from the present research revealed that midwifery students perceive their role to be challenging. The students reported feeling stressed and overwhelmed with the requirements of their course and the professional practice experiences. Debriefing, pastoral care and student advocacy

provided by the midwifery CF were seen to be important aspects of supportive midwifery clinical facilitation. The students felt that learning opportunities improved when midwifery CFs understood their needs and advocated for them. Students perceived that midwifery CFs could reassure clinical placement staff and ensure that students were included in clinical activities appropriately. They identified that the opportunity to debrief with a knowledgeable and experienced advisor was valuable, and appreciated having an empathetic, supportive person available to them. It offered students the chance to process clinical events and achieve understanding, clarity, and reassurance. This has been supported in the literature where students have reported the benefits of debriefing and critical reflection in helping them to make sense of their professional practice experiences (Carolan-Olah & Kruger, 2014; Courtney-Pratt et al., 2012; Sanderson & Lea, 2012). It has been identified in the study presented in this thesis, that students also appreciated the pastoral care provided by CFs. Supporting students emotionally and acting as a counsellor and advocate has been acknowledged by nursing CFs as one of the more challenging aspects of the role (Andrews & Ford, 2013; Ryan & McAllister, 2019; Taylor et al., 2015). These findings in the context of existing evidence have implications for how CFs should be prepared for and assisted in their role in relation to student support through counselling and advocacy within the clinical setting.

5.2.2 Unsupportive Midwifery Clinical Facilitation

Most of the midwifery students interviewed in the current research described in this thesis had experienced unsupportive midwifery clinical facilitation while completing their professional practice experiences. Students

perceived that this resulted in an unproductive relationship and led to the feeling that they had missed out on learning opportunities. It has been identified in the nursing literature that CFs are often not prepared well and learn their role as they go (Andrews & Ford, 2013; Needham et al., 2016; Ryan & McAllister, 2019). Also, CFs have reported that they receive limited formal feedback and support, and want to know how they are doing in their role and how they can improve (Andrews & Ford, 2013; Needham et al., 2016; Taylor et al., 2015). It is, therefore, not surprising that students have had experiences with clinical facilitation that did not meet their needs or expectations given that CFs are likely to have learnt how to facilitate with minimal support and guidance. This is why careful consideration is needed as to the characteristics, qualifications and experience of those in the role of CF as well as the model of employment. The development of a best practice model is recommended, to ensure students receive supportive clinical facilitation that promotes learning and prepares them for the workplace (Courtney-Pratt et al., 2012; Franklin, 2013; Jayasekara et al., 2018; McKellar et al., 2018).

Participants in this study explained that it was important that CFs spent time with students working clinically, debriefing, providing pastoral care and completing portfolio reviews. They perceived that supportive midwifery clinical facilitation included a balanced approach to role operationalisation. However, participants reported that some midwifery CFs prioritised one aspect, often debriefing, over all others and this was perceived as unsupportive midwifery clinical facilitation. The participants recognised that midwifery clinical facilitation was operationalised in a variety of ways and they

were sometimes unclear about what they should expect of the relationship and what was expected of them. If this was unresolved and students perceived that their needs were not being met due to an unbalanced operationalisation of the role, students felt that their clinical placement experiences were negatively impacted. Midwifery students' perceptions of how midwifery clinical facilitation is operationalised has received minimal attention in the literature. However, in contrast to the participants of the study presented here, Australian midwifery students in other studies have previously suggested that they highly value and would benefit from more debriefing (Carolan-Olah & Kruger, 2014; McKellar et al., 2018). As previously discussed, the literature reveals that CFs are generally not well prepared or supported in the role and receive limited feedback (Andrews & Ford, 2013; Needham et al., 2016; Ryan & McAllister, 2019; Taylor et al., 2015). Further research aimed at the student experience of midwifery clinical facilitation is warranted to assist in comprehending students' perceptions of how the role should be operationalised. Also, education providers should ensure students are well prepared for professional practice experiences and understand how to maximise clinical facilitation. This combined with midwifery clinical facilitation preparation, monitoring and support strategies and examining the CF perspective can inform the development of a best practice model of midwifery clinical facilitation.

When participants in this study felt that there had been a lack of presence of the midwifery CF in the professional practice experience, they perceived this as being unsupportive. They described the lack of presence as either physical or emotional, and the two often went hand in hand. They

attributed a physical lack of presence to a limited time investment or unavailability of the midwifery CF. A lack of emotional presence was perceived by students where midwifery CFs were unenthusiastic or uninterested. Midwifery students felt that experiences with a midwifery CF who was not present were unsupportive because it resulted in missed opportunities for learning, development, and support. It also made them question the validity of the assessment process when being assessed by such a CF. This is supported by findings from another Australian midwifery study that identified an equivalent midwifery CF position as being at times not visible, impacting the effectiveness of the clinical learning and student assessment (Griffiths et al., 2021). As mentioned previously, there was a suggestion that the lack of presence may be associated with the CF having a dedicated workspace in the clinical setting as opposed to those who did not and attended the placement site relative to the students' shifts. Henderson and Tyler (2011) reported that it was important for CFs to be available when opportunities presented so that students are facilitated through the experience appropriately. The literature also demonstrated that students perceived a lack of support, interest, communication, and encouragement as unhelpful characteristics of a clinical supervisor and this impacted their professional practice experiences (Bluff & Holloway, 2008; Licqurish & Seibold, 2008; Ranse & Grealish, 2007). While the present study provides insight into the student experience of midwifery clinical facilitation, further research related to students' perceptions of presence or visibility of midwifery CFs is needed. Such information would be useful in preparing CFs for their role as it will help them to understand student expectations and how students

interpret interactions. The following section provides some initial insights on how midwifery clinical facilitation could be improved from the perspective of the students represented in this thesis.

5.2.3 Recommendations for how to Improve Midwifery Clinical Facilitation

Generally, students that participated in this research highly valued midwifery clinical facilitation and recognised the benefits that came from flexible role operationalisation. However, the varied approach by midwifery CFs also could cause confusion for students. The students' recommendations for improving midwifery clinical facilitation were related to resolving the differences in the way CFs operationalise the role, balancing the different aspects of clinical education and support, and developing relationships with students. The participants in the current study suggested a more structured approach to midwifery clinical facilitation would result in a more unified understanding of the role of the CF. They also proposed it was important that the different aspects of the role, such as working clinically, debriefing, providing pastoral care and reviewing portfolios, were balanced and that quality, student-focussed time was allocated to the student as they needed it. Students felt that unifying and balancing the approach to midwifery clinical facilitation would reduce the initial process of discovering mutual expectations and ensure that the role operationalisation met the learning needs and preferences of the individual student. In the literature, nursing CFs have identified the importance of an initial assessing period and orientation (Needham et al., 2016; Ryan & McAllister, 2019; Sanderson & Lea, 2012). This allowed for the CF and student to become acquainted and

establish the expectations of the relationship and professional practice experience. This is relevant for education providers in the way CFs are prepared for the role and the way students are prepared for professional practice experiences.

Students from the present study suggested that continuity of midwifery CF would be one way of resolving these issues related to variations between CFs, differing role operationalisation and CF student relationships. Lambert and Glacken (2005) described that there was a lack of consensus regarding the role of the CF but highlighted the importance of it being enacted to meet the needs of the specific clinical area and individual student. Providing continuity of clinical supervision has been identified in the literature to improve learning and professional practice experiences by providing consistency in the clinical area and individualised support (Chenery-Morris, 2014; Courtney-Pratt et al., 2012; Hallam & Choucri, 2019; Hauck et al., 2017; McIntosh et al., 2013). These findings, in the context of existing knowledge related to clinical supervisor continuity, support the need for further investigation into its impact on midwifery clinical facilitation. It has been suggested that CFs are best positioned to promote the development of cognitive skills, integration of theory and practice, and to maintain the university expectations and presence in the clinical area. Developing an understanding of how to improve the midwifery student-CF relationship will promote student development and help prepare competent graduate midwives. It will also have the added benefit of improving CF job satisfaction and performance in the role.

A lack of emotional or physical presence was perceived by students in the current study as unsupportive and aligned with existing evidence revealing the same (Bluff & Holloway, 2008; Griffiths et al., 2021; Licqurish & Seibold, 2008; Ranse & Grealish, 2007). Participant accounts provided in this thesis identified that regular communication and more time with the midwifery CF added to the pastoral care aspect of the role. This assisted in developing rapport and a nurturing relationship and helped to improve the student experience with midwifery clinical facilitation. These findings are supported by other students in the professional practice environment requesting more time with CFs (Severinsson & Sand, 2010; Walker et al., 2013). Preceptors also appreciate the support of CFs when supervising students in the clinical area. Students require additional time to complete clinical care, and this can impact the preceptors' ability to manage their workload (Courtney-Pratt et al., 2012; Franklin, 2013; Henderson & Tyler, 2011; McKellar et al., 2018; McKellar & Graham, 2016; O'Brien et al., 2014). Additional clinical facilitation time with students would further assist preceptors to complete their dual responsibilities to their clients and the students.

It has been recognised that an important part of the nursing CF's role was to allow adequate time with students to enable the relationship to be developed and sustained, building trust, and the ability to assess the strengths and needs of individual students (Needham et al., 2016; Ryan & McAllister, 2019). Further consideration is needed to determine if increasing clinical facilitation hours is required, as this has ramifications for the financial viability of clinical education. As many CFs are employed by education

providers on casual contracts (sessional capacity), increasing the number of hours for clinical facilitation will increase its costs and may make it unviable. As a counterpoint, this study has provided an early understanding for CFs that students value the time spent with them, even when they are perceived to be coping well with the experiences. Using this knowledge to improve the way clinical facilitation is enacted, combined with a more balanced role operationalisation, may mean that students would perceive the time spent with the CF as adequate. Clarifying the expectations of the role and developing preparation and support programs for both CFs and students would help to determine if the issue of time is one of quantity or quality.

Students in the study presented in this thesis, appreciated being involved with and leading their learning, and described that this was further facilitated when they had established a schedule for what the midwifery clinical facilitation should focus on. Creating a plan between the student and midwifery CF allowed for mutual expectations to be established and the relationship to develop. The literature supports the importance of maintaining open communication, assisting in the development of individualised learning objectives, and establishing mutual expectations of the relationship and professional practice experience. This student-centred approach to learning promotes the development of lifelong learning skills, the achievement of goals and a positive professional practice experience (Chenery-Morris, 2014; Grealish & Smale, 2011; Needham et al., 2016; Sanderson & Lea, 2012). In response to these findings and the need to develop a more uniform approach to clinical facilitation, it may be useful for education providers to create a tool

or template that guides CFs in establishing the relationship with students and providing direction for their learning.

Participants represented here identified several barriers to providing feedback on midwifery clinical facilitation, with fear of reprisal being a significant factor. They suggested that a mechanism for providing anonymous feedback without risk of negative consequences would allow for improvements in the provision of midwifery clinical facilitation. This finding is similar to Griffiths et al. (2020) who also identified that midwifery students did not perceive that they could raise any concerns regarding clinical placements. Andrews and Ford (2013) reported that nursing CFs found feedback from students useful and wanted more, in addition to ongoing education and support to further develop in the role and gain confidence. This is a vital aspect of the continuous quality improvement cycle and is crucial to ensure that midwifery students are receiving the best possible clinical education to prepare them to be independent practitioners when they graduate. It is also important for midwifery CFs to know that they are appreciated, and where there are areas for improvement to promote validation and development in the role and enhance job satisfaction and engagement. Aligning midwifery clinical facilitation with education providers would ensure that the university procedures for student evaluation of teaching were applied to the role of midwifery CF, helping to provide ongoing formal student feedback on clinical facilitation.

5.3 Limitations

Providing a clear description of the limitations of research demonstrates the researcher’s understanding of the research process and allows the

reader to determine the relevance of the findings to their context (Richardson-Tench et al., 2018). This research was conducted for a Master of Philosophy higher degree by research whereby the primary researcher was a student and still developing research skills. In qualitative research, the researcher is the research tool and thereby results may be affected by the skill level of the researcher. For this project, supervision was provided throughout the process by experienced researchers to reduce the impact of a novice level researcher on the findings. The descriptive exploratory methodology was chosen because it aligned with the study aims and objectives, was suitable for candidacy requirements and was appropriate to the experience of the student. A limitation of the chosen method is that it can only yield a broad and surface level exploration of the phenomenon. While this may be used in the future to develop more theory-based research, the descriptive exploratory method does not provide an in-depth inquiry. Finally, the target population for the study presented in this thesis was WA undergraduate midwifery students. Findings, therefore, represent the experiences of the select participant group and might have limited transferability to other midwifery courses or students in other contexts. However, quality enhancement strategies have been documented throughout this thesis to provide the reader with enough information to determine the degree to which the findings of this study may have meaning in their varying context.

5.4 Conclusion

Chapter 5 (Discussion) has discussed the findings of the study presented in this thesis in the context of the existing literature. Clinical

facilitation in the midwifery context has not been well researched, however, the findings from this study support the literature, indicating that clinical facilitation is a highly valued model of clinical supervision. From this research and the relevant literature, it is clear that midwifery students value and understand midwifery clinical facilitation as a unique process that supports them during professional practice experiences with the integration of theoretical and practical knowledge. Midwifery students find it advantageous to have continuity with a CF in the clinical area, who is an independent, trusted representative of the university.

Clinical facilitation is impacted by the role operationalisation, models of employment and individual characteristics of the midwifery CF. Clinical facilitation, and its evaluation, is an ANMAC accreditation requirement therefore midwifery specific research is needed to investigate the models of clinical facilitation being provided. Acknowledging midwifery clinical facilitation as a primarily educational role and aligning the midwifery CFs more closely to education providers would allow for a more uniform approach to preparation, monitoring and improvement strategies. Examining the experiences of midwifery CFs in the different models of employment, as well as the perceptions of the health services and academics, would deepen the understanding of midwifery clinical facilitation.

The study presented by this thesis has contributed to the growing body of evidence regarding midwifery clinical facilitation by providing a voice for WA midwifery students and enabling their experiences with midwifery clinical facilitation to be used to help improve this important aspect of midwifery education. It has demonstrated that midwifery clinical facilitation is a crucial

element of developing midwifery students into midwives, making it essential that it be done well. The importance of midwifery clinical facilitation has been aptly described by the following quote:

> "*I think the facilitators play a very underrated but extremely important role in making people into midwives, turning students into midwives … You couldn't be a student midwife without that*." (P2)

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Appendix A

Participant Information Form

Exploration of midwifery students' perceptions of clinical facilitators and experiences of clinical facilitation.

Participant Information Form

HREC Project Number:	HRE2017-0585
Project Title:	An exploration of midwifery students' perceptions of clinical facilitators and experiences of clinical facilitation during midwifery clinical placement in Perth, Western Australia.
Student researcher:	Peta Cornell, Masters Student, School of Nursing, Midwifery and Paramedicine, Curtin University
Supervisors:	Assoc. Prof Ravani Duggan (RN, RM, PhD), School of Nursing, Midwifery and Paramedicine, Curtin University Helen Godwin (RN, RM, MHPE), School of Nursing, Midwifery and Paramedicine, Curtin University
Version Number:	1
Version Date:	02/Oct/2017

What is the Project About?

Midwifery clinical facilitation is currently not well represented in the literature. We know that student midwives value positive role models in the clinical area and that clinical experience is an essential part of training to become a midwife. Clinical supervision while on placement may be provided by preceptors, buddies, mentors or clinical facilitators. Your clinical facilitator is the university representative that supports you while you are on clinical placement.

This research project aims to explore your (student midwife) perceptions of the role of the clinical facilitator and your experiences of clinical facilitation while on clinical placement.

It is important to gauge how clinical facilitation is experienced by midwifery students to offer insight and clarity to the role, provide feedback to facilitators and universities and identify areas for improvement. It is also important as it will add to the midwifery specific body of knowledge and identify aspects of clinical facilitation that may be unique to midwifery.

This study is being completed as part of a Higher Degree by Research course.

Who is doing the Research?

This study is being undertaken by Peta Cornell as part of a Master of Philosophy higher degree by research course. Peta will be supervised by Assoc. Prof Ravani Duggan (RN, RM, PhD) and Ms. Helen Godwin (RN, RM, MHPE) from the School of Nursing, Midwifery and Paramedicine, Curtin University. There will be no costs to you and you will not be paid for participating in this project.

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Curtin University

Exploration of midwifery students' perceptions of clinical facilitators and experiences of clinical facilitation.

Why am I being asked to take part and what will I have to do?
We are looking for students who are enrolled in an undergraduate midwifery program in Western Australia who have attended at least one clinical placement. You are invited to participate in a one-off interview (face to face or by telephone as is your preference). Interviews will be arranged at a time and place that is mutually convenient and is expected to take between 45 minutes to 1 hour. You will be asked questions about your experiences with clinical facilitation and your perception of the role of the clinical facilitator. A digital audio recording will be made so the researcher can concentrate on what you have to say and not be distracted with taking notes. After the interview the researcher will make a full written copy of the recording.

Are there any benefits' to being in the research project?
There may be no direct benefit to you from participating in this research however sometimes people appreciate the opportunity to discuss their feelings and opinions. We hope the results of this research will add knowledge about the student experience with clinical facilitation and may lead to improvements that benefit future students.

Are there any risks, side-effects, discomforts or inconveniences from being in the research project?
Apart from giving up your time, we do not expect that there will be any risks or inconveniences associated with taking part in this study. We do not anticipate this process will cause you to feel distress. But if you feel anxious about any of the questions you do not need to answer them. If the questions cause any concerns or upset, you can stop the interview and discontinue with the process. Sometimes just thinking about experiences can be upsetting. If you become distressed during the process or afterwards, please contact:

Curtin University Counselling Services
Telephone: +61 8 9266 7850 or 1800 651 878 (Free call)

http://life.curtin.edu.au/health-and-wellbeing/contact_the_counselling_service.htm

Edith Cowan University Counselling Services
Telephone: (61 8) 9370 6706

http://intranet.ecu.edu.au/student/support/counselling

Who will have access to my information?
The information collected in this research will be re-identifiable (coded). This means that the stored information will be re-identifiable which means we will remove identifying information on any data or sample and replace it with a code. Only the research team have access to the code to match to your name if it is necessary to do so. Any information we collect will be treated as confidential and used only in this project unless otherwise specified. The following people will have access to the information we collect in this research: the research team and, in the event of an audit or investigation, staff from the Curtin University Office of Research and Development. Electronic data will be password-protected and hard copy data (including audio tapes) will be in locked storage. The information we collect in this study will be kept under secure conditions at Curtin University for 7 years after the

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research has ended and then it will be destroyed. The results of this research may be presented at conferences or published in professional journals. You will not be identified in any results that are published or presented.

Will you tell me the results of the research?
We are not able to send you any results from this research while the study is ongoing, the final results will be disseminated in a publication in a journal after June 2020. The researcher's contact information is provided below should you wish to follow-up to obtain the results of the research.

Do I have to take part in the research project?
Taking part in a research project is voluntary. It is your choice to take part or not. You do not have to agree if you do not want to. If you decide to take part and then change your mind, that is okay, you can withdraw from the project. You do not have to give us a reason; just tell us that you want to stop. Please let us know you want to stop so we can make sure you are aware of any thing that needs to be done so you can withdraw safely. If you choose not to take part or start and then stop the study, it will not affect your relationship with the University, staff or colleagues. If you chose to leave the study we will use any information collected unless you tell us not to.

What happens next and who can I contact about the research?
Thank you for your time, interest and participation. Please do not hesitate to contact me with any further questions.

Peta Cornell

Masters Student

School of Nursing, Midwifery and Paramedicine, Curtin University

Telephone: 0423 987 796

E-mail: peta.cornell@postgrad.curtin.edu.au

If you decide to take part in this research we will ask you to sign the consent form. By signing it is telling us that you understand what you have read and what has been discussed. Signing the consent indicates that you agree to be in the research project and have your information used as described. Please take your time and ask any questions you have before you decide what to do. You will be given a copy of this information and the consent form to keep.

Curtin University Human Research Ethics Committee (HREC) has approved this study (HREC number HRE2017-0585). Should you wish to discuss the study with someone not directly involved, in particular, any matters concerning the conduct of the study or your rights as a participant, or you wish to make a confidential complaint, you may contact the Ethics Officer on (08) 9266 9223 or the Manager, Research Integrity on (08) 9266 7093 or email hrec@curtin.edu.au.

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Appendix B

Participant Consent Form

Exploration of midwifery students' perceptions of clinical facilitators and experiences of clinical facilitation.

<u>Consent Form</u>

HREC Project Number:	To Be Arranged
Project Title:	An exploration of midwifery students' perceptions of clinical facilitators and experiences of clinical facilitation during midwifery clinical placement in Perth, Western Australia.
Student Researcher:	Peta Cornell, Masters Student, School of Nursing, Midwifery and Paramedicine, Curtin University
Supervisor:	Assoc. Prof Ravani Duggan (RN, RM, PhD), School of Nursing, Midwifery and Paramedicine, Curtin University Helen Godwin (RN, RM, MHPE), School of Nursing, Midwifery and Paramedicine, Curtin University
Version Number:	*Must align with footer details*
Version Date:	*Must align with footer details*

- I have read the information statement version listed above and I understand its contents.
- I believe I understand the purpose, extent and possible risks of my involvement in this project.
- I voluntarily consent to take part in this research project.
- I consent to being audio-recorded.
- I have had an opportunity to ask questions and I am satisfied with the answers I have received.
- I understand that this project has been approved by Curtin University Human Research Ethics Committee and will be carried out in line with the National Statement on Ethical Conduct in Human Research (2007).
- I understand I will receive a copy of this Information Statement and Consent Form.

Participant Name	
Participant Signature	
Date	

<u>Declaration by researcher:</u> I have supplied an Information Letter and Consent Form to the participant who has signed above, and believe that they understand the purpose, extent and possible risks of their involvement in this project.

Researcher Name	
Researcher Signature	
Date	

Note: All parties signing the Consent Form must date their own signature.

Appendix C

Interview Question Guide

Interview Guide

1. Tell me about yourself and what stage of the course you are at?

Age	gender	midwifery primary degree/previous occupation
level of education	stage of course	how many placements with clinical facilitator
Most recent placement	what area/model	

2. Tell me about your most recent clinical placement and the clinical facilitation that you received?

3. Describe how you see the role of the clinical facilitator?

4. How did interaction with your clinical facilitator during your last clinical placement prepare you for your next clinical placement?

5. Describe how the role of clinical facilitator could be improved?

6. Do you have anything further you would like to add?

7. Is it ok for me to contact you again?

Appendix D

Data Management Plan

Research Data Management Plan

Research Project Title

An exploration of midwifery students' perceptions of clinical facilitators and experiences with clinical facilitation during midwifery clinical placements in Perth, Western Australia.

Research Project Summary

Clinical facilitation forms an integral aspect of the clinical experiences of midwifery students and provides a link for students between university and clinical placement. It is important to gauge how clinical facilitation is experienced by midwifery students to offer insight and clarity to the role of clinical facilitator in the midwifery context, provide feedback to clinical facilitators and universities and identify aspects unique to midwifery that may require further investigation.

Student Researcher/ Principal Investigator

Peta Cornell, Masters Student, School of Nursing, Midwifery and Paramedicine

Supervisor

Assoc. Prof Ravani Duggan, School of Nursing, Midwifery and Paramedicine

Ms Helen Godwin, School of Nursing, Midwifery and Paramedicine

Summary of the Research Project Data

This project involves the following data:

1. Approximately 20 digital audio recordings of interviews

2. Approximately 20 files of transcribed interviews

3. Files containing process of data analysis

Storage of Data

Audio recordings will be transferred to the Curtin University central research data storage (R drive) as soon as possible, which is set up according to standard Curtin Information Technology Services security and safeguarding protocols. Interviews will be de-identified during transcription. Files will only be transferred to a personal computer when they are being actively worked on. When work is completed they will be transferred to the Curtin University R drive and deleted from the personal computer. Files will be named to protect participant privacy and confidentiality.

Ethical, Confidentiality or Privacy Considerations

This project is a Masters project and will gather data from undergraduate midwifery students regarding their experiences and perceptions. Approval will be sought from the Curtin University Human Research Ethics Committee and work will not commence prior to this. Ethical permission will also be sought from Edith Cowan University before their students are contacted. The appropriate approval process for each of the universities on recruitment of students will be completed prior to commencement. The data is confidential. Data will be de-identified during transcription.

File Formats

Audio files and word documents.

Volume of Data

5GB

Retention Period

7 years (Minor outcomes).

Access and Re-use of Data

Only the researcher and the supervision team will have access to the data. Re-use of data will be addressed on a case by case basis.