

MEASURING THE QUALITY OF NURSING CLINICAL PLACEMENTS IN AUSTRALIA. DEVELOPMENT OF THE PLACEMENT EVALUATION TOOL (PET): A CO-DESIGN PROJECT.

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Authors

Lead and corresponding author

Simon Cooper, Professor, RN, BA (Hons), MEd, PhD, FHEA. Associate Dean Research, School of Nursing and Health Professions, Federation University Australia, Room 2W-249, Gippsland Campus, Churchill, Victoria Tel. +61 3 5122 8032. Email s.cooper@federation.edu.au

Twitter: [The ESS Collaborative@TheESSCollab](https://twitter.com/TheESSCollab)

Robyn Cant, Associate Professor, PhD, MHlthSc, Federation University Australia, Churchill, Victoria, Australia. Tel. +61 3 5122 8032 r.cant@federation.edu.au

Donna Waters, Professor, RN Paed Cert, BA, MHP, PhD, FACN. Head of School and Dean The University of Sydney Susan Wakil School of Nursing and Midwifery, M02C - 88 Mallett Street - Building C, The University of Sydney. Telephone +61 2 9351 0519. Email donna.waters@sydney.edu.au

Elise Luders RN RM MMid GCHPE GDCCU Lecturer School of Nursing and Healthcare Professions Federation University, Gippsland Campus, Churchill, Victoria Tel 0351226079. Email e.luders@federation.edu.au

Amanda Henderson, Associate Professor, RN, BA(Hons), PHD. Head of School, School of Nursing Midwifery and Paramedicine, University of the Sunshine Coast, University of the Sunshine Coast, Locked Bag 4, Maroochydore, DC QLD 4558, Australia. Email ahender1@usc.edu.au

Georgina Willetts RN RM MEd DEd FACN CMgr FIML Associate Professor. Head of Discipline & Course Director in Nursing; Department of Health Professions Faculty of Health, Arts and Design Swinburne University, Hawthorn VIC 3122 P: +61392148747 Email gwilletts@swin.edu.au

Marion Tower, RN, BN (Hons), MN, PhD. Director, Undergraduate and Pre-registration Nursing & Midwifery, School of Nursing, Midwifery & Social Work, University of Queensland, St Lucia, QLD 4072, Tel. +61 7 3365 3028. Email m.tower@uq.edu.au

Kerry Reid-Searl AM (RN, RM, Bhlth Sc, MClIn Ed, PhD) Deputy Dean Simulation, School of Nursing, Midwifery and Social Sciences, CQUniversity, Rockhampton. (07) 4930 9741 - Ext: 59741 Email k.reid-searl@cqu.edu.au,

Colleen Ryan RN, BHLTHSC, CERTIV TAE, GCCE, MHPE. Industry Liaison Educator, School of Nursing, Midwifery and Social Sciences, CQUniversity Australia, Noosa Campus, Noosaville, QLD Tel. +61 07 5440 7018. Email c.l.ryan@cqu.edu.au Twitter: [@ColleenLRyan12](https://twitter.com/ColleenLRyan12)

Kerry Hood, Head of School, Nursing at Holmesglen Institute, Melbourne, Australia. Tel 03 9209 5445 Kerry.Hood@holmesglen.edu.au

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MEASURING THE QUALITY OF NURSING CLINICAL PLACEMENTS IN AUSTRALIA. DEVELOPMENT OF THE PLACEMENT EVALUATION TOOL (PET): A CO-DESIGN PROJECT

ABSTRACT

Background: The quality of nursing clinical placements has been found to vary. Placement evaluation tools for nursing students are available but lack contemporary reviews of clinical settings.

Aim: To develop a feasible, valid and reliable clinical placement evaluation tool applicable to nursing student placements in Australia.

Design/methods: An exploratory mixed methods co-design project. Phase 1 included a literature review; expert rating of potential question items and Nominal Group Technique meetings with a range of stakeholders for item development. Phase 2 included on-line pilot testing of the Placement Evaluation Tool (PET) with 1000 nursing students, across all year levels at six Australian Universities and one further education college, to confirm validity, reliability and feasibility.

Results: The PET included 19-items (on a 5-point agreement scale) and one global satisfaction rating (a 10-point scale). Overall placements were positively rated. The total scale score (19 items) revealed a median student rating of 80 points from a maximum of 95 and a median global satisfaction rating of 8 of 10. Criterion validity was confirmed by item correlation: Intra-class Correlation Co-efficient ICC = .629; scale total to global score $r = .743$; and items to total score ranging from .609 to .835. Strong concurrent validity was demonstrated with the Clinical Learning Environment and Supervision Scale ($r = .834$). Internal reliability was identified and confirmed in two subscale factors: Clinical Environment (Cronbach's alpha = .94) and Learning Support (alpha = .96). Based on the short time taken to complete the survey (median 3.5 minutes) and students' comments, the tool was deemed applicable and feasible.

Conclusions: The PET was found to be valid, reliable and feasible. Use of the tool as a quality assurance measure is likely to improve educational and clinical environments. Further evaluation of the instrument is required to fully determine its psychometric properties.

Keywords: Clinical placement; clinical practicum; education; quality improvement; students; nursing.

INTRODUCTION

Nursing education programs across the world incorporate clinical placements experiences to assist learners to assimilate theory and practice (Kilminster, 2000). Approaches to quality assessment vary from 'in-house' reviews by education and clinical providers to the use of published student, educator and organisational survey instruments (Mansutti et al., 2017). Internationally, the quality of clinical placements is known to vary with reported positive (Lamont et al., 2015, Papastavrou et al., 2016, Warne et al., 2010), ambivalent (Jonsén et al., 2013, Budden et al., 2017) and negative experiences (Jarvelainen et al., 2018, Jamshidi et al., 2016). Clinical learning environments are varied and complex with multidimensional social networks which makes evaluation complex (Hooven, 2014).

In Australia, the Deans of Nursing and Midwifery (Australia and New Zealand) commissioned work to improve the quality of placements, which in the first instance requires the development of a contemporary instrument to measure students' placement experiences. As such the aim of this study was to use co-design principles to develop a feasible, valid and reliable clinical placement evaluation tool applicable to nursing student placements in Australia.

(NB: the use of the word 'supervisor' in this paper refers to the role of nurse mentor/ facilitator/ educator which, depending on the clinical placement model, may be a tertiary or organisational based position).

BACKGROUND

Undergraduate nursing students are required to complete clinical placement hours as part of their educational preparation. Internationally these hours vary from 800 hours in Australia, 1,100-1,500 in New Zealand, 2,300 in the UK, and 2,800 in South Africa (Miller, 2016). It is accepted that exposure to quality 'real world' clinical placement is essential to ensure competence and appropriate development of professional identity (Henderson et al., 2012); whilst the literature identifies that organisational, relational and individual factors influence the quality of clinical placements (Dale et al., 2013).

Within organisations there is a need for a consistent approach between educational and industry sectors to ensure appropriate management of clinical placements (Jokelainen et al., 2013). Enabling a sense of belonging during placement ensures that students feel welcome (Levett-Jones et al., 2007, Ford et al., 2016, Courtney-Pratt et al., 2015, Cooper et al., 2015, Jokelainen et al., 2013) whilst the support of a clinical supervisor generates a positive learning environment (Courtney-Pratt et al., 2015).

Relations that are encouraging and supportive promote mutual respect, trust and open and honest communication (Dale et al., 2013). Consistent and positive approaches from supervisors can overcome challenging clinical situations (Courtney-Pratt et al., 2012) whilst an awareness of students' level of

competence and learning requirements improve outcomes. Exemplary supervisors are well versed in the curriculum, clinical expectations and teaching practice whilst being motivated and approachable (Dale et al., 2013, Cooper et al., 2015, Jokelainen et al., 2013).

Individual students also harbour wide ranging interpretations of the clinical setting depending on their experience, resilience, and 'life skills', with the need to reduce vulnerability and create a positive learning culture (Ford et al., 2016). Thus, preparation of nursing students for graduate practice requires engagement in the learning process and accountability for their learning (Henderson et al., 2018). Frameworks that support active learning across educational and clinical settings and learning partnerships between supervisors and students are known to improve the quality of clinical placements (Perry et al., 2018).

With these considerations in mind it is imperative that rigorous evaluation instruments are available that measure the quality of placement experience, enabling improvements at placements sites and enhancing educational opportunities. There is therefore a climate of readiness for change and an essential need to develop a valid, reliable and feasible contemporary evaluation instrument that promotes national standards in clinical placement (Schwartz, 2019). The following sections describe the development of the Placement Evaluation Tool (PET).

DESIGN/METHODS

An exploratory mixed methods project incorporating participatory co-design principals was planned to actively involve those who will become 'users' of the tool throughout the development process (Sanders, 2008). Such user-centric methods included individuals with lived experience of clinical placements (i.e. students, lecturers, supervisors, etc.) engaged as active design partners to generate ideas, prototype, gather feedback and make changes (Streiner, 2015). Incorporating these principals, the aim was to develop a deep understanding of clinical placements and relevant high utility assessment approaches (Victorian Council of Social Services (VCOSS), 2015). The project was undertaken and supported by a working group of 10 nursing academics in seven Australian tertiary educational institutions across three states. The project included a Phase 1 tool development stage, incorporating six key steps, and Phase 2 pilot testing.

Ethical approval

Ethical approval for Phase 2 of the project (pilot testing) was obtained from the lead institution (Federation University Human Research Ethics Committee - B19-070) with reciprocal approval from a further six institutions/pilot sites. Informed consent was required and no incentives, such as gifts, payments, or course credits were offered for participation.

PHASE 1: Tool Development

Stage 1: Literature Review. A literature review was conducted to identify existing placement evaluation instruments. Ten original tools published between 1995 and 2015 were identified (see Appendix A) incorporating a total of 303 rated items.

Overall there was a lack of contemporaneous language, international and cultural differences, grammatical and translation errors and outdated contexts. Further, from a feasibility perspective, most tools were considered too lengthy with the majority including over 30 items.

At this stage the project team decided not to include negatively worded items based on their tendency to cause confusion. Acquiescence was thought to be unlikely as participants would be rating personal clinical experiences (Colosi, 2005, Dillman, 2011). Further, for feasibility, transferability and dissemination the tool was developed as a one page document, with generic ratings that are applicable for clinical placements in any health profession and country.

Stage 2: Review of published items. Two researchers reviewed the identified items, removing duplications and non-applicable statements, leaving 190 items for consideration. An expert panel of six clinical academics (mean years of nurse registration - 32) rated the 'Relevance' and 'Clarity' of these items to produce an Item Content Validity Index (I-CVI) (Polit and Beck, 2006). This enabled the exclusion, after discussion, of items that did not reach an acceptable level, i.e. an I-CVI of < 0.78. Approximately half the items were relevant and clear and were retained for further deliberation. Finally, several items from other broad generic training evaluation tools were selected e.g. Q4T (Grohmann and Kauffeld, 2013) and H-PEPSS (Ginsburg et al., 2012) with the intent of triangulating items with data generated in the Nominal Group meetings (described below) in the selection and adaption stage (Stage 4).

Stage 3: Nominal Group meetings. The Nominal Group Technique (NGT) is designed to generate ideas, explore opinions and determine priorities (McMillan, 2016), with previous use in, for example, diabetes education (Miller, 2000) and emergency care (Harvey, 2012). The Delphi Technique is an alternative consensus generating approach (Hsu, 2007), however questionnaires are circulated anonymously, as opposed to face-to-face meetings in the Nominal Group Technique, enabling a greater exploration of the field of focus (McMillan, 2016).

Two Nominal Group University based meetings were held, one in the State of Victorian and the second in the State of Queensland, Australia. The aim was to generate 'fresh' or 'novel' additional question

items related to clinical placement quality from participants with first-hand experience. In order to comply with the co-design principals of the PET project we recruited a convenience sample from a range of stakeholders in each University region to attend one of the two three-hour meetings. Participants were recruited by a researcher at each site aiming to ensure adequate representation. In the Victorian group two 2nd year students, three 3rd year students, two graduate year nurses, one clinical placement coordinator and one clinical educator attended. In the Queensland group two 2nd year students, five 3rd year students, two clinical placement coordinators and two nursing academics attended. Total attendees for the two groups was therefore 20.

The Nominal Group Technique is described in detail elsewhere (Cooper, 2020) but in summary the process included:

1. An introduction to the project aim and the NGT process.
2. Silent/individual generation of potential survey items on cue cards.
3. Round robin listing of items with discussion.
4. Group discussion and clarification of items.
5. Ranking of items.
6. Review and discussion regarding final listings.

By the end of each meeting a set of high priority evaluation statements was identified based on individual participants' ranking. Ranking was achieved by accepting only high priority items prioritized by at least three participants. Fifty-six items in total were carried over to the next stage.

Stage 4 - Selection and adaption of items. The principal researcher (SC) performed an independent primary analyses of items, followed by a five-hour meeting with three additional clinical researchers. Their clinical experience ranged from 27-37 years (mean 32). Potential items from the above stages were selected, adapted and thematised using a paper based tabletop approach. The principal researcher's initial development was then used as a reference point/check aiming for consensus. Individual items were listed under key themes e.g. supervision, the culture of the clinical environment, learning outcomes. A priori specification of items to Kirkpatrick's evaluation model (Kirkpatrick, 2007) - Level 1 (Reaction to the experience/clinical environment), Level 2 (Learning outcomes) and Level 3 (Behavioural change/practice impact) was also performed at this point. Items were then selected and wording was adjusted if necessary, generating a 20 item questionnaire.

A five point Likert scale was selected with a scale ranging from (1) 'strongly disagree' to (5) 'strongly agree'. An even numbered scale (forced choice) was not selected as participants were likely to require a mid-point response i.e. 'neither agree or disagree'. Further, a five point scale enabled a direct concurrent validity comparison with another validated tool - the Clinical Learning Environment and Supervision Scale (Saarikoski and Leino-Kilpi, 2002) (described below). A 20th item was included, as an overall satisfaction rating, with a response scale of 1 (very dissatisfied) to 10 (extremely satisfied).

Stage 5 – Tool review (educators and students). The draft tool was then circulated to 10 clinical educators from the states of Queensland, New South Wales, and Victoria and to 12 nursing students from Queensland and Victoria, in order to calculate the I-CVI prior to final selection. The expected I-CVI of >.78 was exceeded for relevance and clarity in all but three educator rated items, which were resolved with minor changes to wording.

Stage 6 - Deans of Nursing review. A final review was provided by 37 Deans of Nursing at a meeting in Brisbane (July 2019) where minor wording changes were adopted.

PHASE 2: Pilot testing and validation

Stage 1 - Pilot testing. The tool was pilot tested through an on-line survey at six Australian universities and one Technical and Further Education (TAFE) institution where Bachelor of Nursing degree students were enrolled (i.e. excluding Enrolled Nurse trainees). These sites were selected as they were led by a project team member who was also the Dean of School or their representative. One site ran a two year graduate entry Masters program whose students were excluded and a double degree nursing/midwifery four year program, where students were surveyed only after a nursing placement. At the time of reporting (19th November 2019) approximately 2,800 students had attended placement and were invited to complete the survey.

Purposive population sampling aimed to include all 1st, 2nd, 3rd and 4th year nursing students who had completed a clinical placement in 2nd Semester (July-December 2019). Invitations to complete the PET were distributed by a clinical administrator at each site, who provided the survey access link and distributed e-mail reminders. In this pilot testing phase, participants and their review sites were not identifiable. Participants were asked to rate their 'most recent' clinical placement with only one placement rating enabled.

The survey was uploaded to Qualtrics survey software (Qualtrics, Provo, UT, USA) enabling anonymized student responses. Three academics tested the survey for accuracy, flow, and correct response options. Access to the Participant Information Statement was enabled and consent requested via a response tick-box. Seven questions regarding demographics were included e.g. age group, year of study course, placement category (see Appendix B). This was followed by the 20-item PET and two open ended questions relating to students' placement experience and suggestions for improving the PET. Access to the survey was enabled via smart phones and computers. The survey remained open between July 2019 and February 2020 whilst students were completing their placements (*here we report survey outcomes from July to October 2019*). Finally, 62 students were approached at one university in order to measure the concurrent validity of the PET against the Clinical Learning Environment and Supervision Scale and to measure the test-retest reliability of the PET with the same test seven days later.

Stage 2 - In this final stage the aim was to confirm the validity, reliability and feasibility of the PET using applicable statistical and descriptive analyses. Outcomes are described in the results section below.

Data analysis

Survey data downloaded from the Internet were analysed using IBM SPSS vs 25 (IBM Corp, Armonk, NY, 2016). Descriptive and summary statistics (means, standard deviations, Chi-square) were used to describe categorical data whilst between group associations were explored using inferential statistics. Pearson's product moment correlational analysis of item-to-total ratings and item-to global-scores was conducted. The Intra-class Correlation Co-efficient (2-way random-effects model) (Koo, 2016) was used to examine inter-item correlation. $P = <0.05$ was regarded as significant. The internal consistency reliability was computed using Cronbach's alpha.

A Principle Component Analysis was conducted to identify scale items that grouped together in a linear pattern of correlations to form component factors, using the method of Pallant (2013; p. 189). The sample exceeded the recommendation of at least 10 participants for each variable (10 x 19) (Pallant, 2013). The factorability of data was confirmed by Bartlett's test of sphericity ($<.05$) of $p = <.0001$ and the Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy (range 0-1, .6 minimum) of .970, $p = <0.001$. The high KMO of .97 indicates a compact range of correlations with data appropriate for factor analysis (Field, 2013 p.877). An eigenvalue >1 was applied to extract the number of factors and a Scree plot showed two components. The correlation matrix was based on correlations above .3. Assisted by the large sample, the variables loaded strongly, as described below.

RESULTS

The validity and reliability of the PET was based on responses from the first 1,000 pre-registration nursing students who completed the survey (see Table 1). The response rate is estimated at 35% (1000/2500). The sample comprised students enrolled in the first to fourth years of a nursing degree. Participants represented three Australian States but the majority were in Queensland (50.9%) or Victoria (44.2%). Nearly all were female (89.9%); most were in the second year of their course (44.3%) and the most common age group was 20-25 years (31%). The majority were responding about their experiences of clinical placement in an acute health services setting (59.7%) followed by Mental Health (16.3%) or Aged Care (16%).

Table 1: Characteristics of nursing student sample (n=1,000)

Variable	Category	Total no./%
Gender	Female	898 (89.9)
	Male	100 (10.0)
	Other	1 (0.01)
Age group	19 or younger	137 (13.7)
	20-25	308 (30.9)
	26-30	115 (11.5)
	31-35	116 (11.6)
	36-40	106 (1.1)
	41-45	99 (1.0)
	46-50	71 (7.1)
	51 or older	46 (4.6)
State in which enrolled	New South Wales	58 (0.06)
	Queensland	500 (50.0)
	Victoria	442 (44.2)
Course year: BN, BNSc	First year	235 (23.5)
	Second year	415 (41.5)
	Third year	303 (30.3)
	Fourth year	10 (0.01)
		(total n=963; 96.3%)
Double degree BN/BMid	First year	15 (1.5)
	Second year	18 (1.8)
	Third year	0 (0.0)
	Fourth year	4 (0.04)
		(total n=37; 3.7%)
Setting	Acute hospital	597 (59.7)
	Mental Health	163 (16.3)
	Aged Care	160 (16.0)
	Rehabilitation service	45 (4.5)
	Primary care/ community	23 (2.3)
	Other (palliative care, ambulatory care)	12 (1.2)
Placement Duration (days) by course year		Major responses in decreasing rank order:
	First year	10, 15 or 20; (range 2-120)
	Second year	15 or 10 (range 2-120)
	Third year	30, 25, 40, 15, 20, 10 (range 1-160)
	Fourth year	30, 55 (range 14-99).

Summary of participant ratings

Overall placements were positively rated. The total scale score (19 items) revealed a median student rating of 80 points from a maximum of 95; a mean of 77.7%; interquartile range 69-91; and a standard deviation of 16.2. Table 2 lists the means responses for each item.

There was positive skewness towards higher ratings; 15 of 19 items were rated above a mean of 4.0 of five points. The highest rated item was (6). 'Patient safety was fundamental to the work of the unit(s)', with a mean of 4.32, followed by item (19). 'I anticipate being able to apply my learning from this placement' (M = 4.23). The lowest rated items were (7) 'I felt valued during this placement' (M = 3.84) and 'I received regular and constructive feedback' (M = 3.89). Such responses indicate areas for future explorations.

Table 2: Summary statistics for nursing students' response to the prototype PET (n=1,000)

Scale item	Mean	Std. Deviation
1. I was fully orientated to the clinical area	4.04	1.10
2. Staff were willing to work with students	4.08	1.06
3. Staff were positive role models	3.99	1.06
4. Staff were ethical and professional	4.08	.97
5. Staff demonstrated respect and empathy towards patients/clients	4.17	.90
6. Patient safety was fundamental to the work of the unit(s)	4.32	.86
7. I felt valued during this placement	3.84	1.20
8. I felt safe in the clinical environment (e.g. physically, emotionally culturally)	4.18	.96
9. This placement was a good learning environment	4.12	1.17
10. My supervisor(s) helped me identify my learning objectives/needs	3.99	1.13
11. I was adequately supervised in the clinical environment	4.13	1.03
12. I received regular and constructive feedback	3.89	1.16
13. I was supported to work within my scope of practice	4.17	1.01
14. My supervisor(s) understood how to assess my clinical abilities	4.02	1.11
15. I had opportunities to enhance my skills and knowledge	4.09	1.14
16. I had opportunities to interact and learn with the multi-disciplinary team	4.05	1.20
17. I achieved my learning objectives	4.12	1.01
18. I have gained the skills and knowledge to further my practice	4.19	.97
19. I anticipate being able to apply my learning from this placement	4.23	.95
20. Overall, I was satisfied with this placement experience [rated out of 10]	8.7	1.82

From item 20 overall satisfaction with the placement experience was rated as high (median 8 of 10; 80%) with 285 (28.5%) participants being 'extremely satisfied' (10 out of 10) and an additional 356 (35.6%) rating between 6 and 9. A total of 33 students (3.3%) were 'very dissatisfied' and a further 83 (8.3%) were dissatisfied and rated the experience between 2 and 4 points. The open-ended comments provided by participants may help to deconstruct these issues in future.

The normality of the total scale score was confirmed by the Kolmogorov-Smirnov statistic (0.143, df 1000, $p < 0.001$) and Shapiro-Wilk Test (0.884, df 1000, $p < 0.001$). Although positive skewness was noted with scores clustered towards higher values (Skewness: 1.252) and Kurtosis (1.633), the conclusion was that these data were within the acceptable normal distribution range (Pallant, 2013).

Validity and reliability outcomes

The first objective in developing a measurement instrument is to demonstrate its validity - the degree to which it measures what it is intended to measure (Polit, 2013). This can be established using several statistical approaches including assessment of face/content validity, and construct validity (Streiner, 2015). The second main requirement is to test the reliability of the scale; the extent to which measurements are free from error and can be replicated (Daly, 2000), generally measured with correlational tests. Below, we describe the findings and present a summary in Table 3.

Table 3: Validity and reliability of the PET (19-items) (n=1,000)

Variable	No. in sample	Result	Significance (p-value)	Outcome
Construct validity				
<u>Content validity</u> I-CVI: Stage 5	12 students 10 educators	.82 .95	N/A	Valid: >.78 Valid: >.78
<u>Concurrent validity:</u> Correlation with CLES scale	62 students	.834	0.01	Valid: highly significant
<u>Criterion validity:</u> (a) Item to Total score (b) Scale vs Global score (c) Inter-Item correlation (ICC) (CI: 95%)	1,000 1,000 1000	.609 to .835 .734 .629 (CI: .618-.660)	0.01 <0.001	Valid >.7: highly significant. Valid- moderate correlation
Reliability				
<u>Internal consistency reliability</u> (Cronbach's alpha)				
(a) Clinical Environment	1,000	.94	N/A	Reliable (>.70)
(b) Learning Support	1,000	.96	N/A	Reliable (>.70)
Scale: Test and retest (Wilcoxon signed rank test)	8 students	z= -.677	.498	Acceptable non-significant difference at retest

Adequate construct validity was demonstrated by content validity measures, concurrent and criterion related validity all of which reached or exceeded expected values. In development stages the expertise of educators and students was used as a filtering mechanism to assure face validity and usability with acceptable outcomes from the I-CVI (Polit, 2013).

Concurrent validity with a volunteer sample of second year nursing students (n=62) in Victoria was measured using both the PET and the Clinical Learning Environment and Supervision Scale (Saarikoski et al., 2002, Saarikoski, 2018). Correlation was high $r = .834$ supporting the notion that the PET had high concurrent validity.

Criterion validity was measured via inter-item correlations, item-to-total score and correlation of the scale total score with the independent 'global' score. The 19 items were moderately to strongly

correlated. The Intraclass Correlation Coefficient (random effects model) of .639 for single measures showed non-significant differences among the 19 scale items ($p < 0.001$) - classified as a 'moderate' correlation (Koo, 2016). The corrected item-to-total correlation for the scale ranged from .609 to .835 and Friedman's Chi-square confirmed consistency ($p < 0.001$). There was no redundant outlier item with a low correlation. The total scale score was also strongly correlated with the independent global score ($r = .734, p = 0.01$) (two-tailed).

Test-retest with a sample of eight nursing students showed stability across PET ratings that were repeated after one week ($p = .498$).

Factor analysis

PCA was conducted to ascertain how the pattern of correlated items was able to describe experience. Analysis using Varimax rotation yielded a two-factor solution that explained 72.92% of the variance. The first factor had an eigenvalue of 12.624 and explained 64.44 % of the variance; the second, an eigenvalue of 1.22, explaining 6.475% of the variance (see Table 4).

The two factors that emerged were clinically meaningful: items number 1-8 formed one component that was labelled factor 1 'Clinical Environment'. Items 9-19 formed a second component which was labelled factor 2 'Learning Support'. Both subscales were found reliable (1) ICC= average measures .937 (CI .931 - .943), $p < 0.001$, alpha = .94 (8 items); (2) ICC= average measures .963 (CI .959 - .966), $p < 0.001$, alpha = .96 (11 items).

Table 4: PCA: Rotated Component Matrix (n=1,000)

Scale item	Component	
	1	2
1. I was fully orientated to the clinical area	.422	.486
2. Staff were willing to work with students	.424	.751
3. Staff were positive role models	.423	.809
4. Staff were ethical and professional	.344	.833
5. Staff demonstrated respect and empathy towards patients/clients	.292	.815
6. Patient safety was fundamental to the work of the unit(s)	.338	.759
7. I felt valued during this placement	.516	.694
8. I felt safe in the clinical environment (e.g. physically, emotionally, culturally)	.407	.738
9. This placement was a good learning environment	.658	.577
10. My supervisor(s) helped me identify my learning objectives/needs	.766	.290
11. I was adequately supervised in the clinical environment	.672	.482
12. I received regular and constructive feedback	.751	.408
13. I was supported to work within my scope of practice	.699	.499
14. My supervisor(s) understood how to assess my clinical abilities	.771	.330
15. I had opportunities to enhance my skills and knowledge	.790	.408
16. I had opportunities to interact and learn with the multi-disciplinary team	.718	.416
17. I achieved my learning objectives	.839	.328
18. I have gained the skills and knowledge to further my practice	.792	.400
19. I anticipate being able to apply my learning from this placement	.792	.397

Extraction Method: Principal Component Analysis.

Rotation Method: Varimax with Kaiser Normalization; two components are shaded.

In addition to test-retest reliability the Cronbach alpha statistic is a measure of the internal reliability/consistency with a range of 0- 1 and an expected standard $\geq .7$. The alpha reliability of the PET scales was: (1) Clinical Environment .94 (8 items); (2) Learning Support .96 (11 items). While these data appear high, inspection of the item-total correlation matrix for each scale revealed tightly clustered correlations with no downward influence on the overall alpha if a single item was removed (Tavakol and Dennick, 2011).

Translational impact: Kirkpatrick's Four Level Model of evaluation

Good practice in educational evaluation has been described as incorporating four levels of evaluation (Kirkpatrick and Kirkpatrick, 2007). Table 5 illustrates how items in the PET scale address the first three levels: Reaction, Learning and Behaviour. Level 4 Results - patient impact was not applicable in this instance.

Table 5: Translation of PET items to Kirkpatrick’s levels of evaluation

Kirkpatrick’s Level	PET Factor	PET Scale Items
LEVEL 1: Reaction to experience	Clinical Environment	(1) I was fully orientated to the clinical area (2) Staff were willing to work with students (3) Staff were positive role models (4) Staff were ethical and professional (5) Staff demonstrated respect and empathy towards patients/clients (6) Patient safety was fundamental to the work of the unit(s) (7) I felt valued during this placement (8) I felt safe within the clinical environment (e.g. physically, emotionally and culturally)
LEVEL 2: Learning	Learning Support	(9) This placement was a good learning environment (10) My supervisor(s) helped me identify my learning objectives/needs (11) I was adequately supervised in the clinical environment (12) I received regular and constructive feedback (13) I was supported to work within my scope of practice (14) My supervisor(s) understood how to assess my clinical abilities (15) I had opportunities to enhance my skills and knowledge (16) I had opportunities to interact and learn with the multi-disciplinary team (17) I achieved my learning objectives
LEVEL 3 Behaviour change	Learning Support	(18) I have gained the skills and knowledge to further my practice (19) I anticipate being able to apply my learning from this placement
LEVEL 4 Patient impact	<i>Not applicable</i>	

Students’ open text comments

Respondents were asked how the PET could be improved. The few responses received indicate that the overall tool was ‘good’, relevant and clear (see Table 6). Students’ comments about their personal placement experiences were numerous and diverse and will be described in a later report.

Table 6: Respondents open text comments concerning the tool quality

- *“The questions were really good and relevant”.*
- *“The survey covered all important aspects that facilitate our learning”.*
- *“Very good and precise”.*
- *“Appropriate amount of questions and great layout”.*
- *“Could include more room to discuss the needs of the student and what we as students felt was missing from the placement”.*
- *“Not all supervisors and staff can be judged the same. Some deserve a 1 and others deserve a 5”.*
- *“Was a bit unsure whether 'supervisor' meant RN buddies/ward CNE/university facilitator, but did not alter my answers as all were very supportive during my placement”.*
- *“I’m very glad this is something I’m able to complete and hope it will assist with placement selection”.*

Feasibility

The tool was planned as a short survey in order to increase participant acceptability (Qualtrics, 2019), however there was a degree of attrition with 91% of 1,196 who accessed the survey completing all items. For example, 5% percent (n = 59) exited at consent stage; 2% (n = 31) before providing personal details; and 1% (n = 23) at first survey item page break (Question 9).

In relation to completion time, noting that some participants may have left the survey open to return at a later date, 12 outliers (duration >1 hr) were removed identifying a median completion time of 3.5 minutes (SD 4.5) (range 1.1 mins to 44.5 mins).

DISCUSSION

There is international evidence that clinical placement experiences vary considerably (Jarvelainen et al., 2018, Dimitriadou et al., 2015, d'Souza et al., 2015, Warne et al., 2010). Organisational management, supervisory relations and student expectations need to be considered in order to adequately prepare nursing students for safe graduate practice (Dale 2013). With these concerns in mind we aimed to produce a feasible, valid and reliable clinical placement evaluation tool that would enable students to rate the clinical and educational environment and their learning experience, generating a national profile of placement experiences and quality.

The final PET includes 20 plain English items measuring two key factors – ‘Clinical Environment’ and ‘Learning support’ and three Kirkpatrick evaluation domains (Kirkpatrick 2007) - participant reactions to the experience/clinical environment, self-reported learning outcomes and behavioural change/practice impact. The latter is particularly important as educational programs rarely measure practice impact (Lim,

2011, Reio, 2017). As shown in Table 3, the tool exhibited statistically valid and reliable properties in all respects tested, for example reliability was established with a Cronbach alpha of .94 for the Clinical Environment scale and an alpha of .96 for the Learning Support scale.

The two key factors identified reflect the importance of a welcoming atmosphere and educational support, as expressed in many other published instruments (e.g. Salamonson et al. 2011). In the current study, although the single-item overall satisfaction rating was generally rated as high (mean 8/10; 80%), one in every eleven students were dissatisfied. This finding is of concern and confirms the need for a quality assessment tool and regular placement reviews.

The final participant open access PET is listed in Appendix C. Nineteen items are rated on a scale of 1 to 5 and the final global rating from 1 to 10. Potential scores therefore range from 20 to 105. A summed score of the first 19 items and the overall global rating are likely to be useful in feedback processes. No quality assessment 'cut score', i.e. acceptable or unacceptable placements, have been set as institutions should consider individual placement evaluations from multiple students with a combination of evaluation approaches. In this pilot trial of the PET institutions/students were not identified, but for quality improvement future sites must be identified to enable feedback and action.

The long term aim of this work is to produce a placement evaluation tool that is applicable across health disciplines in the developed world (McAllister et al, 2018). As such this primary development of the PET is limited as it focusses on one discipline –nursing, three States in one country – Australia and in the English language only. Future iterations will therefore be required including a national Australian nursing trial, testing and development for other health disciplines and rigorous translations (forward- backward) into additional languages. Additionally larger sample sizes are necessary to be sure of the test-retest reliability. Broader limitations of such tools must also be considered as the PET is an individual self-rating of experience with the need to take into account additional stakeholders reviews e.g. educators and hard outcome measures i.e. student retention, employment offers etc.

In summary, widespread use of a tool such as the PET, perhaps as a suite of assessment tools within a national registry of clinical placements, is likely to have an impact on both educational and clinical outcomes through applicable quality improvement programs.

CONCLUSION

In a survey of 1000 nursing students in Australia the PET was found to be valid, reliable and feasible across a range of measures. Use of the tool as a quality assurance measure is likely to improve educational and clinical environments. Further evaluation of the instrument is required to fully determine its psychometric properties. Future work with the PET will include a national nursing survey across Australian States and Territories, international and additional health discipline trials.

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Appendix A

Table A: Ten quantitative validated instruments for self-evaluation of pre-registration nursing clinical placements and their derivatives. Identified during the literature search in Stage 1.

Instrument	Author/ Year/ setting
Clinical Learning Environment Scale (CLE scale)	Dunn & Burnett, 1995 Australia, setting n/a (Dunn, 1995)
Clinical Learning Environment Inventory (CLEI)	Chan 2001, 2003 (Chan, 2002, Chan, 2003) Shivers, 2018, UK (Shivers et al., 2017) Salamonsen 2011 (Salamonson et al., 2011)
Clinical Learning Environment and Supervision scale (CLES)	Saarikoski and Leino- Kilpi, Finland (2002) (Saarikoski et al., 2009) Six further studies 2002-2012, various countries
Clinical Learning Environment, Supervision and Nurse Teacher scale (CLES + T)	Saarikoski et al. (2008) (Saarikoski et al., 2009) Ten further studies to 2016, in various countries and settings including hospital, primary care and in various disciplines. Four nurse studies in 2018 using interpreted tools. Mueller et al 2018 (Mueller, Mylonas, & Schumacher, 2018)
Modified Clinical Learning Environment, Supervision and Nurse Teacher scale (modified CLES + T)	D'Souza et al. (2015), Oman (d'Souza et al., 2015)
Clinical Learning Environment and Diagnostic Inventory (CLEDI)	Hosoda 2006 (Japan) (Hosoda, 2006)
Student Evaluation of Clinical Education Environment (SECEE)	Sand-Jecklin (2009), USA nursing students
Clinical Learning Environment instrument (CLE instrument)	Chuan and Barnett, 2012, Malaysia (Chuan and Barnett, 2012)
Teaching and Learning Survey- Students and Preceptors.	Robinson et al, Tasmania, Aust. 2007 (Robinson et al., 2007)
Quality Clinical Placement Evaluation Tool [QCPE]	Courtney-Pratt et al, 2013, 2015, Australia- nursing- Tasmania (Courtney-Pratt et al., 2012, Courtney-Pratt et al., 2014).
	Ford et al 2016, Aust nursing- Tasmania (Ford et al., 2016)

Source: see reference list for citations.

APPENDIX B

Demographic framework for collection of student data during pilot trial

1. Do you consent to this data being used for research purposes?

Yes No

2. What is your gender?

Male Female Other

3. To which age group do you belong?

19 or younger 20-25 26-30 31-35 36-40 41-45 46-50 51 or older

4. In which State are you enrolled in a nursing degree?

New South Wales Queensland Victoria

5. In which year are you enrolled? *(if a combination, list highest year)*

(a) If Bachelor of Nursing or Bachelor of Nursing Science

First year Second year Third year Fourth year

OR

(b) If another course (e.g., dual degree: Bachelor of Nursing/Bachelor of Midwifery)

Course title:

First year Second year Third year Fourth year

6. In which specialty/field was your most recent clinical placement?

Acute hospital Rehabilitation service Aged care Primary care Mental Health

Other Please identify speciality/field

7. How many days did you spend at this clinical placement?

.....days

Appendix C



The Placement Evaluation Tool (PET)

The student placement evaluation tool is found overleaf. In addition to this, institutions may wish to collect the following data. Please edit as required.

Citation: Cooper S, Cant R, Waters D, Luders E, Henderson A, Willetts G, Tower M, Reid-Searl K, Ryan C, & Hood K, 2019.

Funding: Council of Deans of Nursing and Midwifery (Australia and New Zealand).

Introduction

This survey has been designed to enable you, as a student, to evaluate your clinical placement. Please rate your experience and return this form to your university placement co-ordinator. This feedback will enable quality improvements with benefits to educators and students.

Your details

1. **Student name** **Student ID:**

2. **In which University/TAFE are you enrolled?**

.....

3. **In which State or Territory?**

Australian Capital Territory ¹

New South Wales ²

Northern Territory ³

Queensland ⁴

South Australia ⁵

Tasmania ⁶

Victoria ⁷

Western Australia ⁸

4. **In which year of a degree are you enrolled?** (if a combination, list highest year)

First year Second year Third year Fourth year

5. **In which specialty/field was your most recent clinical placement?**

Acute hospital ¹ Rehabilitation service ² Aged care ³ Primary care ⁴

Mental Health ⁵ Other ⁶ (Please name)

6. **What is the name of your placement health service?**

.....

7. **When did you attend placement (dd/mm/yyyy)?**

First day/...../.....

8. **My primary clinical supervisor was a:**

Facility Registered Nurse ¹ Facility Clinical Educator ² University Educator ³

The Placement Evaluation Tool (PET)

Use this scale to rate question items about your placement experience:

Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
1	2	3	4	5

Please circle the number that best matches your opinion

	Rating				
	1	2	3	4	5
1. I was fully orientated to the clinical area	1	2	3	4	5
2. Staff were willing to work with students	1	2	3	4	5
3. Staff were positive role models	1	2	3	4	5
4. Staff were ethical and professional	1	2	3	4	5
5. Staff demonstrated respect and empathy towards patients/clients	1	2	3	4	5
6. Patient safety was fundamental to the work of the unit(s)	1	2	3	4	5
7. I felt valued during this placement	1	2	3	4	5
8. I felt safe in the clinical environment (e.g. physically, emotionally, culturally)	1	2	3	4	5
9. This placement was a good learning environment	1	2	3	4	5
10. My supervisor(s) helped me identify my learning objectives/needs	1	2	3	4	5
11. I was adequately supervised in the clinical environment	1	2	3	4	5
12. I received regular and constructive feedback	1	2	3	4	5
13. I was supported to work within my scope of practice	1	2	3	4	5
14. My supervisor(s) understood how to assess my clinical abilities	1	2	3	4	5
15. I had opportunities to enhance my skills and knowledge	1	2	3	4	5
16. I had opportunities to interact and learn with the multi-disciplinary team	1	2	3	4	5
17. I achieved my learning objectives	1	2	3	4	5
18. I have gained the skills and knowledge to further my practice	1	2	3	4	5
19. I anticipate being able to apply my learning from this placement	1	2	3	4	5

20. Overall, I was satisfied with this placement experience. (Decide your overall rating on a scale of 1-10) (1 being very dissatisfied, 10 being extremely satisfied)	1	2	3	4	5	6	7	8	9	10

Please feel free to add additional comments about your placement experience:
