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Interpreting the Value of Feedback: Older Adult Feedback to Nursing Students in a Simulated Environment in Residential Aged Care

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Abstract

As patients, older adults are often involved informally with the teaching of nursing students in real clinical environments. This involvement is recognised as valuable; however, the role of the recipient of care is often passive. In recent years there has been recognition of the value that real people can offer from their patient experience to student education, and a move toward incorporating real patients into the formal education of students.

The Australian Institute of Health and Welfare report that adults aged 65 and over are the largest group of individuals admitted to Australian hospitals in the years 2014–2015.1 For students to be adequately prepared to care for the older adult, it was seen as essential that their involvement be formalised in nursing student education. In this education initiative, older adults, from both the hostel and independent living units (ILU) of a Residential Aged Care Campus (RACC), participated in simulated learning events as simulated patients, providing feedback to nursing students on the carative aspects of learning activities.

The aim of this study, therefore, is to contribute to the body of knowledge in the area of engaging older adults in simulated clinical activities, specifically in the provision of feedback to nursing students. To do this, the study will explore the experience of the participants giving feedback to nursing students. Of particular interest were the participants’ thoughts, beliefs, knowledge, reasoning, motivations and feelings about giving feedback.

A qualitative interpretive methodology was applied to this research to best capture the experience of the older adults providing feedback as simulated patients. This included the collection of data through participant observation, recording of field notes,
collection of a written feedback form, and semi-structured interviews with participants. Thematic analysis of the data was undertaken to identify emergent themes in the data.

Five main themes were identified from the data analysis: bringing self to the role, which referred to the influences from previous experiences and perceptions on how care should be delivered, which impacted on how and on what feedback was given; assisting students in their learning, which related to how verbal and written feedback was given; concern for students, which considered the responsibility the participants felt toward preparing the students for future practice; looking for clarity, which revealed the uncertainties felt by the participants in their role; and, finally, enjoying the role, which provided insight into the motivations for involvement of the participants in the learning activities.

The goal of this research was to contribute to the understanding of how older adults as simulated patients described their experiences of providing feedback. The findings from this study have emphasised the value of including the patient voice in nursing education and the unique feedback that they are able to provide through real-life experience, providing an understanding for students of the patient experience. The findings have also supported that provision of feedback by the older adults helped to support and nurture the carative aspects of nursing.

Unique to this study, however, was the finding that although the participants received no formal training in the delivery of feedback, all utilised frameworks recognised within the literature. A recommendation linked to this finding is that a feedback training program would be of benefit in reducing some of the feelings of uncertainty expressed by the older adults when giving feedback and better equipping them to deliver constructive feedback, enhancing the learning for the student.
Declaration

In accordance with the regulations for presenting theses and other work for higher degrees I hereby declare that this thesis is entirely my own work and has been completed during course enrolment at The University of Western Australia and has not been submitted for a degree at this or any other University.

Helen Dugmore (20908701)

25th August 2016
Acknowledgment

As this journey comes to its conclusion, I find myself reflecting on how I have reached this end. Like many of the participants in this study, the journey has been fraught with some challenging personal and professional times. I wish to gratefully acknowledge the following people who have assisted me in many ways to reach this milestone.

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On a personal note, I would like to extend endless thanks and love to friends and family who have been on this journey with me. To my husband John who lost his father after a long illness toward the end of this journey, but still managed to support me, your patience and strength is endless. To my sons Callum and Dalton, you are wonderful souls who make me laugh every day. Helene, thank you for the ‘Bun Runs’ and the opportunity to ask just one more research question; and to my sister Noeline for your unwavering support of me – if somewhat blinkered.
Glossary

Australian Nursing and Midwifery Accreditation Council - The organisation that is responsible for the development of accreditation standards for nursing and midwifery programs and the accreditation of Australian providers of nursing and midwifery education, and nursing and midwifery programs leading to registration and endorsement.

Clinical Skills Facilitator - Term used to describe the educator who is facilitating the teaching and learning of clinical skills in a simulated learning environment. In the context of this study, a Clinical Skill Facilitator is a registered nurse.

Simulated Clinical Learning Environment - Term used to describe the space that was created as a simulated learning environment as part of the Beyond the Teaching Nursing Home: Community Partnership of Learning and Care program.

Hostel – A term defined by the Australian government to categorise a residential aged care facility providing accommodation for older adults assessed as low care on admission, but the facility could allow residents to remain in the same facility as their care needs increased if services were available. (Since 1st July 2014 the term hostel is no longer in use and there is no distinction in facility name.)

Independent Living Unit – A term used to describe accommodation for an independent, older adult who does not require assistance with day-to-day living.

Nursing and Midwifery Board Australia – The organisation that is responsible for development of standards, codes, and guidelines leading to the registration of nurses, midwives, and students.

Older Adult – According to the World Health Organisation an Older Adult is classified as any person 65 years and above.
Registered Nurse – A nurse registered with the Australian Nursing and Midwifery Board of Australia after completing a degree from a higher education institution or equivalent accredited program.

Residential Aged Care Campus – Accommodation on the one site for older adults that includes a residential care home (offering different types of care based on assessment of needs including dementia, palliative, and respite care) and independent living units for persons aged 55 years and over.

Simulated Patient – A term used to describe an individual trained to act as a real patient in order to simulate a set of symptoms or problems.

Standardised Patient – A term used to describe an individual who is trained to give a consistent and pre-defined account of their condition. Standardised patients present identical/reproducible patient accounts.
List of Abbreviations

AIHW – Australian Institute of Health and Welfare

ANMAC – Australian Nursing and Midwifery Accreditation Council

BTNNH: CPLC – Beyond The Teaching Nursing Home: A Community Partnership of Learning and Care

SCLE – Simulated Clinical Learning Environment

CSF – Clinical Skills Facilitator

ILU – Independent Living Unit

SP – Standardised Patient

SiP – Simulated Patient

SPIF – Student Participant Information Form

SPCF – Student Participant Consent Form

OASiP – Older Adult Simulated Patient

PIF – Participant Information Form

PCF – Participant Consent Form

RACC – Residential Aged Care Campus

RN – Registered Nurse

WHO – World Health Organisation
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Chapter 1  Introduction

This study is the result of a desire to explore questions that arose whilst facilitating clinical skill learning activities at the University of Western Australia (UWA), where older adults living in residential aged care volunteered as simulated patients for nursing students. My experience found that the older adult residents in the simulated patient role provided a unique learning experience, and their ability to provide feedback to students contributed to the overall learning experience. This type of meaningful learning with real people, receiving simulated patient feedback, has the potential to contribute to the student’s future clinical practice.

As a Nurse educator, it has always been easy to recognise the benefits of students interacting in simulated and real clinical environments with simulated or standardised patients and actual patients. However, during my interactions I also observed the enthusiasm in which these older adults approached their simulated patient role and the commitment to the role over a three-year period. It was this sustained commitment and enthusiasm which ignited a curiosity in myself about the experiences of the older adults in the simulated patient role and how they gave feedback to nursing students.

My initial search of the literature found a dearth of literature to support the use of simulated, standardised, and real patients as a teaching strategy in health professional education. Limited literature was found to describe the experiences of simulated, standardised, or real patients in these roles, or of providing feedback to students. Not surprisingly there was no documented research of older adults living in residential care undertaking a simulated patient role or their experiences of giving feedback. Older adults living in aged care have not traditionally been utilised as simulated or standardised patients. To better understand their individual experiences and add to the
literature surrounding the involvement of older adults as simulated patients, formal Masters Studies were undertaken.

1.1 Background

It was not until the mid-1980s that nursing shifted from the traditional apprenticeship model of nursing to nursing as an academic discipline. With this shift, nursing education progressed through various iterations, from diploma qualifications to a bachelor degree, consistent with most other health professions. Nursing education is now situated within the higher education setting and is now student centred, the focus on students developing clinical reasoning and critical thinking skills rather than being passive recipients of information transmitted by the teacher. Nursing education is now theory led rather than practice led and students are now surplus to the requirements of the health service and learning opportunities closely linked to the course curriculum.

The transition of nursing has seen increased concern over the preparedness of newly qualified nurses for clinical practice and debate given to what is commonly known within the profession as the theory-practice gap. In an effort to ensure students were industry-ready upon graduation, the Australian Nursing and Midwifery Council (ANMC) adopted national competency standards for registered nurses in the 1990s to support nurses to deliver high quality, safe, and competent nursing care. The Nurses and Midwifery Board of Australia (NMBA) is now the governing body that is responsible for overseeing the regulation of these standards for registered nurses to obtain or retain registration. To ensure that higher education providers are producing graduates that meet these national competencies, the Australian Nursing and Midwifery Accreditation Council (ANMAC) provides a set of accreditation standards to guide the development of a nurse curriculum. These standards clearly outline that entry to practice programs
must “facilitate the integration of theory and practice,” and that “content and sequencing of the program of study prepares students for workplace experience and, wherever possible, incorporates opportunities for simulated learning.”

To ensure that theoretical teaching matches the clinical situation, educational strategies such as simulation have been extensively developed and incorporated into the contemporary nursing curriculum. Patient simulators are utilised to create patient scenarios; however, they lack authenticity and realism which can only be seen with the introduction of the real patient. There is an increasing tendency towards the use of volunteer patients in clinical teaching in the form of standardised or simulated patients, due to competition for clinical placements amongst health professions and the availability and appropriateness of use of the real patient. Volunteer patients provide a highly authentic learning opportunity, but also have the added bonus of providing students with immediate and constructive feedback, from the patient’s perspective.

Evidence from the literature suggests that Australia’s population is continuing to age. According to the Australian Institute of Health and Welfare, the number of people aged 65 and over has increased threefold in the past fifty years to 2014, with the most dramatic increase occurring in those aged 85 and over. The Australian Bureau of Statistics projects that in the next fifty years there will be 9.6 million people aged 65 and over, and 1.9 million people aged 85 and over. This presents a number of challenges to the health care system and, in particular, the provision of care to this ageing population. It is essential that nurses are provided with the knowledge and skills to care for this group. Indeed, it is a requirement of ANMAC that students are provided with the knowledge to meet the NMBA Registered Nurse Competency Standards. These standards state that registered nurses are expected to provide evidenced-based care to people of all ages and cultural groups.
The involvement of older adults as simulated patients in nursing student clinical skill learning activities not only provides a valuable learning opportunity with older people, but also provides a unique opportunity to receive feedback from a group of people who most likely have had their own patient experiences.

1.2 Context

This study arose from the researcher’s work as an academic tutor and clinical skill facilitator (CSF), teaching clinical skills with first year nursing students in a simulated clinical learning environment (SCLE). These classes were being taught in a purpose-built simulated ward, located within a residential aged care campus (RACC). The researcher observed that real benefit of this environment was the inclusion of older adults as simulated patients.

The current research is part of the project, Beyond The Teaching Nursing Home: A Community Partnership of Learning and Care (BTTNH: CPLC). This project was a partnership between UWA and an aged care provider (The Bethanie group) in Western Australia. The development of BTTNH: CPLC was modelled on the principles of the Teaching Nursing Home (TNH). A concise definition is difficult to establish; however, Barnett, Abbey, and Eyre\textsuperscript{13} have defined a TNH as a residential aged care facility in which care, education, and research are linked.\textsuperscript{13} The key characteristics of a TNH have been described by the authors as having a link between academic institutions and nursing homes with the goal of promoting patient care by increasing the knowledge of health professionals in the care of older adults.\textsuperscript{13} Another key characteristic of the TNH is the provision of education and clinical experience for students, which helps bridge the theory-practice gap of the older adult. When looking at the benefits of a TNH, Barnett, Abbey, and Eyre\textsuperscript{13} suggest they include: reduced hospital costs related to a reduction of hospital admissions; less functional decline of residents; and a reduction in the use of
sedation and restraints. Other benefits included positive student experiences and retention of staff.

The SCLE is located within one of two co-located hostels on the RACC, providing a dedicated learning space for clinical teaching and a link between the learning in clinical skills laboratories and that of the clinical environment. Health professions students from UWA, including nursing, medicine, and social work, are able to participate in clinical learning activities with the older adult residents of the hostels or ILU, who undertake a simulated patient role within the SCLE, developing a holistic view of care, and also participate in clinical care activities within the surrounding aged care environments.

Within the context of the SCLE, the older adults are referred to as participants in nursing activities and undertake a simulated patient role in scenario-based activities with nursing students which focus on a particular aspect of nursing care. For the purposes of clarification, the older adult residents who undertook the role of the simulated patient will be referred to as an Older Adult Simulated Patient (OASiP). Academic staff members provide the participants with a simulated patient script of the scenario and encourage them to share any previous experience of the healthcare system or hospitalisations, thereby enhancing the uniqueness and realism of the activity.

The ability for the OASiP to give constructive feedback to nursing students throughout their interaction within the SCLE is an integral component of the clinical learning activities. Feedback is provided by the OASiP, firstly through an informal process to the students (from a patient perspective), and secondly through a formal process via written feedback. This written feedback is given following the clinical activity and is centred on their thoughts and feelings of the nursing care they received from the students. The OASiP verbal feedback is focused on the professional and
carative components of the activity and is natural and immediate, whilst feedback from academic staff is focused on the knowledge, skills, and attitudes of the student, as well as the communication and personal interaction accompanied with the care delivered. This model of feedback can be seen as a novel approach as students receive feedback on their performance from both the older adult and the academic staff member.

1.3 Rationale of the study

According to Braun and Clarke,\textsuperscript{15} the rationale for a research study is to determine what the significance of the research is and what the research will add to the existing body of knowledge. The authors state that qualitative research “should have some social relevance and originality.”\textsuperscript{15(p 44)} Originality is described in terms of adding something completely new to knowledge or adding to it from a different perspective. Social relevance is described as the “so what” of the research – what does the research add and for what purpose is the research to be used\textsuperscript{15}.

The intent of the study was to explore older adults’ experiences of giving feedback as simulated patients to student nurses in a simulated environment during care activities. Following a detailed review of the literature, it was evident that literature existed to support the use of standardised, simulated, and real patients in health professional education. A great deal of literature also discussed the benefits of feedback to students to improve performance with some expansion on the benefits of feedback from standardised, simulated, and real patients. There was little literature discussing the experiences of standardised, simulated, or real patients, and none specific to older adults’ experiences of providing feedback as part of learning activities with health professional students.

This research study is aimed at contributing to the understanding of this unique group of people undertaking a simulated patient role and to explore their feelings and
motivations for doing so. Furthermore, the findings from this study may provide knowledge to educators wishing to incorporate older adults within clinical teaching for health professional students.

1.4 Research question

This study aims to explore the experience of older adults in a simulated patient role giving feedback to nursing students as part of clinical learning activities in a simulated environment.

The focused question for the proposed research then is:

"What is the experience of older adults in a simulated patient role giving feedback to nursing students in a simulated environment?"

From the main focus question, two sub-questions were addressed:

1. What is the experience of giving verbal feedback to nursing students in a simulated environment?

2. What is the experience of giving written feedback to nursing students in a simulated environment?

1.5 Organisation of the thesis

The thesis is organised into six chapters. Chapter 1 provides the background and the context to the research, followed by the rationale, aim of the study, and the research questions which guided the study. Chapter 2 explores the literature relevant to the study in two key areas: i) simulation: the theoretical underpinnings of simulation and the utilisation of standardised and simulated patients in health professional and nursing education; and, ii) feedback, and its use in health professional and nursing education and the provision of feedback by standardised and simulated patients. Chapter 3
presents the research design and methodology and approach to data analyses. This includes the setting for the research, the sampling and data collection techniques used, and the criteria for trustworthiness for the research. Chapter 4 presents the results and findings of the study, including demographic data and emerging themes. Chapter 5 discusses drawing comparisons to the literature and highlighting where new knowledge has been added. Finally, Chapter 6 presents conclusions, limitations, and recommendations for future research.

1.6 Summary

In summary, this introductory chapter has provided a context for the research within the tertiary education sector and the use of innovative teaching strategies of partnering with aged care providers for the engagement of older adults in teaching clinical skills to nursing students and providing feedback from the patient’s perspective. This was followed by the rationale, aim of the study, and research questions. The following chapter presents a review of the literature and the theoretical basis of the research.
Chapter 2  Literature review

2.1  Introduction

The purpose of this chapter is to explore the literature relevant to this study. Fain\textsuperscript{16} suggests that a review of the literature is necessary to discover what is already known in the research area, avoid duplication, and provide insights into developing a logical framework. Fain\textsuperscript{16} states that the literature review “provides the researchers with important information concerning what has been done and what needs to be done.”\textsuperscript{16(p73)} This chapter examines current literature relevant to this study in two key areas:

1. Simulation: the theoretical underpinnings of simulation and the use of standardised and simulated patients in health professional and nursing education;

2. Feedback; and its application in health professional and nursing education and the provision of feedback by standardised and simulated patients.

In conducting the review, the main strategy used was a search of the electronic databases for nursing, medicine, and education. These included CINAHL (Cumulative Index to Nursing and Allied Literature), Medline (Medical Literature Analysis and Retrieval System Online), and ERIC (Education Resources Information Centre) databases. Other sources of literature included reports, theses, dissertations, and reference lists contained in articles obtained from searches of the databases. The key words used to conduct the search included: older adults, feedback, verbal feedback, written feedback, standardised and simulated patients, real patients, feedback by simulated standardised and real patients, simulation, clinical learning environments, nursing education, and health professional education. The following literature review is structured to address the two key areas outlined above. Within each section, key
concepts are identified and explored, and the literature reviewed and discussed in the examination of these key concepts.

2.2 Simulation

To enhance the realism of the clinical learning within the SCLEs, educators have adopted the use of varying levels of simulation. Billings and Hallstead’s definition has been widely used within the literature and defines simulation as “a near representation of an actual life event; may be presented by using computer software, roleplay, case studies or games that represent reality and actively involve learners in applying the content of the lesson.” Nunn explains how simulation has been used in the fields of aviation and the armed forces where high-risk situations are commonplace; however, its use within the health professions for simulation of high-risk patient scenarios is relatively new. Bland et al. ascertain that simulation relating to clinical education is gaining momentum and the introduction into nursing education can be traced back to the 1950s in the United Kingdom, and is becoming more integrated into nursing education in the past twenty years. Over this period, Human Patient Simulators (HPS) have become increasingly sophisticated, offering different levels of fidelity from part-task trainers to full-sized mannequins. The development of medium- and high-fidelity simulators have made learning opportunities widely available and have allowed students to engage in realistic and clinically-focused learning strategies.

Fidelity in simulation refers to the accuracy or degree of realism. Baille and Curzio explain that the higher the fidelity the more realistic the experience. In a discussion paper on the concept of authenticity and fidelity in simulation, Bland et al. found that fidelity is essential when replicating clinical practice; however, they also believe that authentic environments can be created with a low level of fidelity. The authors add that the challenge for educators is to ensure that simulated environments are
an authentic representation of the clinical situation.\textsuperscript{23} Reid-Searl et al.\textsuperscript{25} highlight that a common complaint of students is that the simulation “does not appear real” especially with the use of low-fidelity simulation.\textsuperscript{25}(p78) The authors highlight that this perception then leads to a focus being placed on the acquisition of specific skills by the student, rather than considering the holistic nature of the person and their environment.

Patient involvement in teaching is becoming part of a more recent, broad trend in health professional education where patients, carers, and the community participate in health professional education in a variety of settings, and also contribute to research.\textsuperscript{26} This is consistent with the Australian Commission on Safety and Quality in Healthcare\textsuperscript{27} who advocate the use of engagement with patients, consumers, and their carers in order to achieve safer, more effective, and more responsive care. The use of simulated patients within SCLEs helps to address concerns highlighted by Berragan\textsuperscript{28} in an article examining the effectiveness of simulation as a pedagogical approach in nursing education. Whilst recognising the benefits of simulation, Berragan\textsuperscript{28} also asks the question “where is the patient?”\textsuperscript{28}(p661) highlighting that it is the patient with whom nurses interact on a daily basis through which they learn “how to be a nurse” as well as the skills required to be a nurse.\textsuperscript{28} Berragan\textsuperscript{28} suggests that, with the use of simulation, we may lose touch with the realities of patient care and, as such, simulation should occur as an adjunct to clinical practice and not as a replacement.

As a teaching pedagogy, simulation is used in contemporary nursing education worldwide\textsuperscript{9,21,28} as it provides greater opportunity for experiential learning, and students are able to learn by trial and error.\textsuperscript{9,23} In essence they are allowed to fail which is not permissible in the clinical environment. Simulation is defined by the Australian Nursing and Midwifery Accreditation Council (ANMAC)\textsuperscript{8} as “any educational method or experience evoking or replicating aspects of the real world in an interactive manner.”\textsuperscript{8}(p22) Simulation offers the student nurse the opportunity to practice
fundamental clinical skills but also provides the opportunity to experience and explore how it feels to be a nurse.28

Benefits of the inclusion of simulation in nursing education include: assisting students to apply theoretical knowledge to the clinical context helping to close the theory practice gap; development of the confidence and competence of the student in a structured safe environment thereby meeting concern for patient safety; immediate feedback is provided, thereby improving practice.22,23,28-31 Students have also reported enjoyment in simulation activities, stating that they feel engaged in the learning and that it may improve teamwork skills.32 In a systematic review of the use of simulation in nursing education between 1999 and 2009, Cant and Cooper29 reported on twelve studies finding simulation may be an effective educational method, citing that all twelve studies showed improvements in knowledge, skill, critical thinking, and confidence after simulation education.29

In response to concerns about the educational outcomes of simulation as an teaching and learning strategy in nursing and medical education, Jeffries33 developed a framework to assist in the designing, implementation, and evaluation of simulations. Jeffries claims that a framework for simulation is necessary to help guide research and determine the educational outcomes. The framework consists of five major constructs with associated variables within each, as highlighted in Figure 2-1.
The model draws on the work of Chittering and Gamson’s (1987) principles of good educational practice to define the educational construct of the model. Feedback is highlighted as essential within this construct to include in simulation design and implementation. Jefferies\textsuperscript{33}(p99) highlights that feedback in simulation provides students with immediate feedback on the cognitive, affective, and psychomotor elements of learning, helping to guide the student toward learning outcomes.

### 2.2.1 Theoretical underpinnings of simulation

Although simulation has been widely adopted within health professional education, the theoretical framework and best practice in simulation has been debated in the literature.\textsuperscript{34} Theories on experiential learning have been the most widely cited theories linked to simulation with Hope et al.\textsuperscript{9} drawing on the work of educational theorist John Dewey’s theory of experientialism where the “meaning of an action is related to its consequence.”\textsuperscript{9}(p711) Hope et al.\textsuperscript{9} propose that simulation is therefore an educational strategy in which students are able to observe the consequences of their
actions by trial and error, maintaining that learning in this way in the clinical environment may have negative outcomes for the patient.

The theoretical underpinnings of simulation as cited by Bland et al.\textsuperscript{22} lie in Kolb’s\textsuperscript{35} 1984 theory of experiential learning, and Lave and Wegner’s 1991 theory of situated learning. Berragan\textsuperscript{28} explores the work of both Lave and Wegner and Vygotsky (1978) as a medium through which simulation may be an effective pedagogy in nursing education, finding that the social environment in which nurses learn is vital. The author draws on the work of Lave and Wegner’s\textsuperscript{36} theory of situated learning to highlight the importance of the social element of the nurse’s role and how this links to learning in a community of practice. The authors claim that simulation as a learning environment offers not only the opportunity to practice and develop skills but also the opportunity to explore what it feels like to be a nurse.

Akella\textsuperscript{37} discusses Kolb’s experiential learning theory in terms of lifelong learning, finding it “spans the lifecycle of human development from young childhood to adulthood and encompasses activities, career choice, education, problem solving and interpersonal relationships.”\textsuperscript{37(p101)} Being broad in scope has enabled Kolb’s experiential learning theory to be used across disciplines such as nursing, medicine, education, and business. Thistlethwaite and Ridgway\textsuperscript{38} acknowledge Kolb’s\textsuperscript{35} theory of experiential learning as the foundation of working with simulated patients.

Kolb’s\textsuperscript{35} theory draws on the theoretical concepts of Dewey, Lewin, and Piaget, to provide an approach to education and learning. In the introduction to the revised edition of Experiential Learning\textsuperscript{39(pxiii)} Kolb\textsuperscript{39} asserts that he did not create experiential learning theory; rather, he discovered it in the work of other twentieth century theorists whose theories centred on the role of experience in human learning and development. Kolb describes these theorists as the “intellectual ancestors of experiential learning
Dewey stressed that learning through experience was of greater significance than learning through texts or teachers. Lewin focused on the integration of theory into practice, and Piaget focussed on the influence experience has on cognitive development. The aim of Kolb’s experiential learning theory was not to offer an alternate theory to those above, but to present experiential learning theory as an “integrative perspective on learning that combines experience, perception, cognition, and behaviour.” Kolb also acknowledges that there is confusion and debate as to the meaning of experiential learning, defining learning as “the process whereby knowledge is created through the transformation of experience.”

Experiential learning theory has four elements to describe how individuals grasp experiences and they transform experiences. Grasping experiences is described as the process whereby information is taken in and includes Concrete Experience (CE) and Abstract Conceptualisation (AC). Transforming experiences describe how information is interpreted and acted upon, including Reflective Observation (RO) and Active Experimentation (AE). The experiential learning theory process is represented in a cycle in which the individual touches all four elements.

The cycle is described as beginning with the learner having an experience (CE). This is followed by the learner making sense of the experience through a process of reflection (RO). Following this, the meaning that the learner draws from reflection on the experience is then conceptualised (AC) and learning needs are determined. Finally, the learner incorporates new learning into future practice (AE). The cycle can be entered into at any point, allowing for flexibility; however, for optimal learning, the learner should go through all four elements.

Most learners do not use the entire learning cycle and may only use one or two elements depending on their individual learning style. Kolb describes three learning
styles: diverging learners, who learn through concrete experiences and reflect upon their experiences; assimilating learners, who learn through reflective observation and abstract conceptualisation; converging learners, who learn best through abstract conceptualisation and active experimentation; and accommodating learners, who learn best through concrete experiences and active experimentation. Figure 2-2 provides an overview of Kolb’s experiential learning theory.

Figure 2-2 Kolb’s\textsuperscript{35} Experiential Theory

Kolb's model is applicable broadly to simulation experiences for learners, but is also applicable to the older adult as simulated patients within this study. Simulation represents the concrete experience of learners and reflective observation occurs during and after the simulation debriefing phase. Kolb's phase of abstract conceptualization allows learners to consider the relevance of the IPE experience, stimulates new ideas, and offers learners an opportunity to consider if anything should have been done differently during the simulation. During the active experimentation phase, learners test what was learned by applying knowledge to new situations such as additional simulations, clinical experiences, or work experiences.\textsuperscript{40}
Experiential theory was developed primarily for teaching and learning; however, it has been applied more recently for use with volunteers. The United Nations Volunteer program promotes the use of reflection as a tool to assist volunteers in gaining an understanding of the impact of volunteering, thereby enhancing the volunteer experience. Kolb’s theory is used by the program to give guidance as to how individual volunteering experiences lead to reflection, learning, planning, and application of learning to new experiences.

2.2.2 Standardised and simulated patients in health professional education

Within the context of this study, the older adults have been referred to as OASiP, referring to the role undertaken with students as part of learning activities. It is necessary to now provide background to the terms “simulated” and “standardised” patients to help the reader fully understand the role undertaken by the older adults.

Throughout the literature the terms standardised or simulated patients are used interchangeably, and are also referred to as “patient instructors”, “clinical teaching associates”, “volunteer patient,” or “programmed patients” and are described as individuals with or without “real” symptoms, who are trained by health care educators to act as patients. Neurologist Howard Barrows first documented the use of the standardised patient, suggesting that a “lay person” could be trained to simulate an illness and subsequently give feedback to medical students about their history and communication skills, leading to the term standardised patient. Barrows defined a standardised patient as an umbrella term for both a “simulated patient” – a lay person trained to portray an illness – and an “actual patient” – a person trained to present their illness in a standardised manner.
Nestel and Bearman\textsuperscript{49} suggest that the terms simulated and standardised patients refer to a largely similar group in that they are well people trained to portray a patient. The authors argue that standardisation of patient encounters in the learning environment is less crucial than in an assessment environment and can be advantageous in introducing all features of human behaviour. They have also suggested that within Australia the term simulated patient has been widely adopted to avoid confusion and that these patients present the gestalt of the patient being simulated, not only in terms of their history, but also the body language, the physical findings, and the emotional and personality characteristics.\textsuperscript{49}

The Australian National Health Education and Training in Simulation Program (NHET-Sim)\textsuperscript{51} and the Association for Standardised Patient Educators (ASPE)\textsuperscript{52} also recognise that terms are used interchangeably; however, they do acknowledge that the fundamental feature of the role is that these are well people trained to portray a patient. Stewart et al.\textsuperscript{45} and Boken\textsuperscript{53} have provided a clear definition of the terms seeing a Standardised Patient (SP) as an individual trained to portray consistent, reproducible patient problems, accurately depicting realistic clinical scenarios. The Simulated Patient (SiP) then is an individual trained to portray a patient; however, interactions with each student may differ, therefore not being consistent and reproducible.\textsuperscript{45,53}

Nestel and Bearman\textsuperscript{49} suggest the abbreviation SP be used to refer to either the standardised or simulated patient; however, within this study, to avoid confusion, SP refers to Standardised Patients and SiP to Simulated Patients. A clear definition between the two terms was seen in this study as the older adults did not portray consistent and reproducible patient problems consistent with a SP, but changed their performance in response to individual student care best fitting with the definition of a SiP.
Teaching strategies that incorporate SPs and SiPs have the benefit of enhancing educational experiences by moving learning from didactic acquisition of knowledge to practical application in patient encounters. SPs and SiPs provide a realistic, safe teaching experience, whereby clinical and communication skills can be practiced by students without negative impact to the “real patient.” As highlighted by Williams and Song, the effectiveness of this teaching method in improving clinical competence has been brought under review. In a recent study, Williams and Song conducted a scoping study of health literature aiming to explore the SP role in health professional education and how SPs contribute to the development of students' skills. Of the 968 articles identified, 33 were included and categorised into three domains: technical, non-technical and cognitive skills. As a result of the study, 24 of the 33 studies reviewed supported the use of SPs in health professional education, providing evidence for their continued use as a teaching methodology.

However, the literature has mentioned that cost has been a constraint on the use of SP and SiPs, leading education providers to consider alternatives to the usual paid SP and SiP. Owen and Ward-Smith adopted the use of near-peers (students in a more advanced stage of the course) as standardised patients. They suggested that the advantage of this model was decreased costs and recruitment time, mainly because volunteers were recruited from within the school. To overcome the identified issues with cost, Mandrusiak et al. adopted the model of using senior (Year 4) physiotherapy students to act as SPs for junior (Year 2 and 3) physiotherapy students. Mackey et al. also evaluated the use of senior undergraduate nursing students as SP. Whilst cost was recognised by these authors as a factor, the focus of the research was to identify if, through taking on the role of the SP, the students’ knowledge and skill was enhanced.

The impact of participation on the SP and SiP should also be recognised. As far back as 1995, Woodward and Glivia–McConvey found that SPs and SiPs developed a
“more balanced perspective regarding health care professionals.”

Although this study is nearly 20 years old, the findings are supported by contemporary literature as evidenced by Sielk et al. who suggested that these individuals gain a rare insight into the medical services. Gillespie et al. also explored the insight gained and found that, following this role, individuals became more actively involved in their own health and were critically concerned about the quality of care they subsequently received. Wallach et al. also found SP and SiP reported positive changes around expectations and understanding of healthcare providers and services.

Performance-related stress symptoms of SiPs have been reported in a number of studies. Rubin and Philp reported on a five-year longitudinal study in which simulated patients perceived their health to be worse one year after participation. In a study examining the impact of simulation upon those undertaking the SiP role, Bokken et al. found that 73% of the SiPs reported negative effects from performing in the patient roles. Stress symptoms suffered by the SiPs were reported as fatigue, dissatisfaction about their performance, and anxiety. The degree to which the symptoms were reported were relatively mild and it did largely depend upon the “role” the SiPs were playing. McNaughton et al. found that 69% of surveyed respondents reported residual effects from undertaking the patient role; however, they also found that through focus group questioning all SiPs reported residual effects lasting several days. Both studies found that the symptoms were mild and did not diminish their motivation for continued participation.

Blake et al. and Hardoff and Schonmann both reported on the use of adolescents as SiPs with medical students in separate studies. Both studies reported no adverse outcomes for the SiPs; however, Hardoff and Schonmann recognised that monitoring of the young SiPs was essential, recognising the vulnerability of these people and the emotional impact that taking on cases may have on them. Spencer and
Dales\textsuperscript{69} emphasise the importance of meeting the needs of SiPs and caring for them, recognising that it may be difficult for the SiP to detach from the role. The need to carefully recruit, provide good support for the SiP, and allow the SiP to de-role and debrief has been cited as essential steps in supporting the use of SiPs.\textsuperscript{38,69}

2.2.3 Standardised and simulated patients in nursing education

The clinical environment in which nurses now practice is increasingly complex. The patients which nurses now encounter as part of normal practice are more acute and have multiple complex health problems. A challenge for education providers of nursing programs then is to ensure that upon registration graduating registered nurses are skilled to cope with these challenges.\textsuperscript{70}

As highlighted, simulation and the incorporation of SPs and SiPs are an effective means by which students can be immersed in simulated scenarios which closely replicate the real clinical environment, thereby preparing students for practice. These benefits have been recognised within the medical arena; however, Bornais et al.\textsuperscript{71} suggest that this learning approach is relatively new to the field of nursing education and its benefits to undergraduate nursing education continue to be under investigated. This view is supported by Aebersold and Tschannen\textsuperscript{21} who claim there is a lack of empirical evidence showing the impact on patient outcomes.\textsuperscript{70} Bornais et al.\textsuperscript{71} add that there are limited studies that assess the usefulness of SP and SiP in undergraduate nursing education, citing that the literature identifying their use in nursing has been largely limited to postgraduate nursing programs or nurse practitioner programs.\textsuperscript{71} Bornais et al.\textsuperscript{71} examined the effectiveness of using SPs to improve health assessment skills amongst first-year undergraduate nursing students. Findings from the 108 students recruited to the study suggested that SPs were an effective teaching strategy, showing
that the students performed better in their Objective Structured Clinical Examination (OSCE).

Literature reviewed shows that SPs and SiPs are utilised in nursing education to predominantly teach interpersonal and therapeutic communication skills such as history taking and clinical skills such as and examination and assessment skills. The reason for this is perhaps understandable given that effective communication skills are an integral part of nurses being able to build therapeutic relationships with patients and lead to positive patient outcomes. Incorporating SPs in student nurse teaching initiatives provides an opportunity for students to practice how they communicate with patients, while learning and developing their interpersonal skills. Becker et al. also identifies that teaching nursing students therapeutic communication skills begins in the classroom and extends to the clinical environment, with the usual method of instruction consisting of random patient encounters observed by faculty in the clinical area. The authors suggest that using SPs offers an alternative approach to the traditional method of teaching and presents a patient problem in a clinically relevant and realistic way.

Recognising that the practice environment for nursing is becoming more acute and complex, requiring nurses to have sound clinical decision making skills, Schlegel et al. in a study of 70 second-year nursing students evaluated the effects of using SiPs in teaching students to plan nursing care. The authors felt that traditional educational methods did not encourage critical thinking and the transference of theoretical knowledge to the clinical environment. Through this study, Schlegel et al. found that students were able to identify and plan care more effectively, showing that the use of SiPs as a teaching methodology increases the students’ clinical decision-making skills.

Engagement of SPs in nursing has been shown within the literature to facilitate effective communication skills by undergraduate, postgraduate and Nurse
Practitioner students. In their scoping review of 33 health professional studies, Williams and Song included four nursing studies. One pilot study of 129 nursing students compared the effect of adding SPs to the usual didactic lecture delivery on teaching communication skills. Interestingly, this study by Becker et al. showed no significant difference between the two groups. Results did indicate, however, that students who participated in the SP methodology overwhelmingly described the experience as positive, creative, and meaningful. Schlegel et al. conducted a similar pilot study, comparing the learning outcomes of nursing students who received teaching on communication skills, which included SPs, with those students who were taught using traditional classroom-based methods. The results of this study did show that, through immediate oral feedback, the SPs positively influenced the communication skills of the nursing students.

2.3 Feedback

Hattie and Timperley define feedback as “information provided by an agent (teacher, peer, book, parent, self, experience) regarding aspects of one’s performance or understanding.” Providing effective feedback to students has been identified as an essential component of student learning and a core element of the educational process. Meaningful feedback is feedback that assists to guide learning, and reinforces effective behaviours, and should discontinue ineffective behaviours. The link between feedback and student learning and development was highlighted by Carless, discussing findings by Hounsell’s 2003 work, which found that with feedback on what was done well and what may need improving, students learnt faster and more effectively.

Within the health professional context, feedback was described by Thomas and Arnold with reference to Ende’s 1983 work, as “an informed, non-evaluative, and
objective appraisal of performance intended to improve clinical skills.”\textsuperscript{82} (p233) Within this definition, feedback is described as being focussed on observed behaviours, non-judgemental and formative, aimed at informing and improving future performance.\textsuperscript{82}

The process and format by which feedback is given varies. It can be described as formal (scheduled) or informal (spontaneous), defined by the number of participants (one-to-one or group), or by format (verbal or written).\textsuperscript{82}

The role of feedback then is to help the learner consistently achieve a desired level of performance. To assist the learner to achieve a high level of clinical performance, Thomas and Arnold\textsuperscript{82} suggest that feedback can be given for two purposes. Firstly, feedback can be given to address areas in which the learner is already performing well. The purpose being to reinforce and increase the frequency in which the behaviours are used. Secondly, feedback can be given to address identified gaps in performance. The aim then is to assist the student toward learning and reaching the required standard.\textsuperscript{82}

A review of the literature conducted by Hattie and Timpereley\textsuperscript{78} examining the factors that impact on learning and achievement of students, found that “feedback is among the most critical influences on student learning.”\textsuperscript{78}(p79) This was supported in a 2006 systematic review of literature by Veloski et al.\textsuperscript{85} looking at the impact of assessment and feedback on medical education. In their review of 41 studies, the authors found 32 demonstrated that feedback had a positive impact on performance.\textsuperscript{85}

2.3.1 Feedback in health professional education

As identified, feedback is crucial to the learning context; however, literature shows that health professional students feel they are receiving insufficient feedback, whilst faculty feel the feedback that is given is sufficient.\textsuperscript{80,86,87} Reasons for these differing opinions have also been discussed. In a qualitative study of undergraduate
students from a range of Schools completing degrees in Health sciences, Poulos and Mahony\textsuperscript{88} sought the students’ perspective of what constituted effective feedback from university teachers. From this study, the authors found that the students’ perceptions of what constituted feedback impacted on how effective the feedback was perceived. The authors also found that the timeliness of the feedback was essential to its effectiveness. Credibility of the feedback was also highlighted, showing that the students’ perception of the lecturer influenced how credible or not they perceived the feedback as being.

Carless\textsuperscript{81} reported on a mixed methods study of 460 staff and 1740 students across eight universities in Hong Kong. The students and staff’s perceptions on feedback were examined through the administration of a large-scale questionnaire survey, which explored various aspects of assessment and feedback. Further qualitative data was gathered to explore in more depth the perceptions of students on feedback through semi-structured interviews. From this study, Carless\textsuperscript{81} also determined that feedback was based in social processes and perceptions. Feedback may then be interpreted in different ways, and what constitutes feedback may also be disputed.\textsuperscript{81(p223)} The author also found that students’ perceptions and staff’s perceptions of what constituted useful feedback also differed.

From a critique of the literature on effective feedback in health professional education, Archer\textsuperscript{89} found that the challenges to giving effective feedback – that is feedback that is specific, positive and used to promote desirable performance – lie in current feedback models. The author found that these models are reductionist in their approach and are one-way, educator-driven processes.\textsuperscript{89(p101)} Possible reasons for this approach to feedback may lie in the challenging nature of attempting to deliver feedback in diverse settings in healthcare, such as small group settings, clinical skills sessions, and bedside teaching. These environments complicate how feedback is given and received. The feedback given must be honest and accurate, but also consider both
the emotional needs of the recipient and the safety of the patient. Archer also found feedback to have either a directive or facilitative function. Directive feedback informed the learner of what required correction, whereas facilitative feedback was a two-way process allowing suggestions and comments that assisted the learner to identify and develop their own learning plans.

Literature recognises that for feedback to be effective it must be specific, timely, and delivered within a positive framework. For this to occur in the health professions, performance in the clinical setting must first be observed which, as recognised, can be challenging. In a review of literature looking at the power of feedback in medical education, Norcini found that the observation of medical students in the clinical setting happens infrequently, thereby limiting the effectiveness of feedback. The author suggested that a cultural shift was required within the context of medical education to ensure that feedback was given priority and clinicians were given “protected” time in which to engage in the process. This concept of a change in culture is also supported by Archer who asserts that an integrated approach is required in which feedback is embedded in all activities and is a two-way process whereby students give feedback to teachers, and teachers to students.

An additional source of feedback which is unique to health professional education, is the feedback received from the patient. The patient is ideally situated to provide feedback that is immediate and highly contextualised which may be more influential on changing behaviours than that received from academic staff. In a mixed methods study of patients, students, and educators, Kent and Molloy explored whether patients could contribute to the learning of undergraduate physiotherapy students through providing feedback. The authors found that an obstacle to student feedback on performance was that often clinicians were not present to observe students clinically with patients, suggesting then that patients may help to fill this gap.
from this study are consistent with other studies which found patients provide valuable feedback on communication and interpersonal skills.\textsuperscript{55,86} Kent and Molloy\textsuperscript{86} found that there was potential benefits for the patient, the student, and the educator through the utilisation of patient feedback. The authors assert that the patient benefits as they develop a voice in the training of students, the students benefit as they receive feedback from non-traditional sources, and the educator benefits as a clearer picture is developed on student performance.\textsuperscript{86}

2.3.2 Feedback by standardised and simulated patients

Standardised and simulated patients are ideally situated to provide feedback to students from the perspective of the patient, as most have had experience of an illness and of seeing a health professional, and are therefore able to provide feedback and offer insight into the experience of being a patient.\textsuperscript{38} Howley and Martindale\textsuperscript{91} support this view and ascertain that feedback from the patient’s perspective is valuable in developing students’ interpersonal skills. Through a study in which the authors sought to determine the efficacy of feedback from standardised patients to medical students, they found that although further research was required there was evidence to support this process.\textsuperscript{91} Lin et al.\textsuperscript{92} offer a different perspective, finding that the efficacy of feedback from standardised patients was not supported in their qualitative study which explores the effectiveness of SPs in teaching interpersonal communication skills. The authors did highlight, however, that further research was required.

In a systematic review of the literature of feedback by SiP in medical education, Bokken et al.\textsuperscript{55} did not refer to efficacy but made reference to the value of feedback provided to the students by SiPs. This value is explained as the students valuing the feedback provided by SiPs “equally or more positively” than feedback provided by tutors. The authors found that students who had worked with SiPs were able to perform
skills better at six months than those that did not, surmising that perhaps the feedback received by the SiPs may have contributed to this.55

Bokken et al.’s55 systematic review made the distinction that, whilst there was a theoretical difference between the SiPs and SPs, they did not see this difference as significant. The term SiP in this study was adopted to define the lay person trained to portray a patient role. The authors’ search revealed 49 studies in which feedback by SiPs was described. In the majority, it was found that feedback was used to teach clinical and communication skills to students despite it being recommended that SiPs provide feedback from the patient’s perspective. It was also found in the review that the processes by which feedback was provided, and the domains in which simulated patients gave feedback, can lack scientific basis.55

A lack of clear standards with regard to what constituted effective feedback training for SPs and SiPs has also been identified in the literature.55 In critiquing the literature on feedback in health professional education, Archer89 highlights the need for training by asserting that feedback can be both productive or harmful if carried out without some knowledge of the feedback process. Webster et al.’s73 case study exploration of patient volunteers giving structured feedback to nursing students highlighted that training in the provision of verbal face-to-face feedback was essential to enhance the quality of healthcare training. The authors provided a training workshop to volunteer patients in the provision of verbal face-to-face feedback. They reported that after the volunteer patients had worked with the students they actively sought feedback on their performance but also on the feedback given to further develop their skills in feedback provision.73 A study by Stewart and Thistlethwaite45 also found training by volunteer SiPs to be beneficial, with 50% of participants in a feedback training session describing improved confidence in giving feedback.
Feedback by SPs and SiPs is given in various forms. From a literature review spanning 1996–2006 on training SPs to give feedback, Hatchett et al.\textsuperscript{54} found that the most commonly used formats were verbal or written feedback such as checklists. Bokken et al.\textsuperscript{55} support this, also finding that verbal feedback was often based on completed checklists. Of significance to this study is that Bokken et al.\textsuperscript{55} were only able to identify three studies in which SiPs gave written and verbal feedback from the patient’s perspective.\textsuperscript{55}

Literature exists to support the use of simulated patients within health professional curricula and highlights the value of feedback provided as part of learning activities. However, literature regarding feedback by simulated patients to nursing students has been limited, with the majority of literature highlighting work with medical students. The process of giving feedback and the need for training has been described in the literature; however, the experience of SPs and SiPs and, in particular, the older adults’ experience of participating in giving feedback to nursing students has been limited

\subsection*{2.4 Summary}

This chapter examined the literature relevant to the current research. This has included an exploration of clinical learning environments and the use of simulation with SPs and SiPs in health professional education. There is a wealth of literature outlining the use of SPs and SiPs in the teaching of clinical skills to health professional students; however, there is limited literature in regards to SPs and SiPs providing feedback to students. Whilst literature exists to support the use of simulated and standardised patients and the benefits for student learning, it is evident from the literature review that no literature was able to be located relating to the involvement of older adults in health
professional education or their involvement as SiPs providing feedback to nursing students. Chapter 3 presents the research methodology and design of the study.
Chapter 3  Methodology

3.1  Introduction

This chapter describes the research methodology and design of the study. It describes the research aims and questions as well as providing an explanation of the data collection process in two stages: conducting the field work, and conducting the interviews. This is followed by a description of the setting of the research, the sampling of participants, and the recruitment of participants for the study. In addition, reliability, validity, credibility, trustworthiness, generalisability, and ethical considerations are presented.

3.2  Interpretive approach

The interpretive paradigm was as the chosen for this study, as this paradigm, allows the participant to construct their own meaning of a situation and focuses on understanding and interpreting the phenomenon from the perspective of the participant. When looking at the notion of a paradigm in research, it can be seen as a framework or overarching system of beliefs and feelings about the world and how it should be understood and studied. Polit and Beck further support this statement by identifying that a paradigm is a general perspective on the complexities of the real world. There are five paradigms or worldviews generally accepted within the literature and can be described as positivism, post positivism, interpretivism/constructivism (or naturalistic inquiry), modernism, and post modernism. Quantitative research is centred mainly in the positivist paradigm, whilst qualitative research is centred within the naturalistic or interpretive/constructivist paradigms.

In naturalistic inquiry, realities are not fixed but are socially constructed according to naturally occurring events, with the content being dependent on individual
experiences and influenced by life experience.\textsuperscript{95,96} Multiple realities are therefore said to exist due to the varied versions of reality, which are individually and socially constructed. Interpretative inquiry requires interaction between the researcher and the study participants in order for meanings to emerge from the data; collaboratively, a meaningful reality is constructed.\textsuperscript{95} A relationship exists therefore between the researcher and the participant and cannot be separated with the goal being a deep, self-reflective engagement with the phenomena.\textsuperscript{95,97,98} Research characteristics include natural settings, qualitative methods, purposive sampling, inductive analysis, and tentative application of findings.\textsuperscript{96}

The interpretive paradigm was selected for the research to gain an understanding of the unique nature of the engagement of the OASiP in nursing student teaching. This understanding is important in providing insight into their experiences of giving feedback so as to inform development of resources to support and enhance teaching with older adults and simulated patients.

3.3 Qualitative approach

Streubert and Carpenter\textsuperscript{99} acknowledge that qualitative research is often undertaken to study human behaviour, and is grounded in the fields of social and behavioural science. Whilst originally generated for sociological research, qualitative research has been adopted by a diverse range of disciplines including health and education.\textsuperscript{99-101} It is concerned with understanding and illuminating naturally-occurring lived experiences and interactions within the social contexts of the participants – information that cannot be fully measured or understood through quantitative research methods.\textsuperscript{101} Quantitative research methods emphasise objective observation, accuracy, control, and collection of statistical data to test hypotheses and establish cause and
effect\textsuperscript{,93,95} whereas qualitative research focuses on the way people make sense of their experiences by exploring behaviours, feelings and language.\textsuperscript{98,100}

The main features of qualitative research have been described as being inductive, interactive, reflexive, holistic, and flexible.\textsuperscript{93} Inductive approaches are useful when little is known about an area of study as the researcher remains open to ideas which emerge from observing and listening to study participants. This “bottom up” approach is in direct opposition to quantitative research methods which take a “top down” approach to testing research ideas and hypotheses.\textsuperscript{93} Interactive and reflexive processes refer to the researcher getting close to the study participants in order to understand their perceptions and experiences whilst being reflexive or responding to participant cues in interviewing.

In order to gain a depth of information, and for participants to reveal their personal views, it is essential to build trust with the participants. Within this, the researcher becomes the data collection tool, whereas in quantitative methods the researcher administers the research tools.\textsuperscript{93} Holistic exploration focuses on understanding that participants cannot be viewed as separate from the environment – experiences are constructed by the environment in which they are bound. This holistic approach is consistent with nursing philosophy.\textsuperscript{93} Flexible methods of data collection allow the researcher to be creative and use multiple strategies to achieve understanding. This differs from quantitative research in which standardised tools are used and don’t differ from participants.\textsuperscript{93}

As highlighted in the literature review, there is relatively little known of the experience of volunteer patients in giving feedback to students. Therefore, in line with the features of qualitative research, an inductive approach was adopted whereby, through observation of feedback interactions and exploration of the OASiP experiences
of giving feedback in semi-structured interviews, impressions and understanding were formed providing a rich depth of data. A trusting relationship had been established with the older adults over a three-year period in which the researcher had worked as an academic tutor within the clinical skills environment, recruiting the older adults and facilitating the activities with the students. It was felt that, because of this relationship, the older adults would openly share the experiences of giving feedback, both positive and negative. The holistic nature of qualitative research was important to consider as the environment in which the research took place was located within the campus in which the older adults also resided. The experiences within the SCLE with nursing students may also overflow into daily life for the older adults, which may become apparent in the observation and interviews.

3.4 Situating the research

3.4.1 Research setting

This research was undertaken in a purpose-built SCLE within an aged care facility in Perth, Western Australia. The SCLE was constructed to resemble a 12 bedded ward, similar to those seen in a typical tertiary hospital and housed within a residential aged care environment (part of the Bethanie group).

This site consisted of two co-located hostels accommodating 60 residents and 50 Independent Living Units. At the time of the research (2014), the age range of the residents was 61–102, and across the two hostels 36 residents were classified as high care and 16 as low care. This classification system is based on the needs of the resident in relation to activities of daily living such as hygiene, mobility, and feeding. Importantly, this classification was reclassified in July of 2014 to accommodate individual needs and ageing in place for residents.
The SCLE was originally a 21 bedded Nursing Home, located within one of the hostels. This site was identified by UWA as a space that could be adapted for the education and training of a variety of healthcare students. This disused space was refurbished and equipped to a high standard with funding awarded from Health Workforce Australia (HWA) in 2012 to create the dedicated SCLE.

Within this space there is also a purpose-built tutorial room, suitable for up to 30 students to attend relevant lectures and workshops. There is also a community flat which enables students to replicate a community care environment alongside a Nurse Practitioner clinic, and a General Practitioners clinic. To add to the authenticity of a hospital environment, there is a treatment room where medications can be dispensed, as well as showering and waste disposal facilities.

Nursing students in their first year of the Master of Nursing Science (entry to practice) degree participated in clinical learning activities within the SCLE. As part of their course, students would attend the SCLE one day per week in which learning activities were constructed, whereby students could learn and practice clinical skills. In semester one and two of their course, nursing students participated in scenario-based activities with residents from the hostels and the independent living units who participated as the OASiP. Interaction with residents from the hostels or independent living units occurred for approximately one hour per day during the time period the students were on site. In all learning activities within the SCLE, students were expected to be in the UWA nursing uniform and have name badges clearly displayed, as would be the expectation in the real clinical environment.

The OASiP were provided with a script that described the patient scenario they were required to participate in. To encourage critical thinking by the students, relevant questions related to the scenario were also provided and the OASiP were encouraged to
ask any other questions from the patient perspective as the activity progressed. The scenario and scripted questions were essential for the learning activities as they provided the prompts for the feedback provided to the students. The scenarios were detailed and inclusive of the presenting complaint, previous medical history, social history, and medications relevant to the scenario. A sample of the patient volunteer script showing activities related to administration of intravenous therapy is displayed in Appendix A.

On completion of the learning activities with the students, the participants were encouraged to complete a written feedback tool which was collated and provided to the students during preparation for skills activities. This feedback tool was developed by the older adults as part of a Reference Group. This group was established for the purpose of providing insights from the older adult perspective on issues that may affect health professional education and the simulated patient experience (Appendix B). The model of learning between the OASiP and the nursing students within the SCLE is represented in figure 3-1.

Figure 3-1 Model of Learning with Students and OASiP in SCLE
The photographs below show the renovation of the site into a fully equipped clinical learning environment (Figure 3-2) and the interaction of the OASiP with the nursing students (Figure 3-3).

![Figure 3-2 Photograph of Refurbished Treatment Room in SCLE](image1)

![Figure 3-3 Photograph of Students Learning with OASiP](image2)
3.4.2 Sample selection

Sampling in qualitative research differs from quantitative research in that sampling is not made on a number of participants that will give statistically significant data; rather, sampling is made by looking for repetition or confirmation of previously collected data. A sample size in qualitative research tends to be smaller than those used in quantitative research. As the researcher is concerned with obtaining as complete an understanding about a phenomenon as possible, the size of the sample should not be the focus; rather, the purpose for which the sample is required should decide the number of respondents. According to Sandelowski, the objective of sampling in qualitative research is to obtain a sample size that is large enough to allow for a deep narrative inquiry leading to a new understanding of experience.

The population from which the sample for this study was identified were the older adults who participated in the learning activities with the nursing students in the SCLE. In the period of the 2014 study, 30 older adults from either the hostels or ILU participated over a period of 11 weeks: six weeks in semester one; and five weeks in semester two. Of this population, 16 were residents of the hostels, and 14 resided in the ILU accommodation.

3.4.3 Recruitment

Sampling within this study utilised a non-probability purposive technique. As the identified focus of analysis was the older adult’s experience of giving feedback, participants of the study were invited to take part in the research because they were of similar characteristics: older adult simulated patients from a residential aged care site engaged in the learning activities with the nursing student in a SCLE. This sampling strategy is consistent with qualitative research methodologies where participants are chosen deliberately in order to provide the necessary information. The sampling
strategy can also be considered an inclusion or exclusion criteria for the study, as recruitment was dependent upon the participation as an OASiP in the SCLE. Additionally, all participants were required to speak and understand English as the study collection method was an observation of verbal interaction and face-to-face interviews asking participants to recount their experiences of giving feedback. Due to the potential for miscommunication and misunderstanding, non-English speaking participants were not included in the sample.

All 30 older adults participating in the activities within the SCLE with nursing students were invited to participate in the research. An explanation of the research was provided to the older adults by the researcher, and those who expressed interest in the research were provided with the OASiP Participant Information Form (OASiP PIF) (Appendix C) and the OASiP Participant Consent Form (OASiP PCF) (Appendix D). These were taken by the older adults and any additional enquiries were answerable through researcher contact details on the OASiP PIF. Completed consent forms were returned to the researcher by the participants.

Although not interviewed by the researcher for the research, nursing students were also provided with information in regard to the research. As part of the study, nursing students needed to be informed that the researcher would be observing the feedback interactions between the participants and the nursing students. All students were given a Student Participant Information Form (SIF) (Appendix E) and Student Participant Consent Form (SPCF) (Appendix F) for the researcher to observe the feedback interactions which the students completed and returned to the researcher. Students were also given information that during the weeks of observation the researcher who was normally the academic tutor and CSF in the clinical learning environment would be present in the capacity of the researcher only and any queries in
relation to the skills being undertaken should be directed to the CSF employed by the researcher to cover teaching commitments during this time.

For the purpose of clarity, from this point forward, the term “participant” will be used when referring to the OASiP who participated in this study.

### 3.5 Data collection

In conducting the study, there were two distinct stages to the collection of the data:

Stage one: Conducting the Field Work consisted of:

1. Participant observation
2. Recording of field notes
3. Collection of written feedback

Stage two: Conducting the Interviews consisted of:

1. One-to-one, semi-structured interviews, conducted with each of the participants
2. Transcription of the semi-structured interviews

Each of these approaches to data collection are described in Figure 3-4, below.

<table>
<thead>
<tr>
<th>Data Collection Stages</th>
<th>Stage 1 - Conducting the Field Work</th>
<th>Stage 2 - Conducting the Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>May - September 2014</td>
<td>October - December 2014</td>
</tr>
<tr>
<td>Participant observation n=10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 minutes per participant. Five one hour sessions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recording of field notes and researcher reflections</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collection of participant written feedback tools</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Semi structured face to face interviews with participants n=10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transcription of semi structured interviews</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 3-4 Data Collection Stages
3.5.1 Stage 1: Conducting the field work

As identified above, stage one of the research study consisted of participant observation by the researcher, specifically looking at the feedback interactions between the participants and the nursing students. Participant observation is described in Holloway and Wheeler\(^{100}\) with reference to Jorgensen’s 1984 work, as allowing the researcher to uncover or reveal the meanings that individuals attach to everyday life. In essence, it allows the researcher to understand the individual, group, or culture being studied.\(^{100}\) Methods of participant observation are carried out in two distinct ways: structured or unstructured.

Structured observation occurs when the researcher has defined in advance what they will observe. Structured observation usually involves the use of checklists or schedules to observe physical or verbal behaviours and occurs within positivistic research.\(^{104}\) Unstructured observation occurs when the researcher has no predetermined ideas of what may occur, or if they do, these ideas may change over time as data is gathered. This type of observation occurs when the researcher wishes to understand and interpret behaviours and recognises that the individual cannot be separated from the environment.\(^{104}\)

The observation that was undertaken in this research was unstructured with the intention of exploring the experiences of the participants in giving feedback, watching when the feedback occurred, listening to what language was used, and observing the body language of the participants and students, all of which have been identified by Scott\(^{87}\) as essential skills when giving feedback. In preparation for entering into the participant observation period, a guide for observation was developed by the researcher (Appendix G) based on dimensions developed by Spradley’s 1980 work and adapted by Holloway and Wheeler,\(^{100}\) described in Table 3-1.
Table 3-1 Adapted Foci of Observation

<table>
<thead>
<tr>
<th>Dimensions of Social Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Space:</strong> the location in which the research takes place</td>
</tr>
<tr>
<td><strong>Actor:</strong> the participants in the setting</td>
</tr>
<tr>
<td><strong>Activity:</strong> what is being done</td>
</tr>
<tr>
<td><strong>Objects:</strong> the material object present in the setting</td>
</tr>
<tr>
<td><strong>Act:</strong> single actions that persons in the setting carry out</td>
</tr>
<tr>
<td><strong>Events:</strong> related activities and happenings</td>
</tr>
<tr>
<td><strong>Time:</strong> sequencing and length</td>
</tr>
<tr>
<td><strong>Goal:</strong> what people are aiming to do</td>
</tr>
<tr>
<td><strong>Feeling:</strong> what people feel and how they express their emotions</td>
</tr>
</tbody>
</table>

To assist in preserving the memory of the participant observations, audio recordings of the feedback interactions were taken with permission of participants and students, and hand-written field notes taken by the researcher. The researcher describes field notes as a method of recording what has been seen, heard, thought or experienced; however, they do not, in themselves, provide explanations and must be used alongside other qualitative data to establish meaning. These notes were then used as prompts to further develop field notes which were transcribed soon after the participant observation; again, this was to preserve memory. The researcher’s personal reflections and narrative about what was experienced was added to the field note transcript at this point. An example of this personal narrative is seen below.

_This was a positive learning experience for both the older adult volunteers and the students and a joy to watch as an educator. Both parties seemed to enjoy this experience immensely. I had the feeling that they were learning together! (Field notes 11/09/2014)_
3.5.1.1 Participant observation and recording of field notes

Participant observations took place from May to September in 2014, during the weekly nursing clinical skill learning sessions. Seven periods of observations were undertaken where the researcher observed the interaction of the participants in the simulated patient role with the nursing student for approximately 30 minutes (Appendix H). This time period ensured that a single interaction between a student and participant was observed in its entirety before the participant undertook the simulated patient role with another student. The period of four weeks ensured that all the participants in the study were observed for one session and that saturation was reached as no new data emerged after all participants were observed.

The presence of an observer has been noted to affect the behaviour of the participant in a number of studies. This was acknowledged by Turnock and Gibson\textsuperscript{106} who noted that the researchers in their observational study found their presence impacted on the behaviours of those being observed. In order to avoid this situation, Turnock and Gibson\textsuperscript{106} performed their observation from two varying positions: one close to the bed area, and the other further away. The authors discovered that by occupying a position further away from the bed area where the observations were occurring, new activities and interventions were noted.\textsuperscript{106} This was also noted by the researcher of this study who initially planned to sit close to the bed area so as to be immersed in the experience and to take field notes as the feedback occurred; however, it became apparent that the presence of the researcher as an observer may have impacted on the student’s interaction with participants and the activity to which they were involved. This is documented in the field note statement below.

\textit{I moved to just beyond the closed curtains were I could still see the interactions but was not in the line of sight of the student in response to the male student saying “Helen you are very scary today” to which I responded “I’m sorry I will stop}
writing if it is making you uncomfortable.” I feel this helped in the observation; the male student seemed to relax a little although still looked occasionally in my direction (Field notes 15/5/2014)

As a result of the above statement, future participant observations occurred with the researcher sitting further away from the bed area and recording of the field notes as dot points that could be elaborated on immediately after the period of observation.

Due to the number of participant observations that occurred, over time, the nursing students appeared to become more comfortable with the presence of the researcher which was demonstrated by the interactions appearing more natural. This is consistent with the work of other authors who acknowledge that the effect produced by the observer’s presence cannot be fully eliminated, but that after a while their presence can lead to the observer becoming “part of the furniture.” Four types of participant observation have been documented within the literature. The first is the complete observer, where there is no interaction between the researcher and the participant. The second is the observer as participant, whereby the researcher observes and may also participate in activities. The third is the participant as observer in which the researcher studies the group by becoming part of the group. The final type is the complete participant in which the researcher conceals their purpose and becomes a member of the group.93,101 In line with the flexible nature of qualitative research, the role of the researcher shifted from complete observer to observer as participant. This role was less limiting and did not require the participants or the students to separate the role of the researcher from that of an academic tutor (the researcher’s usual role).

3.5.1.2 Written feedback tool

The final data collection in stage 1 consisted of the distribution of a written feedback tool for participants to complete. The written feedback form was developed by the BTTNH project reference group and was completed by the participants after each
learning activity session with the students. The form consisted of two sections. The first section contained six statements which addressed the overall interaction of the students with older adult patient volunteers. The group decided that a yes/no response in this section rather than a traditional Likert response would be used to answer the questions.

The second section of the form allowed for expanded comment, whereby participants could provide comments relating to “Positive comments for the students”, “Suggestions for improvements for the students,” and “Any other feedback or comments.” Participants were encouraged to complete the form and give it to the tutor after the activities, but some preferred to take the form home and deliver it to the secure onsite program mailbox.

3.5.2 Stage 2: Conducting the interviews

In stage two of the research study, the ten participants were invited to provide further detail of their experiences through an in-depth, semi-structured interview. At the start of the interviews, descriptive demographic data was collected to identify the characteristics of the participant sample. This included age, gender, accommodation type (either hostel or independent living), marital status, and highest educational level. Previous experience in participating as an OASiP within the clinical learning environment with the nursing students was also gathered.

3.5.2.1 Semi-structured interviews

A range of data collection is used within qualitative research amongst which interview and observation are used predominantly. Interviews and observations in qualitative data collection are seen as the most effective methods to gain an emic perspective, that is, to gain an insider’s view of the participant’s experience. Interviews may occur on a one-to-one basis or take place in the form of focus groups
and can be structured or semi-structured. Semi-structured interviews generally utilise an interview guide which will cover the focus issues and lines of inquiry that the researcher wishes to follow; this ensures that similar types of data is collected from all participants. The researcher is, however, able to be flexible in the sequencing of questions and remains reflexive to the participant’s cues, expanding on some responses to gain a deeper view. The narrative that is gained from the interview forms the basis of the qualitative data, where new ideas or areas are uncovered that were perhaps not anticipated by the researcher. The purpose of the semi-structured interviews with the participants in this study was to provide in-depth information about the thoughts, beliefs, knowledge, reasoning, motivations, and their own feelings about giving feedback.

The interviews with the participants were held in their own rooms at a time suitable to the participants and were audio recorded with the permission of the participants. As stated, these were semi-structured, in that the participants were asked the same questions; however, they were also encouraged to speak freely of their experience. Different wording and prompts within the interviews were used to further elicit or clarify the participant’s experience of giving feedback to nursing students. The face-to-face nature of the interviews also encouraged an environment that was personal and enabled the development of rapport between the researcher and the participants. This has been highlighted as essential to creating an environment in which the interviewee feels supported to share information.

The questions for the interviews were designed to explore the aims of the research with the interviews generally starting with a broad guiding question such as “Tell me about your experience of giving feedback to nursing students”. This prompted a generalised discussion about the participant’s experiences. These guiding questions were then broken into prompting questions which addressed areas around “how”
feedback was given and “what’ elements of the students” performance the participants felt comfortable giving feedback on (Appendix I). Whilst these broad questions guided the interview process, it became evident after commencing the interviews that it was important to let participants start where they wished in recalling experiences of feedback. This allowed the interview to develop, adding richness to the data which comes from allowing people to retell their own stories. A challenge during the interviews was ensuring that the researcher had a clear understanding of the participants’ responses. During the interviews, when the researcher was unsure of responses, additional probing questions were asked to clarify understanding. An example of this is seen in the interview transcript, below, with the researcher clarifying what is meant by “feeling.”

Researcher: When you think about the feedback that you gave, would you give verbal feedback throughout the scenarios?

Participant 10: Yeah I think so and, and well I tried to anyway, and let them know how I was feeling.

Researcher: How you were feeling? So you’d give feedback from a patient perspective, is that what you’re saying?

Participant 10: Yes, from a patient perspective. Like they’d say how are you going and I’d say oh you know, ‘cause we were playing the roles so I would go into the, oh not too well today it’s a bit sore or whatever the wound or illness was that we were treating.

All interviews were transcribed verbatim and each participant was assigned a code to ensure all data was de-identified. All data for each participant – interview, audio recording of observation, field notes, and written feedback form – were assigned the same code: Female Participant 1 – Interview Transcript (IT), Female Participant 1 – Field Note (FN), Female Participant 1 – Participant Observation (PO) and Female Participant 1 – Feedback Tool (FT). Consistency in the coding for the participants
ensure complete sets of data for one participant could be reviewed and then compared with other participants’ complete sets of data.

3.6 Data analysis

Qualitative data analysis is an interpretive process of reviewing, integrating, and interpreting data collected to describe and explain the phenomenon being studied. It is more subjective in nature than the positivist approach to data analysis and involves progressively and repeatedly exploring the data and comparing and contrasting different elements of the data to build a comprehensive meaning. The analysis of data in qualitative research begins with the researcher immersing themselves in the data in the search for categories or themes. A definition of a theme that is widely accepted in the literature is provided by DeSantis and Ugarriza. “A theme is an abstract entity that brings meaning and identity to a recurrent experience and its variant manifestations. As such, a theme captures and unifies the nature or basis of the experience into a meaningful whole.”

Thematic analysis has been described as a foundation for qualitative research analysis and can be seen as a research tool that is flexible and useful and thus yields a rich, detailed, and complex account of data. Braun and Clarke describe thematic analysis as a method of analysis used to identify, analyse, and report patterns (themes) within data. The authors describe themes emerging from the data in two fundamental ways: either inductively or a “bottom-up” approach; or in a deductive or “top-down” approach. An inductive approach means that the themes are strongly linked to the information derived from the data and are not driven by the researcher’s preconceptions. In contrast to this approach, a deductive approach to analysis is driven by the researcher’s predetermined theoretical framework in order to test or prove a hypothesis.
As described by Braun and Clarke,\textsuperscript{15} an inductive approach to thematic analysis was undertaken in this study to explore the data collected for emerging themes. These phases are described in Table 3-2.

Table 3-2 Braun and Clarke\textsuperscript{15} Phases of Thematic Analysis

<table>
<thead>
<tr>
<th>Phase</th>
<th>Description of Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Familiarising yourself with the data</td>
<td>Transcribing the data, reading, and re-reading the data, noting down initial ideas.</td>
</tr>
<tr>
<td>2. Generating initial codes</td>
<td>Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.</td>
</tr>
<tr>
<td>3. Searching for themes</td>
<td>Collating codes into potential themes gathering all data relevant to each potential theme.</td>
</tr>
<tr>
<td>4. Reviewing potential themes</td>
<td>Checking if the themes work in relation to coded extracts and the entire data set, reviewing data for additional themes, generating a thematic map of the analysis.</td>
</tr>
<tr>
<td>5. Defining and naming themes</td>
<td>Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.</td>
</tr>
<tr>
<td>6. Producing the report</td>
<td>Selection of the vivid, compelling extract examples, final analysis of selected extracts, relating the analysis back to the research question and previous literature reviewed.</td>
</tr>
</tbody>
</table>

A combination of manual data analysis and a computer-assisted software package NVivo\textsuperscript{112} were used by the researcher in the analysis and display of data from transcripts, and was organised according to emerging themes and concepts. The codes and themes were also confirmed by an external reviewer. Initial analysis of the data was undertaken in the stages of the study identified above.

Data obtained in phase 1 of the study was revisited and all field notes, audio recordings, and feedback forms for each participant were listened to read and re-read to gain an overall impression of the information. Interview recordings for each participant were transcribed and checked against the original audio recordings for accuracy. These were again read and re-read to immerse the researcher in the participant’s experience.
At this point, notes were taken by the researcher of all the data to start the critical process of thinking about what the data meant and to help identify ideas for coding.\(^{111,113}\) Once familiarised with the data, phase 2 of analysis involved organising all data into data sets for each participant; as described previously, this included field notes, participant feedback forms, and interview transcripts for each participant, and systematic analysis of the data through coding commenced. In this process, the researcher continuously moved across each participant’s data, identifying and coding elements of the data that related to the researcher’s question. As each participant’s data set was coded, recurrent codes began to emerge and some provisional codes modified to incorporate and be representative of new material.\(^{113}\) This process of coding was guided by the research question and objectives.\(^{118}\)

An example of the coding process is displayed in Table 3-3 with the coded data from the interview transcripts relating to the question, “Can you tell me about your experiences of giving feedback to the nursing students?” Aspects of the transcript highlighted various elements of the participants’ experiences which impacted on how the participants gave feedback or what the influences were on how feedback was given...
### Table 3-3 Example of Coding Process

<table>
<thead>
<tr>
<th>Data Extract</th>
<th>Coded For</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well I, I often find that the main problem with them is nervous. They, they have, have what they’ve got to do in their minds and they fumble a bit because you can see they’re uptight. Yeah often, often this is the case. (Participant 3)</td>
<td>Observing student</td>
</tr>
<tr>
<td>And I’m not, I’m not particularly surprised at that because I can plainly remember that when I was a youngster and working in the early years at my trade, that if there was a, a charge hand or a foreman standing close by me and watching what I’m doing and I probably felt the same then. (Participant 3)</td>
<td>Experience of receiving feedback</td>
</tr>
<tr>
<td>But they seem to do what you’ve taught them I think and they do, they start off very nicely and polite, they’re always polite and make sure does that hurt or whatever. They do, they do interact quite well (Participant 1)</td>
<td>1. Uncertainty</td>
</tr>
<tr>
<td>But they seem to do what you’ve taught them I think and they do, they start off very nicely and polite, they’re always polite and make sure does that hurt or whatever. They do, they do interact quite well (Participant 1)</td>
<td>2. Observing student behaviour</td>
</tr>
<tr>
<td>Yes. I found that they were, well I thought it was a really good thing to do because it was good for us as well as good for the students because we both learned from each other and you know they were all lovely young people and from different countries too. You know and you know they, they found, I mean some of them might not have had grandparents so I think instead of using like the ordinary dummies, using us they got interaction so they had to talk to us. (Participant 2)</td>
<td>1. Learning new things</td>
</tr>
<tr>
<td></td>
<td>2. Exposure to older adults</td>
</tr>
<tr>
<td></td>
<td>3. Realism</td>
</tr>
</tbody>
</table>
In phase 3 of the data analysis, the coded data were reviewed to identify themes. Themes were identified using an inductive approach, meaning the themes were formulated by the data rather than the data fitting a preconceived theme formulated by the researcher. In this, patterned responses or relationships across the codes were identified and interpretation was made in relation to the research question. These themes were then reviewed and, if appropriate, collapsed into a broader theme or split into more specific themes in phase 4. Once themes were identified, all data sets were revisited to enable review and amalgamation of subthemes under main themes. All main themes were checked and rechecked against the coded data to establish that they were relevant to establishing the experience of giving feedback.

As identified by Braun and Clarke, a thematic map was developed in phase 5 giving a visual representation of the identified themes and subthemes. Table 3-4, below, provides a section of the thematic map developed showing the initial development and naming of themes “Bringing Self to the Role” and “Looking for Clarity.” This was a useful tool in assisting the researcher to stay close to the research aim and answer the questions of what was occurring in the experiences of the participants. Further definition and refinement of the themes occurred during this phase to determine the final themes for discussion presented in Chapter 4.
Table 3-4 Thematic Map Example

<table>
<thead>
<tr>
<th>Code</th>
<th>Expansion of code</th>
<th>Subtheme</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience as a patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experience of receiving feedback</td>
<td></td>
<td>Reflecting on past experiences</td>
<td>Bringing Self to the Role</td>
</tr>
<tr>
<td>Experience as a health professional</td>
<td>Positive or negative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal view of nursing and caring</td>
<td>Reflecting on experiences</td>
<td>Influences on feedback</td>
<td></td>
</tr>
<tr>
<td>Feelings about giving feedback</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Role boundaries</td>
<td>Referring to tutor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scope of knowledge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feedback on feedback</td>
<td>Feeling stressed or unsure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reassurance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Need for training</td>
<td></td>
<td>Reflecting on the role</td>
<td></td>
</tr>
<tr>
<td>No need for training</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3.7 Research trustworthiness

Research rigour in qualitative research has been debated within the literature, leading Lincoln and Guba to propose standards of “trustworthiness” for qualitative research; these include credibility, dependability, confirmability and transferability. These criteria have been used by the researcher within this study to ensure research rigour which is demonstrated by the accurate representation of the participant’s experiences of giving feedback to nursing students.

3.7.1 Credibility

Within this research, credibility or confidence in the data was established by utilising three strategies: prolonged engagement, member checking, and peer debriefing. To address prolonged engagement, all participants who were engaged in learning activities with nursing students were given information about the research by the researcher prior to activities commencing with the nursing students. Those who expressed interest consented to participation in the study and informed they could withdraw at any time. Contact was made with the participants to inform them of the dates for the observational field work and to allow them to ask questions and clarify information prior to this occurring. Following on from the field work, contact was made with the participants to arrange suitable dates and times for interviews and all participants were contacted again on the day of the interview to ensure the timing was still suitable. As the researcher has spent an extended time with the participants through engagement in nursing activities over several years, a trusting and open relationship was established and participants felt at ease to tell their stories.

Peer debriefing has been noted as a means of improving the credibility of the finding of qualitative research. Throughout all stages of the research project, contact
was maintained with the researcher’s supervisors in order that the design and methodology were consistent with the aims of the research. Throughout the analysis and reporting of findings, regular review of materials was sought to ensure that emergent themes were consistent with the data.

3.7.2 Dependability

Dependability of the research has been addressed through the detailed description of the research process, the analysis of the data, and accuracy of the findings in relation to the data. Triangulation of the data was evident through the confirmation of findings through multiple varied data collection methods.101

3.7.3 Confirmability

Confirmability or the data accuracy, relevance, and meaning was determined through supervisor review of the qualitative allocation of themes and subthemes in order to determine the accuracy of the findings.114,115 Added to this was the maintenance of a clear audit trail ensuring that the research can be replicated.94,101,114

3.7.4 Transferability

The findings of this research study are accurate to the context of the study and are therefore not meant to be generalised to other settings; however, transferability has been addressed by providing sufficient descriptive data so that the research may be evaluated as to its applicability in different contexts.94

3.8 Timeline for study

The timeframe for the research was over a two-year period as displayed in Table 3-5. Elements over this time included development of the research proposal including a literature review; this was ongoing so as to inform analysis of the data and reporting of
finding in the study. Ethics was submitted and approved in January 2014 and recruitment of participants commenced at the beginning of semester 1 (February) 2014. All data collection was finalised by January 2015. Analysis of the data commenced in October 2014 with examination of the field notes from participant observation. Thematic analysis of all data collected commenced in January 2015. Writing up of the report and findings of the study commenced in January 2015 and continued through to the projected completion date of August 2016. Publication and presentation of findings from the study to the research community will commence after completion of the project.

Table 3-5 Timeline for Study

<table>
<thead>
<tr>
<th>Activity</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Jan-Feb</td>
<td>Feb-July</td>
<td>July-Dec</td>
</tr>
<tr>
<td>Proposal development</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Literature review</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Ethics application</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participant selection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data collection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data analysis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report writing</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Publication writing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data collection</td>
<td>2014</td>
<td>2015</td>
<td></td>
</tr>
<tr>
<td>Participant recruitment</td>
<td>March – May</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participant consent</td>
<td>March – May</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Observation field notes and audio recording</td>
<td>May – September</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collection of written feedback</td>
<td>May – September</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Semi structured interviews with participants</td>
<td>September – December</td>
<td>January</td>
<td></td>
</tr>
</tbody>
</table>
3.9 Ethical considerations

Approval to conduct the proposed research was sought from the Human Research Ethics Office (HREO RA/4/1/6690) from the University of Western Australia and from the Research Office of the residential aged care facility in which the participants reside. Prior to the commencement of learning activities with the nursing students, the researcher met with the older adults for the purpose of explaining the research study and inviting participation. Participants in the research were given a participant information form which outlined the purpose of the study, provided contact details of the researcher and the researcher’s lead supervisor. Prior to the commencement of the research activities, all participants signed a consent form. Consent was also obtained from the nursing students as they would be involved with the participant observation component of data collection.

The consent form clearly indicated that the participation in the research was voluntary and the participants were able to withdraw from the study at any time without explanation or prejudice. These consent forms, along with demographic data, participant feedback forms, field notes, and transcribed interview data, were locked in the researcher’s office in a secure filing cabinet and stored on a secure server at UWA. Audio recordings of participant observations and participant interviews were also stored on a secure server at UWA and were kept for the duration of the research study after which they were destroyed.

3.10 Summary

This chapter has provided a description of the research paradigm which guided the methodological approach to this study. It has described the study participants and the research setting giving the research context. The approaches undertaken to collect data have been explained and the process of data analysis through thematic analysis
clarified. Trustworthiness of the research has been justified, addressing credibility, dependability, confirmability, and transferability. Ethical considerations have been considered in relation to the collection and storage of the research data and implication for the research participants. The next chapter reports the findings of the research with discussion of the themes identified through analysis.
Chapter 4  Results and findings

4.1 Introduction

The purpose of this study was to explore the older adult’s experience as a simulated patient giving feedback to nursing students in a simulated environment. Qualitative data from this research was gathered via participant observation, with researcher field notes, feedback forms, and semi-structured interviews. Thematic analysis of the data for each participant was undertaken and the main themes were identified. This chapter presents the findings of the study that has been organised into two sections. Section One describes the demographics of the participants, including age, gender, marital status, highest education level, accommodation type, and length of time participating in learning activities with nursing students. Section Two presents the findings from the interviews, observation and the feedback forms. The themes and subthemes which emerged are described and supported with exemplars.

4.2 Participant profile

According to Burns and Grove\textsuperscript{116(p127)} demographics or demographic variables are the characteristics or attributes collected to provide a picture of the sample population. Commonly used demographics include gender, race, age, marital status, income, and disabilities.

4.2.1 Age, gender, marital status, and accommodation type

Of the thirty older adults who regularly participated in the clinical learning activities, seven women and three males took part in this study with an age range of 60–89 years. Three of the participants lived in hostel accommodation and seven lived in independent living units; most were widowed. The higher ratio of female to male
participants in this study is consistent with statistics of the older adult population within Australia. As highlighted by the Australian Bureau of Statistics’ 2014 report of Australian demographics, in the period from 1994 to 2014 there has been an increase in the proportion of people aged 65 years and over from 11.8% to 14.7%. Above the age of 70, the ratio of male to female reduces significantly due to increased male mortality in this group and above the age of 85 there are twice as many females as males.  

4.2.2 Highest level of education and experience as a patient

Of the ten participants in the study, three participants did not progress beyond a primary school level of education. Five participants achieved a high-school education and two progressed to a Diploma level of education. All participants were asked to undertake a simulated patient volunteer role, drawing on previous experiences of the healthcare system or hospitalisations to enhance the realism of the activities. Eight of the ten participants reported having experience as a patient in the past five years. Two participants stated that they had not been a patient; however, they had visited hospitalised friends or relatives. Demographics of the participants are described in Table 4-1.
Table 4-1 Participant Demographics

<table>
<thead>
<tr>
<th>Participant #</th>
<th>Age</th>
<th>Gender</th>
<th>Marital Status</th>
<th>Accommodation</th>
<th>Education Level</th>
<th>Patient Experience in the last 5 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>74</td>
<td>Female</td>
<td>Widowed</td>
<td>ILU</td>
<td>High School</td>
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<td>2</td>
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<tr>
<td>3</td>
<td>89</td>
<td>Male</td>
<td>Widowed</td>
<td>ILU</td>
<td>Primary School</td>
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<tr>
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<td>Diploma</td>
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<td>5</td>
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<td>Male</td>
<td>Married</td>
<td>Hostel</td>
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<tr>
<td>6</td>
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<td>10</td>
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<td>Widowed</td>
<td>ILU</td>
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</tbody>
</table>

4.2.3 Length of involvement and number of sessions attended

The majority of the participants had volunteered in learning activities with nursing students for two years or greater, as shown in Table 4-2. Four had participated since commencement of the program (over three years ago). Participation in the one-hour learning activities with nursing students occurred either once or twice weekly. The majority participated regularly with most participating in two sessions per week, as described in Table 4-3. Over the eleven weeks of activities in the 2014 period, a maximum of twenty-two sessions were available for participation. Nine participants attended two sessions per week with one attending one session per week during the study period. Table 4-2 summarises the feedback experience in length of years, and Table 4-3 provides a summary of sessions attended by each participant.
Table 4-2 Length of Participation

<table>
<thead>
<tr>
<th>Length of time as an OASiP</th>
<th>Number of OASiP</th>
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</thead>
<tbody>
<tr>
<td>12 months</td>
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<tr>
<td>1–2 years</td>
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</tr>
<tr>
<td>2–3 years</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 4-3 Number of Sessions Attended by Participants

<table>
<thead>
<tr>
<th>Participant Code</th>
<th>Sessions attended per week</th>
<th>Total sessions attended</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Thurs</td>
<td>Fri</td>
</tr>
<tr>
<td>1</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>4</td>
<td>10</td>
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<tr>
<td>10</td>
<td>9</td>
<td>1</td>
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</tbody>
</table>

4.3 Participant experience of giving feedback

Exploration of the older adult’s experience of giving feedback through integration of field notes, interviews, and feedback forms has provided a starting point to understand the unique contribution this group can make to health professional education. Five key themes with subthemes were identified, describing the participants’ experience of providing feedback and are illustrated in Figure 4-1. These themes are: 1) bringing self to the role; 2) assisting students in their learning; 3) concern for students; 4) looking for clarity; and 5) enjoying the role.
Figure 4-1 Themes and Subthemes
Participants described their experiences to varying degrees and shared how they enjoyed helping the students to learn. They were able to reflect on past experiences of feedback and of being a patient or of working in health to bring what they perceived as a patient perspective to how feedback was given. The participants also described a sense of value in contributing to student learning and sharing their stories; however, they also expressed being unsure about their role. The researcher considered these perspectives to be essential in understanding their perspective.

4.3.1 Bringing self to the Role

Following analysis of data, one of the themes that appeared was the notion of participants reflecting on past experiences and “Bringing self to the role.” It became evident from the participant comments that several aspects influenced how feedback was given. These influences are described in two subthemes – reflecting on past experiences and influences on feedback – which were identified from all participants. Previous experiences clearly contributed to their perceptions of how nurses should deliver care which in turn is the perspective from how they examined nursing student practice and then provided feedback.

4.3.1.1 Reflecting on past experiences

Past patient hospital experiences were shared by the participant’s during the interactions with students, and also in the interviews and noted in the observation. The details of these experiences are described in detail in the interview transcripts and supported through the participant observation in the field notes. Several participants shared their hospital experience and provided realistic depictions of what it was like to be a patient. The negative patient experiences of the participants were shared with students to provide examples of poor practice and to highlight the need for best practice. The ability of the participants to reflect on these past experiences as a patient gave the
students a personal patient representation which in turn made learning relevant and powerful for the students.

*I’ve been in hospital so much and had a few rough times in there and it’d be nice to see that the nurses (meaning nursing students) are a little bit more compassionate.* (Female participant 9 IT)

*..when I was in the hospital I really felt the lack of care for to help, not any medical thing was fine they did that beautifully but to see that I was comfortable with my bed trolley and my pillows and that, they didn’t, nobody fixed that and I had to reach or ask them to bring my meal across, things like that you know, yeah.* (Female participant 6 IT)

The ability of the participant to draw on previous patient experiences to add to the learning activities with the nursing students was confirmed in the researcher field notes of participant observation. In this example, the participant shared a recent inpatient experience in which she had surgery for a Total Hip Replacement (THR). She was able to express to the students her frustrations of not being able to care for herself and being left to sit on a bed pan unable to change her position without assistance from the nurse.

*The participant sat forward and said in a humourous way “Don’t tell me you will be back in 5 minutes when I am sitting on a bed pan and leave me there for 15 minutes. You wouldn’t do that to me in hospital would you girls?” It was interesting to see the students’ reaction to this statement as I am not sure if they had considered the strength of the reaction of the patient being left to sit helpless. I had the feeling that the participant felt it was important that the students understand the perspective of the patient, also saying to the students “I am not a nobody” in relation to this.* (Female participant 6 PO)

Personal health experiences of friends and family were shared by the participants to illustrate the importance of the feedback given to nursing students. In a student learning activity observed by the researcher, one participant shared the experience of visiting a close friend who was hospitalised and had contracted
Methicillin-resistant Staphylococcus Aureus (MRSA) during the hospitalisation. During this activity, the student had required correction by the tutor on a technical aspect of a wound dressing. The participant queried what would be the outcome if the procedure was done incorrectly. The student responded saying they may have introduced MRSA into the wound. The participant used this interaction to relay her feelings and experience.

“Oh don’t even joke about that! MRSA” “my friends husband had that and he was very unwell terrible.” (Female participant 2 PO)

The reaction of the students to the participant comments was noted by the researcher in the field note, below, in which the researcher was able to observe both the immediacy of the feedback from the participant and the student reaction to the feedback. The effectiveness of the feedback is noted by the researcher as closing the gap between theory and practice.

_The students were I think shocked about the feedback from the participant, re the MRSA, as she became emotive sitting up a little straighter and raising her voice slightly; she seemed to feel passionately about this point. This I felt was really powerful feedback from the participant and was made more relevant because of her firsthand experience. Although the students have been taught about MRSA in the “classroom” I don’t think the connection to impact on patient care was perhaps made until the participant recited her experience. All students stopped what they were doing and listened to the participant asking questions about the friend’s experience with MRSA. (Female participant 2 PO)_

When the participant was reminded of this interaction during the study interview with the researcher, she was able to highlight again the importance of this experience related to the students’ learning.

_Yes I had, I’ve got a friend and her husband has been in and out of hospital,... and I happened to be up visiting my friend or another friend and she had her husband in there and I went in and I got a shock when I seen [sic] him. I’d seen_
him oh a few weeks before ... I said oh what happened to him and she said oh he’s got MRSA ... But I honestly think that when it’s an infection like that because they've [student nurses] got to be so particular you know because so that it doesn’t spread, I think sometimes it maybe makes them a bit uneasy. (Female participant 2 IT)

This participant was able to recognise through her experience the potential impact of poor practice: “I mean that could save somebody’s life. I know it sounds silly but it could save somebody’s life.” (Female participant 2 IT)

4.3.1.2 Influences on feedback

Many factors were identified by the participant’s which influenced how they gave feedback to the students. One male participant revealed during the interview that his previous negative experience of receiving feedback in the workplace as a younger man influenced how he structured the feedback to nursing students.

I remember when I was a youngster the charge hand who was in charge of us boys, I was a machinist and he was not a very pleasant character and he, he made everything which was a little bit wrong much worse than what it was and I’m aware of that and I’ve always remembered it. So consequently when I’m in a situation like that I try to make it as easy as possible. (Male participant 3 IT)

Two of the female participants were retired nurses and both decided not to reveal to the students at the start of the learning activities that they were former Registered Nurses (RN). However, the participants did reveal this information to the students at the end of the learning activity. One participant noted that the she felt the students were aware she had some training due to the language that she was using throughout the activity. The participant felt that her experience as a RN allowed her to question and challenge the students more deeply to encourage critical thinking in the student.
They [the nursing students] said I should have known you were a nurse with the questions you were asking. But then other people a lot of them are just common sense questions, you’re querying it as to what they were doing and why they were doing it and I think that was good for them just to challenge them a little bit on their yeah ... On their techniques and what they were doing and why they were doing it, yes, yeah. (Female participant 8 IT)

Researcher field notes of this activity with this participant and the nursing students, noted: “There were no formal periods of feedback during the activity except at the end when the students said to the participant ‘I liked your questions’” (Female participant 8 PO). The participant then revealed to the students her experience as a RN with the students responding: “I thought so with some of the questions you were asking” (Female participant 8 PO) indicating that her experience as a RN was reflected in the questions she asked the students.

Choosing to reveal they were RNs at the end of the session may have indicated that they felt the information may have impacted on the learning activity with one of the participants suggesting: “Yeah but I couldn’t really be so open about my experience” (Female participant 4 IT). This participant also found that she referred to her experience in nursing when guiding students through the activities stating: “I think they cottoned onto the fact that I’d had some experience and ‘cause I probably ask leading questions and I shouldn’t of” (Female participant 4 IT).

In the interviews, these participants shared that their perception of the nursing students and the care that they delivered was based on their experiences as a RN and influenced how they gave feedback to students. One of the participants shared in the interview how she found a disconnect with some of the technical skills she knew from her experience as a RN as current practices had changed. She provided an example of the use of wearing gloves during wound management.
I’ve always you know been taught to wear gloves when you’re doing dressings but you see the ideal situation is if it’s a clean wound you don’t have to as long as you’ve washed your hands...I found that a bit strange. (Female participant 4 IT)

The other participant commented on the caring nature of nursing and felt that touch was an important aspect of nursing from her experience:

*I mean I don’t know whether they’re taught that but touch is so important ... It is, is your fingertips touch, it’s with the baby, from the babies right the way through your life touch is one of the most important parts of your life to be able to touch yeah.* (Female participant 8 IT)

Perceptions of what constituted good nursing practice and nursing care were also expressed by other participants. These included elements such as caring, comforting, touching, and thoughtfulness in care delivery. These were words that were used consistently during the interviews with the participants and in turn influenced the main focus of the feedback during the simulated learning activities.

Interestingly, one participant commented on the use of alternative health practices in a past hospitalisation: “I mean years ago when I had my hip done and I got an infection, one of the nurses came in and she used to practice a bit of Reiki” (Female participant 10 IT). This participant felt the treatment that she had received constituted nursing care, reflecting, “she sat with me for about an hour putting her hands up and down her hip, and that to me is part of nursing” (Female participant 10 IT). Nursing care in this instance may not refer to the alternative treatment as much as the time spent by the nurse with her and the expression of care through touch and the “laying of hands” which constitutes Reiki therapy.

Caring was expressed by another participant reflecting on a recent hospitalisation in which she felt the nurses did not express caring, stating: “Yes the caring, just a little bit of thought to say well are you comfortable” (Female participant
The participant shared that, due to her limited mobility following the surgery, she was not able to wash herself or reposition easily and she felt her needs were overlooked by the nursing staff. She recalled one response from the staff: “She [the nurse] said ‘oh we must have forgotten’” (Female participant 9 IT). This experience has influenced what this participant sees as essential for nursing students expressing this as “so things like that you know just a wet flannel even just to wipe your face or something you know... just little things like that, thoughtful (Female participant 9 IT).

A female participant referred to what she perceived as a “care ethic” in the comment below. This aspect of nursing care was referred to as ensuring the patient was comfortable and felt the student nurses did not display this in their approach towards her in the learning activities. She felt this was an element of their nursing care that she was able to give feedback on.

There was no “are you comfortable,” “can I fix your pillows,” there was no...From all of the students there was, they just didn’t seem to have that care ethic. (Female participant 6 IT)

Lack of care by nursing students delivering the simulated care was also mentioned by the participant during the interview several times with the researcher, indicating this was something that she felt strongly the students should learn stating: “But I hope they would learn about the care” (Female participant 6 IT). Participant observation by the researcher of this participant also notes when describing the space that: “The participant was lying on the bed with the head of the bed elevated to around 45 degrees. There are no pillow slips on the pillows of the participant’s bed” (Female participant 6 PO). Written feedback from the participant confirmed the participant’s interview transcript with the participant providing feedback to the students that again they need reminding to pay attention to the patient stating: “They [the students] forgot. I expanded again on the need for ‘care and attention’ to the patient” (Female participant...
6 FT). The perceived lack of care as expressed by this participant and observed by the researcher can perhaps be explained by the novice nature of the students. The students at this stage are concerned with learning a new skill and have difficulty seeing beyond the skill to the patient as a whole.

4.3.2 Assisting students in their learning

The participants were able to see the broad, overall perspective or “big picture” undertaking the simulated patient role, and how the students interacted with themselves as simulated patients to deliver simulated nursing care as part of the learning activities. Feedback was provided by the participant’s on professional role requirements, such as wearing a name badge, closing curtains, and checking patient identification prior to nursing procedures. This was also a strong focus in the verbal and written feedback, and was identified as the second theme assisting students in their learning and was separated into the two subthemes verbal feedback and written feedback. These subthemes describe how the participants approached giving feedback and what verbal and written feedback was given. This theme was important to consider, as regular feedback – both written and verbal – is important in student learning as it helps to support skill development and real practice.

4.3.2.1 Verbal feedback

Verbal feedback given to the nursing students during the clinical skills activities was primarily from two sources: from the academic tutors; and from the participants. The students were in pairs for the simulated activities with the participants and were encouraged to provide peer feedback during the activities. The focus of the feedback from the academic tutors was on clinical skills acquisition and theoretical knowledge which ultimately supported the assessment of the students. Feedback from the participants was from the simulated patient perspective and was directed toward
increasing the student’s awareness of the “patient.” The participants provided immediate feedback in a spontaneous way that was timely, specific, and contextualised, and reinforced to students the need for attention in all aspects of care delivery. One participant clearly differentiated the patient role that she undertook and the purpose of her feedback compared to that of the tutor, stating: “Well just that we’re giving feedback as a patient being treated, you’re [referring to the tutors] giving feedback as a teacher teaching them” (Female participant 8 IT).

Several of the participants also clearly articulated this concept in the interviews, explaining that they felt they gave feedback from the patient perspective and on the elements of care they received and how they felt they were treated.

Yes, from a patient perspective. Like they’d say “how are you going” and I’d say “oh you know,” ’cause we were playing the roles so I would go into the, “oh not too well today; it’s a bit sore,” or whatever the wound or illness was that we were treating. (Female participant 10 IT)

I normally give them feedback on how they have treated me. (Female participant 7 IT)

Feedback from this “patient” perspective was expressed by one female participant during the interview where she commented that the eagerness of the students to commence the learning activities prevented them from addressing professional role requirements such as introducing themselves, ensuring her privacy, and identifying her as the correct patient.

Well sometimes when we started they would tend to launch straight in and not sort of come in as you know introduce themselves sort of slowly, “we are so and so” and then go through the routine of drawing the curtains. (Female participant 8 IT)
It was observation of these things that the participant felt she was able to give immediate verbal feedback to the students during the activities, expressing the feedback she gave as:

*So I think that was, that would be, I would say you know, you know about the curtains or say “check the name band” yes…, and that one time when we, had an allergy I should have a red band on and yes I would point that out. (Female participant 8 IT)*

In contrast, one of the male participants recognised that there were professional requirements of the students, but he did not feel it was an area of concern for him as the learning activities were simulating real practice; however, he did remind the students of these areas of practice:

*They’re minor things like you’re saying about their badge and about pulling the curtains and that sort of thing I don’t, [I don’t] worry too much… Because I, [I, I] have said to them if they’ve been a bit slow pulling the curtains I said “it doesn’t matter a bit to me if you don’t pull them but I believe you’re supposed to pull them.” (Male participant 4 IT)*

The participants were also able to promote the concept of patient-centred care by encouraging the students to be present during the activities and that the needs and concerns of the patient should be supported. The participants did not hesitate to remind students of simple things such as talking with the patient, and not discussing personal things with their colleagues in the presence of the patient. This is illustrated in a comment from a female participant:

*Remember that the patient is listening to everything you say and if you’re talking, well if of course if she’s only there by herself she’s got nobody to talk to, but in that situation there were against you know talking to each other and occasionally a personal thing would come in etc. I would say you know, try to remind them that this was not a clinical environment but that’s what they would be going into so they had to practice that. (Female participant 2 IT)*
Building a sense of rapport with the students was felt by the participant’s as an important beginning point to facilitate verbal feedback. It was felt by the participants that by building rapport with the students it helped to create an environment in which the students felt comfortable and would be more open and receptive to the feedback. This was illustrated by one of the three male participants in the comment below:

*Mostly they’re great because I mean I’ve got a certain way of delivering the response and they all relax and think oh yeah they’ll take that on board and the next time they see me that’s good... And if I put a smile on their face they relax.* (Male participant 7 IT)

The ability to build rapport quickly is also an important skill for the students to learn as it is essential for developing trusting therapeutic relationships with their clients in the professional careers. Observation of the same male participant by the researcher confirms the ability of the participants to put the students at ease:

*The students appeared to be slightly reserved at the start of the scenario, they tended to stand back and wait for each other... the participant was patient and encouraging; he laughed with the students and made a few jokes which seemed to put the students at ease quickly.* (Male participant 7 PO)

This sense of building rapport was also confirmed through the researcher’s observations and field notes in which the body language of the participants was consistently commented on as being “open” and “relaxed” and that the participants were “smiling” and sometimes “laughing” with the students. There was also the observation from the researcher that this sense of rapport was built upon as the students engaged with the participants – sometimes the same participant – over a number of weeks. This was observed in an activity and noted by the researcher:

*On commencement of the activity the students introduced themselves and used the scenario name Mrs Brennan then referred to the patient by her given name with consent of the participant. Both students had looked after the participant in*
previous weeks and so revisited the relationship with the students asking of the participant. “How are you, haven’t seen you for a while.” (Female participant 9 PO)

Previous experience with the students in the previous semesters allowed for rapport to be quickly established. One participant described her experience with two male students with whom she had participated in learning activities on previous occasions. The rapport between the participant and these students had developed so that conversations extended beyond the structure of the activities. The participant shared this: “He said that he’d had no trouble with the books, able to do exams but he just couldn’t cope with the, the practical side” (Female participant 4 IT). Improvement in the student’s practice over time was seen by the participant: “there was a definite improvement” (Female participant 4 IT). This sense of seeing improvement was confirmed with other participants: “Oh saw a big change in the students from, you know from the day, the first days when they were very hesitant and not you know not sure of themselves at all to gradually you know getting, getting better at it” (Female participant 8 IT). The development of rapport was a factor in enabling the participant to give verbal feedback encouraging the student to participate in activities where confidence was lacking. “I was really pleased to see him to get really involved … He got in and did it and I didn’t feel like saying to him look it’s your turn now ‘cause I was a patient but I did ‘cause I knew he was going to be capable” (Female participant 4 IT).

The employment of humour was also a strategy that was identified across all participants that assisted to establish rapport. Humour was used by one female participant as a means by which they were able to help relax the students: “‘cause we’d have a giggle you see … The ice was broken before we start really” (Female participant 4 IT). This was also noted in researcher observation: “There was a lot of joking around
and ‘fun’ in the language that was used. The participant seemed relaxed and used some humour to help the students feel at ease” (Female participant 2 PO).

Nursing students engaged in the learning scenarios with professionalism, communicating and treating the participant as they would a real patient. However, both the participant and students could also see the humour in some of the simulated equipment used within the scenarios. One participant reflected on an experience which involved the students moving a mannequin:

I mean the blessed man [referring to the mannequin] was on the bed one time with these two boys and I said “you’re not allowed to take him off the bed” and they said “well I’m going to” and they put him in the chair... That was so funny so we had a laugh about that and of course that held us up a wee bit. (Female participant 4 IT)

A female participant reflected on an activity in which the students were required to remove staples from a craniotomy wound and the difficulty with securing the simulated wound:

But we did have some giggles over the time... I had the bandage and it was slipping slightly over here and I must have looked absolutely hilarious, you know, and I’m trying to hold it on with one hand, and they’re trying to do the dressing and one of them took a photograph and they were in fits of laughter over this and ‘cause I looked so woebegone! (Female participant 10 IT)

After the interview with the researcher in which the participant shared this experience, a copy of the photograph (Figure 4-2) was requested by the participant who was also happy share as part of this research.
The use of humour in language was also employed by the participants when they felt they needed to provide constructive feedback to the students in relation to the activity that was being undertaken. This was expressed by one participant:

*When I’m about to give a verbal to them which isn’t exactly complimentary I try to look at, look at it and say to them in a humour manner so that, so that it doesn’t hit them too hard. They’ve got a little bit of a smile on the end of it though you know.* (Male participant 10 IT)

By giving the constructive feedback, with humour the participants felt it was received better by the students, with one male participant commenting: “‘cause I mean
as I say if I don’t sort of give the feedback with a little bit of humour then they probably wouldn’t accept it” (Male participant 7 IT).

Humour was also noted by the researcher during the study observation to be used as part of constructive feedback and also when prompting students during the learning activities to remember aspects of care. In one field note reflection, the researcher was observing an activity in which the students were required to conduct a Brommage assessment of the patient. The students had spent a lengthy time reviewing the assessment form and not engaging with the patient. Researcher notes describe: “The students had their backs turned on the participant and were talking quietly to themselves” (Female participant 6 PO). In order to remind the students to be mindful of the patient in the delivery of the care, the participant was able to use humour to prompt the students. This was noted with the participant saying: “Ladies I could be dying here!” (Female participant 6 PO). This feedback prompt was effective with the researcher noting: “The students laughed hesitantly and moved to the next activity with the participant engaging once again” (Female participant 6 PO).

When the participant was reminded of this interaction during the interview she was able to explain her use of humour to prompt the students: “Just a little bit of humour to let them know I wasn’t down on them which I wasn’t” (Female participant 6 IT). The participant reinforced that it was important for the students to remember the patient and by giving immediate feedback to the students in the simulated environment assisted students to learn this prior to real-world practice. This was expressed as:

I just thought they can get very irate patients who don’t see, who are ill and I wasn’t. But if you are ill you see things in a different light and you tend to be a bit irritated and bad tempered with the people. Well of course I wasn’t ill so I wasn’t bad tempered so I just made the little joking remark you know of, I could have died and they smiled and I smiled you know. (Female participant 6 IT)
Several participants felt that, rather than giving constructive feedback verbally to the students, they preferred to focus on the positive aspects of the care they were receiving. This was expressed as: “I would, to encourage them, I would say they had done it very nicely” (Female participant 8 IT). A male participant during the interview expressed: “I inclined to look for the good points and because I feel that instead of pointing out too much bad things about them it’s more encouraging for them if they’ve got somebody who is cheering them on if you understand what I mean” (Male participant 3 IT).

The use of positive and encouraging language did extend to occasions when constructive feedback was required with the same participant commenting that, “I don’t lay it on too heavy and I’ve sort of like, ‘oh never mind I’m sure that you’re going to do a lot better in the near future’ – that sort of thing” (Male participant 3 IT). Another participant felt that constructive feedback was received better by the students when delivered in this manner: “I give them sort of comp, complimentary comments… I like that because they walk away with a smile and so do I. But I’m not telling distruths – I’m giving my opinion!” (Male participant 7 IT).

Encouraging language to give feedback was also noted in the researcher’s reflections of the participant observation: “On completion, the participant feedback to the students was ‘you have done really well the BP is the same as my normal’” (Female participant 8 PO). The participant’s language was noted by the researcher as encouraging the students towards critical thinking: “The participant is very thoughtful and encouraging in what she says to the students. She gently asks more questions of the students to get them to think a bit deeper about what they are doing” (Female participant 4 PO).
Some of the participants felt that, as they became familiar with the learning environment and more familiar with the learning requirements of the students, they were more comfortable to give constructive feedback. This was expressed by a participant: “I realised being critical was going to help them so, so no I felt much easier about giving you know some critical comment as well as some positive comment, that it would be important” (Female participant 8 IT).

The reference group for BTTNH, which consisted of residents, nursing students, and nursing academics, was also recognised by a participant as an opportunity in which feedback was discussed with the students. She was able to reflect on this meeting during the interview and how this had helped her to understand what feedback was required, giving her confidence to provide constructive feedback.

We had students there [reference group meeting] and at that time we talked about you know feedback and what we could say and what we couldn’t say … we did talk about you know positive feedback for them and then you know constructive feedback. (Female participant 8 IT)

Student response to the verbal feedback was important to consider in describing the experience of the participants. Generally, the student response was described positively: “Well they, they usually stop and listen to you, stop and listen to you and check whatever you’re saying fairly well in the majority of cases” (Male participant 3 IT). The gratitude of the students was commented on by one participant: “they always were wanting you know you to tell them anything that was, that you could help them with, yeah. And they were also grateful” (Female participant 8 IT). Another participant highlighted the age of the students as a factor as to whether feedback was retained; however, this reinforced the positive response of the students: “Mostly they accept what you say. Hopefully they retain it. I don’t know, you know, they’re young and they’ve got
things to learn but they did, they were very you know accepting of what you said” (Female participant 6 IT).

What was perceived as a negative response or a rebuff to the feedback that was given to a student during a learning activity, was reflected on by one of the male participants: “I plainly remember saying on one occasion to a young fellow who was doing it, “are you sure that’s the right way to start and he didn’t take it too well” (Male participant 3 IT). The participant recalled the student response: “His response was well “I’m, doing it the correct way as I was taught”… And you could see, you could see that he didn’t accept my verbal feedback very well at all” (Male participant 3 IT). The participant recalled reflecting on this response by the student after the activity and at the time questioning his own knowledge and how he had given the feedback: “Because afterwards myself perhaps I jumped the gun there and he was, he was right, yeah. Because I can’t think just what it was but it was something which didn’t gel to me” (Male participant 3 IT).

4.3.2.2 Written feedback

The feedback form provided collaborative feedback for the pair of students who were delivering the simulated care to the participant and was used to different degrees by the participants with some completing all sections of the form and others choosing only to complete the first section. Some participants provided feedback addressed to the student pair and others directed the feedback to individual students. Based on the observation of the verbal feedback, the written feedback often reinforced the verbal feedback that was provided during the learning activity.

This can be seen in the example, below, where a participant is reflecting in the interview on giving feedback to three students and the difficulties when one student is more confident and takes a lead in the learning activities. The feedback given during the
activity observed by the researcher correlates with the comments expressed in the interview and is confirmed by the written feedback tool:

Well I would try and, as I say there was nearly always one who was to the fore, but I would directly look at the other people you know that weren’t sort of involved. I would look at them and ask them my question. (Female participant 6 IT)

In this learning activity the participant had three students. It appeared that one of the students was more confident and engaged more readily with the participant doing most of the activities. This student gave all of the explanations related to the activities whilst the other students quietly watched on. The participant seemed to be aware of this and looked over to the two students and tried to engage them asking one of the students to fetch a glass of water for her. The students seemed pleased with this and engaged in the activity after this massaging the participant’s leg. (Female participant 6 PO)

Allow colleagues to get a word in. (Female participant 6 FT)

Written feedback was collated and discussed by the tutor with the nursing students during the debriefing session at the end of the learning activities. The nursing students were keen to receive this feedback and often reminded the OASiP to complete the feedback form at the end of the session. One participant expressed this, stating: “As regards to the written feedback, they always make sure that you’ve got it because they want you to do it” (Male participant 3 IT).

During the study period, eight of the ten participants completed feedback forms. The feedback forms from the period of observation with the OAPV were collated and analysed with the results displayed in Table 4-4, below.
Table 4-4 Completed Feedback Forms

<table>
<thead>
<tr>
<th><strong>Please comment on the overall interaction of the students (n=8)</strong></th>
<th><strong>YES (n=)</strong></th>
<th><strong>NO (n=)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The students started with a self-introduction</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>The students showed understanding and concern for me as a patient</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>The students clearly explained the nursing activity</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>The students used the curtains to provide privacy during the nursing activity</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>The students were organised in the delivery of the nursing activity</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>The students listened to my concerns</td>
<td>8</td>
<td>0</td>
</tr>
</tbody>
</table>

As stated earlier, completion of the feedback form was optional, and two participants did not complete the feedback form during the observation period. One participant had difficulties in completing the tool due to his right-sided weakness, confirming in the interview: “Yeah ’cause I was having to print left handed and left just doesn’t work” (Male participant 7 IT). This participant would, however, often request that the tutor write his feedback on the form.

From the analysis of the feedback forms it is clear that the participants agreed the nursing students were professional in their approach, introducing themselves, explaining all activities, and providing privacy. In response to a question in the interview about how the participants completed the feedback tool, several commented that they liked to complete the tool at the end of the session. One participant described how she has changed from taking the tool home to complete to now completing it at the end of the session. Perhaps this shows that her ability to give feedback has improved over time: “I used to come back but this semester I’ve done it at the time” (Female participant 6 IT).

Other participants felt that they needed to consider their responses and would always complete the tool at home, taking time to reflect on the activities with the students:
I always brought mine home with me because I wanted to think about what had happened you know during, during the afternoon and because there was a lot that they did. A lot of it I found was easy to do but some of it was difficult because if you had a couple of the students you would think one was doing it very well and then the other one wasn’t as good. But you know you had to sort of say a little bit between the two of them. (Female participant 8 IT)

The written feedback tool was utilised by the participants to different extents and recognised some of the challenges with the tool. Overall, the participants felt that, rather than being individualised to the student, feedback should be given as a whole, as with most activities the participants would have two or three nursing students working with them: “I always gave it as a whole even you know it was, when we ended up with three students it was as all of them acted together” (Female participant 8 IT).

Two participants chose to give individualised feedback on the written feedback tool. One of these participants stated the names of the students writing: “Kris [pseudonym] and Matt [pseudonym] on the road to being very good nurses. Both these young men were in charge of the above procedures ... Kris states he is a little nervous about doing the procedures” (Female participant 4 IT). During the interview, the participant reflected on why she had chosen to name the students, using the tool as a means of providing individualised feedback to these students: “I think what I did in this case was write how much improved they were, especially this young man and I hope that he might, might have got that back” (Female participant 4 IT).

The other male participant instead chose to state the gender of the students providing more generalised but gender specific feedback. “Three students, two female and one male. Slight nervousness with the two girls, despite that they were obviously very competent with their procedure; the young man was very efficient in every way” (Male participant 3 FT).
4.3.3 Concern for students

Through taking on the simulated patient role, the participants became partners with the tutors in the clinical learning environment, and in the learning activities with the students. As previously explained, the participants felt that they were able to provide a unique simulated learning experience for the students, providing an environment in which the students could build confidence and skill prior to entering the real world of nursing. As such, the participants developed a sense of concern for the students and their learning, showing empathy for the student situation. This concern was identified as the third theme – concern for learning – and included two subthemes: current and future practice; and, empathy for the students as learners.

4.3.3.1 Current and future practice

The participants recognised the value of their involvement as real people contributing to learning with the nursing students and how important this was for the student’s current and future nursing practice. They were able to see a direct link between the feedback they provided as part of the clinical learning activities and the student’s clinical practice.

From observation of the learning activities between the students and the participants, it was apparent that students responded positively to the learning environment and actively engaged with the participants in the patient role. For example, during an observed interaction, one student asked the participant in the patient volunteer role if they were comfortable before undertaking a simulated wound dressing and enquired as to whether they had any pain in relation to the simulated wound. This was an example of students valuing the learning experience with real people. The engagement of the students was confirmed in the researcher’s reflections: “The students seemed keen to learn and treat the scenario and participant as a real patient; this was
enhanced by the participant’s eagerness to take on the role of the patient scenario” (Female participant 1 PO).

There was a sense that through their participation and feedback to the students, the participants were positively influencing future clinical practice in hospitals and other care environments, not just for themselves but for other patients or users of healthcare services. One participant commented on this in regard to an increased understanding of the care of older adults: “Well, I’d like to see them take a little bit more care with elderly people and be a little bit more thoughtful that we can’t bounce around and jump around like younger ones can. We don’t bounce anymore” (Female participant 9 IT).

A male participant who shared his experience of having a stoma with the students, showing the students his stoma and how he cared for it, explained to the researcher why he felt it was important for the students to see: “I thought it was something they might come across in the job, you know?” (Male participant 5 IT). The participant was able to recognise that there may have been mixed reactions by the students towards his stoma: “They might have been shocked when they saw it, you know?” (Male participant 5 IT). The relevance to clinical practice for the students was expressed by the participant: “But, I mean these things happen and people put up with them” (Male participant 5 IT), indicating that he considered an understanding of stoma care was essential for care of other patients.

One participant who had a history of stroke with a resultant permanent severe right-sided weakness felt strongly that it was important for the students to see his disability and learn how to care for other patients with similar abilities:

*I mean, in there, in there [referring to the hospital environment], they’ll get people that come in off the roads and they’ve got to move them and they want to know just exactly what to do. I think this is a perfect example [making reference to his body and disability]… So you get some trauma coming in and the person’s got exactly
the same problem they would probably remember how to deal with it after dealing with me. (*Male participant 7 IT*)

This was also confirmed in the researcher reflections in the field note observations for this participant. The activity the students were undertaking involved caring for a simulated patient with a similar history to the participant’s own. The students within this scenario were required to take the blood pressure of the patient asking the patient to raise his right arm to apply the blood pressure cuff. The reaction of the students to the participant’s response was noted by the researcher: “I can but you will need to move it for me, I can’t move that arm.” The student’s response appeared to be shock and embarrassment that she had asked him to do something he was unable to” (*Male participant 7 PO*). The participant was happy to then share with the students his history and reasons for his stroke. Relevance to clinical practice for the students was noted by the researcher: “The participant was able to make the students feel at ease by responding to the students ‘helps you out in clinical’” (*Male participant 7 PO*).

In response to a question from the researcher about what the students might take forward into clinical practice from engagement in the learning activities and feedback from themselves, the participants reinforced the notion of “thinking about the patient.” One participant expressed the desire for the students to understand that the priority of the care is the patient, and through good communication, patient care needs can be understood:

*That they can converse with their patient I think is more the thing … Have a conversation, yes, and getting used to people, getting used to their patients ‘cause they see so many different types of people and with different complaints.* (*Female participant 1 IT*)

To assist the students to engage in the learning activities, the participants used the simulated patient scenario scripts to differing degrees. The scenarios drove the
nursing student clinical learning activity and provided a guide for the simulated patient role. It was written in patient terms about the presenting condition of the patient they were simulating, including some previous medical history, social history, and medications. The scenarios also provided questions relevant to the scenario that could be asked of the nursing students in relation to the care they were receiving. Some participants chose to follow the scenarios using all questions suggested: “The participant used the scenario as a script referring to the information to answer the questions asked by the students and asking all questions suggested on the scenario” (Female participant 1 PO).

Others chose to loosely use the scenarios and introduced elements of their own health history to the activities, finding it difficult to purely play the patient role as per the scenario. The participants could see that there was value in using their own personal health history to add to the learning experience of the students. One of the female participants reflected on an activity in which the scenario she was simulating; the patient did not have a previous medical history that would result in an irregular pulse. The participant did, however, have a history of Atrial Fibrillation (AF) and she was able to use this to question the students on their findings:

“The pulse,” I said to them, and they came back and they said it was alright or something, not alright but not a bad pulse and I said “so you didn’t notice the irregularity in there?” ‘cause as you know I’d just been diagnosed with the AF and they hadn’t. (Female participant 10 IT)

The added value to learning for the students by the integration of the participant’s own health history to the scenario was recognised by the participant:

I sort of interacted my own personal bit in with that ... and I think that was, they found that interesting ... ‘cause I thought well it’s probably interesting for them to listen or feel for something that’s quite different and they may have felt it but not realised what it was. (Female participant 10 IT)
Another participant was able to use her history of low blood pressure to let the students try and problem-solve why they were unable to obtain a reading. She reflected on this in the interview:

*I’ve got really low blood pressure and the first time they tried to take my blood pressure it was poor Jeremy [pseudonym] and they, you know they were trying it and thinking it’s not working and they went away and got another thing ‘cause I didn’t tell them at first and it still wasn’t working.* (Female participant 2 IT)

This engagement in the scenarios and the use of the participant’s own personal health history encouraged the students to move from focusing only on the clinical skill acquisition, which is normal for a beginning level of learner, toward a more holistic approach to patient care, which is essential for patient care. The participants were able to provide immediate feedback as a “real” patient as a result of the care provided. For example, they encouraged the students to consider the pain levels of the patient when completing a wound dressing by adding verbal effects to enhance realism:

*It gave them, well to me it gave them, different experiences of what they were going to face when they went in and like I did talk to them like it was a real experience like you know and I would “ooh, ooh that hurt” and things like that and you know.* (Female participant 2 IT)

*Doing things with the swabs and they swabbed something and I said “oh that’s a bit sore” and they said “oh is it, oh I’m very sorry” and I said “it’s cold” and they said “oh we know that” but you know, and so they knew what I was saying. I wasn’t complaining I was just trying to act like a patient.* (Female participant 6 IT)

The immersion of the participant in the simulated patient role was also reflected in the researcher’s reflections in the field note observations, showing the impact of the participant providing immediate feedback to changing the student’s actions.

*The participant used some verbal cues “ooh, that hurts” when students were conducting the dressing. This caused the students to stop what they were doing and ask the patient if they were in pain (using an appropriate pain scale) and*
check the medication chart to see if analgesia was charted for the patient. 
(Female participant 1 PO)

A particularly memorable experience was recalled by one participant where the she felt as though she had contributed uniquely to the student’s education and the student’s clinical practice. In the interview, she described having her blood pressure taken during a scenario in which a student had indicated that he would take it on her right arm. As she had had a mastectomy, she was able to give feedback to the student that this was contraindicated. In recalling this experience during the interview, she gave a sense that she felt strongly about the importance of sharing the information and that her feedback had changed the student’s practice.

The very first young man came in said “I’m going to take your blood pressure” and he just reached for my right arm. I said, “No, I’m sorry, you can’t do that,” and he said “oh, why not?” and I said “well, you don’t take blood pressure from a person who’s had a mastectomy on that side which I have.” Well he didn’t know that so but he also didn’t know that that was the case. So he very quickly switched round and he said “I never knew” he said “and I’ll remember that for the rest of my life.” (Female participant 6 IT)

There was a sense from the participants that they had contributed to the student’s education and that what they were able to provide was unique and not something the students would have been able to gain without their contribution. One participant described the link between theory and practice for the students: “She said ‘that’s not something we would learn in the classroom’” (Female participant 6 IT). The contribution to the student’s education was described by the participant: “Well I felt as though I had contributed and hoped that it had been absorbed” (Female participant 6 IT). One participant recognised the social value for the student’s interaction with them as real patients: “I mean some of them might not have had grandparents so I think instead of using like the ordinary dummies, using us they got interaction so they had to talk to us (Female participant 2 IT).
The uniqueness of the feedback provided to the students by the participants and the impact to future clinical practice was expressed by participants as being able to provide patient feedback. One female participant discussed the impact of feedback from the patient’s perspective on student learning and the ability for it to change behaviours:

“They don’t really realise some of the little things that they do until you give them feedback to do that. They might do things unknowingly that you notice that, so giving them feedback afterwards I think is important (Female participant 8 IT).

She also recognised that this source of feedback is not normally provided by patients to nursing staff within the hospital setting:

Oh, because it’s from a completely different perspective. This is from the patient which they wouldn’t get, in a hospital they wouldn’t get patient feedback but while they’re doing the student and they’re learning it’s coming from the patient themselves. So that’s something that they wouldn’t get otherwise. So even though it’s a make believe one I think it’s important. (Female participant 8 IT)

This participant also felt that the clinical learning activities prepared students for real clinical practice and that the students should be more prepared for practice through an increase in confidence in their clinical skills: “Their [referring to the students] little bits and pieces on us and they were more than confident then going into a ward that they could do the same things” (Female participant 8 IT). She also made the students accountable for their practice by reminding them to be prepared before approaching the patient: “Once they’ve started with a patient, run back and collect things that they’ve forgotten ... Yes I did, I did mention that in one of the things that you know to have everything ready on their trolley before they, before they started” (Female participant 8 IT).
4.3.3.2 Empathy for students as learners

Empathy towards the students as learners was displayed by the participants with them almost putting themselves in the student’s shoes. The participants were able to consider how the student may be feeling as a learner and also what the possible impact this may have upon the students’ performance of skills. Several participants expressed this sense of empathy in the interview; however, overwhelmingly, this was evident in the researcher’s observations of the learning activities.

The ability of the participants to understand the student perspective was expressed, with a male participant identifying nervousness in the students: “Well, I often find that the main problem with them is nervousness” (Male participant 3 IT). The participant was able to recognise that the student’s sense of nervousness impacted on the ability of the students to conduct the skills: “They, they have, have what they’ve got to do in their minds and they fumble a bit because you can see they’re uptight. Yeah often, often this is the case” (Male participant 3 IT). Another participant recognised the difficulty in learning a new skill: “But one of the poor students it was his first time taking blood pressure” (Female participant 2 IT). The environment in which the students completed the skill was also recognised as leading to a sense of nervousness by the students. One participant was able to highlight the difference between himself and the tutor and the impact on the student:

Myself and, not somebody they know. I should imagine when they are participating between each other that the nervousness probably isn’t there, unless of course there’s somebody like yourself [referring to the researcher role as tutor] who is breathing down their necks. (Male participant 3 IT)

Reference to the age of the student and life experience was made by one participant in attempting to understand the student’s situation: “We’re older so we have more experience than they have and I think an awful lot of their not drawbacks or
faults, no criticism just a lack of experience” (Female participant 6 IT). This same participant was able to show that she had developed an understanding of the student’s perspective over time: “I’ve learned to be with the young ones and not to be too cross if they giggle too much you know and to remember that I was young once and things like” (Female participant 6 IT).

An individual difference in the students and the ability of each student to offer a unique experience was also recognised by one participant. This participant was able to recognise that different students will each bring something different to nursing. She expressed this in the interview when referring to quieter students: “But it doesn’t mean to say the others are not going to make good nurses ... So if you’re really, really sick you just don’t, so the quiet ones might get on alright there” (Female participant 1 IT).

Rich data in relation to empathy emerged from the researcher’s field notes on observation of the learning activities. The participants were able to pick up on emotional cues from individual students and altered how they then interacted with the students. This was displayed in an interaction observed by the researcher of a female participant and two male students. In this interaction, one of the students appeared more reserved, standing behind the other student, and was noted by the researcher as: “Seemed happy to be in the background” (Female participant 4 PO). The participant also seemed to be aware of this and made attempts to bring the student into the learning activity: “The participant seems aware of the reservations of the student as is using his name to bring him into the conversations” (Female participant 4 PO).

The nonverbal language of the participants was consistently noted by the researcher as being “open” and “relaxed” with “arms resting next to the body.” This was reflected in a field note observation of a male participant: “The participant appeared relaxed in his own clothes and resting on the bed; he is smiling and nodding toward the
students in response to questions” (Male participant 3 PO). In response to hesitancy and possible embarrassment from the students to do an abdominal assessment, which required the students to request the participant to expose his abdomen, the participant’s use of nonverbal and verbal language was noted by the researcher. This reflection highlighted the sense of empathy that the participant seemed to have for the students:

The participant seemed to sense that the students were reluctant to ask him to expose his abdomen for the abdominal assessment. He smiled towards the two female students patiently waiting for them to ask permission after which he said “I don’t mind a bit.” He asked the students to assist him to undo the buttons on his shirt [although he lives independently] perhaps encouraging them to move past their fears. (Male participant 3 PO)

Touch was by a female participant to portray her understanding and sensitivity to the student situation. This was noted in an interaction in which the students were having difficulty in determining the participant’s blood pressure, resulting in the cuff being inflated for longer than usual on the participant’s arm. Upon completion of the skill, the participant provided feedback to the student: “That was a bit tight” (Female participant 8 PO). The researcher’s notes show the response of the student, the ability of the participant to pick up student cues, and effectively ease their concern:

The student realised at this point that the cuff had been inflated for too long, showing concern on her face and apologising to the participant. The participant seemed to empathise with the student and leaned across and patted the students arm saying: “It is ok dear, we all have to learn; you will get better.” (Female participant 8 PO)

4.3.4 Looking for clarity

Emerging from the participant’s sense of contributing to the student’s learning was a need for reassurance or feedback on the role they were undertaking as a simulated patient. This was identified as the fourth theme: looking for clarity. Within this
exploration by the participants for clarity, a subtheme – *unsure of the role* – was identified which involved the participants identifying their own role boundaries and scope of knowledge. A second subtheme – *reflecting on the role* – describes the process of reflection that the participants undertook to examine their contribution and improvements they considered for the role.

4.3.4.1 *Unsure of the role*

The importance the participants attached to the role of the simulated patient with the students has been explored in the previous theme, and the concept of the participants as becoming co-creators of the learning experience for the students discussed. Emergent from this theme, and a feeling of concern the participants had towards the students’ learning, was a sense of accountability for the roles that they were undertaking. This accountability led to the participants seeking feedback about their role as a simulated patient and the feedback they provided to the students in that role.

Many participants, through the interviews with the researcher, took this opportunity to seek reassurance about how they performed the simulated patient role: “*I just wondered if my performance was up to*” (Female participant 6 IT). Another participant questioned how much information she was able to provide the students in her role: “*Am I allowed to tell them?*” (Female participant 8 IT). One of these participants also questioned if she had been too exacting in the detail in which she had given feedback to the students.

> *Am I being stupid in telling them all these things, or asking them what this was for and why should I take this medicine and things like that, and little bits you know about the care. Am I being too pernickety about that and that, that sort of thing?* (Female participant 6 IT)

Several participants questioned the quality of the feedback they had provided the students, wondering about its clarity and if it had prompted a deeper thought process.
with the students: “Well I hope I was giving them some feedback to make them think. I think I waffled on a bit sometimes” (Female participant 10 IT). One of the male participants questioned the accuracy of the feedback he had given, wondering if he had been incorrect in the information he provided: “I was possibly wrong because I’ve never been taught in that line” (Male participant 3 IT). Participants also sought clarification from the researcher in regard to what others thought and did in relation to the verbal feedback: “Do people [other residents] say that to you, do they? (Female participant 1 IT); and written feedback: “Do other people [other residents] put a lot of comments in?” (Female participant 8 IT).

The seriousness with which the participants approached the simulated patient role was expressed by participants seeking feedback, not only on their own performance, but also that of the student, wondering if the contribution impacted on student assessment. One participant specifically asked about student results: “And what are their results, what do their results look like at the end of the year?” (Female participant 6 IT). The researcher sensed that this participant felt she shared the responsibility of teaching.

Clarity about what constituted feedback was evident with several of the participants. One male participant, in response to the researcher asking how he decided to give feedback to the students, stated: “No I can’t say that did ... I don’t think so, if they ask me of course if I were comfortable I’d reply, ‘yeah’” (Male participant 5 IT). A female participant commented similarly, although she did acknowledge that she asked questions, explaining: “I don’t think I verbally give feedback – I only ask questions, I don’t say ‘oh that’s good.’ No I’m just really asking questions on whatever we do” (Female participant 1 IT). This participant did, however, seek clarification from the researcher, giving a sense that she was unsure about her role: “You’re not call[ing] that feedback or you are?” (Female participant 1 IT). An example of a blood pressure cuff
being too tight was used by the researcher to prompt the participant to give an example of the feedback she would provide. The participant’s response was of interest and provides evidence that there was confusion and uncertainty about the role:

No, I just let them carry on. I think well I don’t know any better than they do so you know eventually they’ll do it or sometimes the cuff is a bit tight but you know I think it’s going to go down soon, she’s going to pump it down. But I do ask how much the blood pressure is so I know it’s ‘round about the same each time for me. (Female participant 1 IT)

Further clarity about the responsibilities of the participants when giving feedback to the nursing students was highlighted by several participants. One participant, when considering a question from the researcher about how she gave feedback, highlighted the importance of constructive feedback, explaining: “I wouldn’t say you didn’t do that right that wasn’t my place to say that” (Female participant 8 IT). Another participant was also able to confirm this when reflecting on an experience with a student where a correction in technique was required: “Yes, yes. I didn’t think it was my place to say that ... I felt that, everybody knows even if you’re not a nurse you don’t take it [pulse] with your thumb” (Female participant 8 IT).

Students worked in groups of two or three when engaged in learning activities with the participants. This was highlighted by some of the participants as a part of the simulated role which raised difficulties for them and which they felt unsure about. One participant highlighted difficulties, saying: “The three was difficult,” going on to suggest strategies that she used to try and deal with this: “I would look at them and ask them my question ... I tried to bring them into the body of the sort of thing” (Female participant 6 IT). These difficulties were confirmed by another female participant: “Two, I think, is about enough to you know look at the two of them and between three it was a bit harder, yeah” (Female participant 8 IT). Participants were also sensitive to the difficulties in engaging quieter students, and were conscious of ensuring the learning
was equal amongst all students. One participant explained that, whilst this was a concern, it was also beyond her role: “There would always be one that was quieter ... So I’d have to sort of monitor it wouldn’t I, but that’s not my responsibility (Female participant 1 IT).

The participant’s own depth of knowledge in relation to the activities that the students were carrying out and their ability to give feedback was also highlighted as requiring clarity for the participants. Feedback provided to the students was given by the participants from their experiences of being a patient; however, at times, it was felt that perhaps the feedback required extended beyond this experience. This was reflected in a response from a participant who acknowledged that the depth of knowledge required by the students was greater than his previous experience:

I had some very minor education on wound dressing and that sort of thing during the war because I worked in, the company I was in, as a stretcher bearer and you had to have a certain amount of ideas, tourniquets and that sort of thing, but, yeah, nothing like the students have to learn really. (Male participant 3 IT)

To deal with this issue, one participant shared in the interview how she had, on occasion, asked the students to seek out more information from the tutors. The comments show the participant felt that the feedback required for the student was beyond her scope, but also highlights that they felt supported by the tutors in the teaching environment.

I have asked them, and, on occasion, to go and find out from one of you [tutor], one of the supervisors. I think I’ve twice done that which they did and once one of them said “oh, I’ll have to find out about that” and she did it on her own initiative. (Female participant 6 IT)

Seeking guidance when they felt specific clinical knowledge was required was also confirmed by the researcher in the observation of the learning activities. There were
several occasions in which field notes reflected interactions occurring between the tutor and the participant. During the observation periods, the participants would often refer questions to the researcher or include the researcher in the interactions with the students to provide further clarification. An example of this interaction occurred as the students were taking a participant’s blood pressure and noted: “The participant asked why it would be high and the students were unable to respond. Both the students and the participant looked to myself [the researcher] for an explanation” (Female participant 6 PO).

A similar interaction occurred and was noted by the researcher when a participant asked the students to find the tutor to help them understand the findings of an irregular pulse, which was normal for the participant: “The participant asked the students to find the tutor to explain why she had an irregular pulse as she thought the tutor would be able to give them more detail” (Female participant 10 PO). In this interaction, the field notes record “a great example of the tutor and the participant working together to provide a holistic learning experience for the student. Theoretical knowledge from the tutor has been combined with patient experience of living with a condition” (Female participant 10 PO).

4.3.4.2 Reflecting on the role

Searching for clarity by the participants about their role in providing feedback to the students prompted some to look back on their experiences and identify what could improve their effectiveness in giving feedback to the students. That the participants wanted to reflect on their roles for improvement confirms again the commitment that they felt and with which they undertook the simulated patient role.

The contrast between the students practicing with the participants as simulated patients and the use of mannequins was explored by the participants: “Otherwise, you’d
only be practising on those dummies” (Female participant 1 IT). This created a sense that the participants were drawing comparisons and confirming for themselves that the simulated patient role was useful, “cause they can just move them anywhere and they don’t say ouch or anything” (Female participant 1 IT). In this process of reflecting on the simulated patient role, several participants sought the student’s perspectives: “I asked them sort of ‘do you find this strange having us or the mannequins’” (Female participant 6 IT). The response from the students confirmed again the usefulness of the role for the participant and the relevance to clinical practice: “cause it’s live and we’re [students] listening to what they [participants] say and most of the patients are elderly and have obviously been in hospital and been in the situations that they’re acting out” (Female participant 6 IT).

A female participant expressed that she felt the students enjoyed the engagement with the participants, reflecting that the role was again useful in comparison to the use of mannequins due to the “live” nature of the interactions:

And they, and I heard one of them say “oh, this is better than doing it on our little mannequins yeah.” And yes I think they, I think, you know, they do really appreciate it that you know that we do that and it doesn’t worry me at all you know to give them the feedback. I think they really like that to do it that way. (Female participant 10 IT)

That the participants were able to interact as a real patient and give feedback to the students was reflected on positively by the participants; however, they also identified that some training in what to expect of the role and how to give feedback to the students would have been useful prior to undertaking the role. Suggestions about what should be covered were put forward by participants:

Perhaps there could have been a class say of participants and you could have told these participants what you actually wanted us to look for and to say because it was very much off the cuff as you know. Whereas, if we’d had some knowledge of
your requirements, we could have then passed that on to them. (Female participant 6 IT)

Oh, yes, that probably would maybe if we’d had just one week maybe before we got the students to give us an idea of what you really wanted us to say. Maybe do a scenario, play a role you know ‘cause that can help sometimes. (Female participant 10 IT)

One participant thought information would have been useful in how to give constructive feedback: “I think it would have, especially as it was a little bit negative” (Female participant 4 IT). This participant had also identified in the interview that this was an area which she found difficult. In response to questions from the researcher addressing her thoughts on the barriers to feedback she stated: “criticising someone…I didn’t want to do that so much in a lot of cases” (Female participant 4 IT).

Reflecting on the role, one participant felt that feelings of stress and apprehension were experienced by other participants due to uncertainty about the role, highlighting that training by the tutors would have been beneficial.

Maybe at the beginning, before the students arrived and did things, you know, we could have had a little mock up ourselves. A little role play ourselves with one of yourselves as you know doing it with us just to give us an idea of what we might be experiencing when the students came, because some of them [other residents] have got absolutely no idea what’s going to happen. And I think some of them, even though they’ve been told, might come slightly apprehensive of what actually is going to happen to them. (Female participant 8 IT)

In contrast, two of the male participants in the study felt that no training was required for the role, and the feedback provided should be spontaneous and come from a personal perspective. Feedback training may have been perceived by these individuals as potentially altering how they viewed and gave feedback:

Yes, yes, yes. I can’t think any prior training should come into it, no. No I think it should be as you personally feel at the time. (Male participant 3 IT)
I don’t think so ‘cause I mean the feedback that was given was our observation of what was going on and also how we felt about how we were treated. I mean, I could have told you and you would have put it down in your words and that wouldn’t have been my words would it? (Male participant 7 IT)

4.3.5 Enjoying the role

The final theme to emerge was one which describes the participants’ overall experience of providing feedback to the nursing students in the simulated patient role. This theme – enjoying the role – helps to explain the participant’s commitment to the role and sustained involvement. The theme was separated into two subthemes: learning new things, which explores the participant’s feelings of being engaged; and how, through sharing stories, participants made new connections.

4.3.5.1 Learning new things

An unexpected outcome of participating as a simulated patient for many of the participants was the notion that they were learning alongside the students. Participants recognised this learning as being beneficial, although did not expand on what they meant by this. That they participated over a sustained period of time perhaps added to the participant’s enjoyment and continued engagement in the learning activities. This link between learning and enjoyment was expressed: “It’s been an enjoyable experience ‘cause I’ve learned things too” (Female participant 6 IT).

One participant highlighted the learning as beneficial and gave the sense that the learning was incidental and occurred purely through interacting with the students: “Well, I found, what was beneficial about it, while talking to students I was learning as well and I really enjoyed that” (Male participant 7 IT). Through this interaction, the participants entered into a collaborative learning relationship with the students: “It was
good for us as well as good for the students because we both learned from each other and you know” (Male participant 2 IT)

Learning for the participants was expressed in several ways: learning new health-related knowledge; learning new personal insights; and learning new confidence in giving feedback. Several participants expressed that they were learning new health-related knowledge: “I’ve learned for instance that your tummy can make four sounds, quarters, and I never knew that” (Female participant 6 IT). One participant also related this new knowledge to a new understanding on management of health conditions: “Well I’m learning so much about how the body works and how it can be treated” (Male participant 7 IT). Another participant acknowledged that she had learnt a great deal: “I’ve learnt quite a lot, you do learn things. Yeah, yeah, well I didn’t realise that and didn’t realise that and I think ‘oh yes I’ve really learnt that’” (Female participant 1 IT). This participant did link the learning to possible benefits to managing health but did not feel this was relevant to herself: “There was probably nothing there that related to me, but I mean it could eventually but there was sort of lots of things that yeah that I’d learned about” (Female participant 1 IT).

A female participant defined learning for her as not just confined to learning new health-related knowledge but went beyond to provide new personal insights for herself. This participant reflected on how providing feedback to a student was memorable for her: “He said ‘I’d never known that’ and I thought ‘well, there you are – that’s why I’ve been born to show him’” (Female participant 6 IT). This experience shows the participant felt a sense of purpose and provided her with new meaning.

Many participants expressed learning also took place experientially, through an increased confidence in giving feedback to the nursing students over time. The participants were provided with an overview of the simulated patient role at the start of
semester and again in weekly pre-learning activity briefings. This included describing the weekly scenario and any simulated equipment that was part of the scenario, and reviewing the questions that could be directed at the student. Specific training was not provided about the process of giving feedback, but participants were encouraged to provide spontaneous feedback in response to the simulated care delivery and to student responses to patient questions. Initially, participants adhered closely to the scripted questions; however, over time they felt more confident in questioning the students further. One participant expressed this as: “*I seemed to get carried away with all the questions. I asked more questions than ever. I found more, different questions to ask*” (Female participant 1 IT)

It was observed that the participants learnt to give feedback through a process of doing and reflecting on their experiences of interacting with students. Field notes from the participant observation highlight an interaction in which the researcher reflected on previous interactions with a participant, noting a difference in the feedback.

*I have interacted with this participant in previous activities with the students as a tutor and feel the participant has moved beyond just simulating a patient to now questioning beyond what is suggested in the patient scenario. When a student was completing a skill, the participant asked the other ‘student ‘what do you think of how he is doing the dressing?’ This was interesting as I felt the participant was asking the student to assess their partner’s skill and she was “testing” their knowledge and giving them feedback on what they thought.* (Female participant 4 PO)

An increase in confidence and comfort in giving feedback was also expressed by participants in the interview in which the participants were asked to reflect upon their experience and comfort in how they approached and gave feedback to students. One participant stated: “*Yes, I probably got more comfortable about doing that, probably sort of more questions than when I, when they first started*” (Female participant 1 IT).
Another participant felt that, over time, their comfort in giving constructive feedback, in particular, improved: “Yes. I think I was a bit apprehensive to start with as to whether I could be critical or not” (Female participant 8 IT). This participant explained further that she was now comfortable in giving constructive feedback, but always gives positive feedback as well: “Some critical comment as well as some positive comment” (Female participant 8 IT).

4.3.5.2 Sharing Stories

Another unexpected benefit expressed by the participants was the enjoyment they expressed at being able to meet new people and share their stories. These stories ranged from sharing experiences of participating with the students with each other and with family members, through to sharing the many experiences throughout their life with the students.

Bringing together of participants in briefing sessions prior to the learning activities provided the opportunity for the participants to get to know each other. These sessions, although brief in duration, provided an opportunity, once per week, for social engagement in which they were able to expand their social connections and connect with residents from both the hostels and the ILUs. Some participants found that it helped to establish new networks and from these activities new friendships developed:

I see him [referring to one of the other participants] and he says “hello.” But it’s, for me, it’s a very pleasant way of learning people’s names, even though I forget them sometimes. (Female participant 4 IT)

The social benefit to the participants of these sessions was expressed by one resident in terms of interacting with other participants and the students: “I think it’s very good for them [other participants] to come and interact with whoever we meet before, you know, it starts and there’s the odd chat and then we interact with the youngsters
Another participant, having shared her experiences of engaging with the students with family, described the advantages of this social engagement as seen by her daughter: “And meeting other people, and that’s one Rachel [her daughter] said, ‘Mum, thank goodness you are doing something,’ because she knows I must have been bored to tears” (Female participant 4 IT). These comments suggest that the debriefing sessions, although not deliberately designed to do so, provided an enjoyable break to routine, leading to meaningful engagements with others.

An ongoing consequence found by the participants, of having joined in the activities was the opportunity to share their experiences with other participants outside of the clinical learning environment. One participant commented on the enjoyment the activities brought to her, the sense of anticipation she felt, and opportunities for discussion it created after: “It was a case of looking forward to it and then talking about it afterwards” (Female participant 8 IT). This same participant further expressed the enjoyment felt by the participants in participating with the students and how they compared their experiences with the students:

We’ve had little talks afterwards and they’d sort of say ‘oh, you know what was wrong with you today?’ You know, and going through it, and you know, some of the problems that we’d had, and nearly all of them really look forward to coming down. (Female participant 8 IT)

One participant, who has been an ILU resident for many years, found that the sessions and the activities with the students provided the opportunity to reconnect with hostel residents in a different environment, adding this was a valuable outcome for her: “Brought us back together again [referring to hostel residents], because once upon a time we had, we were encouraged to go into the hostel and sort of talk to them and help them and do things with them” (Female participant 8 IT). This same participant was able to reflect on the benefit of the social engagement in assisting to address issues of
social isolation for older adults within the hostel and ILUs: “There’s ILU people who are lonely as well. So you know to have somebody to interact with I think was good, it was good” (Female participant 8 IT).

Sharing of stories with the “young ones” was highlighted by the participants as a benefit of having engaged with the students in the weekly activities and one which they enjoyed immensely. In this, the participants shared a broad range of experiences from their life with the students:

I didn’t labour the point very often but just when it happened to be suitable I would tell them [the students] my experiences as an evacuee during World War II, how I was nine and my sisters were eleven and seven and how we were just stuck there ourselves with nobody to put out a clean dress or a clean pair of pants or things like that. (Female participant 6 IT)

Enjoyment for the participants was not so much from the process of telling someone their stories but feeling as though their stories were contributing to something worthwhile in the nursing student education. Several participants were originally from the United Kingdom and highlighted that, through sharing their stories with the students, the cultural and social factors that affect health:

Yes, I mean, I try to make what I said to them and me being Scots I tried to emphasise that, that I was a Scots person and different and I had different views and I expected them to have different views but basically they had to be very clinical and confident in that. (Female participant 6 IT)

The participants felt that being able to share their stories helped the students to develop an understanding of the older generation and their specific health needs, as expressed in the theme concern for learning. However, it also helped to debunk some misconceptions that the participants may have held in regard to younger people: “I mean a lot of my generation now are thinking that most young people don’t give two monkeys about elderly people” (Female participant 2 IT). The influence that the
interaction with the students had for this participant in changing her beliefs was expressed by the participant: “Then you have this group of young people who want to do positive things with their life and pay attention to you and then some of them that are from other countries are going to take that back to their country. (Female participant 2 IT).

Participating in the student learning activities and through the collateral benefits that the participants found in learning new things, meeting new people and sharing their stories, contributed to feelings of satisfaction and pride in the role:

*Well I, ‘cause when I come up here I feel satisfied that I’ve played my part in helping them to, to learn about things that goes on with the body and as I said this body’s pretty good; it’s a perfect example for them to work.* (Male participant 7 IT)

A male participant also expressed this earnestly: “I know for a fact that I walk away from having done it each time with a, a sort of a warm, satisfied feeling” (Male participant 3 IT). This same participant experienced many health problems and hospitalisations with prolonged recovery periods during his three years of engagement with the students. Throughout this time he continued to undertake the simulated patient role, overcoming problems with mobility to continue his attendance. The enjoyment and benefit that he felt is obvious through his commitment to attend in often challenging circumstances, and expressed this in an interview: “I’ve been of some help in some way and just doing it has been a help to me” (Male participant 3 IT).

### 4.4 Summary

This chapter has discussed the five themes that emerged through the analysis of ten interviews, periods of observation, and feedback forms, from the participants engaged in learning activities with nursing students. The five themes illustrate the
participant experience of giving feedback, highlighting that they are not just a passive observer in the activities with nursing students, but that they were engaged in the process through observation of nursing student practice, reflection of expected practice, and communication to students (verbal and written) about their practice.
Chapter 5  Discussion

5.1  Introduction

This study explored the experiences of a group of older adults as they gave feedback to nursing students while acting as simulated patients. The older adults who participated in this research were unique in that they resided in either the hostels or ILUs located on the RACC, in which the learning environment was located and had varying levels of cognitive ability. These older adults are representative of a wider group of volunteers that have not been considered as a valuable resource in health professional education, but each had firsthand experiences of healthcare which they brought to their role. The older adults also received no remuneration for the simulated patient role; however, there was sustained involvement over a long period of time, suggesting that the motivation for participation went beyond a monetary value. Exploration was undertaken using an interpretive qualitative perspective, having collected data from participant observation, interview, and a written feedback tool.

The findings clearly answered the research question, five themes identified in the previous chapter explored how individualised life experiences of the healthcare system, work, family, hospital experiences and of having received feedback influenced the process of giving feedback. By providing both verbal and written feedback, the older adults assisted students in their learning and were motivated by a genuine concern for student learning. The student’s future practice and a sense that they were advocating for patient care were also motivators, along with enjoyment of the role. Finally, the participants reflected on their role as “teachers” and sought clarification when unsure about the feedback process, which raised questions about the need for training.

The final chapter considers the research findings in light of the aim of the study and includes a comparison of these findings with other relevant published literature. It
discusses the researcher’s interpretations, based on the findings in chapter four. Key aspects are discussed including valuing the patient’s voice, enriching the learning experiences in nursing education, and SiPs enhancing the understanding of caring in nursing.

5.2 Valuing the patient’s voice in nursing education

Feedback is of critical importance to health professional student learning and is seen by most students as a welcome opportunity whereby strengths and limitations of practice can be discussed. The aim of feedback is to encourage self-reflection and self-awareness, enabling students to consider past performance and identify strategies to enhance future learning and practice. Cantillon and Sargeant assert that “feedback is the cornerstone of clinical teaching,” without which, desired practice is not reinforced or poor practice corrected.

Many models for delivering feedback are described in the literature and it is acknowledged that feedback has the potential to be both productive and harmful if carried out without an understanding of the feedback process. The older adults in this study had received no formal training in delivering feedback; however, of note was that all delivered the feedback utilising recognised best practices. The feedback provided by the older adults was immediate and was based on the observed and experienced aspects of care being provided from the students, making it highly specific and was delivered within a positive framework.

Through questioning, provided as part of the scenarios and individual questions, the older adults encouraged the students to move beyond simply completing a task, to considering the impact of the care delivery on the patient’s physical and psychological wellbeing. For example, during the study observation period of a wound dressing, the older adults asked questions such as “will it hurt?” prompting the student to consider
the need for pain relief, or “are you sure that is ok?” prompting the student to reflect on their own knowledge and to seek further clarification.

Feedback, which encourages the learner through questions and comments to self-reflect and identify areas of learning needs, has been described as facilitative. Facilitative feedback, such as that between the older adult and the students, encourages a two-way process where the student and the giver of feedback engage in an exchange of information in which positive and encouraging language is used to explore ideas and questions. This two-way process is recognised as important in delivering feedback; however, Archer,89 in examining the feedback in the context of health professional education, acknowledges that feedback often remains an educator-driven, one-way process.89

This facilitative approach to feedback enabled the participants to give the students an understanding of how they felt as a patient during the learning activities, which is not often received in the real clinical context. The value of including the patient’s voice in health professional education has been recognised in the literature as an effective teaching pedagogy in preparing students for clinical practice.118-121 Findings from this study confirm the literature, showing that the involvement of the older adults in learning activities with provision of feedback, allowed the students to develop an understanding of patients’ care needs, thereby preparing them for practice. This finding is consistent with other studies that recognise the value of patient volunteers and their interactions, including the provision of feedback.45,73

When discussing the theoretical and practical basis of simulation, Nestel and Bearman49 support the notion of simulated patients being in a unique position to provide feedback from the patient perspective. These authors acknowledge that simulated patients not only portray the role of a patient, but also play a significant role in teaching
through feedback. They feel that the simulated patient is an expert who can deepen the theoretical learning of the student by bringing understanding to the patient experience of illness. Similar findings were found in this current study as the value of the contextualised feedback from the older adult closely replicated clinical practice. Students were able to utilise the older adult’s comments to prepare themselves for interactions with “real” patients in clinical practice. Casey and Clark \(^\text{122}\) concur with this, finding the unique insight offered through the inclusion of patients into their experience of care provides students with the opportunity to reflect on their practice. The authors add that patient feedback can assist students to develop insight and self-awareness. \(^\text{122}\)

The older adults’ ability to provide the students with an understanding of the patient perspective was a key finding of the research. Feedback was provided from a simulated patient perspective; however, feedback was based on actual patient experiences. There are limited studies in the literature which describe feedback from the patient’s perspective, as most relate to simulated patients giving feedback on clinical or communication skills. Bokken et al. \(^\text{55}\) support this finding in a study examining the impact of simulation of people who act as simulated patients, stating that the “uniqueness and strength” of feedback from simulated patients is that they are able to relate their individual responses to the care they received back to the student. Archer \(^\text{89}\) (p109) concurs, stating that, unique to health professional practice, is the provision of feedback by patients, finding that it can be most influential in changing health professionals’ performance. Archer \(^\text{89}\) also states that feedback must be on observed behaviours and that this often does not occur within the clinical environment and that it rarely occurs from the patient perspective.

In an article discussing the role of feedback in teaching medical students, Moorhead et al. \(^\text{123}\) discuss that, for feedback to be effective, the context of the feedback must be specific. When this takes place, the feedback received on the learner’s
performance is more highly valued than non-specific feedback by the learner. The authors also acknowledge that patient feedback was the most valued by learners. The student perspective was not examined as part of this research study; however, the findings show that, through feedback sought by the older adults from the students, the students also valued the experience.

The literature highlights a lack of research from the consumer perspective and theory to support the inclusion of patients/consumers in healthcare education. In a review of the literature of patient involvement in health professional education, Towle et al., discuss how initiatives are described in the literature as “one-off” events and are reported as basic descriptions. From their critique of current literature on the engagement of patients and the public in medical education, Regan de Bere and Nun highlight that patients are central at all levels of medical education, citing benefits that include the relevance of learning, encouraging empathy, and development of communication skills. However, the authors also add that the lack of a clear theoretical framework or evaluations for the inclusion of patients in education means learning outcomes for student involvement is unknown. Despite this, within nursing in Australia, accreditation bodies such as the Australian Nursing and Midwifery Accreditation Council (ANMAC), make reference in accreditation standards to the inclusion of consumers in curriculum design and the application of innovative teaching methods that immerse the student in the context of the nursing profession.

The unique nature of the clinical learning environment in this study immersed the student in an environment that closely replicated the “real world.” The findings from this study found that this real-world context enabled the older adult to take an active role in teaching and supporting learning through the provision of feedback from the patient perspective that is timely, specific, and contextual. This is what underlies the uniqueness of feedback provided in this way and is applicable to nursing education in
preparing students for clinical practice. Webster et al.\textsuperscript{73} concur, stating that feedback from volunteer/simulated patients simulates closely what should occur in clinical practice. Additionally, the authors argue that the value of the patient’s voice is to encourage the student to learn and reflect on the experience, taking new knowledge and skills forward into practice. However, Bokken et al.\textsuperscript{126} found that, whilst the authenticity of the real patient and feedback was valued by students, it was the feedback by simulated patients was more instructive for the students.

The feedback from the simulated patient perspective was felt by the participants to be highly valued by the students: “Well, they, they usually stop and listen to you, stop and listen to you and check whatever you’re saying fairly well in the majority of cases” (Male participant 3 IT). During participant observation, the study found that students actively sought feedback on the care they provided and the student’s response to the feedback was immediate and resulted in a change of behaviour: “The feedback resulted in an immediate correction in behaviour from the student” (Female participant 3 PO). The research also found that the students and the participants often moved between the scenario of the learning activity and the participant’s own health history, suggesting that both found benefits in utilising real health conditions in learning. These findings are comparable with research by Giesbrecht et al.\textsuperscript{127(p247)} who found that students placed a higher value on the feedback provided by standardised patients over that provided by educators as these reflected the “true” patient experience. Consistent with findings from this study in relation to students valuing the patient experience, Giesbrecht et al.\textsuperscript{127} found that students preferred the opportunity to practice with a simulated patient who had a real health condition as opposed to those that enacted a condition.

Participants within the study identified that a positive aspect of their experience of providing feedback was the ability to build a rapport with the students. Positive language and humour were strategies utilised by the participants to build rapport and
establish an environment in which they felt the students would be more receptive to feedback. Rapport is described as the ability to make people feel comfortable and has been defined as a “harmonious relationship.” Ross furthers this claim in relation to health professions, stating that rapport promotes communication, collaboration, and an understanding of the patient perspective. Within the health professions, developing rapport with patients is particularly important so that patients feel comfortable in disclosing vital information for diagnosis and treatment and is linked to positive patient outcomes.

The importance of rapport can also be applied to the feedback relationship in terms of the need to build a positive environment to enhance learning through trust and respect. This rapport was not limited to verbal communication, but also included the employment of non-verbal behaviours. The observational aspect of the study found that the body language used by the participants was “open” and “relaxed” and that the participants were “smiling,” “nodding” and “laughing,” and “regular eye contact was made with the students.” Ross confirms the claim that verbal and non-verbal interpersonal communication skills are key to developing rapport. Ramani and Krackov also confirm that positive body language can create an environment in which the position of authority can be reduced.

The perception of power or authority in the feedback relationship can affect how the feedback is accepted, and, in turn, how the feedback is responded to. The ability of the participants to put the students at ease enabled common ground to be found through mutual interest in the learning activities. Power in this relationship was shared, enabling students to accept and respond to participant feedback. This is an important finding of the research, as traditionally, within the clinical environment, the health professional is perceived as being in a position of power and the patient does not see it as their role or place to provide feedback or question the care they are receiving.
older adult in the role of the volunteer patient felt that it was their duty or role to provide the feedback on performance, thereby altering this traditional perception of power. This is supported by Weinstein who discusses the benefits of service users in the classroom in the teaching and learning of mental health nurses. The author found that the power dynamics were changed between the student and the service user and were now more equally balanced, creating an environment in which more open dialogue was created and where service users were seen as the experts. This is significant as feedback from the patient perspective to the nursing students during their education, has the potential to refocus for the students what a patient is at the beginning level of learning.\textsuperscript{133}

Another key finding was the use of humour by the participants to assist in creating a non-threatening environment, fostering the development of rapport, but also its use when giving verbal prompts and constructive feedback to the students. Humour can assist in lightening sometimes stressful situations in giving feedback and also make the student more receptive to hearing constructive feedback. Humour was used in a cryptic way – “\textit{Ladies I could be dying over here}” – as a mechanism to remind students they were not responding to the patient’s care needs. Literature supports the use of humour as a strategy in developing rapport\textsuperscript{134}; however, limited literature was found to support its use in giving feedback. In fact, literature suggests that, when giving constructive feedback, language should be respectful, precise, and neutral in wording.\textsuperscript{130} The use in this study to give constructive feedback from the patient perspective in relation to the care they were receiving is consistent with patients using humour to express grievances with care within healthcare settings.\textsuperscript{135}

Humour was also self-deprecating and used by a male participant to make light of physical disabilities: “\textit{Participant used humour with the students when discussing his disability – making light of the obvious deformity in his skull and his limited physical...}
abilities. Branney et al.\textsuperscript{135} concur that humour is useful in developing rapport, finding it reduces tension and embarrassment. However, they also found that men can often experience feelings of vulnerability when faced with health issues and employing humour is a way in which they cope with this vulnerability. Literature does exist for the use of humour in nursing with Adamle and Ludwick\textsuperscript{136} finding in their study that, in the majority of nursing interactions with hospice patients, humour was used. Within education there is also literature to suggest that humour can be used to create positive learning environments and enhance the learning experience. Chauvet and Hofmeyer\textsuperscript{137} support that humour can facilitate increased learning, reduce stress levels, and improve performance. That the patients drew on their own experiences of health care in their interactions with the nursing students may assist in explaining and understanding the use of humour.

One of the most compelling themes expressed by the older adults during the interviews was the concern expressed for the students and their learning. The older adults expressed a sense of compassion for the students as they learnt, recognising nervousness and course-related stresses may have impacted on the students’ performance. This concern for student learning is supported by the literature and has been cited as a source of possible stress for the simulated patient.\textsuperscript{73} In a study looking at the impact of simulation on people who act as simulated patients, Bokken et al.\textsuperscript{55} suggested that the majority of the simulated patients they interviewed experienced negative effects from participating in simulation. It was felt by the simulated patients that what contributed to the feelings of stress was the concern that they had not given effective feedback to the students.\textsuperscript{55} This sense of concern and empathy is also expressed in a study by Webster et al.\textsuperscript{73} in which volunteer service users are trained to give feedback to nursing students. Similar to the current study, the authors found that the volunteers strongly expressed a sense of empathy and concern for the students and
volunteers recognised that nervousness and stress felt by students may have contributed to students not performing to their full potential.

It is important to acknowledge that feelings of uncertainty were expressed by the older adults about their role in giving feedback – uncertainty on what feedback should be given on and in some cases what constituted feedback. Webster et al.\(^\text{73}\) highlights that, to look at the impact of providing feedback, service users should first be provided with feedback training. The unique nature of the clinical learning environment, however, enabled authentic learning to occur in which students are able to gain an insight and understanding through the older adult on what it is like to be a patient – an experience that they would not get in traditional learning environments. The feedback that is provided in this environment was instant and relevant to the context of care delivery as it is from the patient perspective.

Beyond this concern felt by the older adults for the students’ learning, was the concern that was expressed for the patient. This concern was expressed by the older adults through ensuring that in the student’s future nursing care they were providing quality care. The older adults saw their role as assisting the student to become a competent registered nurse and through this positively influencing patient care: “I got a lot out of that to think here are these students now up and coming and they’re you know our future nurses!” (Male participant 7 IT). The older adult saw a direct link between their role and future patient care; in essence, they saw themselves as advocating for the patient. In a study by Johnston et al.,\(^\text{138}\) preparation of the students for their future practice was also seen as a key driver of standardised patients. This study examined the experience of standardised patient raters in Objective Structured Clinical Examinations (OSCE) of medical students. The findings of these authors confirm the finding of this study that the older adults felt they were advocating for future patient care.
5.3 Enriching the learning experience

A key finding of this study was that the participants were able to bring “themselves” and their own unique experiences of health and the healthcare system to the learning activities with the nursing students. The participants’ own values, perspectives, and experiences encouraged the students to move beyond learning and practicing a skill, to considering the holistic patient-centred nature of nursing, providing a richness to the learning experience for both the student and older adult.

Enriching the learning experience of students through the incorporation of patients is comparable with research which recognises the value of patient involvement in student learning.\textsuperscript{139} Towle et al.\textsuperscript{118,121} highlights many advantages to including patients in health professional education, emphasising how it promotes patient-centred care as well as suggesting that it is the feedback that students receive from patients which is remembered. Older adults noted that the nursing students preferred the interactions with themselves as simulated patients than learning activities with the mannequins. Mannequins have been used extensively in nursing education to teach psychomotor skills, and, whilst they are effective in teaching and testing knowledge and skills, it is difficult to develop the desired attitude and behaviours required to prepare students to provide holistic nursing care.\textsuperscript{140}

Patient-centred holistic care and reflective practice are key theoretical and pedagogical concepts in nursing curricula and practice, which were highlighted by the older adults during the learning activities with the nursing students. The older adults nurtured the concept of patient-centred care by equipping the students through the sharing of their experiences with the knowledge, skills, and attitudes that moved the student from focusing on the patient as an individual with a disease or group of symptoms to a patient with individual preferences, needs, and values. The scenarios simulated by the older adults promoted a holistic approach to patient care, inclusive of
the health history and the social history. Adding to the complexity of the activities was the cognitive ability of the participants, requiring students to respond at times to unpredictable events. Casey supports the value patients offer to learning, finding that learning activities that closely replicate the clinical environment and complex patient needs are events that cannot be simulated within the classroom.

Through sharing their individual experiences, the older adults encouraged the student to actively reflect on their practice. Students were able to evaluate the care they were providing against that which the older adults expressed as a need. Reflective practice has long been recognised and acknowledged as a valuable tool by which healthcare professionals are able to identify their own areas of learning need, and also as a tool to recognise and meet changes in patient care expectations. An interesting finding of this study was that reflection was also used as a tool by the older adults. The approach taken by the older adults toward providing feedback to the students was based on their own individual experiences, not only of health and the healthcare system, but also their own personal experiences of having received feedback. The older adults reflected on these experiences when giving feedback to the nursing students and, on occasion, altered their approach according to the reaction of the student. The findings also showed that when reflecting on the learning activities with students, the older adults sought clarification of concepts through independent research or by the tutor to assist them to assimilate previous knowledge with new knowledge.

The ability of the older adults to reflect on previous experiences to formulate and experiment with alternative methods to give feedback aligns with Kolb’s Experiential Learning theory. There is a wealth of literature that supports the use of Kolb’s experiential learning theory in student learning across diverse disciplines and, as highlighted within the literature review, Kolb's theory of experiential learning is recognised as a framework for developing simulation
activities. However, there is very limited literature for its application to the simulated patient or patient volunteer. The older adults have shown that in line with Kolb’s assertion that experiential learning is a “continuous process grounded in experience,” the application of this theoretical model is applicable to the older adult patient volunteer as the learner in this context.

Kolb asserts that, for learning to occur, the learner must pass through all phases of the cycle; however, the learner can enter the cycle at any point. The older adult, in approaching the experience of providing feedback to the student, has entered the learning cycle at the point of reflective observation (Figure 8), drawing on memories of previous experiences of being a patient, of the healthcare system, and having received feedback. Memories were consistently described by the older adults when explaining how they approached the feedback interactions with the students: “I can plainly remember that when I was a youngster,” “my past personal experience of similar things,” “none of the nurses had been in to see him,” and “consequently when I’m in a situation like that I try to make it as easy as possible.” Drawing on memories is supported by Kolb who states that “experiences are integrated with memories to create meaning.”

There is evidence in this research that the older adults cycled through these first two phases of the learning cycle (Figure 5-1). They reflected on the current experience of giving feedback in the simulation depending on the reaction of the students: “you could tell that he was uptight for a short while afterwards” and “perhaps I jumped the gun there and he was right.” They also reflected after the simulation when speaking with other volunteer patients: “we’ve had little talks afterwards...and going through it and you know some of the problems that we’d had.” To try and assimilate this new experience of giving feedback with their previous experiences, the older adults sought feedback and clarification from the academic tutor or researched independently,
bringing new knowledge to the subsequent feedback interactions with the students. At this stage older adults expressed that, with experience, they felt more confident and able to give more constructive feedback.

![Figure 5-1 Kolb’s Experiential Learning Cycle as Applied to the OASiP](image)

That the older adults were engaged in the learning process with the students was evidenced by their continued and sustained attendance on a weekly basis, sometimes in challenging health circumstances. The motivation for this sustained engagement can be explained by the strong sense of concern felt by the participants for the students’ learning. The value of their involvement as real people was felt by all participants with the findings determining that participants felt a compelling desire to see the students develop the knowledge, skills, and attitudes required of nurses. This commitment and emotion is supported by Webster et al. who suggests that central to the actions and motivations of service users in nursing education was the welfare of the student and
future nursing care. The authors also suggest that this concern could have been a cause of worry for the participants in relation to how feedback was given.\textsuperscript{73}

A sense of apprehension in relation to the quality and value of the feedback that was provided to the students was conveyed by the older adults in the interviews, suggesting that this uncertainty was a cause of concern and possible stress. Varying degrees of stress-related symptoms of simulated patients have been reported by authors.\textsuperscript{53,64,65,144} Boken et al.\textsuperscript{53} concur with the findings of the research, suggesting that dissatisfaction with the simulated patients' own performance and the impact on student learning could be a source of stress. Although these feelings were described as mild, the authors concluded that they warranted monitoring.

The confusion expressed by the older adults as to what constituted feedback, and uncertainty as to whether they were giving feedback clearly, demonstrates that strategies to reduce this uncertainty and stress are warranted. Webster et al.\textsuperscript{73} (p.137) goes so far as to suggest that it would be negligent to not first prepare volunteers or simulated patients to give feedback, ensuring that they are comfortable to do so. The older adults recognised this need for preparation, and strategies suggested by them were inclusive of both undertaking the role of a simulated patient – “\textit{role plays would be useful}” – and the ability to be effective in the feedback provided – “\textit{some tips on what to say}.” Webster et al.\textsuperscript{73} support this, finding that volunteer patients within their own study identified that the ability to give appropriate feedback was a developmental need for themselves.

There was, however, some indecision amongst the participants regarding the benefit of formal feedback training, due to the thought that this may potentially alter how they gave feedback: “\textit{It would be your words then}.” It was important for the participants that feedback was from their own perspectives as a patient. Participants
reported that they felt confident to provide face-to-face feedback to the students; however, they also identified that when constructive feedback was required this was stressful and they preferred to utilise the written feedback tool. That corrective feedback was not provided immediately, potentially reinforces poor practice and makes the learning less meaningful for the student. This is significant as for feedback to be effective it should be contextual. Archer also suggests that when feedback is provided without knowledge and understanding of the feedback process the impact on student learning can be harmful. Literature describing the involvement of simulated or volunteer patients in providing feedback to health professional students, support the claim that these people should receive feedback training to optimise student learning. The findings from this study also support that formal training would improve the older adult’s knowledge of feedback and skills in providing feedback, especially constructive feedback.

However, what is more significant is that the study found that briefing sessions designed to provide some instruction of the scenarios and tips for feedback had a supplementary benefit. These sessions facilitated friendship and companionship, helping the older adults to connect and in some cases reconnect socially. The increased social engagement was not an intentional outcome but was nevertheless welcomed by the older adults. They described the activities with the nursing students as becoming topics of conversation outside of the learning environment, giving the sense that the older adults felt a sense of value and rapport. Stewart et al. concurs with this, finding that alongside increases in self-confidence, enhanced communication, and feedback skills, feedback training sessions also reinforced a sense of camaraderie and showed an appreciation for the importance of the volunteer role.
5.4 Simulated patients enhancing the understanding of caring

Participants strongly expressed their thoughts on how nurses should deliver care and in turn gave feedback to the nursing students on their perceptions. The perception of what constituted nursing care was a significant finding of the study and confirms similar findings in the literature. Individual perceptions were drawn from personal experiences of being a patient and from interactions with the healthcare system, but also reflected how they felt as a patient during the learning activities with the students. The older adults drew on these previous experiences and used this as a benchmark on which to compare the care being delivered by the students during the simulations. An older adult described her interaction with the students as “they’re thoughtful, check and see if it’s hurting you,” judging this as the standard of care she would like to see reflected in nursing care. Her benchmark being how she felt care was delivered during a recent hospitalisation: “You don’t always get that in the hospital.”

In a qualitative exploratory descriptive study examining the patient experience of compassion and perceptions of developing compassionate nurses, Bramley concurs with the findings from this study. Bramley found that compassion was broadly aligned with the actions of care of the nurses. Thompson and Sunol also agree that patients’ perceptions of nursing care was informed by individual beliefs and values and based on prior experiences, providing a framework by which current experiences are likened. Schmidt also found that patient’s prior experiences also affects current perceptions and experience of hospitalisation. To understand these perceptions and form a discussion on how the older adults enhanced the “caring” aspect of nursing in the simulated environment, it is important to first try to define nursing care.

Historically, caring was considered by nursing theorists to be the foundation, the essence, and central focus of nursing. In contemporary nursing, care and caring are terms that are used widely in conjunction with nursing and have been cited in the
literature as its core business.\textsuperscript{145,148-151} Attree\textsuperscript{152} describes “good quality care” as individualised, patient-focused, and provided through a caring relationship. Shields\textsuperscript{149} and Fry et al.\textsuperscript{153} support this, adding that these qualities include compassion, empathy, trust, respect, and a humanistic approach to support the individual patient’s dignity, comfort, and self-esteem. Bramley and Matiti\textsuperscript{145} concur with this, finding, however, that patients did not delineate between the terms “care” and “caring” and “compassion” when describing the qualities of nursing.

Caring, however, is a term that is not confined to nursing, but applied to health professions broadly to describe services provided to patients. Richardson et al.\textsuperscript{151} debate that the terms caring, compassion and empathy are ill-defined, yet users of healthcare have clear expectations of what these concepts represent in nursing.\textsuperscript{154} Confirming this finding from the literature, the older adults clearly expressed the aspects that they perceived as being essential for nursing as “caring,” “comfort,” “touch” and “thoughtful.” The older adults recognised that the students needed to be skilled technically; however, they valued these humanistic concepts more highly.\textsuperscript{147,152,154} “Seeing the patient” was a term used by one participant to express her desire that the students be able to recognise and deliver care that was individualised, holistic, and patient-centred in nature. Schmidt\textsuperscript{147(p395)} found that patients perceived nursing care as falling into four categories of which “seeing the individual” patient was one.

The aspects of care that the older adults provided feedback on were small, such as “providing a flannel,” or “making sure I can reach my water,” and seemingly inconsequential when viewed from the lens of the nursing student. Students are novice practitioners whose focus is on the technical aspects of skill development and linked to passing assessments. By introducing the older adults as the SiP to the simulations, the students were able to view nursing care from the lens of the patient, suggesting that this
may lead to increased awareness of therapeutic behaviours and an improvement in the quality of their practice.\textsuperscript{145}

Patient-centered care is central to nursing practice and describes practice that is respectful and responsive to preferences, needs, and values of patients. Dimensions of patient-centered care are described as respect, emotional support, and physical comfort and align with the values expressed by the older adults. A “care ethic” was described in the findings by a participant and aligns with this view of patient-centred care. This care ethic was described in terms of nurses not overlooking care needs and for nurses to be more observant to individual patient needs, especially when there may be physical limitations related to medical or surgical reasons for admission. When these qualities were felt by the older adult as having not been displayed, either as a patient in the healthcare system or as the simulated volunteer patient, they felt devalued and equated this to poor nursing practice.

Bramley and Matiti\textsuperscript{145} support this, finding that there is a lack of care and compassion within the healthcare system worldwide due to the increased complexity and specialisation of services. The authors argue that an increased focus on compassion and caring is needed within nurse education; however, they also recognise that research in regard to patients’ perceptions of compassion and its development in nursing care is lacking. Boylan et al.\textsuperscript{125} suggest that, to promote patient-centred care, a more active role of the patient as teacher is needed, suggesting that active involvement provides a platform in which the concept of compassionate patient care is promoted. The authors concur that research is “sketchy” and is needed in the areas of patient involvement, where this takes place, learning outcomes, and the patient experience.

This has led to debate in the literature as to how these values can be taught and if in fact caring can be taught or if it is innate.\textsuperscript{145,151} As the “core business” or “essence”
of nursing has been identified as caring, nursing education has a role in developing the knowledge skills and attitude of students to assist them in providing nursing care which encompasses these values. Exposing students to learning activities that encompass activities such as hearing stories of others, case studies, and role playing has been highlighted by Bramley and Matiti\textsuperscript{145} and Richardson et al.\textsuperscript{151} as a means in which caring qualities can be taught. Dewar\textsuperscript{155} has furthered this, suggesting that qualities of compassionate care should constitute professional development competencies.

The older adults facilitated learning of caring values for the students by encouraging the student to consider the learning activities from an alternative perspective, rather than the pure delivery of the care intervention. Through repeated interactions with the older adults, students gained an understanding of the patient’s perspective, their needs, values and experiences and how this impacts on how the patient perceives care. The student is therefore better equipped to meet these needs as part of a holistic patient-centred approach to nursing care.

5.5 Summary

The study findings are positive and have highlighted the value of verbal and written feedback. The study is unique, showing that older adults residing in a RACC can make valuable contributions to health professional education, providing a perspective of patient care that is not normally provided in the clinical environment. The findings overwhelmingly showed the older adults found enjoyment in their role as simulated patients and saw the value of their role in providing feedback to the nursing students.

The aim of this study was to contribute to the body of knowledge in the area of utilising older adults in simulated clinical activities, specifically in the provision of feedback to nursing students. Findings from this study support other research in the area
advocating for the engagement of real people in student learning.\textsuperscript{45,73} however, the findings from this study were also distinctly different.

Another unique finding was that although the older adults received no formal training in the delivery of feedback, all utilised frameworks that are recognised within the literature. Linked to this finding and of interest is the educational level of the participants. The majority of older adults did not progress beyond a high school level of education with two only reaching a primary school level. The study did find that, consistent with the literature, formal feedback training would be of benefit in reducing some of the feelings of uncertainty expressed by the older adults and would better equip them to deliver constructive feedback, enhancing the learning for the student.

This chapter outlined the key findings of the study and drew on the findings of other research published in this area. Chapter 6 concludes and summarises the findings of the study and draws conclusions as well as outlining the limitations of this study and areas of further research.
Chapter 6  Conclusion

This chapter presents a summary of the research findings and conclusions drawn. Additionally, the limitations of the study and implications for practice in relation to the inclusion of this unique group of patient volunteers in health professional education as well as directions for future research are also presented.

This research study sought to explore the individual experiences of older adults as simulated volunteer patients giving feedback to nursing students as part of learning activities. These experiences were explored using a qualitative descriptive, interpretive design. Data was collected from three sources. In Stage one of the research, participant observation, recording of field notes, and collection of a written feedback form provided rich qualitative data that was confirmed in the next phase of the research. Stage two was concerned with conducting semi-structured interviews with the participants of the study and transcription of the audio recordings. All data was collected and thematic analysis commenced. The main focus of this study was to determine how a group of older adults described their experiences of providing feedback.

6.1 Limitations of the study

While the present study contributes to the body of knowledge in this field, there are some limitations. Firstly, the sampling strategy used was a purposive sample. Purposive sampling is widely used in qualitative research for the identification and selection of participants who possess similar characteristics and can provide the information being researched. This sampling strategy may have introduced an element of bias to the research as the participants who chose to participate may have had ulterior motives for doing so. Consistent with this was the concern expressed by all participants during the interviews with the researcher of the recent announcement of the closure of
the Master of Nursing Science (entry to practice) program from which the nursing students were a part. Older adults may have seen the participation in the research as an opportunity to influence this decision and held overly positive views of their interactions with the students.

The small sample of participants was chosen based on similar characteristics and the ability to provide specific information; however, the sample was limited to residents of one RACC which may also limit the generalisability of the results to the wider simulated or volunteer patient group.

This study set out to explore the experiences of older adults in giving feedback; however, it would have been useful to also examine the experiences of the nursing students in receiving feedback from this group and the impact of feedback from the older adults on learning and practice. The comparison of data from the students and the older adults would have permitted more detailed examination of this type of feedback for student learning and their implications on practice and patient care.

6.2 **Recommendations for health professional practice**

The results of this study have provided rich data that has implications for practice, through the engagement of older adults as simulated patients in educational activities. It is evident through this research that the inclusion of real people, and, more specifically, older adults, in teaching strategies provided a simulated experience that closely replicated the real clinical environment in which nursing students were able to practice clinical skills and gain a patient’s perspective.

The findings should be used within contemporary nursing education, by education providers to design teaching activities that move students toward a more patient-centred approach to nursing care. Through the provision of feedback by real
people as simulated patients within education initiatives, students are able to gain insight into and understand the patient perspective and what is valued by the patient within nursing interactions. This is a perspective that can only be provided by the patient and could possibly outweigh the insight that the lecturer could provide to the student.

Through greater understanding of patient perspectives and perceptions, there is potential with the involvement of older adults as simulated patients in nursing education to influence and improve the students’ knowledge and understanding of compassionate care. Simulated patients have the benefit of providing students with a safe environment in which skills can be practiced and better links between theory and practice are made. However, feedback by older adults as simulated patients throughout care interactions enables the student to develop awareness of what experienced people value as patients and make connections between theory and real-life experiences. Learning activities which allow students to hear the patient’s stories should be considered as valuable educational tools in developing compassionate care attributes in students. The implications for health professional practice are that students are equipped with skills at the beginning level of practice to understand what it is to be a patient and are able to provide care that is responsive to changing patient needs, thereby improving the quality of care provided.

The older adults within this study are representative of a larger group of residents living in aged care. These participants offered a unique insight into health and the healthcare system that they were able to share to enhance the students’ understanding of patient care. The sustained involvement of this group without monetary remuneration suggests that their motivation to participate was the desire to contribute to the development of the students as nurses. Partnering with aged care providers as an educational resource is recommended as students not only develop new
skills but it also has the potential to alter attitudes toward aged care. As reported in this study, this engagement also has benefits for the older adults such as enjoyment and inclusion.

Training in the provision of verbal feedback to students during activities is highly recommended to support the older adults and make feedback more effective for the student. Training may involve the running of workshops that provide training on the principles of verbal feedback through role play. Workshops would also serve to inform the participants of the areas of student performance in which to give feedback and how to give difficult feedback, which was highlighted as a concern for the participants in this study.

When designing workshops and learning activities, instructors should be cognisant of the older adult’s prior experiences and how these may influence the experience of providing feedback. Through understanding the experiences, needs, and wants of the older adults in this study, feedback training and educational initiatives involving older adults can be informed and guided, ensuring these are meaningful and directed. It is also essential that the older adults receive feedback on their own performance to ensure they remain encouraged and motivated to participate.

6.3 Future Research

The goal of this research was to develop an understanding of how older adult as simulated patients viewed their experience of providing feedback to nursing students. The findings from this study have emphasised the value of standardised and simulated patients to support learning in nurse education; however, they also highlight the value of incorporating real people as volunteer patients.
Students are provided with opportunities to hear from real people how care interventions are perceived, share and exchange information with their peers to enhance their capacity to learn, and critically reflect as a member of a collaborative community of inquiry. However, despite these potential benefits further research is needed to explore how the feedback from older adults can impact on student learning and provide insight into their performance. Further research might also explore how the feedback delivered from these older adults differed in quality and impact from that delivered by academic staff.

Further research that explores the unique contribution by older adults to health professional education would provide insight and understanding about the motivations and drivers of this group and may assist in the future recruitment and retention of older adults in educational initiatives.

To conclude, findings from this study has contributed to building a richer picture of older adult perceptions of giving feedback and has provided valuable insight into how older adults give feedback, the influences on feedback, and the motivations for older adults giving feedback to nursing students. There is a need to better understand the student perception of feedback and the impact of learning outcomes so that educators can more effectively incorporate this unique group into teaching strategies.
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Appendices

Appendix A  OASiP Script
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Appendix A

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<td><strong>Age:</strong></td>
</tr>
<tr>
<td><strong>Doctor:</strong></td>
</tr>
<tr>
<td><strong>Admission Date:</strong></td>
</tr>
<tr>
<td><strong>Health Problem:</strong></td>
</tr>
<tr>
<td><strong>Social information</strong></td>
</tr>
<tr>
<td><strong>Other problems:</strong></td>
</tr>
<tr>
<td><strong>Health History:</strong></td>
</tr>
<tr>
<td><strong>Medications:</strong></td>
</tr>
<tr>
<td><strong>Student activities</strong></td>
</tr>
</tbody>
</table>

**SUGGESTED QUESTIONS FOR NURSING STUDENTS:**

1. Why do I feel so sick?
2. The nurses have been listening to my stomach, why are they doing this?
3. Why do I need to have the fluids?
4. What sort of fluids are they?
5. Will the fluids affect my breathing like before?
6. Why are you taking that small tube out of my arm?
Appendix B

Beyond the Teaching Nursing Home: A Community Partnership of Learning and Care

Participant Feedback Tool

Participant Name (optional):

Date:                        BED NO:

Please comment on the overall interaction of the students  YES  NO*

The students started with a self-introduction.

The students showed understanding and concern for me as a “patient.”

The students clearly explained the nursing activity.

The students used the curtains to provide privacy during the nursing activity.

The students were organised in the delivery of the nursing activity.

The students listened to my concerns.

*(If no please comment below)

Positive comments for the students


Suggestions for improvements for the students


Any other feedback or comments


Thank you
Appendix C

Older Adult Simulated Patient experience of giving feedback to nursing students in a simulated environment

Dear Participant

Purpose:

Patient volunteers or participants are frequently involved with student nurses within the clinical skills environment at Bethanie Joondanna and participate in providing nursing students with feedback. As such patient volunteers provide an invaluable contribution to student nurses’ learning. The aim of the study is to examine the experiences of participants giving feedback so as to inform development of resources to support and enhance teaching with patient volunteers.

Decision to Participate:
Your decision to participate in this study is voluntary, that is, you may decide to be in this study or not take part in it at all. If you do decide to participate, you are able to change your mind at any time during the study.

Before you make any decision, it is important that you understand why this study is being done and what it will involve, including your rights and responsibilities.

Methods:
The research will examine the experience of older adult participants giving feedback to nursing students as part of a clinical learning activity in a simulated environment. There are different stages of data collection for this study:

1. Participant observation
If you agree to take part, you will be asked to allow me to observe you interacting with a nursing student in the clinical skills environment. I will be taking notes of the interaction you have with the nursing student and will be recording them in a diary (field notes) as well as taking an audio recording. You will not have to say or do anything you do not feel comfortable with.

2. Written Feedback
Complete a written feedback form on the completion of the interaction with the nursing student.

3. Semi-structured interview
If you agree to participate in the semi-structured interview, you will be asked about your experience of giving feedback to a nursing student. Some areas of focus may be “how” you felt when giving the feedback, “what” you gave feedback to the student about, “how” comfortable you felt about giving feedback, and “how” you felt the feedback was received by the student. At the beginning of the interview you will also be given a short questionnaire which will ask about your age, gender, ethnicity, previous occupation and...
previous experience in giving feedback.

**Benefits:**
The research will contribute to the body of knowledge in this field through publication of findings thereby providing educational institutions teaching nursing students with an insight into the experiences of participants giving feedback so as to inform development of resources to support and enhance teaching with older adults.

**Recruitment:**
The participants recruited for this study will be residents who participate within the clinical skills environment from Bethanie Joondanna

**Data Collection:**
The data that is collected in this research will be analysed to help improve the resources and support available for patient volunteers who provide feedback to health professionals The results of the study may be used for publication or presentation.

**Withdrawal from the study:**
Participants are free, at any time, to withdraw consent to further participation without prejudice in anyway. No reason or justification for such a decision is required. On withdrawal, the record of that participant will be destroyed, unless otherwise agreed by the participant.

**Contact person:**
If you have any questions about the study please contact:

If you have any queries in relation to this research please contact Professor Sandra Carr (Sandra.carr@uwa.edu.au, ph 6488 6892) or Helen Dugmore a postgraduate student at UWA, this study forms part of her Master of Health Professional Education (Helen.dugmore@uwa.edu.au, ph 6488 7830)

"Approval to conduct this research has been provided by The University of Western Australia, in accordance with its ethics review and approval procedures. Any person considering participation in this research project, or agreeing to participate, may raise any questions or issues with the researchers at any time.

In addition, any person not satisfied with the response of researchers may raise ethics issues or concerns, and may make any complaints about this research project by contacting the Human Research Ethics Office at the University of Western Australia on (08) 6488 1610, or (08) 6488 3703, or by emailing to hreo-research@uwa.edu.au"

All study participants will be provided with a copy of the information sheet and consent form for their personal records.
Appendix D

Older Adult Simulated Patient experience of giving feedback to nursing students in a simulated environment

Consent Form

I __________________ have read the information provided and any questions I have asked have been answered to my satisfaction. I agree to participate in the research proposed and understand that I may withdraw my participation at any time without reason and without prejudice.

I understand that all information provided through observation, audio recordings, field notes and interviews is treated as strictly confidential and will not be released by the investigator. I have been advised as to what data is being collected, what the purpose is, and what will be done with the data upon completion of the research.

I understand that if I withdraw from the study all data provided by myself will be destroyed unless otherwise agreed

Please indicate by checking the boxes below which research activities you would be happy to participate in.

☐ Observation of feedback interaction
☐ Interview post feedback interaction with researcher

I agree that research data gathered for the study may be published provided my name or other identifying information is not used.

________________________________________  ____________
Participant                              Date

If you have any queries in relation to this research please contact Professor Sandra Carr (Sandra.carr@uwa.edu.au, ph 6488 6892) or Helen Dugmore a postgraduate student at UWA, this study forms part of her Master of Health Professional Education (Helen.dugmore@uwa.edu.au, ph 6488 7830)

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All study participants will be provided with a copy of the information sheet and consent form for their personal records.
Appendix E

Older Adult Simulated Patient experience of giving feedback to nursing students in a simulated environment

Dear Participant

Purpose:

Patient volunteers or participants are frequently involved with student nurses in the clinical skills environment at Bethanie Joondanna and participate in providing nursing students with feedback. As such patient volunteers provide an invaluable contribution to student nurses learning. The aim of the study is to examine the experiences of participants giving feedback so as to inform development of resources to support and enhance teaching with patient volunteers.

Decision to Participate:
Your decision to participate in this study is voluntary, that is, you may decide to be in this study or not take part in it at all. If you do decide to participate, you are able to change your mind at any time during the study. Before you make any decision, it is important that you understand why this study is being done and what it will involve, including your rights and responsibilities.

Methods:
The research will examine the experience of older adult participants giving feedback to nursing students as part of a clinical learning activity in a simulated environment. Although data will not be collected from nursing students for the purpose of this study, to enable the researcher to examine the experiences of the older adult in giving feedback, observation and audio recordings of a feedback interaction between the OASiP and the student will be taken. Data collected from the observation and audio recording will focus on the older adults responses in the interaction.

Participant observation
If you agree to take part, you will be asked to allow me to observe you interacting with an older adult in the clinical skills environment. I will be taking notes of the interaction between the OASiP and the nursing student and will be recording them in a diary (field notes) as well as taking an audio recording. You will not have to say or do anything you do not feel comfortable with.

Benefits:
The research will contribute to the body of knowledge in this field through publication of findings thereby providing educational institutions teaching nursing students an insight into the experiences of participants giving feedback so as to inform development of resources to support and enhance teaching with patient volunteers.

Recruitment:
The participants recruited for this study will be residents who participate within the clinical skills environment from Bethanie Joondanna.

**Data Collection:**
The data that is collected in this research will be analysed to help improve the resources and support available for patient volunteers who provide feedback to health professionals. The results of the study may be used for publication or presentation.

**Withdrawal from the study:**
Participants are free, at any time, to withdraw consent to further participation without prejudice in any way. No reason or justification for such a decision is required. On withdrawal, the record of that participant will be destroyed, unless otherwise agreed by the participant.

**Contact person:**
If you have any questions about the study please contact:

If you have any queries in relation to this research please contact Professor Sandra Carr (Sandra.carr@uwa.edu.au, ph 6488 6892) or Helen Dugmore a postgraduate student at UWA, this study forms part of her Master of Health Professional Education (Helen.dugmore@uwa.edu.au, ph 6488 7830)

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All study participants will be provided with a copy of the information sheet and consent form for their personal records.
Appendix F

Patient volunteers experience of giving feedback to nursing students in a simulated environment

Consent Form

I ________________ have read the information provided and any questions I have asked have been answered to my satisfaction. I agree to participate in the research proposed and understand that I may withdraw my participation at any time without reason and without prejudice.

I understand that all information provided through observation, audio recordings and field notes is treated as strictly confidential and will not be released by the investigator. I have been advised as to what data is being collected, what the purpose is, and what will be done with the data upon completion of the research.

I understand that if I withdraw from the study all data provided by myself will be destroyed unless otherwise agreed.

I agree that research data gathered for the study may be published provided my name or other identifying information is not used.

_______________________  ______________
Participant                Date

If you have any queries in relation to this research please contact Professor Sandra Carr (Sandra.carr@uwa.edu.au, ph 6488 6892) or Helen Dugmore a postgraduate student at UWA, this study forms part of her Master of Health Professional Education (Helen.dugmore@uwa.edu.au, ph 6488 7830)

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All study participants will be provided with a copy of the information sheet and consent form for their personal records.
## Appendix G

Experiences of Patient Volunteers Giving Feedback to Nursing Students in a Simulated Environment

<table>
<thead>
<tr>
<th>Date of Observation</th>
<th>Name of Observer</th>
<th>Time Observation Commenced</th>
<th>Time Observation Concluded</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Location

1. **Space**
   - Describe the physical space where the observation is taking place. What was the layout of the environment? Is it 2 bed, 4 bed room?
   - Level of noise within the room.

2. **Actor**
   - Description of participants (gender) involved in the activity. How many students (gender) were involved in the activity with the participant?

3. **Activity**
   - What activities were the participant and student completing?

4. **Language**
   - How did the participant communicate with the student? What sort of language was used? How did the student respond to feedback from the participant?

5. **Non-verbal language**
   - What sort of body language was used by the participant?

6. **Feelings**
   - Did the participant express any feelings during the activity? What were the observer’s feelings of the interaction?
## Appendix H

<table>
<thead>
<tr>
<th>Date</th>
<th>Time of Observation</th>
<th>Number of Students</th>
<th>Location within CLE</th>
<th>Learning Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>15/05/2014</td>
<td>1300-1330</td>
<td>2 students initially. 1 more student joined the group 10 minutes into the activity</td>
<td>Bed B in 4 bedded simulation room</td>
<td>Vital sign assessment Abdominal assessment and completion of assessment of bladder function.</td>
</tr>
<tr>
<td>28/08/2014</td>
<td>1300-1330</td>
<td>3 students</td>
<td>Bedspace A in 4 bedded simulation room</td>
<td>Vital sign assessment Removal of staples from Craniotomy wound and referral to Hospital in the Home</td>
</tr>
<tr>
<td>28/08/2014</td>
<td>1330-1400</td>
<td>2 students</td>
<td>Bedspace D in 4 bedded simulation room</td>
<td>Vital sign assessment Removal of staples from Craniotomy wound and referral to Hospital in the Home</td>
</tr>
<tr>
<td>29/08/2014</td>
<td>1300-1330</td>
<td>3 students</td>
<td>Bedspace A in 4 bedded simulation room</td>
<td>Vital sign assessment Removal of staples from Craniotomy wound and referral to Hospital in the Home</td>
</tr>
<tr>
<td>29/08/2014</td>
<td>1330-1400</td>
<td>3 students</td>
<td>Bedspace A in 4 bedded simulation room</td>
<td>Vital sign assessment Removal of staples from Craniotomy wound and referral to Hospital in the Home</td>
</tr>
<tr>
<td>4/09/2014</td>
<td>1300-1330</td>
<td>3 students</td>
<td>Bedspace A in 2 bedded simulation room</td>
<td>Vital sign assessment Complex wound management and care of a client with a wound drain. Left Malleolus wound requiring packing with normal saline</td>
</tr>
<tr>
<td>Date</td>
<td>Time of Observation</td>
<td>Number of Students</td>
<td>Location within CLE</td>
<td>Learning Activities</td>
</tr>
<tr>
<td>------------</td>
<td>---------------------</td>
<td>--------------------</td>
<td>--------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 5/09/2014  | 1300-1330           | 2 students         | Bed A in 2 bedded simulation room          | Vital sign assessment  
Complex wound management and care of a client with a wound drain. Left Malleolus wound requiring packing with normal saline |
| 11/09/2014 | 1300-1330           | 2 students         | Bed C in 4 bedded simulation room          | Vital sign assessment  
Comprehensive pain assessment, Brommage assessment and patient education             |
| 11/09/2014 | 1330-1400           | 3 students         | Bed D in 4 bedded simulation room          | Vital sign assessment  
Comprehensive pain assessment, Brommage assessment and patient education             |
| 12/09/2014 | 1300-1330           | 2 students         | Bed D in 4 bedded simulation room          | Vital sign assessment  
Comprehensive pain assessment, Brommage assessment and patient education             |
Appendix I

Plan of questions for semi structured interviews with participants

1. Can you tell me about your experience in giving feedback to nursing students
   a. How long have you been participating
   b. As part of participating with nursing students did you provide verbal feedback?
   c. If yes: Why do you think giving verbal feedback was important?
      i. Did you feel comfortable giving feedback?
      ii. How did you decide to give feedback?
      iii. Did you provide written feedback?
      iv. How did you decide what written feedback to give the students?

2. Can you give me an example about a feedback moment with the nursing students that has stayed with you – an event that you remember
   a. If the participant is unable to recall an event prompt memory with researchers observation of the feedback observed.
   b. Is there a positive moment - what made this positive?
   c. Is there a negative moment – what made this negative?

3. How do you think your feedback impacted on the nursing students?
   a. What was the student’s reaction to the feedback?
   b. Tell be about a moment where you felt that you ‘connected’ with the students, what was happening at the time?

4. Do you feel as time has progressed that you are more comfortable in giving feedback to the nursing students?
   a. Has the feedback you have given changed over time?

5. Do you think that your feedback to the nursing students is valuable?
   a. Why is it valuable?
   b. Is there anything that would have helped you to give feedback to the students?

6. Do your feel that training in how to give feedback would have assisted you in giving verbal and written feedback to the students?