THE ROLE OF THE LECTURER IN THE PRECEPTOR MODEL OF CLINICAL TEACHING

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ABSTRACT

The role of the lecturer in the clinical area is the subject of much debate within nurse education. The purpose of this study is to explore the role of the lecturer within the preceptor model of clinical teaching in the clinical area within one school of nursing. The question that guided the study was:

how do lecturers perceive their role working in the clinical area within the preceptor model of clinical teaching?

The study utilised an exploratory/descriptive qualitative approach and twelve lecturers took part in the study. Data was collected through two rounds of focus group interviews and the data was analysed using the constant comparative method associated with a grounded theory approach.

Five themes emerged from the data. Four of these themes identified lecturer responsibilities in relation to the lecturer role. The most dominant of these themes was *evaluating students* and the other three themes were *teaching students, working with preceptors* and *creating a positive learning environment.* A fifth theme also emerged from the data and this was central to the other four themes. This theme was named *being negotiable* and referred to an attitudinal stance or way of being that the lecturers adopted in order to function within the clinical setting.

The findings of the study identify that the lecturers role is complex and contextually bound by school determinants. Implications for the school involved in the study and also for wider nursing education are discussed.

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TABLE OF CONTENTS

TABLES

FIGURES

Chapter One

INTRODUCTION

Nursing faculty - are they lecturers, teachers, instructors, or clinicians? Even the variance in titles reflects the changes that have evolved, and the debate that continues, around the role of the nurse lecturer involved in teaching students in the clinical area. The clinical area is a crucial learning environment for applied disciplines such as nursing and the role of the lecturer has significance for, and relevance to, the quality of student learning (Myrick, 1988; Wong & Wong, 1988; Reilly & Oermann, 1992). The role of the lecturer in the clinical area has been subject to many pressures over the years and has evolved according to internal and external forces within nursing education and practice (Lee, 1996).

The introduction of preceptorship as a clinical teaching model has been a recent change within nursing education and is increasing in popularity. This has necessitated a change to the role of the lecturer in the clinical area. Preceptorship is defined by Chickerella and Lutz (1981) as:

> *an individual teaching/learning method in which each student is assigned to a particular preceptor ... so that she/he can experience day to day practice with a role model and resource person immediately available within the clinical setting. (p. 102)*

In 1996 our school, a nursing school within an Auckland tertiary educational setting, piloted the preceptor model of clinical teaching at a large metropolitan hospital. Following the success of the pilot project, the preceptor model was introduced as the major clinical teaching model within the undergraduate nursing programme. There are varying models of preceptorship, and the model adopted by the school utilises a collaborative triumvirate approach to student

learning involving the student, the preceptor and the lecturer. Collaboration between lecturer, preceptor and student underpins the model and is an essential principle of the model of preceptorship within the school.

Previous research within the school, discussed later in the chapter, has explored the views of the preceptors and the students involved in preceptorship. The specific purpose of this study is to explore the role of the lecturer within the preceptor model of clinical teaching from the perspective of the lecturer. The question that guides the study is:

> ***How do lecturers perceive their role working in the clinical area within the preceptor model of clinical teaching?***

The following terms are defined for the purpose of this study:
Preceptor: a registered nurse who provides on-site supervision and clinical instruction of a nursing student on a one-to-one relationship (Grealish & Carroll, 1998).

Faculty: academic members of an art or science department of an educational institute.

Lecturer: an employee of a nursing educational faculty who has responsibilities for teaching nursing students in both the classroom and the clinical areas.

Clinical teaching: those activities related to teaching and learning undertaken by faculty lecturers with students and clinical staff in the clinical areas.

Clinical area: placements within health care environments where students undertake planned clinical learning experiences. These placements range from acute health care institutions to community care facilities and involve varying

lengths of time. The clinical areas involved in this study involve several metropolitan hospitals where students gain medical, surgical and paediatric nursing clinical experience.

Due to the paucity of research in this area, and the complexity and contextual nature of clinical teaching a qualitative research design has been selected. A qualitative design is appropriate when a new area is being explored and the aim is to gain further insight and understanding concerning an issue according to Burns & Grove (1987). Qualitative research generates in-depth data which the researcher has a commitment to view through the eyes of the participants. In this study an exploratory, descriptive approach was used whereby the role of the lecturer was explored through focus group discussions which generated rich data. Although the grounded theory method of research (Glaser & Strauss, 1967) was not fully utilised, the data was analysed using the grounded theory method of constant comparison.

Background

To place the study into context, a brief historic overview is presented of the changes that have occurred within nursing education in New Zealand. The role of the lecturer in the clinical area is discussed in relation to the changes. This is followed by a discussion of the introduction of the preceptor model of clinical teaching within the nursing school under study.

Nursing schools were established in New Zealand at the end of the 19th Century and subscribed to the Nightingale ethos of nurse training. Nightingale firmly believed that the training of nurses should be under the auspices of nurses and advocated that novice nurses should be taught and trained by more senior nurses such as the ward sisters (Palmer, 1983 in Myrick, 1988). However health care was dominated by medicine and nursing education was unable to avoid this dominating force. Medical staff became instrumental in

defining nursing curricula, writing nursing texts, teaching nurses and monitoring nursing examinations.

It was not until the 1920s that New Zealand appointed tutor sisters to teach nursing students especially in the introductory period of their training (Salmon, 1982). Nursing students were paid to work in the hospitals and their learning in the clinical area was based on an apprenticeship model of learning. Nurses were withdrawn from clinical duties for short periods throughout the three year course to attend school based theoretical study blocks. The medical socialisation of nursing was very apparent as the theory blocks were based around medical specialties and the content was primarily medically driven. Medical staff continued to teach much of the classroom content and write many of the nursing texts in use until the 1970s.

Nursing tutors were involved in teaching the theory blocks but ventured into the clinical area very rarely. In the clinical area their main purpose was evaluation as they assessed nurses in a variety of practical skills at the mid and end point of the three year course. These practical skill examinations had to be achieved in order to qualify as a registered nurse. Despite minimal contact with the clinical area, nurse tutors were charged with the important function of assessing nursing students' clinical competence.

This model of nursing education prevailed relatively unchallenged for over twenty years. The focus of nursing training was to meet clinical service needs rather than the educative needs of the nurses. The large numbers of nursing students provided a mobile, cost effective and expendable work force for the various health care institutions. Such benefits to hospital administrators over rode the learning needs of the nurses.

The situation in New Zealand reflected that of nursing education overseas. There was growing dissatisfaction with an educational system whereby the

educational needs of the students were subordinate to the work force needs of the hospital. In 1988 Myrick (1988) reported that nurse leaders from many countries sought to change this situation and there was an increasing call for the profession of nursing to assume the control and governance of nursing education. This was the catalyst for the relocation of nursing education from hospital based schools to the tertiary education setting.

In 1969 the New Zealand government contracted the WHO nurse consultant, Dr Helen Carpenter, to explore the possibility of transferring nursing education to the tertiary education system. Dr Carpenter's (1971) report criticised the apprenticeship training of nurses as being too strongly medically modelled and disease focussed, with little emphasis on health education and community welfare. Her report maintained that nurses were not educated to meet societal health care needs and had minimal awareness of cultural issues related to Maori people or social issues such as aging, stress and mental health.

Carpenter (1971) also expressed concern at the quality of nurse tutors educational qualifications. Only 30% of all tutors held the minimum recommended teaching qualification, the one year Diploma from the School of Nursing Studies (Carpenter, 1971). This was, however, the only nursing qualification available at that time which prepared nurses for leadership roles (McCallin, 1993). Nursing tutors were selected on the basis of their clinical expertise rather than their educational qualifications and they learned to teach on the job with an underlying premise that a good nurse would be a good teacher.

Based on the recommendations of the Carpenter (1971) report the transfer of nursing education to the tertiary education sector began in New Zealand in 1973 and followed the earlier leads of America, Canada and Australia. This move had two main aims. Firstly, the focus of the learning model would be educative rather than service based thereby centring on student learning rather

than the work force needs of the hospital. Secondly, the course would be more comprehensive in nature to meet societal needs and address the issues mentioned previously. A three year comprehensive nursing course was established in 14 technical institutes throughout the country. In clinical areas the nursing students had student status and were supernumerary to the regular work force - this constituted a fundamental change from the previous model.

In this new model nursing lecturers assumed control of student nurse learning and assessment within both the classroom and clinical settings. This was based on an assumption purported by American and Canadian nurse leaders that such control was critical to the quality, intent and evolution of nursing education (Myrick, 1988). Nursing lecturers therefore had both classroom and clinical teaching remits. Most commonly a nursing lecturer would have a group of 8-12 students in the clinical area and supervised the clinical experience for that group of students. This included one-on-one teaching of students, student assessment and liaison with clinical staff. Students were buddied with registered staff in the clinical area who were required to maintain responsibility for patient care. However the teaching of students by clinical staff was informal, relatively unplanned and haphazard and clinical staff had minimal input and involvement into the assessment of students or curriculum content.

This model, often referred to as the traditional model, of clinical teaching has endured for over 20 years. More recently, a variety of local and national factors have impacted upon the effectiveness and appropriateness of this model, leading our school to consider the need for change.

Nationally there has been increasing concern that new graduates in New Zealand are not adequately prepared for practice. While much of the information on this issue was based on anecdotal evidence it was raised at the Nursing Consensus Conference on First Year of Nursing Practice, held in Auckland in 1995. The personal stories of new graduate's transition to the

work force, at this forum, were compelling and disturbing. The Nursing Consensus Conference (1995) specifically identified three main areas of concern:

- perception by clinical staff that nursing education was too idealistic and nurses were unprepared for the actual reality of clinical practice
- lack of support for new graduates by clinical staff and lack of adequate orientation programmes
- lack of agreement between the nursing education sector and clinical sectors regarding the expected clinical competencies of new graduate nurses.

These issues are not confined to New Zealand and reflect major concerns elsewhere in the nursing world. As far back as 1974 in the United States Kramer (1974) coined the term *reality shock* to describe the difficulties related to the transition from student to registered nurse role. New graduates consistently reported feelings of inadequacy and incompetence, and were criticised for difficulty in assuming full patient care responsibilities, and inability to meet employer and practice expectations (Kramer, 1974; Shamian & Inhaber 1985; Grealish & Carroll, 1998.) Some argue that this is the result of the transfer of nursing education to the tertiary education sector and to the consequential loss of supervision of student learning by clinicians (Myrick, 1988). The shift to higher education has also been blamed for widening the theory-practice gap as the courses concentrate on theoretical learning which is not always realistic or applicable in the practice setting (Baillie, 1994). Many clinical nurses would argue that this is a direct reflection of nursing lecturers lack of clinical competence and ability to role model and teach clinical nursing skills (Myrick, 1988).

On the other hand, there is also the perception from some clinical staff and management that new graduates should be immediately able to perform as fully functioning staff members without support following graduation. Educators

argue that such an expectation is unrealistic and not widely found in other professions.

It is interesting to note that over ten years ago the New Zealand Department of Health (1986) set up the Review of the Preparation and Initial Employment of Nurses (RPIEN) to assess the transfer of nursing education to the tertiary sector and to explore concerns related to the adequacy of new graduate preparation. One of the recommendations of RPIEN (Dept of Health, 1986) was to improve the method of induction and orientation of new graduates into the work force, with special reference to the transition phase. A RPIEN National Action Group (Dept of Health, 1988) was convened in 1988, and recommended that an orientation of at least six months be provided for new graduates, utilising a supervisory model. However the implementation of such programmes was very variable and constantly subjected to financial constraints. Issues around new graduate transition continue, and various suggestions for change, including preceptorship pre and post registration, have been mooted.

Financial issues have been another motivating factor for change. Technical Institutes across the country are experiencing increasing financial restraints. Nursing programmes are expensive to fund in comparison to other undergraduate programmes due to the high clinical component. Recent changes in Government funding have resulted in the unbundling of clinical training costs for health care professionals. This move was intended to remain fiscally neutral, however combined with other factors, especially the strong business philosophy now apparent in health care, health care institutions are charging increasing amounts for student clinical experience. This has impacted on the cost effectiveness of lecturers in the clinical area leading to increasing lecturer-student ratios, and as Pierce (1991) reports, shorter time with students means that few students receive in-depth clinical instruction. Nursing faculty are, by necessity, having to scrutinise their programmes and explore innovative, cost

effective methods to deliver high quality, effective nursing education programmes.

The Education Amendment Act (1990) granting Technical Institutes in New Zealand the right to confer degrees led to the restructuring of nursing programmes. This has resulted in expectations by management that lecturers will seek advanced educational qualifications and undertake research and scholarly activities. This is currently particularly relevant for staff within our school as the institute seeks university status. Overseas literature strongly suggests that clinical teaching is vulnerable under such conditions. Writers such as Wong and Wong (1987) and Myrick (1991) maintain that, in light of such pressures, clinical teaching is often delegated to sessional teachers or the most junior staff while more experienced staff concentrate on the more highly valued activities such as classroom teaching and research activities. While there is no research data available in New Zealand in this area, anecdotal information suggests that casual lecturers are often employed to undertake clinical teaching and promotion and reward often centre around activities other than clinical teaching.

A major factor that has supported change locally has been our school's increasing collaboration and co-operation with the nursing management and staff of some health care institutions. This is especially true of an alliance that has developed between our school and the large metropolitan hospital that was involved in the pilot of preceptorship. This alliance has recently been strengthened by the signing of a formal strategic alliance agreement. This has engendered considerable discussion between the two institutes and addressed many issues including undergraduate nursing education and the preparation of new graduate nurses. The alliance has also led to the delivery of collaborative post graduate nursing programmes and the establishment of a jointly funded evidence based research centre. In 1988 the RPIEN National Action Group (Dept of Health, 1988) called for committed communication between nursing

education and practice yet historically this has, and continues to be, difficult to achieve. Our situation is therefore unusual, advantageous to both parties, and supports well considered collaborative change initiatives.

Lecturers within our school, particularly those in the undergraduate programme, were increasingly voicing the concern that student learning in the clinical area was being impacted upon by the many pressures already discussed. It was generally felt that change was needed, particularly if clinical learning for students was to continue to be valued by the school. With strong support from the school's senior management and with the sanction of significant clinical agencies it was decided, after much discussion and consideration of possible alternatives, to introduce the preceptor model of clinical teaching.

Preceptorship as a teaching and learning strategy is not a new concept in nursing. In the late 1800s Nightingale maintained that first year nurses should be taught in the hospital setting by nurses who had been *trained to train* (Palmer, 1983, in Myrick, 1988). Benner (1984) argued, more recently, that experienced nurses should sponsor and support less experienced nurses as they moved toward competence in practical situations. Preceptor programmes have been commonly adopted to assist new graduates in the transition process as it is thought to reduce the reality shock as described by Kramer (1974). Reality shock - the difficulties experienced by new graduates as they adjust to the reality of the work force - is experienced by many new graduates and although a lack of support by registered nurses in the clinical area has been identified as one of the contributing factors to this scenario, involvement of the clinical staff in student education prior to registration is thought to be beneficial. Preceptorship is being increasingly utilised in undergraduate nursing programmes to address many of the issues previously discussed. Nehls, Rather and Guyette (1997) also maintain that the preceptor model of clinical teaching is often introduced to meet three demands: high cost of nursing education;

increasing demands on lecturers; and interest in developing collaborative relationships with clinical agencies.

As previously stated the preceptor model of clinical teaching involves clinical nurses teaching and supervising student nurses on a one-to-one basis in the clinical area. The preceptor-student relationship is likened to a master craftsman-apprentice relationship in which the trained, skilled practitioner enables the learner to develop his/her skills, knowledge and attitudes (Morris, John & Keen, 1988). The preceptor serves as a role model and provides direct teaching, support and guidance to the preceptee (Shamian & Inhaber, 1986; Chickerella & Lutz, 1981).

It could be argued that there are similarities between the preceptor model of clinical teaching and the apprenticeship model that prevailed in New Zealand for many years until the 1970s. Both models acknowledge that learning occurs between registered nurses and the nursing students, however in the old apprenticeship model the student learning was always secondary to the work force needs of the hospital. Furthermore there was no consistency, planning or formalisation in the learning relationship between the student and the registered nurse. While learning certainly occurred it was informal, haphazard and accidental. To a lesser degree this was also true of the learning that occurred in the later traditional model, after nursing education transferred to the tertiary education sector, as there was no continuity of teaching or supervision between clinical staff and student. A hallmark of the preceptor model of clinical teaching is the continuity between the preceptor and the nursing student for a student's clinical learning experience, up to ten weeks duration (Packer, 1994).

There are various models of preceptorship utilised within nursing in the clinical area. Overseas literature, especially that of Canadian and American origin, suggests that the preceptor model of clinical teaching is often a

predominantly two way process between student and preceptor while the lecturer retains a relatively passive role, rarely venturing into the clinical area. The preceptor model selected by our school, in collaboration with the clinical areas, was based on the Project 2000 model in the United Kingdom. Project 2000 was the name given to a governmental review of nursing education in Britain in the 1980s. This review precipitated the transfer of nursing education into tertiary education systems and the introduction of supernumerary status for nursing students within a preceptor model of clinical education (Camiah, 1996). Project 2000 utilised the triumvirate approach to student learning between a registered nurse as preceptor, the student and the lecturer (Packer, 1994). The model may be visually depicted as:

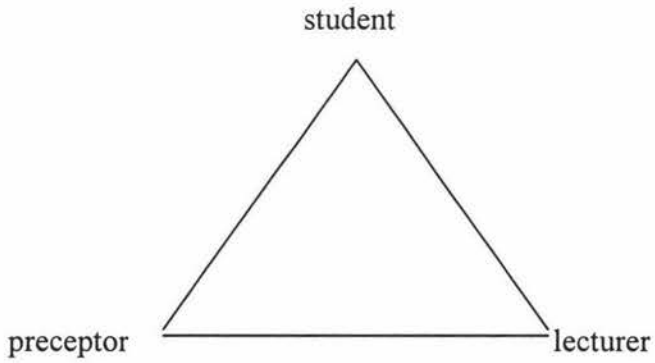

Figure 1. Preceptor model introduced within the school, highlighting relationship between student, preceptor and lecturer.

This model (Fig 1) was adopted as it best suited our particular contextual needs and best utilised the skills of those involved. Our school has a strong commitment to retaining a role for the lecturer in the clinical area hence the decision to adopt the triumvirate approach which required lecturers to be involved, collaborative and visible in the clinical practice learning arena. This was strongly supported by the staff of the clinical areas who requested active involvement of lecturers in their clinical area and accessibility of lecturers by the preceptors and clinical staff. According to Packer (1994) the triumvirate

preceptor model provides opportunity for lecturers and clinicians to work collaboratively. It is premised that this may benefit nursing education and nursing practice and advance patient care. This model is more likely to narrow the theory-practice gap which, as Baillie (1994) maintains, has evolved since nursing education transferred to the tertiary sector.

A pilot project was undertaken early in 1996, by the school, to trial the preceptor model in an acute surgical setting, at a large metropolitan hospital, over an eight week period. A qualitative, descriptive study of the pilot project demonstrated increased satisfaction by both the students and the preceptors and overall strong support for the continuation of the preceptor model (Dyson & Thompson, 1996). Following the success of the pilot project the preceptor model was introduced as the major clinical teaching model within the undergraduate nursing programme.

The roles in the preceptor model adopted by the school have been provisionally articulated based on overseas literature and negotiated with those concerned. The role of the preceptor involves working with the student in day-to-day clinical practice, sharing her/his clinical skills and knowledge with the student and involvement in student assessment (Appendix A). This relationship continues for the duration of the clinical block experience i.e., 4-10 weeks.

The role of the student includes working as many shifts as possible with their preceptor, maintaining documentation, being a proactive learner with awareness of their learning needs and meeting contracted times with the lecturer (Appendix B). Due to preceptor demands such as rostering, shift work and annual leave and student availability restricted to week days only, the consistency between preceptor and student is variable. At times the consistency is very good, with the student working up to 80% of shifts with the preceptor but at other times the consistency is much less. The preceptor assigns the student to another staff nurse if they are not on duty.

The role of the lecturer has been much harder to define, mainly due to a lack of research in this area, but was envisaged as involving negotiation of clinical experience, teaching students, co-ordinating student assessment and assisting preceptors in their role (Appendix C). Currently there is an expectation that lecturers spend at least 2 hours with each student/preceptor per week and some lecturers may spend up to 4 days per week in the clinical area, depending on their student clinical numbers. Overseas literature suggests this amount of clinical contact time is very high (Clifford, 1993) and, while this is discussed elsewhere, it highlights the need to research the role of the lecturer. Anecdotal reports from faculty lecturers suggest that their role includes those activities referred to previously, but there is also some confusion around actual responsibilities and role boundaries.

Currently in our school there are two studies being undertaken researching preceptors and students experiences within the preceptor model, and results will be available to integrate with the current study. The role of the lecturer in the current model has not been researched prior to this current study.

Significance of the Study

The preceptor model of clinical teaching has been a major change within our school's nursing curriculum. Unfortunately attempts to research the application of the preceptor model have been hampered by a paucity of both local and overseas research studies and a lack of audit tools. This is especially noticeable in the area of the role of the lecturer where there is confusion and uncertainty around the responsibilities and activities related to the lecturer role (Forrest, Brown & Pollock, 1996; Lee, 1996).

The purpose of this study is to explore the role of the lecturer working in the clinical area within the preceptor model of clinical teaching, in an effort to gain

some understanding of the lecturer's role with a view to providing a base for future refinement and development of the role. The contextual factors in this study are especially important, as the preceptor model has been adapted from an overseas model.

It is expected that the results of the study will facilitate clearer articulation of the role of the lecturer within the preceptor model and may also be beneficial in informing the definition of the student and preceptor roles. The study will be instrumental in staff development programmes to promote the efficacy of the model. It is also expected that the results of the study will allow the model to be evaluated more comprehensively, which becomes increasingly important in the current climate of cost containment and cost effectiveness. It is intended that this study may also lead to further studies which refine, evaluate and promote the education of student nurses in the clinical learning environment.

Structure of the Thesis

In this chapter the topic of the thesis has been introduced and a background to the role of the lecturer within nursing education has been provided. The context and setting for the study was also described. A discussion and critique of relevant literature is presented in Chapter Two. The research method is described in Chapter Three and rationale for the choice of research method is offered.

The findings are presented in Chapters Four to Eight. Specifically, Chapter Four looks at the theme *evaluating students* and Chapter Five addresses *teaching students*. The theme *working with preceptors* is presented in Chapter Six and *creating a positive learning environment* is presented in Chapter Seven. Chapter Eight addresses a central theme which runs through the four themes and is called *being negotiable.*

Chapter Nine presents a discussion of the findings and integration is made with literature. Chapter Ten is the final chapter and addresses the limitations of the study, the implications of the study for the school and for wider nursing education and research. The concluding statement of the study is also included in Chapter Ten.

Chapter Two

LITERATURE REVIEW

The role of the lecturer in relation to teaching in the clinical area has been the subject of long standing confusion and debate. It appears there is minimal consistency in either the role, activities or the responsibilities of the lecturer. This is surprising considering that teaching in the clinical area should be the justifying element of nursing education and primary to a practice based profession such as nursing (Charlesworth, Kanneh & Masterton, 1992). Clinical teaching is described by McCabe (1985) as the 'heart' of nursing education as students consolidate and learn new knowledge, socialise into the professional role and acquire professional values. Grealish and Carroll (1998) maintain that nursing is similar to the academic disciplines of law and medicine in that nursing curricula are intended to prepare students both vocationally and educationally and therefore the clinically based teaching component is fundamental to the overall course structure and purpose.

According to Diekelmann (1990) nursing is a way of thinking and being which is contextually bound, reflexive and learned through experience in the clinical area. Benner (1984) differentiates between the *knowing that* and the *knowing how* of practice. Very simply the *knowing that* encompasses theory based and objective, scientific knowledge, often learned in the classroom setting. The *knowing how* refers to the more practical knowledge of nursing that is applied, contextually bound and is developed in practice and evidenced in the quality of the nurse-client relationship. Each way of knowing informs the other and both are crucial to the practice of nursing and the development of clinical

knowledge. Nursing lecturers assist students to integrate theoretical and practical aspects of nursing and encourage the development of understanding and action (Reilly & Oermann, 1992).

As educationalists, lecturers have a role in supporting students in the clinical area and monitoring the clinical learning environment. For nursing students learning takes place in clinical settings that have goals other than educational (Reilly & Oermann, 1992). While the active nature of student learning in the clinical environment contributes significantly to its value in undergraduate nursing education, Wong and Wong (1987) argue that students require support from lecturers as they become actively engaged in patient care and take risks to extend their learning. Learning in the clinical area is less structured than the classroom setting as students are expected to initiate, react and respond to actual clinical events while the safety of the patients must be preserved and maintained at all times (Carroll, 1984). The quality of clinical teaching and learning is fundamental to learning to nurse and the role of the lecturer in the clinical area is very significant to the value and worth of clinical teaching.

Despite the belief that clinical teaching is central to nursing education there is minimal research into the role of the lecturer in clinical teaching. There is also a paucity of research directly related to the clinical role of the lecturer within the preceptor model of clinical teaching.

A major problem when reviewing the literature around the role of the lecturer in the clinical area is that position papers and research studies rarely identify which clinical teaching model is involved in the discussion or research. This has made the task of reviewing literature specifically in relation to the preceptor model of clinical teaching not only very difficult but also often confusing. However, there are several themes or ideas that commonly occur when reviewing the literature. The following themes have been used as a broad

framework for the literature review in this study: preceptor model, liaison, teaching students, student evaluation, and nurses or teachers?

Preceptor Model

Traditionally, the central role of the lecturer in the clinical area has been to teach students. However Lee (1996) maintains that there has been a change in the nature of the lecturers role in the clinical area from the 1980s through to the 1990s, and lecturers are now spending less time teaching students through *hands on* care and clinical role modelling. They are, however, spending more time on liaison and support of clinical staff. The reason for this change is unknown though the introduction of the preceptor model of clinical teaching, which has increased in popularity in recent years, may be a contributing factor.

Some writers offer definitions of the lecturer's clinical role in the preceptor model which reflect the above changes and offer some insight into the phenomenon. These definitions, however, are not research based. Myrick and Barrett (1994) claim that the lecturer role is not nebulous in the preceptor model and involves forming a link between education and practice, formulating learning objectives, undertaking effective teaching strategies and evaluating teaching. Chickerella and Lutz (1981) describe the lecturer's role as broader than that of the preceptor with responsibilities to facilitate, monitor and evaluate student learning. Lecturers encourage students to integrate course theoretical content with clinical experience and also direct evaluation conferences. Zerbe and Lachat (1991) maintain the lecturer should be available for problem solving, to assist with bedside teaching of students and to relay information about the course content and objectives to the preceptors.

Recent studies related to the introduction of Project 2000, a British initiative described in the previous chapter, offers some insight into the lecturer's clinical role. Preceptorship was first introduced in the United Kingdom, within

Project 2000, in post registration education in relation to new graduate programmes to ease the transition to the work force. It is only in more recent years, from approximately 1993, that preceptorship has been recommended as the clinical teaching model for undergraduate nursing programmes (Bain, 1996). Consequently there is limited research available on the application of this concept.

Liaison Role

The lecturer's role in liaising with clinical staff is a consistent theme in the literature around preceptorship and Project 2000. However there is a lack of consistency around the definition of the term *liaison* in relation to the actual activities and responsibilities undertaken by the lecturer. Charlesworth, Kanneh and Masterton (1992) describe liaison as supportive interaction with clinical staff and the maintenance of a good learning environment for students. Liaison is described by Lee (1996) as maintaining good relationships and supporting clinical staff as they carry out the clinical teaching of students. Other authors also support this view and consider that the role of the lecturer in supporting clinical nurses to precept students was a logical and effective development of the role (Acton, Gough & McCormack, 1992; Forrest et al., 1996). However such descriptions lack clarity and are open to varying interpretations. Research studies reflect such ambiguity and inconsistency as demonstrated by the following summary.

In an exploratory study of the lecturer's clinical role in Project 2000 Clifford (1993) found that 35 of the 40 lecturers studied had specific responsibility for liaison with named clinical areas. The responsibility for teaching students was seen by the lecturers as firstly the role of the Ward Sisters and secondly the clinical staff and thirdly the lecturers, although ideally they would like more involvement. The lecturer role was described as visiting, liaison and support. Indeed Clifford (1993, p 284) suggested that "*there are indicators that the*

perception of the role is largely a social one in which the need to maintain a good working relationship played a major part". The also study highlighted the issue of the limited amount of time lecturers spent in the clinical area. While the concept of liaison or support was identified the term was not qualified within the quantitative design of the questionnaire.

The study by Clifford (1993) formed the basis of a later study by the same researcher (Clifford, 1996). A questionnaire survey involving 126 lecturers from four colleges in England explored the lecturer's perceptions of four areas within their role - clinical teaching, classroom teaching, management and research. The findings relating to the clinical role indicated that lecturers linked or liaised with a variable number of clinical areas and those with fewer link areas tended to spend most time in the clinical area and also felt more confident in their ability to give patient care. Only 1 of the 14 statements in the clinical role section of the questionnaire related to liaison activities, and the design of the study did not allow further description of the liaison or linking role with clinical areas. While this was a large study there was only a 51% response rate with a high non-response rate to the clinical component of the questionnaire.

Liaison with clinical staff was also a finding of both Crotty's (1993a, 1993b) studies. In the first study Crotty (1993a) used a Delphi survey of 201 lecturers from twenty five colleges to explore the emerging role of the lecturer within Project 2000 programmes. The findings indicated that clinical teaching was part of the role of 69% of the lecturers and clinical activities including clinical liaison were considered important by respondents and perceived to be increasing in amount. The findings of the first study were then explored more in depth in a second study (Crotty, 1993b). Twelve lecturers from four colleges were individually interviewed. In relation to the clinical teaching role the respondents reported strong commitment to the clinical liaison role. The findings identified a change of role for the lecturers, from working with

students in the clinical area to liaising with clinical staff. The respondents considered the clinical staff more qualified to teach the students through *hands on* care. The lecturers developed their role as a link teacher which involved liaising with clinical staff, supporting the clinical staff in teaching the students and explaining Project 2000. Time was an issue and the respondents reported difficulties in finding adequate time to undertake clinical activities due to college demands. This study was useful in identifying liaison as a major aspect of the clinical role of the lecturer and highlighted the need for further studies to clarify the activities and responsibilities in relation to this concept.

Support of clinical staff also emerged as an important function of the clinical teaching role in a British study by Carlisle, Kirk and Luker (1997). This study was conducted over a three year period and explored the changing role of the lecturer, including the clinical role, in Project 2000. The study sample included educational and clinical staff. Facilitating clinical staff in their student teaching role and acting as a support and resource person for staff was considered highly probable and desirable by the participants. The term link teacher was used consistently in the lecturers' focus groups in terms of the lecturer as facilitator, problem solver and resource person in the clinical area. Very few of the lecturers reported direct patient care and the majority stated their current role with students was making supportive visits. This study was useful for identifying barriers to the lecturers' role which included workload demands and lack of clinical credibility.

Similar findings resulted from another British study by Forrest et al. (1996) exploring the present and ideal role of the lecturer, within Project 2000. The perspective of lecturers, clinical staff and students were included which was useful to gain some consensus. The findings demonstrated that the then current role of the lecturer lacked clarity and participants reported differences in the quantity, frequency, organisation and nature of the role. The lecturers cited workload commitments as having a major influence on the time available and

the quality of their clinical role. All the participants agreed that the lecturers should actively work toward ensuring the quality of the learning environment through supporting and educating the clinical staff to teach students.

Studies from other counties offer similar findings to Project 2000 studies. In a Canadian study Hsieh and Knowles (1990) used an ethnographic approach to explore the development of the preceptor-student relationship. The role of the lecturer was described as a resource person to facilitate the preceptor-student relationship and to guide the student evaluation process. Twelve preceptors, twelve students and two lecturers took part in the study and the findings identified seven themes: trust, clearly defined expectations, support systems, honest communication, mutual respect, encouragement and mutual sharing. The study did not address the one to one teaching of students but implied that this was undertaken by the preceptors. The lecturers consistently liaised and worked with preceptors and students to encourage and support open communication between them in order to develop a good learning environment. This study was beneficial in describing the complexity of the preceptor-student relationship, and it highlighted the clarity that can be gained by studying the application of the preceptor model within one educational institute.

An Australian study by Grealish and Carroll (1998) explored the perceptions of the preceptors and sessional lecturers (part time staff employed by the educational institute to undertake clinical teaching only) of their roles. A Likert scale questionnaire was used to explore statements around clarity, effectiveness and satisfaction of their role as well as open ended questions. Preceptors were much clearer about their role than the lecturers with over half of the lecturers unable to identify their role. Activities related to the lecturer role included helping students identify learning needs, liaison with the clinical area and helping the student interpret their clinical experience. The preceptor role focussed on developing students' practical clinical skills through direct patient

care. The sample size of the study was small. The study did not address the problems and issues around the employment of sessional lecturers, such as lack of sense of belonging to the faculty, low job satisfaction and communication problems, which are well documented. The authors went on to recommend a more collaborative model of preceptorship, very similar to the model under scrutiny in this study.

According to these studies, and other nursing literature, liaison is increasingly being identified as a function of the lecturer in the clinical area, especially in relation to the preceptor model of clinical teaching. This seems logical as the clinical staff are more involved with the students and have a more defined role in the preceptor model than in the traditional model of clinical teaching. However, as the above studies show there is a lack of consistency around clearly defining liaison and supportive activities of the lecturer. These range from supporting clinical staff, educating clinical staff, facilitation and curriculum information sharing. Forrest et al. (1996) and Lee (1996) argue that the role of the lecturer in the clinical area is contextually bound and constructed according to the demands of the educational institute and the health care setting. This may well contribute to the apparently wide range of lecturer activities and account for the varying amount of time spent in the clinical area. Unfortunately studies do not address this issue and it is difficult to discern the influence of school and clinical area demands on the lecturer role. There is a need to research this aspect of the lecturers role not only to guide practice for those involved in the model, but also to ensure that the liaison aspect can be clearly articulated, and therefore included and valued in the preceptorship cost equation.

Teaching Students

The lecturers' role in teaching students on a one-to-one basis in the clinical area is also the subject of much debate and discussion. Recent literature,

including the studies already mentioned, demonstrates that the teaching of practical clinical skills is being delegated to clinical staff especially in the preceptor model of clinical teaching (Hsieh & Knowles, 1990; Lee, 1996; Crotty, 1993b). This was supported by the students in the studies by Forrest et al. (1996) and Nehls et al. (1997) which considered that clinical staff should be the predominant role models for students. Acton et al. (1992) contend that the clinical staff are in the best position to teach students in a one-on-one clinical situation due to their clinical credibility and expertise and lecturers in the clinical area serve only to duplicate this role.

However some opinion papers and studies support an educative role for lecturers working with students. This role concentrates on teaching the *thinking* of nursing rather than the *doing* of nursing. This involves assisting the student to apply theoretical concepts to practice situations and encouraging the development of critical thinking skills through reflection and critique of practice.

Students in the study by Forrest et al. (1996) claimed that the lecturer had an important part to play in clinical teaching by bringing objectivity to clinical practice and assisting students to consider practice from a broad perspective through reflection on practice. While this could involve the lecturer and student in direct patient care it included one on one discussions and tutorials where practice related issues were discussed. Students cautioned that lecturer teaching must be realistic - teaching that accurately reflected the reality of clinical practice.

A small Australian study by Ferguson (1996) found that clinical teaching involved lecturers working with students to assist them to integrate theory and practice through a variety of teaching strategies. Another aforementioned Australian study by Grealish and Carroll (1998) also found that lecturers described their role as helping the students interpret and understand their

clinical experiences, and also as offering the students a different frame of reference for practice, other than that which is usually offered by the health care institutions. Unfortunately these descriptions are not explored or discussed further in either of these studies.

The lecturers' teaching role was also evident in a qualitative study by Nehls et al. (1997) in Wisconsin that explored the lived experiences of students, preceptors and faculty-of-record (Master's or PhD prepared staff who held titles in the nursing school and were employed to work with students and preceptors in the clinical area). The dominant theme emerging from the study was *learning nursing thinking* which encompassed how nurses think and how such thinking is learned and taught. The faculty-of-record worked with both students and preceptors to guide their thinking - working with preceptors to encourage them to make their clinical thinking visible to students through practice and dialogue, and with students to assist them to see the wider picture and context through dialogue and reflection. This study was worthwhile in describing the teaching role of the lecturer. However it did not address the ramifications of separating the educational faculty staff, who undertook classroom teaching, from those who undertook clinical teaching.

Some studies imply a more practical *hands on* approach and more clinical involvement as lecturers teach and interact with students. While many studies do not state the clinical teaching model involved in the study it could be assumed that many of the issues related to the role of the lecturer in the clinical area discussed in the literature will be applicable, in some measure, whichever model of clinical teaching is employed.

Clinical competency and role modelling are lecturer teaching behaviours that are considered important according to several studies. Mogan and Knox (1987) developed and tested an audit tool describing teacher characteristics grouped into 5 categories:- teaching ability, nursing competency, personality traits,

interpersonal relationships and evaluation. The study was replicated by Nehring (1990) in Ohio with a sample of 63 lecturers and 121 undergraduate students and the results were similar. The participants of both studies agreed that the *best* clinical lecturers were good role models, enjoyed nursing and teaching, and demonstrated clinical skills and judgement. Four of these characteristics were from the nursing competency category as described by Mogan and Knox (1987). A later replica study by Benor and Leviyof (1997) involving 123 students from three schools in Israel also found that the category of nursing competency was considered the most important teaching characteristic by students. However this was followed by the student evaluation category which was rated the least important in the previous studies. Nevertheless the authors caution that schools use differing education models, and that some lecturers may not be involved in clinical teaching and evaluation which may alter interpretation of results.

Wills (1997) used the five teaching behaviour categories defined by Mogan and Knox (1987) as a framework of a survey that explored student nurses' views regarding link teacher behaviours that promoted student learning. The categories of behaviours were the same as those in the study by Mogan and Knox (1987), however the statements within each category were drawn from later studies. The 102 students were from a school in central England completing their final year of the Diploma course. A link teacher was described as a faculty lecturer within the school of nursing who was allocated between 3 - 10 clinical link areas. There was no school policy regarding the link teacher role and the role was interpreted individually by lecturers. The findings of the study showed the majority of students were dissatisfied with the amount of contact they received from the link teacher. In a 13 week clinical block 74% of students had only one or two contact visits. The aspects of the link teacher's behaviour the students found most helpful were related to interpersonal relationships and personality. The students wanted more support and contact from the teachers and stressed the need for teachers to be flexible to meet

individual student needs. The study was useful to present the student perspective. However it did not address the communication and contact the link teacher had with the clinical staff regarding student learning over the 13 week clinical experience. The study also took place just prior to the implementation of Project 2000 within the school and a repeat of the study following this would have been useful as a comparison.

Role modelling behaviours of clinical lecturers were the focus of another quantitative study by Wiseman (1994) using a questionnaire. Two hundred and eight students from three schools indicated that students did perceive lecturers as role models, though the students were selective in deciding which of the role modelled behaviours they chose to adopt. The statements in the 28 item questionnaire used in this study were behavioural and the majority focussed on actual delivery of nursing care.

While these quantitative studies are useful there is a need to clarify the clinical teaching model being utilised as suggested by Benor and Leviyof (1997). There are major differences between the traditional model of clinical teaching and the more recent preceptor model. These differences often preclude the use of the same data collection tool. For example, the questionnaires designed by Mogan and Knox (1987) are poorly suited to the lecturer role within the preceptor model as they include behaviours that are more applicable to the preceptor role and do not consider lecturer activities such as liaison and preceptor support. However many of these studies may be useful as a basis for studying the preceptor role which highlights the changing roles and responsibilities within the preceptor model.

In a different approach Mogan and Warbinek (1994) developed an observation tool to record clinical teaching behaviours. Their findings demonstrated that role modelling was an important teaching strategy and also showed that lecturers consistently use questioning as a teaching strategy. The questioning

tended to be of a directive and fact finding style rather than a problem solving style that encouraged students to reflect on practice. The authors suggested that the tool appeared to address a facet of clinical teaching involving lecturer-student verbal interaction that was not captured in the tool developed by Mogan and Knox (1987).

Morgan (1991) undertook an interpretive approach to explore the teaching behaviours of nine lecturers. The lecturers maintained they used role modelling most frequently as a teaching strategy. However the study showed they implemented it less frequently and predominantly used verbalisation, in the form of telling, asking, saying and discussing, with students. This latter finding suggests some similarity with the questioning that emerged in the study by Mogan and Warbinek (1994). Student evaluation was also important and the findings showed that lecturers had difficulty in separating teaching and evaluation activities and in articulating activities they use in the clinical area.

The disparate findings of these studies highlight the lack of concurrence around the teaching role and the teaching behaviours of the lecturer in the clinical area. Lecturers themselves report their own confusion and the lack of clarity in this area (Clifford, 1993; Ferguson, 1996; Forrest et al., 1996). There is a pressing need for studies that further explore these areas from the perspective of the student and the lecturer in order to identify and clearly articulate the most effective teaching behaviours and strategies within the clinical area.

Student Evaluation

Evaluation of students is also an area that shows significant variance and disagreement in the literature. Student evaluation has always been problematic in the clinical area due to the complexity of the clinical environment, lack of reliable and valid standards for the assessment process and a lack of research

into the area. Krichbaum, Rowan, Duckett, Ryden and Savik (1994) contend that student clinical evaluation simply reflects the historic difficulties nursing has had, and continues to have, in accurately describing quality clinical performance.

The role and involvement of clinical staff in student evaluation has compounded the issue in recent years, yet there is minimal literature that considers this aspect of student evaluation. Much of the literature reviewed for this study has not addressed student evaluation and this may be, as Myrick and Barrett (1994) suggest, that many lecturers have transferred the responsibility for student teaching and learning to the preceptor, yet paradoxically have retained responsibility for student evaluation. Ferguson and Calder (1993) maintain that while preceptors contribute useful information to student evaluation, the lecturers are responsible for the final student evaluation as they are contracted to assure the public and the profession of new graduate clinical competence. The study previously mentioned by Nehls et al. (1997) supported this view.

Ferguson and Calder (1993) undertook a study that compared the valuing of specific student clinical competencies between lecturers and preceptors. A clinical competence rating scale was used to compare the two groups and the findings demonstrated that there were more similarities than differences between the groups. While useful, it used a simulated scenario and there is a need to repeat this study in the reality of the clinical area. The study did not address the preparation the preceptors had for their evaluation role.

It is unclear whether seeking information for student evaluation from clinical staff or guiding the evaluation is part of the lecturers' liaison activities as discussed earlier. Perhaps the supportive role of the lecturers as they work with students includes supporting the student evaluation process. The fact remains that the issue of the process and responsibilities for student evaluation in the

clinical area is conspicuous by its absence from the majority of studies. This would appear to be a major anomaly in relation to the educational process, and there is an urgent need for greater clarification through research of the clinical evaluation process for students. This is necessary to meet the needs of all the stakeholders involved, not least the public who expect competent and safe nursing care.

Nurses or Teachers?

The lecturers role in working with students in the clinical area is fuelled by continued debate in the literature around lecturers' primary identity in the clinical area, and there exists a dichotomy between lecturers being considered primarily as *nurses* or *teachers* when working in the clinical area. Lecturers in the study by Forrest et al. (1996) were confused as to whether they were nurses or teachers. Acton et al. (1992) and Nehls et al. (1997) maintain that lecturers should provide academic guidance in the clinical area, creating a positive learning environment for students rather than providing hands on clinical practice teaching and role modelling. Such views support the belief that lecturers are primarily educationalists and that their skills should be used to support clinical staff, create a positive ward learning environment and act as facilitators of student learning through encouraging the transfer of theory to practice.

The other school of thought argues that lecturers should be actively involved as clinical practitioners and teach practical clinical nursing. Charlesworth et al. (1992) maintain that lecturers should be involved in one-on-one teaching with students at the bedside, teaching clinical skills if they are to be considered teachers of nursing. This perspective involves lecturers retaining a professional identity as a *nurse* and supports their maintaining clinical credibility (Forrest et al, 1996). Quinn (1988) considers it a major anomaly that nursing lecturers still teach but no longer practice nursing.

However Osborne (1991) states that lecturers cannot be both expert educationalists and expert clinicians and there is a danger that poor quality teaching and learning may result for students and negative experiences for lecturers if this expectation persists. No research could be found that explores this dichotomy.

The fact that many lecturers spend a limited amount of time in the clinical area must impact on the activities and responsibilities they can realistically undertake. The UKCC (1986) maintains that lecturers should spend at least one day per week, or 20% of their time, in the clinical area, yet studies suggest that this is difficult to achieve (Clifford, 1993). This conclusion was supported by Crotty (1993a) who found that clinical teaching was part of the role of only 31% of the lecturers from 25 colleges in Britain. In a later study Clifford (1996) found 25% of 126 lecturers spent between 5 and 7 hours per week in clinical, with approximately 33% spending two hours or less.

Participants in a study by Carlisle et al. (1997) cited institutional demands as eroding clinical teaching time. The nature of clinical contact and involvement is dependent upon the philosophy and resources of the educational institute (Melander & Roberts, 1994). Wong and Wong (1987) argue that clinical teaching is subsumed under the more highly valued classroom teaching and scholarly activities. Myrick (1991) maintains that the role complexity for lecturers has contributed to the decreased time spent in the clinical area as the lecturer is required to:

> *teach in the classroom, instruct and facilitate in the clinical setting, publish on a prolific basis, research clinical and academic matters, participate and chair numerous committees, act as a student adviser, and demonstrate active involvement in the community at large, but is*

also expected to possess the ability to be on the leading edge of nursing knowledge (p. 44).

Lack of clarity about the parameters and responsibilities of the clinical role is an issue for many lecturers, according to the literature and the fundamental question of the lecturers' role in the clinical area remains unanswered. Forrest et al. (1996) claim that lecturers work in many clinical areas and had diverse and complex responsibilities and that this effected the consistency and quality of their clinical contact. It would appear from a review of the literature that the only consistent theme concerning the role of the lecturer in the clinical area is the lack of clarity and consistency in defining the role, and a real confusion exists that should be of major concern within nursing education.

The number of comment or opinion papers on the topic far exceeds researched work and there is an urgent need for research studies. The advent of the new clinical teaching models such as preceptorship has increased the need for research studies to explore and guide the role of the lecturer in the clinical area. Lee (1996) maintains that a comprehensive understanding of lecturers' involvement in the clinical area is needed and interpretive studies which focus on the lecturers' perceptions and understanding of their role could generate useful insight into the whole area.

This current study seeks to meet that recommendation and explore the role of the lecturer within the preceptor model of clinical teaching, from the perspective of a group of lecturers working within one educational institute.

In the following chapter the research method used will be described and the use of focus groups as a data collection tool will be outlined and discussed.

Chapter Three

RESEARCH METHOD

In this chapter the research design and the method used in the current study, which explores the role of the lecturer in the preceptor model of clinical teaching, is outlined and discussed. An exploratory, descriptive, qualitative approach was taken utilising focus groups. Although the study does not claim to be grounded theory research as described by Glaser and Strauss (1967), data analysis was performed using the constant comparison method associated with grounded theory and referred to by Strauss and Corbin (1990).

Qualitative Research

For many years nursing research was dominated by the traditional positivist view of science and quantitative research methods. Like many other professions based on the behavioural and social sciences, nursing was quick to support the challenge to the dominance of the positivist paradigm, and supported the recognition of the interpretive paradigm and qualitative research methods. Leininger (1985), a strong proponent of qualitative research methods, argued that blind adherence to positivism denied the discovery of truths about what people know, experience, and give meaning to, both subjectively and objectively. Allen, Benner and Deikelmann (1986) maintain that the three philosophies of science, positivism, interpretivism and critical social theory, are beneficial and complementary to nursing and generate fruitful nursing research.

The purpose of research is to produce knowledge that can be utilised to improve and advance a discipline or profession. All methods of research offer unique contributions to nursing knowledge development and Strauss and Corbin (1990) maintain that choice of research methodology is based on the nature of the research question and the researcher's experience and philosophical orientation.

Qualitative research is a systematic yet subjective approach used to describe life experiences and give them meaning. Leininger (1985) supports the use of qualitative research methods to document and interpret the totality of whatever is being studied in order to know and understand the internal and external worlds of people. Qualitative research is humanistic and concerned with understanding the meanings given to social interactions by those involved. Leininger (1985) states the goal of qualitative research is to "*document and record as fully as possible the totality of whatever is being studied in particular contexts from the people's viewpoint or frame of reference" (p. 5).* Qualitative methods are useful to grasp the essential features or essence of a phenomenon that are difficult to grasp using quantitative research methods in the quest for understanding and knowing of a phenomenon (Strauss & Corbin, 1990). A qualitative approach generates rich data with considerable depth according to Hamberg, Johansson, Lindgren and Westman (1994), and there is a commitment to see through the eyes of the participants.

Grounded theory is a qualitative research method initially developed by Glaser and Strauss (1967). Grounded theory is based on the assumption that not everything has been discovered and offers a broader and more comprehensive view of a phenomenon than is possible with quantitative research (Stern, 1985). It is underpinned by symbolic interactionism which is described by Burns and Grove (1993) as:

> *...exploring how people define reality and how their beliefs are related to their actions. Reality is created by people through attaching meanings to situations. These symbolic meanings are the basis for actions and interactions. (p. 68)*

Data collection and analysis are concurrent processes in the grounded theory method involving several stages using the constant comparative method of analysis (Strauss & Corbin, 1990).

Design and Method of the Present Study

Study Design

Qualitative research design was selected for the current study for two main reasons. Firstly the preceptor model of clinical teaching remains relatively new to nursing education, as discussed in the previous chapter, and there is an identified lack of research specifically related to the role of the lecturer in the preceptor model of clinical teaching (Clifford, 1993; Forrest et al., 1996; Lee, 1996). Burns and Grove (1993) argue that qualitative research is particularly appropriate when a new area is being explored and the aim is to gain further insight and understanding concerning an issue. Qualitative research focuses on the experiences of the individuals involved and can provide rich detailed descriptions of previously unexplained phenomena (Field & Morse, 1985).

Secondly the literature suggests that the lecturer role in the clinical area is contextually driven and varies in relation to several aspects including time, activities and responsibilities (Clifford, 1993; Crotty, 1993b; Forrest et al., 1996; Lee, 1996). Field and Morse (1985) and Hamberg et al. (1994) suggest that qualitative research allows for contextual understanding so that behaviour can be understood in a particular context of meaning. Quantitative methods do

not capture phenomena in their totality or recognise their contextual significance. The contextual factors in this study are especially important as the clinical teaching model has been adopted from an overseas model and there is a need to hear the perspective of lecturers working within their particular context in New Zealand.

The current study is at the exploratory, descriptive level only. This is due to the time constraints related to the completion of the study. The purpose of exploratory, descriptive studies is to observe, describe and document aspects of a situation or a phenomenon as it naturally occurs and to summarise the status of a phenomenon of interest as it currently occurs (Polit & Hungler, 1995). LoBiondo-Wood and Haber (1990) contend that a well constructed exploratory, descriptive study can provide a wealth of data about a particular phenomenon of interest even though relationships between variables are not being examined. The findings of the current study will be used to clarify the role of the lecturer in the clinical area, to guide staff development programmes and improve the efficacy of the preceptor model of clinical teaching within the school. Forrest et al. (1996) maintain that the data from qualitative descriptive studies can be used to assess current conditions and practices or to make plans for improving them.

The Study Setting

The setting for the study was the nursing school within one large educational institute in a large New Zealand city. The nursing school was situated with the Health Studies Faculty. The choice of setting depends on the research problem and purpose (Burns & Grove, 1993). The setting was restricted to one nursing school as the preceptor model had been designed and implemented to meet the needs of the school and therefore the role of the lecturer would be contextually bound to some extent. Also, to the researcher's knowledge, at the time the

study commenced preceptorship was not used by other schools of nursing within New Zealand.

Access to the setting was gained by approaching the Head of the School of Nursing and Midwifery and the Dean of the Health Studies Faculty with an outline of the research proposal for their consideration. Approval was gained dependent upon approval from the appropriate ethical committees.

Participant Selection

All lecturers who had current or past experience of working within the preceptor model of clinical teaching were eligible to take part in the study. Due to the limited size of the possible sample group i.e., 12 lecturers, it was decided to study the total accessible population. The sample was therefore purposive which can be advantageous in certain circumstances such as participants' knowledge about an experience and their willingness to share experiences (Morse, 1991).

A short description of the research study was given by the researcher at a staff meeting. The staff were informed that all the lecturers eligible to take part in the study would receive an invitation to participate and a consent form in their staff mail box within the following week. Staff were also asked to contact the researcher if they did not receive the information and felt they were eligible to participate.

Return of the consent form would indicate willingness to participate in the study. The researcher had an ethical responsibility to ensure that the participants were free from coercion or undue persuasion. The researcher was mindful of the language used in the information conveyed to the lecturers and did not approach lecturers personally on an individual basis.

Twelve possible lecturers were invited to participate in the study. The full complement of lecturers agreed to take part in the study.

The Participants

The participants were all women. The lecturers were homogenous in respect that they had all either taught, or were currently teaching, within the preceptor model of clinical teaching. Their experience within the preceptor model varied due to the gradual introduction of the model. Morgan (1988) maintains that the goal of focus groups is homogeneity in background rather than attitudes. All of the participants taught within three areas of clinical practice:- medical, surgical or paediatric clinical areas. The participants taught in the second and third year of the undergraduate nursing degree course. Their experience in nursing education varied from less than a year to 9 years. One of the participants held a joint appointment position between the school and a clinical area that used the preceptorship model.

Ethical Considerations

As the research study involved human subjects, approval was sought, and gained, from the Ethics Committee of the educational institute where the participants were employed. Ethical approval was also gained from the University Ethics Committee where the researcher was enrolled. Ethical approval was gained prior to the commencement of the study.

Researchers are obliged to ensure that research participants have the right of self determination. Burns and Grove (1993) maintain that research subjects must be treated as autonomous agents with the right to participate or not to participate in a study or to withdraw at any time from a study without penalty.

Information about the study was initially given in a large open forum, the staff meeting, and followed by written information (Appendix D) to avoid possible coercion by personal persuasion. The participants signed written consent (Appendix E) to participate in the study and were reminded at the beginning of each focus group that consent to participate was ongoing and they were free to withdraw at any time.

The participants were also made aware through the consent process (Appendix E) that data would be collected through two focus group interview sessions and the data would be tape recorded. Participants were assured that they were free to decline to answer any particular question and that the tape recorder could be turned off at any time during the interview at their request. The focus group interviews were facilitated by a school nursing lecturer, not the researcher, (see section - Researcher Involvement) and this information was included in the participant information sheet (Appendix D).

Based on the right to privacy, research participants have the right to anonymity and the right to assume confidentiality of any data collected (Burns & Grove, 1993). It was made clear to the participants that any specific identifiable information gained through the research process would remain confidential. The interviewer and the transcriber were required to sign confidentiality declarations. The participants were informed that the data would be coded in the final report and would be unable to be linked to their identity. During the research process the tapes and transcriptions were stored safely in the researcher's home and the participant consent forms were stored safely at the researcher's workplace. Interview transcripts, tapes and working data will be destroyed after a 3 year period.

The researcher was aware of the subjects' right to protection from discomfort and harm. Harm to the participants was likely to be minimal but there was the potential that lecturers may incur some psychological distress through the

insight and self reflection brought about by the research process e.g. disparate views amongst lecturers or feelings of self doubt as they compared their practice to other lecturers. This was addressed by including debriefing time within the focus group interviews and the provision of access to the counselling services at the educational institute.

Researcher Involvement

In qualitative research the researcher is always actively involved and their theoretical outlook, interest and experience influence the research process (Hamberg et al., 1994). Strauss and Corbin (1990) refer to theoretical sensitivity in grounded theory method which is derived from the researcher being well versed in the relevant literature and from the researcher's personal and professional experience. The researcher was aware that her experience as a senior staff member involved in introducing preceptorship within the school could hinder some participants' contributions within the focus groups if she was the facilitator. Morgan (1988) claimed that an interviewer who appears to be an expert on the topic may shut off some lines of communication. The researcher decided to engage another nursing lecturer to undertake the focus group interviews. A nursing lecturer with experience of the preceptor model was engaged rather than a trained interviewer, due to her experience of the phenomenon under study to promote theoretical sensitivity. The selected lecturer had previous experience in conducting interviews. Initially the researcher felt some frustration at not being involved in the focus groups and having the opportunity to pursue and clarify points raised by the participants. However, the interviewer facilitated the interviews satisfactorily and her knowledge of clinical teaching influenced the depth of data that evolved. Also the researcher was able to suggest areas derived from the constant comparison analysis of the first transcripts that needed further elucidation in the second round of focus groups.

During the data analysis the experience of the researcher assists in recognising important factors in the data and gives it meaning (Strauss & Corbin, 1990). At the same time this could introduce researcher bias as researchers may interpret data according to their own prejudice and bias. For example, participants in the study often spoke of *trusting preceptors* and the researcher was required to put aside her own interpretation of *trusting preceptors* and concentrate on the meaning offered by the participants. The researcher adhered to the techniques suggested by Strauss and Corbin (1990): of constantly asking 'what is going on here?'; and being sceptical toward themes emerging early in the research.

Data Collection

Data was collected in this study using the focus group method. A focus group can be described as a formal structured group of participants who have joined together to discuss a specific topic or interest within a specified time frame (Morgan, 1988). In some cases focus groups are used in conjunction with other data collection methods such as questionnaires, single interviews and observations. However Morgan (1988), a well known proponent of focus groups, argues that focus groups are also a useful and self contained means of data collection especially at an exploratory or descriptive level.

The introduction of preceptorship has been a major change for lecturers and in order to explore the change a forum, such as focus groups, that enabled the sharing of information is a useful data collection method. Morgan (1988) compares the use of focus groups and participant observation and maintains that focus groups are better suited to topics of attitude and cognition, whereas participant observation is better suited for roles and organisations. While the current study concerns the role of the lecturer in the clinical area the focus of the research was the participants' own perceptions, attitudes and understanding of their role thus focus groups would provide a forum for sharing the personal and group perspective. According to Morgan (1988)) focus groups "*use group*

interaction to produce data and insights that would be less accessible without the interaction found in a group" (p. 12).

The decision was made to conduct semi-structured focus group interviews. A semi-structured format allows the interviewer to focus on issues of particular importance to the research question and probe and clarify comments made by the participants to gain in-depth information (Rose, 1994). A semi-structured format also empowers participants to raise and explore their own points of view and interest (Morgan, 1988). A review of literature by the researcher and anecdotal information had already identified several areas of interest and these were used as interview question zones e.g.,. teacher activities, teacher versus nurse role, nature of student contact. According to Morgan (1988) focus groups are more than an alternation between research questions and participant answers but rely on an interaction within the group to produce insight and data.

Two rounds of focus group interviews occurred. Two focus groups were held in each round therefore making a total of four focus groups. Each participant took part in one focus group in each round i.e., a total of two interviews for each participant. Two alternative times were offered for each round and participants selected the most convenient time. This was designed to prevent the interview being dominated by strong staff members and encourage interaction between group members. Morgan (1988) maintains that for exploratory research approximately 3 or 4 focus groups should be adequate.

In the first round the group numbers were very uneven with nine participants in Interview 1 and only three in Interview 2. However the numbers were more evenly balanced in the second round with seven participants in Interview 3 and five participants in Interview 4 (Fig 2). The length of interviews ranged from 60 minutes to 90 minutes.

The second round of interviews was utilised to pursue information or issues raised in the first round in more depth and allowed the participants to raise and explore their own topics of interest. This allowed the researcher to see which topics continued to be of most interest to participants (Morgan, 1988). Due to the need for preliminary analysis of the first round the second round was held 4 weeks after the initial round of interviews.

The model may be shown diagrammatically as:

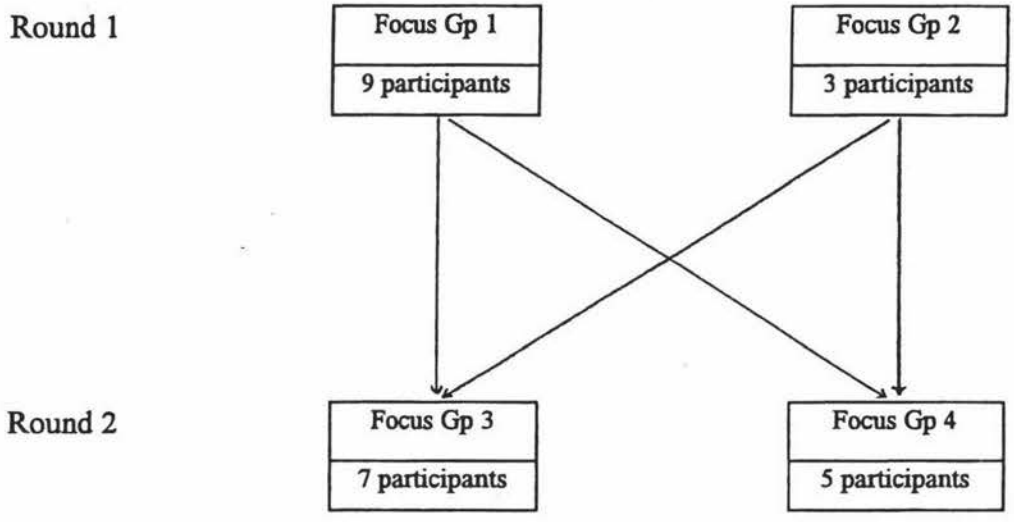

Figure 2. Configuration of focus group interviews showing number of participants in each focus group.

The results were presented to the participants prior to the writing up of the project. Two opportunities were offered in a group format for this purpose. Strauss and Corbin (1990) maintain this is an integral part of the research process as participants confirm or refute the interpretations of the data made by the researcher. The participants' feedback and comments were included in the discussion section of the research report.

Data Analysis

The steps of grounded theory, including data collection and analysis, occur simultaneously. Data analysis employs the constant comparative method which involves the asking of questions about data and the making of comparisons for similarities and differences between each incident, event, and other instances of phenomena (Strauss & Corbin, 1990).

The first stage of data analysis is called *open coding* which involves line by line analysis of the transcribed data to identify concepts. The concepts are then grouped, like with like, into categories (Strauss and Corbin 1990).

The second stage is called *axial coding* by Strauss and Corbin (1990) as data is recoded to make connections between a category and its subcategory. The category is then more multi-dimensional and focussed in terms of the context and causal conditions within which it arises and the strategies adopted to manage the context. The outcome of data analysis at this stage is the thematic analysis or concept development and this is the level to which the current study is developed. Strauss and Corbin (1990) argue *"that at this descriptive level the findings may be presented as themes, précis or summaries, of words or ideas taken from the data with minimal interpretation of the data" (p.29).* This level was reached in the current study and the findings are therefore presented as themes.

The development of a grounded theory requires a further step in data analysis called *selective coding* which involves the selection of the *core category* or social process. The core category is systematically related to all other categories to form an integrated conceptualisation of the central phenomenon of the study (Strauss & Corbin, 1990). While a central theme did appear to emerge it was not possible to fulfil the requirements of a grounded theory study. Due to time commitments and the scope of the thesis at a masterate level

theoretical sampling and data saturation was not attempted. Lack of data saturation precludes the generation of a theory which is grounded in the data.

Despite the limitations of the study, the consistent theme that was apparent may have been substantiated as a core category if the study had been more comprehensive. This theme is offered to the reader in Chapter Eight.

Rigorousness of the Research

Qualitative studies are often criticised for their lack of scientific rigour. This view is generally promoted by the dominant, positivist scientific society who demand rigour through objectivity, internal validity, reliability and generalisability (Hamberg et al., 1994). The researcher was very aware of this criticism and endeavoured to undertake research that was credible and trustworthy by closely following the work of known proponents of qualitative research.

Guba and Lincoln (1989) have suggested that the trustworthiness of qualitative data should be established through four criteria - credibility, transferability, dependability and confirmability. Credibility of data and the conclusions refers to confidence in the truth of the data. Sandelowski (1993) describes a study as credible if it accurately reports individual's experiences and that the people having the experience would immediately recognise it from those descriptions or interpretations as their own. In this study ongoing member checks, or debriefing with participants where researcher interpretations and identification of themes and categories are checked out with participants, were used to establish credibility. This occurred twice in this study. Participants were requested to check transcripts of interviews and also asked to comment on the researcher's interpretation of the data and findings of the study.

Transferability refers to the generalisability of the data (Polit & Hungler, 1995). This is also referred to as *fittingness* by Guba and Lincoln (1989) if the findings of qualitative studies are found to *fit* other contexts. Readers judge the generalisability of a study if they are able to recognise the findings as meaningful and applicable to their situation (Sandelowski, 1993). While this study was specifically designed to fit the educational institution where the study took place it is hoped that lecturers in other contexts may find the findings useful especially as preceptorship increases in popularity in New Zealand nursing schools. The researcher proposes to provide adequate descriptive data about the design method as well as the findings and analysis to enable readers to judge whether the findings may be transferred to another group or context. It is also hoped to present the study in nursing journals and in conference format in a manner that enables lecturers from other nursing schools to identify and recognise similarities and links with their own experiences of teaching in the clinical area.

Guba and Lincoln (1989) propose that the concept of auditability be the measure of consistency in qualitative research. They suggest that a study can be judged as auditable, and therefore reliable, if the reader can follow the decision trail of the research process. It was the researcher's intention to make the research trail of this study transparent, which would allow similar studies to be conducted elsewhere.

Dependability refers to the stability of the data over time and over conditions and confirmability refers to the objectivity or neutrality of the data (Polit & Hungler, 1995). As this is a Masters thesis study it will be scrutinised by an external reviewer or supervisor who will undertake an inquiry audit into the dependability and the confirmability of the data and relevant supporting documents.

An iterative approach was also used to refine the themes and to promote the validity of the themes. The researcher promoted this in two ways. Firstly by returning repeatedly to the data with the themes in mind to check and refine the fit of the themes as suggested by Polit and Hungler (1995). This also aids in establishing trustworthiness according to Guba and Lincoln (1989) and is an essential step to ensure whether the findings or conclusions can be trusted (Burns & Grove, 1993).

Summary

In this chapter the researcher's rationale for the use of a descriptive qualitative method for the study was outlined. The use of grounded theory as a framework for the data analysis was explained and the method of using focus groups to generate in depth data was described. Ethical considerations were also described and the rigorousness of the research was addressed through credibility, transferability, dependability and confirmability.

In the next two pages the findings of the study will be outlined by way of an introduction to the following chapters. The following five chapters contain the findings of the study. The first four chapters are presented according to the themes that emerged from the data. The fifth brief chapter offers a central theme that was consistently evident throughout the data.

Findings

As discussed in the section on data analysis the findings of this study are presented as themes. Five themes emerged from the study and these all reflect an educational orientation to the lecturers' role in the preceptor model of clinical teaching. The matrix of themes are shown in Table 1. The first two themes *evaluating students* and *teaching students* are covered in Chapters 4 and 5 respectively. These two themes are often difficult to separate however they need to be acknowledged as separate facets of the lecturer role due to their differing intent and differing lecturer activities. Within the *evaluating students* theme there are three sub-themes: *lecturer driven, filtering preceptor feedback* and *using a checklist. Teaching students* has two sub themes: *contextually driven teaching* and *teaching the thinking of nursing.*

The third theme is called *working with preceptors* and is addressed in Chapter 6. Preceptors are integral to the preceptor model of clinical teaching. This category includes two sub-themes called *building a relationship* and *supporting preceptors*.

A fourth theme to emerge from the data revolves around *creating a positive learning environment* and is discussed in Chapter 7. There are two sub themes to this theme: being a *consistent link person* and *being visible and credible.*

In Chapter 9 a central theme that emerged from the data and consistently ran through the other four themes is presented and discussed. This theme is called *being negotiable* and describes a way of being, or an attitudinal approach, for the lecturers as they function and work within the clinical area.

Table 1

Themes and Sub Themes in Lecturer Role in Preceptor Model of Clinical Teaching

Being negotiable			
Evaluating Students	**Teaching Students**	**Working With Preceptors**	**Creating a Positive Learning Environment**
Lecturer driven	*Contextually driven teaching*	*Building a relationship*	*Consistent link person*
Filtering preceptor feedback	*Teaching the thinking of nursing*	*Supporting preceptors*	*Being visible and credible*
Using a checklist			

The use of participant quotes is accompanied by a code which denotes the number of the focus group and the page the quote occurred on the transcription e.g. 4(7) indicates the quote came from the fourth focus group interview and is on page 7 of that focus group transcription.

The terms lecturers and participants are often used synonymously in the following chapters, as the participants were experienced lecturers within the preceptor model of clinical teaching.

The participants often use the term *clinical standards* or *standards*. This relates to the school clinical evaluation tool (Appendix F) which consists of five broad clinical processes or standards. Each of these standards has a range of statements or criteria in relation to each year of the course. The student must achieve each of the standards to pass the clinical module.

Chapter Four

EVALUATING STUDENTS

Participants considered that their role involved the teaching and evaluation of students, as they were primarily educationalists in the clinical area. They found that teaching and evaluation often occurred simultaneously and the boundaries between the two responsibilities were indistinct at times. This was evidenced in the lecturer's use of terms such as *teaching and assessing all happening together* and *assessing and coaching all the way.*

Unlike a classroom scenario the very nature of clinical teaching and the unpredicatability and the complexity of clinical practice, does not always lend itself to planned, structured teaching or evaluation sessions. The lecturer was constantly required to respond to the contextual demands of the clinical area and student needs and this could be either evaluation or teaching based. The lecturer may begin to teach a student about a specific clinical skill but find that the student's basic knowledge was less than expected for that level of student and thus had to move rapidly into an evaluation mode.

Despite the obvious interrelationship of the two roles there were also clear differences apparent in the data that made the two roles distinct enough to warrant separate themes.

The evaluation of students emerged as a major, and the most prominent, theme of the lecturer role in the preceptor model. Student evaluation was considered a professional educational responsibility and the process was driven by the

lecturer with some input by the preceptor. The three codes in the *evaluating students* theme are *lecturer driven; filtering preceptor feedback* and *using a checklist*.

Lecturer Driven

The participants considered they were responsible for driving the student assessment process, which involved awarding the final grade and decision making around non achieving students. As educationalists, the participants felt an obligation to both the students and the school to ensure that the evaluation process was fair and open to scrutiny. While the lecturers sought feedback from the preceptor and aimed for a degree of collaboration in the evaluation process they simultaneously orchestrated the process. There was evidence that the lecturers were more willing to share the teaching role with the preceptors than the evaluation role. As one lecturer said:

> *I think I drive it [student evaluation] most of the time. I feel responsible for the outcome in some way, of the assessment process, apart from the fact that the student either does the actions or they don't. But I feel that I own that part and I find it very hard to let go of that to let the preceptors be more involved. 3(17)*

The participants felt an obligation to keep the students informed of their progress in order to assist them to achieve. As lecturers they had expectations of where the student should be at in relation to school expectations. The lecturers would work with the student, evaluate their progress and plan learning strategies to promote student achievement. The student's progress and the learning strategies would be discussed with the student and documented in the students' progress logs. This information would also be discussed with the preceptor if he/she was available. Informing the preceptor was not always achieved in person although the student was expected to share their progress

logs with the preceptor. The lecturers seemed to make a concerted effort to inform the preceptors if they wanted their co-operation. One participant comments:

> *I said to the preceptor - I've talked to the student about time management and it's something she really needs to work on. Would it be okay if you give her 2 or 3 clients at the beginning of the day. She can then plan her day and tell you what needs to be done. And that really worked well and she said - yeah fine. 2(23)*

The participants also considered they had a professional obligation to society to ensure patient safety. In the clinical area the student is actively involved in practice, delivering patient care, while they are still learning. Student evaluation took on new meaning early in the students' clinical experience as the lecturer promoted patient safety by assessing the students' knowledge base. Participants used terms such as *checking the student out, seeing where they are at* and *making sure they are safe*. One of the participants explains the process:

> *it's the information they [the student] can give me about the patient, what they know, what they understand, what is relevant and important, if they are prioritising care and maintaining patient safety. 4(4)*

The final assessment, while driven by the lecturer, was often a process between the preceptor, lecturer and the student. Lecturers endeavoured to include the preceptor in the final discussion and while the ideal was to all sit down together for a period of time this was not always feasible, due to preceptor off duty time or clinical demands. A participant talks of the three way process but also highlights the lecturer control:

> *for the final situation I get together with the student, the preceptor and myself and we just have a discussion and I try to lead it to find out*

some of the information to meet the criteria of the clinical standards. And then I do the final assessment and writing up of my part because I prefer to write it with the student. 4(10)

Participants expressed hope that greater collaboration would develop between the lecturers and the preceptors in the future around student evaluation. However the following comment highlights some reticence toward this development:

I'm hoping that as I become more experienced and as the staff become more experienced in the preceptor model that that [responsibility for student evaluation] will shift slightly so that I can incorporate them more heavily, though not disproportionately, into the final assessment. 4(11)

The power of the lecturer in the evaluation process was recognised by the participants. While the teaching and evaluation roles invariably overlapped, the evaluation aspect seemed to dominate the lecturer-student interaction. Lecturers would try to make the interaction between them and the student non-threatening but there was always the awareness that the lecturer held the power as the evaluator. One of the participants referred to this dilemma:

so you really are assessing them when you go in even though we say we are working [with them] we are really assessing them. 2(19)

This was supported by another participant:

as much as you try to make that a working relationship between you and the student, I guess you are always evaluating them because in the end you have to document everything they do, so it turns into an assessment. 2(19)

Participants also considered they were responsible for ensuring there was adequate documentation on student progress. Written documentation on student performance was necessary to fulfil school requirements and lecturers maintained on going written documentation about each student that was clear, objective and related to the school clinical assessment tool (Appendix F). This was particularly important in relation to students having difficulty in the clinical area and to non-achieving students.

Documentation was also provided by students and preceptors and although this was strongly encouraged it was not mandatory. Students were well socialised into documenting their practice throughout the course and the lecturers often related this to the students' professional role:

> *right at the word go I make it clear to the student that it is their professional responsibility to keep their practice documented, logs up to date, and that they are available to me. 4(10)*

The preceptors had major problems with documentation and lecturers had difficulty in getting the preceptors to document anything concerning student learning in the student's learning contracts. This was a source of much frustration for lecturers but became increasingly important when dealing with struggling or non achieving students. A participant comments:

> *and the preceptors will often say - "yes, well this is a non achieving student perhaps". But if we haven't got the documentation...and that's what seems to fall down at the end of the day at Board of Studies, at the end of the course. 4(9)*

Preceptors were much more willing to offer verbal feedback and some participants addressed the difficulty by documenting the preceptor's verbal feedback in the students learning contract:

> *I actually end up documenting what they have said - the staff nurse has commented on whatever... this has been verbally said to me and I am documenting on their behalf. 4(10)*

Gaining access to the preceptors was difficult and time with the preceptor was often short, incidental, interrupted and secondary to other demands such as ward or patient demands. Preceptors were often unavailable due to off duty time and students spent shifts with other clinical staff. These factors may have contributed to evaluation process being driven by the lecturer. A participant describes her strategies for accessing preceptors and highlights the role division she perceives between the preceptor and lecturer:

> *my time with them [the preceptors] tends to be very moment driven and the only times I've really had to capture someone's time I go at hand over or just after hand over time when they've completed their work and I know that I can actually get more than three minutes of their undivided attention when I need it. I'm very conscious of not stopping them from their real work with patients as opposed to their work with my students. 3(14)*

Filtering Preceptor Feedback

The participants spent considerable time talking and discussing student progress with the preceptors. However once the information was gained the lecturers then decided whether to accept or discard the information. There was evidence of not always trusting the preceptors' feedback and there were many

instances that demonstrated that lecturers were very selective about preceptor feedback and filtered the information they gained.

The reasons for this were not always clear though two factors emerged quite strongly - inexperience of the preceptors and lecturers lack of knowledge of how to gain constructive feedback from the preceptors.

The preceptors' inexperience in giving constructive feedback was evident in their use of nebulous terms such as *fine, doing well* or *OK.* Often the participants felt that the preceptors' lack of knowledge around school expectations of students and evaluation procedures hindered their ability to give descriptive feedback. It was interesting to note that the lecturers strongly felt that school documentation lacked sufficient clarity to be interpreted by the preceptors and was not user friendly. The participants used questions to elicit the information they required as demonstrated by one of the participants:

> *I ask stuff like - "do you trust them?" It's just sort of trying to find out where they are placing them. You can't hand the preceptors the standards and say "read this and tell me what you think". What I do sometimes is have the standards in front of me and just say "what do you think about this, what do you think about that" and giving an example. It's trying to get an in depth version, more than just a yes or no answer. 3(20)*

Another participant supported the use of questioning:

> *I say -" tell me about this student, how they practice, what clients have they been working with, where do you think they are in terms of practice, do they think about things like the theory or principles behind care or are they still at a very skill base level or have they no idea at all?" 4(5).*

Participants also suggested that some preceptors were protective of their students, having built a strong relationship with them, and were reluctant to say 'negative' comments about the student. This was understandable to the lecturers, considering the length of time some preceptors spent with the students, however it was not always helpful when try to assess the student. A participant explains:

> *I think they build up a relationship. They work with that person and they nurture them along ... I've seen them have a really definite relationship with the students and I guess its hard to be the baddie at the end of that. I've found that the feedback is always positive. 2(9)*

Some of the participants also acknowledged that they were often unsure of how to gain constructive feedback and this was a skill they had to learn. A lecturer comments:

> *a lot of the nurses don't understand what it is you want to know and unless you can articulate that really clearly to them it is difficult to elicit the feedback you want. I'm still learning the questions to ask and the language they need to hear to understand. 4(7)*

The combination of the preceptors' uncertainty of giving feedback and the lecturers' uncertainty of asking the right questions may reflect the relative newness of the preceptor model. One of the participants explains:

> *a lot of times its difficult to ask the right questions to actually get the appropriate feedback because sometimes the staff don't really understand what it is you are looking for and don't quite know how to interpret the student's practice to give you sufficient feedback about their performance ... but it's getting better the more runs we do. 1(4)*

There were also some instances of lecturers not trusting preceptor feedback. This was generally due to the lecturer not valuing the preceptors' level of nursing practice or the preceptor's attitude. The lecturers listened to the feedback but did not necessarily take any notice. One participant remarked on the need to get to know the preceptor:

> *there are some staff nurses, or enrolled nurses, that as soon as they have an inkling about someone and want to have a word with me then I know straight away to pay attention to them. Whereas there are some others who are always critical and it wouldn't matter what the student was like or did, they would always be looking for what's not yet perfect. 3(32)*

The participants appeared to assess the preceptors in some way before deciding whether to accept or discard their feedback. Often this assessment appeared to be individually defined. A participant describes her general mistrust of preceptor feedback due to their lack of knowledge around the curriculum:

> *I check out what the preceptor knows about the curriculum, but I find that almost any feedback I get from them I take with a grain of salt because sometimes their expectations of the students functioning are very blurred. 3(17)*

On the other hand participants reported many incidents of valuing and using preceptor feedback. Many of the participants referred to the considerable time the preceptors spent with the student in comparison with lecturer-student contact and for some this encouraged the valuing of preceptor feedback, as one lecturer explains:

> *I think one of the things that help me trust them [the preceptors] is that they are with the student all of the time and we are only touching the tip of the iceberg when we go in. We have to be in the right place at the right time for it to be a really good assessment time. 4(15)*

There was evidence of the lecturers readily acting if the preceptors expressed some concern about a student. The lecturers rapidly checked out the information and acted if they felt it was warranted, as one participant explains:

> *I did find out about one piece of information where the preceptor was very, very concerned about a student's behaviour. It was around not letting the preceptor know where they were going or what they were doing and leaving early, without doing observations - they were not being responsible or accountable for their practice. I talked to the student as soon as I could, checked it out and talked to them about their role. 1(5)*

There also appeared to be differences between individual preceptors and also different clinical areas i.e., experience and familiarity with the preceptor model and also the role of the preceptor. This is also addressed in the theme *working with preceptors.*

Using a Checklist

As with any educative process evaluation of student performance requires measurement criteria. The school evaluation criteria consists of five broad learning standards with sub sets of learning outcomes related to each year of the programme. Lecturers often referred to the use of this tool as a framework for the overall evaluation process and lecturers deliberately sought to gain information pertaining to each of these processes for the final evaluation.

However these processes are very broad and the lecturers had their own, unwritten, informal framework that was their personal checklist around student expectations in the clinical area. The check lists were specifically related to the learning outcomes of the course. There was an expectation that students would apply classroom concepts in the clinical area and lecturers constantly used these concepts to check student learning in the clinical area:

> *most of my time with the second year student it's around what are they doing and what did they notice when they were doing that and pulling it back to their theory papers particularly in med-surg [sic] around pathophys [sic] and psych [sic]. Around what meaning they can make or linking it to their theory papers. 3(3)*

Often these checklists were related to technical skills and lecturers expected the students to demonstrate competence in specific skills that had been taught in the classroom. This was especially true in relation to second year students.

The checklists were also evident in reflection sessions between the student and the lecturer. The lecturers would have their checklist of expectations and they would deliberately direct the reflective session to include certain topics to assess the students' knowledge and understanding. A participant's description highlights the checklist in relation to third year students:

> *I want to know that the student has understood and met certain criteria and met certain issues or standards within practice. And to do that I get them to reflect on certain things and that's the assessment process and that's why I plan it. I want to know that students do actually understand family centred care ... I want to know how they put it into practice, what the principles were, a critique of their performance in terms of the issues ... therefore I have some grounds at the end to assess the student. 4(5)*

The use of the unwritten checklists by lecturers was very apparent and it was clear the checklists were related to the clinical standards (Appendix F). However the degree of commonality between lecturers around the components of the checklist was less clear and it appeared that the checklists were formulated individually by the lecturers. This must raise issues about lecturer reliability in student evaluation. The lecturers argued that the evaluation process should be fair and consistent and that they had the educational preparation to conduct this role. However the use of individually formulated checklists suggests there may be variability between lecturer evaluation standards and criteria and this is compounded by the need to grade students' clinical practice.

Student evaluation in the clinical area has always been fraught with difficulties and the participants suggested that the preceptor model brings its own problems. The weight of responsibility in clinical evaluation is expressed by one participant:

> *how do you decide? Is it yours alone or is it yours and a verbal referee which is the preceptor. Or is it yours, the verbal reference and the documentation of both of you ...I would have to say that I make the decision along with a verbal reference but if I had to go back and justify it as to why I had given the student an achieve with merit, or a non achieve or an achieve ...I don't know? 4(9)*

Summary

Evaluating students was the most dominant theme to emerge from the data. Student evaluation was *lecturer driven* as the lecturers considered they had responsibilities to the school, the students and the patients to ensure that the evaluation process was comprehensive. The lecturers did involve the

preceptors but this was variable. The lecturers spent considerable time seeking preceptor feedback about student performance but then arbitrarily decided whether to accept or discard the information. This sub theme was called *filtering preceptor feedback.* The lecturers considered the preceptors were unfamiliar with school documentation and evaluation processes and were inexperienced in giving feedback. Some participants also did not value some preceptors' practice or attitudes and therefore mistrusted their feedback. Participants formulated personal *checklists* based on the expected learning outcomes which they used to evaluate the students. The checklists were individually formulated and unwritten which raises the issue of lecturer reliability around evaluation.

The evaluation and teaching of students invariably occurred simultaneously. *Teaching students* is discussed in the next chapter.

Chapter 5

TEACHING STUDENTS

Participants considered that teaching students was a significant component of their role as lecturers in the clinical area and they spoke repeatedly of working with students, teaching students and facilitating learning. The participants also acknowledged that the preceptors played a major role in teaching students as they spent a considerable amount of time with students and shared their knowledge and experience with students. There are two sub-themes to this theme: *contextually driven teaching* and *teaching the thinking of nursing.*

Contextually Driven Teaching

The clinical context was the basis and trigger for much of the teaching that occurred between student and lecturer. The participants valued and utilised the rich learning opportunities that were available for the student in the clinical area in comparison with classroom where clinical situations were imagined, devised or contrived. They consistently spoke of utilising what was happening in the clinical context and the clinical practice of the student for teaching purposes. The following comment by a participant was echoed by many others:

> *being there and capturing the moment of whatever they might be doing at the time - take the opportunity as it arises. 4(10)*

Another commented:

> *teaching is driven by the moment. In fact everything a student does is grounds for discussion. 3(2)*

The clinical context was important for two major reasons. Firstly because it provided lecturers with teaching triggers such as actual patient care, clinical incidents and health care team interactions that became the focus for teaching and learning with the student. Secondly the clinical context was the real world of nursing and was therefore considered to be the ideal climate in which to teach and assist nursing students to learn to nurse. Teaching that focussed on the reality of clinical practice gave meaning and context to the teaching and learning process.

Participants commented that lecturers used teaching strategies that focussed on the students' practice to extend learning. They repeatedly referred to spending some time working alongside students, either observing or becoming involved in practice and then using that interaction as a basis for learning, as the following excerpt demonstrates:

> *I try really hard to work with a student when I go in. And then I discuss it with them in terms of what their experience was like, what did they notice, what did they see, what were they feeling about this and why did they do this particular thing. And reflect through the experience of having been there with them. 3(1)*

Role modelling was also used as a teaching strategy as lecturers worked alongside them in the clinical area. At times this related to technical skills, especially with second year students but often it was just working alongside the student and assisting in the care of the client. Such interactions were then used as teaching triggers between the student and the lecturer.

Handover was another teaching strategy used by lecturers. A participant explains this technique in relation to teaching the prioritising of patient care:

> *The handover process is something that I use often. I'll say I'm coming to relieve you for one hour for lunch, tell me what I need to know about your patients. And the next day I'll say I'm coming to do something else and they have to give me the succinct, relevant patient information ... I've just taken on this patient so lets go and find out, lets do that then tell me what you know. 1(28)*

Tutorials were held by most participants, especially for second year students, in the clinical area. There appeared to be a lack of consistency around the frequency and the focus of the tutorial. Tutorials topics included assignment preparation, invited clinical specialist nurses, student presentations or discussion around clinical issues. One of the participants explained her use of tutorials:

> *I think that the tutorials are valuable for the students when issues come up for them in clinical and they need a safe environment to be able to sit there as a group and discuss those issues. I think it is still very important for them. 1(30)*

Time to meet and work with students in the clinical context was expected of the lecturers. Most lecturers contracted times to meet with students at least weekly. Lecturers tended to have less regular contact with the students in their final year but this time was more often planned, structured and tended to be for a longer time period. Lecturers encouraged students to contact them to share learning experiences and stressed their availability for students. All lecturers were available on locator and many spent long periods of time in the clinical area. One participant spoke of her willingness to be involved:

> *I encourage students to let me know if I'm not on the ward at that time, to share their learning with me, or contact me or locate me and say "hey, I've just done such and such and I'd like to share that with you".... and that has actually worked quite successfully. 4(2)*

While the clinical context provided excellent teaching opportunities for lecturers it was also the cause of some frustration. Time spent with students and preceptors, even if previously negotiated, was contextually driven and dependent upon many issues such as patient needs or students being off the wards. The lecturers had to be prepared for disruptions and some lecturers found this irritating and were unsure how to manage this situation.

Teaching The Thinking Of Nursing

The lecturers knowledge and experience of the teaching and learning process was evident as they employed teaching strategies that encouraged the students to uncover and make visible their thinking and decision making processes in clinical situations. The emphasis was not just on promoting theoretical content or concrete, objective knowledge but was focussed on teaching the student to think critically about and reflect on client situations and clinical scenarios.

There was evidence that the lecturers considered they had a different, though complementary role, to the preceptors in teaching students. The preceptor taught the clinical skills and day to day practice while the lecturer concentrated on uncovering and extending the knowledge that underpinned the students' practice. A participant described the difference and her view reflected that of others:

> *actually getting students to critique their performance and to look at what they actually practice rather than getting wound up in the actual*

every day tasks. Its hard work out there doing the skills, but the students need time to look at practice. 4(20)

Lecturers sought to encourage the students to explore the knowledge that underpinned their practice and extend this knowledge further. Due to the pace and acuity of clinical practice the learning needs of students, and the teaching of the preceptors, can easily be task directed and technical skill focussed.

The lecturers' knowledge of the educative process was apparent as they utilised reflection and questioning to uncover and extend the knowledge that underpinned the students practice. One participant explains:

I basically encourage them to think about the experience they have had whether it was showering a patient or transferring a patient from bed to chair. If they felt the whole experience went very well for both the student and the patient then I encourage them to think about why it went well or why it didn't go well and how they thought they could do it differently. And if it did go well what was it about their interaction that made it a positive experience for both of them - I just pose those questions to them. 4(2)

Some lecturers tended to use the terms questioning and reflection interchangeably but their descriptions did not always demonstrate critical reflection as described in literature (Dobrzykowski, 1994). Often this was due to time constraints and lecturers had to make the most of moments snatched in corridors or treatment rooms. Reflective learning is often time consuming and also requires privacy - both commodities difficult to attain in the clinical area, according to the lecturers, due to practice demands and lack of appropriate space. Lecturers often mentioned these difficulties and found them difficult to overcome.

Reflection and discussion with students often focussed on making meaning of clinical practice and exploring the wider picture of nursing. This included encouraging students to think about the broader political, social and cultural aspects of clinical scenarios. Clinical practice is very complex and often chaotic and students need assistance to understand and make meaning of their practice experiences. The reflective process was useful to help students learn when involved in difficult emotional or ethical issues. Such issues are part of everyday nursing practice however students are neophytes nurses and their experience in dealing with such issues is minimal. Reflection encouraged the exploration of the issues and enabled the lecturer to support the student to work through the issues. A participant talks of assisting a student to work through his/her first encounter of child abuse:

> *Reflection ... especially in those moments when anger or distress or helplessness comes in from the student's point of view and they don't quite know what to do with it all. And you just bring them back to exploring what was happening now, why this might be happening and take them through all of it. And they can actually then make meaning of it ... still feel angry but they can deal with it. 3(7)*

Lecturers spoke of role modelling reflection for students hoping that they would learn to use the reflective process themselves to promote their learning:

> *I really like encouraging reflection ...because I'd like them to carry that on with their peers once they've finished. I'd like them to know or use it when they finish and to know that it is a valid sort of tool that can be really supportive of their learning. 3(8)*

Of note was the participants' belief that knowledge of the clinical area and nursing knowledge enhanced their teaching effectiveness. They considered

they could encourage more lateral thinking and deeper learning if they had nursing knowledge related to the clinical area where the student was working. Often the knowledge was gained if they remained constantly in the same clinical areas. One of the participants explains the difference in her teaching following continued contact with the renal area:

> *I had very little knowledge of renal but now I guide their programme for that clinical learning package. I say to them - have you dealt with CAPD [sic] patients, do you really know what happens to them and what it means for them in terms of their lives? How did they choose - where is the ethics in the choice? I would not have done that before. I would not have had that depth of understanding. There is a big difference. 4(20)*

There was evidence that *teaching the thinking of nursing* was not haphazard or unplanned. The curriculum provided a basis for teaching and interaction with students. The participants seemed very aware of the criticism often levelled at lecturers that teaching is divorced from the reality of clinical practice. Lecturers spent considerable time in attempting to bridge the theory-practice gap by promoting what was learned and taught in the classroom as applicable and appropriate in the practice of nursing. While the students' clinical practice became the trigger for the discussion, the lecturer then encouraged the application of classroom theory as a sound rationale for practice and the basis of good clinical judgement. A participant talks of working with second year students:

> *with second year students it's [reflection] around what they are doing and what did they notice when they were doing that and pulling it back to their theory papers particularly in med-surg[sic] and psych [sic], around what meaning they can make and linking it to their theory papers. 3(3)*

In the third year paediatric course, family centred care and paediatric assessment is a focus and the following excerpt typified several participants' comments:

> *I try also to relate things they've learned in that semester, or prior to that, into what they are doing clinically, like - what's your pathophys [sic] knowledge around nursing a child with cystic fibrosis, actually looking at the respiratory system and how it's affected, what's been altered and what's the normal pathophysiology. And theories - we've learned about family centred care and how do you apply it in the clinical setting. 4(2)*

Basically the lecturers strongly believed it was their role to encourage the thinking aspect of nursing and consistently tried to convey to the students that nursing was more than just task or rule driven practice but involved critical thinking, independent thought and sound clinical judgement. One of the participants gives an example:

> *I spend my time asking them why. Why did you do that, What was the reason for that? Like why do we take recordings for four hours? Is it just because it's written down on a piece of paper or is it because a person needs it? Just trying to encourage them to have their practice guided by knowledge rather than by what they are told to do. 2(15)*

Promoting a broad view of nursing and promoting *the thinking of nursing* was supported by another participant:

> *Practice is more than task driven. I always get them to reflect on why they are doing things, to show that they understand that nurses are*

actually not just doing it because they have been told. That they understand what nursing is. 3(8)

Summary

Teaching students emerged as a theme within the clinical role of the lecturer in the preceptor model. *Contextually driven teaching* that focussed on the here and now for the students gave meaning and context to teaching and learning in the clinical area. Participants would try to contract time to meet with the student in the clinical area and spend some time working beside them and use this interaction as the basis for the teaching that followed. The participants demonstrated a difference in teaching focus between themselves and the preceptors. The preceptors focussed on teaching the practical skills and routines of practice while the lecturers focussed on *teaching the thinking of nursing.* This involved encouraging students to develop sound rational for practice and encouraged the transfer of theory learning the classroom to clinical practice. Reflection and questioning were the predominant teaching strategies used by the participants.

The following chapter discusses the theme *working with preceptors.*

Chapter 6

WORKING WITH PRECEPTORS

The preceptors are a pivotal facet of the preceptor model of clinical teaching and students spend many contact hours working alongside the preceptors in the clinical area. In order to effectively work with the preceptors the lecturers found they needed to *build a relationship* with the preceptor. As previously discussed, the lecturer spends considerable time accessing the preceptor to gain information regarding student performance in order to evaluate the student. The lecturer also spends time with the preceptor to assist them in learning and functioning within the preceptor role. This role is broadly addressed within the theme *supporting preceptors*. Of all the themes this one lacks a degree of clarity and participants often used vague terms and descriptions.

Building a Relationship

The lecturers often referred to the need to work closely with the preceptors if the preceptor model was to work effectively. The need to build a relationship was necessary in order to achieve the collaborative aspect of the model as the lecturers became a link between the student and the preceptor and gathered information for the teaching and evaluation process. For some of the participants this was a new notion after working in the traditional model within which there was no consistency between the staff nurses and students. One of the participants talks of her goal of working more closely with preceptors to promote student learning:

Just working more closely with the preceptors. Identifying what are the good parts of the student's practice and what are the weaker parts, the gaps, they found that the student needs to work on. Plus feeding back to them [the preceptor] how we found the student in trying to make the links, feeding back to them how the student performed with the time that we spent with them, making the links. 1(2)

The purpose of building a relationship was very apparent from some of the participants' statements:

And also then I felt they [the preceptors] felt very comfortable to give me feedback about how things were going. I felt that I had a really good relationship and then come to the end it was really easy to get feedback from them. 2(5)

Lecturers are expected to spend considerably more time with staff nurses in the preceptor model than in the previous traditional model of clinical teaching. This was evident in the previous chapters as the participants tried to communicate with the preceptors on a regular basis concerning the teaching and evaluation of students. One of the participant's comments on the time aspect and the need to build rapport based on a genuine desire to communicate with the preceptors:

a false sort of desire to work with them [the preceptors] is transparent immediately so you need to truly want to work with the staff as much as you do with the students. And to actually build that rapport it's almost an equal time sharing between the students and the staff. It definitely benefits the students, if you feel good with the preceptors and staff and they feel good with you. 1(17)

For some of the participants the relationship was built on trust. The relationship worked well if the lecturer was able to gain the trust of the preceptor. Participants often referred to *being trusted by the preceptor* and *gaining their trust* in the relationship. This encouraged the preceptors to feel comfortable in approaching the lecturers and sharing information with them about students. One of the participants describes an incident that reflects the benefits for all involved:

> *In this last run I've had a student who basically got right up all the staff's noses within three days and they told me on the third day - she'd only been there for 16 hours. So OK, if the staff hadn't trusted me they'd have never told me, so that's what I believe the trust is all about. And the student was mortified when I told her, absolutely beside herself, she was in tears for an hour and a half. But all I could say to her was that it was fantastic and that was what the preceptor model was all about and the ward trusted me enough to tell me because they knew that I would act on it ... we, all of us, were able to change her experience through developing that trust. 3(28)*

While the above example epitomised the lecturer-preceptor relationship the participants found a trusting, sharing relationship was not easy to develop. Preceptor trust needed to be earned by the lecturers, which reflected the barriers commonly felt between nurse educationalists and nurse practitioners. Participants felt they were often perceived by clinical staff as critics of practice and they needed to reassure preceptors of their role:

> *The staff nurse made a comment about - "oh, don't watch me!" cause she had this feeling of - are you testing me as well as the student - so we talked a little bit about that and about how my role wasn't there to test people so I suppose I was helping her to perceive me in a different way. 2(4)*

It was interesting to note that the participants attempted to gain the respect and trust of the preceptors but this was not always reciprocated, as the lecturers did not always trust the feedback offered by the staff. The lecturers filtered the preceptors' information as discussed in the previous chapter.

Two factors were suggested that positively influenced the development of preceptor respect and trust. Firstly the preceptor model has become more established over time and the clinical staff are gaining more experience in the preceptor role, and are consequently becoming more comfortable in interacting with lecturers. Secondly those lecturers who have been consistently assigned to the same clinical area felt the staff *got used to them* and the relationship with the preceptors was enhanced over time. One participant said:

> *I've been through now for the third time [in the same area] ... now preceptors are starting to feel more confident to come to me and say - "look I've got a concern, I'm not sure what it is but" ... or "I have some areas of doubt or whatever". Now they feel comfortable to come and sit and discuss those issues with you - they may not know the reason but just the fact that they feel there is something not quite right and we can get right on to it. 1(11)*

Building a good working relationship takes time and accessing preceptors was a constant source of frustration to lecturers. Participants were very aware and accepted that clinical practice dominated the preceptors' time and they had to make the most of any time they could gain with the preceptor. Not only did patient demands dominate preceptor time and override preceptor-lecturer appointments but the preceptors were often off duty and shift changes, 12 hour shifts and meal breaks also made access difficult. Time and access was an issue in all interactions with preceptors, including gaining feedback about student performance and attempting to support the preceptors. Lecturers

constantly had to fit in with the preceptors' practice and often developed their own strategies to cope. A participant describes this difficulty:

> *Time to discuss stuff [sic] tends to be in snippets. Usually I find with the preceptors that any moments I capture of their time tends to be less than three minutes. The longest interaction might only ever occur after half past nine at night, all other moments tend to be three minutes or less and it's while they are doing something. 2(13)*

Supporting Preceptors

The preceptor model is still at the developmental stage and new to many clinical areas and staff education and support is necessary. Also the turnover of clinical staff is constant and the participants identified a need for continual support and education of the preceptor population. They considered it was their responsibility to support preceptors to learn and undertake their role. The participants recognised that preceptors are primarily nurses and have been educated to fulfil a nursing role and would therefore need assistance and guidance to fulfil a teaching role in precepting students. There was a real willingness amongst the participants to work with, and support the preceptors in their role:

> *I think that's where we have the responsibility to actually coach them [the preceptors] as much as we do to seek their advice and get help from them, we need to help them out as well. 1(4)*

Participants highlighted several areas where preceptors required support including: learning outcomes for students; understanding school documentation; giving feedback; teaching students.

Lecturers needed to clarify with preceptors the expectations around student learning in the area. This involved advising the preceptor what level of practice and knowledge the student should enter with into the area, and the expected progress that should be made over the clinical time. Participants used terms such as *explaining where the student is at, telling them the skills they should be practising* and *what they should be looking for.* Participants also spent time explaining the differences between the various student levels within the programme and describing the different expectations of second and third year student performance.

> *It's so that we both understand the same level of what is wanted in the students functioning for Year 2 or Year 3 and that we both understand the same language in terms of the assessment points and in terms of the curriculum covered so far, or what my expectations are of the students functioning. 3(26)*

Participants identified that one of the reasons they had to spend so much time explaining student expectations to the preceptors was because school documentation was not user friendly. Lecturers sought to demystify the language and rescript the documentation, especially the clinical standards, to everyday clinical language that preceptors easily understood. The complexity of the language was also seen as a block to preceptors documenting student performance. The participants addressed this issue by reframing the documentation through using examples of student performance and clinical scenarios. The lecturers often asked preceptors specific questions in relation to clinical standards to elicit the information they required but also suggested questions the preceptors could ask the student in an effort to extend learning or assess knowledge. A participant describes her process:

> *Well often you can't just go up to a staff nurse and ask them in standards - "what do you think of their critical thinking, what do you*

think of their competency?" You can't actually broach it in a category or standard such as we are used to referring to. You tend to have to basically ask them questions that you'd ask the student and that is - "do the students understand why it is that they are doing what they are doing". You have to ask the preceptor the same question and I find I am saying to them "do you feel as if they understand what they are doing? Do they explain reasons for their actions?" 1(5)

As educationalists, the participants were aware that the students needed feedback on their performance and practice to promote further learning. The participants acknowledged that the preceptors worked with students for long periods of time and were in a very good position to observe the student's clinical practice. However the participants reported the preceptors were not proficient at giving good, verbal, descriptive feedback and even less willing to commit themselves in writing in the students progress logs. Lecturers acknowledged their own difficulty in learning the art of documenting student learning and understood the preceptor reticence in this area. While the participants acknowledged that the preceptors needed assistance to give student feedback it was unclear how, and if, they met this need.

The participants identified that the preceptors needed assistance when working with low achieving students. The lecturers directed the evaluation process as described in the previous chapter and worked closely with preceptors to keep them informed and involved. One participant highlighted the complexity around supporting the preceptor involved with a low achieving student:

When she started to articulate her concerns I spent some time with her. It was hard to get time with her in ward time so she decided to stay after report was finished and it took about an hour, but first of all we talked about what she was concerned about in relation to the student's practice. Then we got out the standards and she had trouble

understanding the standards but we wrote her concerns down and then we linked them up to the standards. And I said "right now, that's the language we have to use if we are going to think about giving the student feedback because that's the way we assess them". So then I asked her to document her concerns in this language and we went through them. That took a long time to do and I would not like to have to do that every single time but that was a successful process in getting her to document. I don't see how you can spend a full hour with everyone every time you try to do that. 1(9)

An interesting finding was that while the lecturers were able to describe the areas in which the preceptors needed support and assistance there was a lack of consistency and clarity as to how this was actually achieved. The participants acknowledged the preceptors needed to learn how to teach and give feedback but there was seldom any reference as to how this was undertaken. One participant describes a teaching strategy she used but the description also reflects her uncertainty in this area:

If I'm teaching in the treatment room I try and teach loudly. I ask them [the students] questions quite loudly and I've heard a couple of the preceptors say - "see, she's much worse than I am". So what I'm trying to do is talk my teaching out loud so the other preceptors can over hear it, and maybe that's not the way to do things but it just sort of works ... a little bit of teaching going on for the staff as well, just about some little thing or other. So that's how I try and get around it, I sort of role model it a bit. 3(33)

Apart from this one example there was scant reference to the actual process of teaching the preceptors the teaching role. It was apparent the participants wanted to help the preceptors learn their role but they often did not know how. This was a problematic part of the lecturer's role and they used terms such as

hard, difficult, and *frustrating*. The reason for this is unclear however several participants spoke of the need to learn their own role and may be concentrating on this. Another issue was the constant difficulty in accessing preceptors as mentioned previously. Time to teach and support the preceptors was not formalised in the lecturer role, and contact with preceptors was invariably driven by the need to gather student assessment information as discussed previously.

Summary

In order to promote the collaborative nature of the preceptor model the participants identified a need to *build a relationship* with the preceptors. The participants recognised that the preceptors spent a long period of time with the students. To promote student learning the participants endeavoured to build a relationship with the preceptor that would encourage mutual sharing of information regarding student learning. Many preceptors were new to the preceptor role and the participants tried to support them in learning the role. This involved coaching the preceptors around student learning expectations and interpreting school documentation. While the participants considered *supporting preceptors* as part of their role they were unsure how to achieve this effectively.

The next chapter discusses lecturers' responsibility in creating a positive learning environment in the clinical area to promote student teaching and learning.

Chapter Seven

CREATING A POSITIVE LEARNING ENVIRONMENT

Students in the programme spend approximately 50% of their course time in clinical practice arenas. Lecturers recognise that the quality of the learning environment has a huge impact on student learning and consider they have a responsibility to try to monitor and promote a good learning environment for students. There are two sub themes in this theme: *consistent link person* and *being credible and visible.* Like the last theme, *working with preceptors*, this theme also lacks some clarity and lecturers often use nebulous terms. This may be due to the differences between the various clinical contexts and may also reflect individual differences between participants.

Consistent Link Person

Historically communication between the two areas of nursing education and nursing practice has been a universal problem and has been well documented in the literature (Infante, 1986; Paterson, 1997). There was strong evidence in this study that the lecturers assumed responsibility for providing a crucial link between the school and the clinical area. In the traditional model of clinical teaching there was minimal communication between the lecturing staff and the clinical staff. The clinical staff were often not informed, or involved, prior to students' experiences and their resentment and lack of preparation was often communicated to the students creating a negative learning environment. The participants also recognised that having students in a busy acute clinical area

was an added responsibility to clinical staff and the staff were afforded no time allowance or recompense for precepting students.

In an effort to create a positive learning environment where students were welcomed and supported the lecturers considered it their role to keep the staff well informed of student experiences. The importance of this role was often evidenced in the data as *doing the PR* and *linking with the ward.*

Much of the link person role was pragmatic and involved the sharing of information. This involved pre-clinical visits by the participants to inform staff, especially Charge Nurses, of student numbers, names and dates. While Charge Nurses were given this information early in the year the lecturers made appointments prior to each clinical block in order to remind the Charge Nurses so that students would be expected and staff prepared. Written information to the ward also included the lecturer's name, contact phone or locator number and the method of locating a lecturer urgently. A folder containing information on the preceptor model, various school documentation such as course descriptors and evaluation information was kept updated on each ward by the lecturer assigned to that ward. Some of the lecturers also provided written information around the level of student going to the ward and suggestions to extend learning, however this was not done consistently.

Being a *link* person also included being a resource person and adviser around programmes offered by the school, especially educational opportunities for registered nurses. The participants considered themselves as linking the theory and practice as they often fielded questions concerning the content of undergraduate programmes and responded to challenges about the latest nursing techniques and nursing knowledge. The lecturers were expected to be knowledgeable about matters pertaining to the curriculum, nursing knowledge, nursing research and nursing in general. While this may have been difficult at times the lecturers considered the *link* role was crucial to developing a good

working relationship between the school and the clinical area, as this impacted positively on the learning environment for the student. This was expressed by one participant:

> *The PR [sic] I think is really important. For it sets it [the learning environment] up for the students, and the next lot of students or the next programme that might be implemented from the school - and you do all of that while you are out there, and it's to be visible, that here is this and these are the kind of programmes that they offer - I do a lot of PR [sic]. 4(21)*

The *link* teacher role was very varied at times and tended to be contextually driven. The participants commented that they were often problem solvers or resource persons and had to be flexible and responsive to the needs and requests of the clinical areas. Each clinical area is unique and strongly influenced by personalities, skill mix and management structures. The participants had to consider and address these differences to promote a more positive environment for the students. Often this was time consuming and not always easy, and participants found they spent more time in areas they considered were less conducive to student learning. One of the participants comments:

> *One ward is more accepting of precepting and behind it ... whereas the other ward is really struggling with it and so you work quite differently. You need to give much more support to both preceptors and students in one ward and I spend more time there. 3(14)*

However the participants commented that as the preceptor model becomes more established and staff become more conversant with their roles the learning environment tends to improve, though participants remarked that some areas will always require increased input from lecturers.

Being a *link* person also involved the appointment of preceptors although the level of involvement varied. Lecturers recognised that the quality of the learning environment was strongly influenced by the preceptor. Although it is increasingly being seen as the professional responsibility of all registered staff to precept, the preparation and ability to precept nevertheless remains variable. Ability to precept is influenced by many factors including preparation and education for the role, availability due to annual leave, part time contracts and twelve hour rostering. It was notable that preceptor choice tended to depend on the availability of staff nurses rather than their ability to precept. The Charge Nurse usually appointed preceptors based on their availability and the lecturer then assigned students to preceptors, communicating this to both preceptors and students.

At times there was a lack of trust by the participants in the preceptor's ability to teach the students and the correctness of what was actually being taught. Many of the participants had little choice in preceptor selection however some participants had built a strong relationship with Charge nurses and could influence the process. One of the participants commented on her involvement in preceptor selection but her comments also demonstrate the limits:

> *I've been particularly lucky in both my areas, I have a good relationship with the Charge Nurses and I know that they know their staff. I also know that I can say things to them about their staff, as long as it is not horrendous, that they will listen. I try not to use the same preceptor again and again to get through that battle fatigue. 3(31)*

Consistency with the same clinical areas was a major factor influencing the lecturers' ability to carry out the link teacher role and this factor was stressed by all the participants. Like any relationship, communication and rapport with the clinical staff took time to develop and required consistency between the

lecturer and the clinical area. In the last year most lecturers have been consistently assigned to 2 or 3 clinical areas and the participants constantly referred to the benefits. The adoption of the preceptor model has enabled lecturers to be assigned consistently to the same areas and this has increased lecturers' effectiveness in the clinical area. One of the participants states the importance of consistency:

> *I think it's really important that we stay in our areas. Everyone has been saying that you need to do lots of work with the preceptors around documentation and feedback and helping them get confident and that's not going to happen if they have a different teacher every run, or every second run. 1(13)*

Consistency has enabled clinical staff and lecturers to get to know one another and learn about each other. This has markedly increased communication between the two groups and participants constantly reiterated the importance of maintaining the consistency. Lecturers found that the clinical staff were more friendly towards them the longer they were attached to the ward, and were more likely to approach them early about student issues. Communication between the two groups became more open and honest. One of the lecturers describes the process of building a relationship with clinical staff, helped by becoming known in the area:

> *you start off having to be visible in the ward and you become part of the furniture. And after a while they realise that you're OK, [sic] that they quite like you and sometimes you even help. Then you know that people know who you are, that you belong to the students and they can say things to you about the students - they can trust you. 3(27)*

Consistency also increased the lecturer teaching ability, referred to in Chapter Five, as they became more familiar with ward routine, specialist knowledge

and availability of resources. Teaching was enhanced through the participants having an increased working knowledge of the area.

Many of the participants remarked that clinical teaching is *hard, not easy* and *often lonely*. Consistency increased lecturers' comfort in an area and increased their job satisfaction.

Being Visible And Credible

In order to function effectively the lecturers adopted certain behaviours and attitudes when working in the clinical area to promote a positive learning environment for students. Lecturers have long been considered outsiders in the clinical area and consequently are treated as visitors rather than colleagues. They are required to gain entry to the clinical areas. This has historically not been easy due to their the lack of power and status in the clinical area. Participants were very aware of these attitudes, and had probably experienced the effects previously and sought to overcome them by being visible and credible.

Lecturers sought a level of credibility as a nurse and colleague and often this involved helping out if the ward was busy and being willing to undertake nursing tasks on the ward. The participants felt this showed a willingness to be involved in the clinical area and an understanding of the reality of being a nurse. This in turn encouraged the clinical staff to be amenable and positive toward students. One of the participants reflects on her strategies:

> *Sometimes I ensure that I'm there when lunches are being given out or when dinners are being given out so I know there is something useful I can do ... rather than go in and ask various people is there anything they'd like me to do for them and they sort of look at you sideways and think well, you know, you're not on my side. But if you can just go, just*

> *go and hand out meals or answer the phone rather than actually even talking with them. If they are busy, do really obvious things for them. 1(21)*

Of interest is this participant's use of the term *you're not on my side,* highlighting the outsider role of the lecturer. Not only did the participants try to gain credibility in an endeavour to improve the learning environment for students but, probably to also increase their own self confidence, respect, and job satisfaction.

The need to gain credibility reflects the lack of power and status the lecturers have in the clinical area and highlights a major difference between the functioning of lecturers in the clinical and classroom contexts. While the lack of power was not overtly discussed by participants it was evidenced in comments such as *you're not on my side* and the need to always fit in with clinical demands.

Participants repeatedly referred to the need to be visible in a clinical area. Terms such as *being visible, being seen* and *just being there* were significant in their repeated use. The activities involved in being visible were described rather loosely but related to having a presence in the ward, being seen in the clinical area and undertaking tasks or activities that were visible to clinical staff, such as those mentioned previously. One participant described her *hovering* role:

> *hovering, hovering ... like sometimes just sitting at the back, writing. But actually just being there, being on hand for anything that might happen, helping if it is needed ... I'm still doing a lot of PR [sic] and support and one of my main beliefs is that, as everyone here has said, which sounds bizarre - the more, the greater amount of time that you spend in the area the better the run your student gets. 1(20)*

Credibility also involved having a clinical knowledge base related to the specialist area to which they were assigned. This could either be based on their practice knowledge gained prior to entering teaching or to knowledge gained through continuous contact with a specialist area. Not only did this increase their effectiveness as a teacher when working with students, as discussed in Chapter Five, but it also helped them develop rapport with the clinical staff through being able to talk on the same level and discuss clinical issues. Credibility was also advanced if lecturers were assigned to constant clinical areas as described in the section on the *consistent link teacher* role.

An important point is the considerable time that lecturers spend on creating a positive learning environment. All the above activities could be broadly termed 'PR' or liaison. The lecturers used these terms often and repeatedly referred to the time spent on these activities. One participant succinctly noted the time and the value of this role:

> *Its really important that PR. In fact sometimes I'll think - what have I done today? Only PR. 4(21)*

Summary

This chapter has addressed the lecturers' role in *creating a positive learning environment* in the clinical area. Students spend long periods of time in the clinical area and the clinical learning environment has a considerable impact on the teaching and learning process. Historically collaboration between nursing education and practice has not been positive thus being a *consistent link person* between the education and practice arenas was considered important by the participants. This involved keeping the clinical staff well informed and involved around student and lecturer clinical assignments and the allocation of preceptors. Participants considered their consistency with the

same clinical areas helped establish communication and rapport with clinical staff. The lecturers also sought a degree of *credibility and visibility* in the clinical area as they felt this encouraged a positive attitude from the clinical staff which, in turn, helped create a positive learning environment for students.

In the next chapter a central theme, which was evident throughout the data, is discussed. This theme, which offers a way of understanding the lecturer's role in the clinical area, is called *being negotiable*.

Chapter Eight

BEING NEGOTIABLE

Four themes have been identified so far in this study which describe and clarify the role of the lecturer in the preceptor model of clinical teaching within one educational institute: *evaluating students; teaching students; working with preceptors;* and *creating a positive learning environment.* However, data analysis strongly suggests a central theme running consistently through the data. This theme is called *being negotiable,* and is offered here to give meaning and cohesion to the everyday experiences of lecturers, and to acknowledge their reality of teaching in the clinical area within the preceptor model.

This study did not achieve data saturation and did not fulfil the requirements for a grounded theory study. Nevertheless, *being negotiable* was pervasive throughout the themes. Thus *being negotiable* is not offered as a core category but rather as a *story line* described by Strauss and Corbin (1990) as - the conceptualisation of a descriptive story about the central phenomenon of the study.

Lecturers in the clinical area are required to straddle two worlds - the world of education and the world of practice. *Being negotiable* became the essence of the lecturers' role as they learned to function and work in the clinical area. Lecturers were constantly required to adapt and negotiate their practice in order to *create a positive learning environment* that was supportive to students within an environment that concentrated on the delivery of patient care. Functioning effectively within the clinical world was not always easy for the

participants and *being negotiable* expressed the everyday reality for the lecturer.

As educators, and employees of an educational institute, the lecturers have a primary responsibility and accountability to plan, supervise and evaluate student learning in the clinical area (Baker, 1992). Yet these responsibilities have to occur within a learning environment where the primary purpose is health care delivery and the role of the clinical staff, including the preceptors, orientates around the care of patients rather than the education of student nurses. This fundamental difference, coupled with the long standing education-practice gap, requires lecturers to function in an environment that is often unsupportive toward student learning and demonstrates ambivalence or negativity toward lecturers (Infante, 1986; Paterson, 1997). Paterson (1997) maintains that lecturers and students function as a temporary system within the permanent system of the clinical agency. Infante (1986) argues that in the clinical environment lecturers have minimal status or authority and are seldom viewed as *proper* members of the clinical setting, as their skills are often viewed as pointless and meaningless by clinical staff. These attitudes and values impacted on the participants functioning in the clinical area. In an effort to overcome or reduce their outsider status in the clinical area the lecturers adopted a stance of *being negotiable* in order to accommodate the demands of the clinical area, and also to seek a level of collaboration or rapport with clinical staff.

The participants often expressed feelings of not belonging in the clinical area and sought acceptance thorough *being credible and visible* in the clinical area. This involved being seen to assist around the ward, undertaking nursing tasks and demonstrating an ability to cope with, and be involved in, the reality of nursing practice. The theory-practice gap has been discussed endlessly in the literature and was very evident, as lecturers felt obliged to ingratiate themselves to these staff by undertaking menial nursing tasks to please the

clinical staff. This involved tasks such as giving out meals, bed making and other ward activities.

Building a relationship with the preceptors was also pivotal. Despite being nurses, the participants had to earn the right for collegiality and entry into the clinical area. This was achieved by *being negotiable*, adaptable and personable. *Being credible and visible* included meeting staff requests for information regarding post registration courses, assisting with nurses' assignments and even giving teaching sessions on wards - activities outside of lecturer job descriptions. Glass (1971 cited Paterson 1997) coined the phrase *guests in the house* over twenty years ago, and this continues to describe the lecturers' status in the clinical area. The participants considered that *being negotiable* was crucial to the quality of learning environment for the students and the more negotiable and amenable the lecturers were the better the learning environment.

Being negotiable was also very evident when preceptors were t*eaching students* and *evaluating students*. As a learning environment, the clinical area provided excellent learning opportunities for the students. However, for the lecturer, it differed markedly from the controlled, predictable and ordered classroom teaching environment. Participants could not predict which practice situations they would find the student involved in within the clinical area, so their teaching had to be negotiable in order to provide teaching and learning opportunities that were contextually driven and reality based. Their teaching was therefore, by necessity, spontaneous and unplanned. Teachable moments, as described by Benner (1985), are constant in the clinical area and to be effective the lecturer has to respond to these moments and use them as a trigger for reflection and student learning.

The presence of *real patients* also compounded the situation and lecturers had a professional responsibility to promote patient safety (Reilly & Oermann,

1992). Patient needs are complex and constantly changing and students in their quest for learning do not always appreciate their own lack of knowledge. Participants had to constantly negotiate their role from *teaching students* to *evaluating students,* depending on patient need and student knowledge level.

Even participant's time was negotiable and, despite making contracted times with students and preceptors, this was easily overridden by the needs of the patients and the clinical area. Teaching in the clinical area was far from orderly and the constant need to reschedule time was frustrating for the participants. This was particularly so when working with preceptors because of the clinical pressures. Time to talk to preceptors was rarely either prescheduled or lengthy but was rather snatched in corridors or service rooms. Three way assessment meetings were brief and subsequently preceptor involvement was often superficial. Participants repeatedly referred to the frustration around contacting preceptors, due to clinical pressures and rostering, and some participants visited a clinical area several times in an effort to communicate with the preceptor. This probably accounted for the communication between lecturers and the preceptors focusing on student assessment issues.

The findings of this study are supported by the view of Packford and Polifroni (1992) that lecturers are required to straddle the divide between education and practice, and when functioning in the clinical area have minimal status or credibility. They therefore tend to maintain the status quo, not *rock the boat* and act as diplomats and negotiators. The participants involved in the current study strongly upheld these findings and readily confirmed the central theme *being negotiable*. When the theme was presented the participants responded with comments such as: *that's exactly what I do, all the time; that explains it* and *we are always at the back of the queue.* One of the participants remarked "*That's it! That's my day! I now see why some of my days are so frustrating and muddled. I used to think it was because I was disorganised but its not. That's just so good.*" There was a sense that the theme *being negotiable* had

strong meaning for them and had managed to capture a very real part of their being a lecturer in the clinical area. Such sentiments reflect the findings of Smyth (1988), who contends that so much in the clinical area is down to individual negotiation by the lecturer, and there is the constant need for the lecturer to be flexible and adaptable, and to deal with issues *in the raw*.

The participants were required to *be negotiable* and respond to whatever the needs were of the student and the preceptor. In working with the student the participant would move back and forth from teacher to assessor role depending on the student's knowledge base, setting strategies for student learning and negotiating learning opportunities with staff. At times this would include supporting the student, relieving their anxieties, affirming their learning and performance, or demystifying the complexities of clinical practice. Similarly the participants had to respond to whatever the concerns were of the preceptor, coaching the preceptor around the preceptor role and advocating for student learning needs, while at the same time being cognisant of the preceptor's primary role of patient care. Preceptor availability and preceptor levels of ability were variable, and the participants had to accommodate and address this variability.

It should be noted that many of the participants had also taught in the traditional model of clinical teaching. These participants commented that they felt more comfortable and more accepted by clinical staff when working within the preceptor model than they had in the traditional model. It was very apparent that, as the preceptor model has become more established and lecturers had closer and more consistent interaction with clinical staff, the communication between the lecturer and clinical staff improved. To some degree this is due to the consistency between the preceptor and student, which then gave some consistency between lecturer and student. However the consistency in assigning the lecturers to the same clinical areas was a major factor that assisted lecturers entry into a clinical area. The clinical staff gradually became

used to the lecturers and participants attempted to gain credibility to assist the process. This is supported by Paterson (1997) and Charlesworth et al (1992) who maintain that consistent visibility and contact with an area assisted the lecturer to be seen as part of that area, allowed the lecturer to feel more comfortable and communication with clinical staff was improved.

Despite the participants verbalising that the preceptor model improved their acceptance in the clinical areas, there were clear examples of participants' lack of power and status in the clinical area. Many of the participants had little input into the selection of preceptors, despite their expressed belief that some nurses were not suited to precepting. The participants' lack of power was evident as, at times, they did not always trust the preceptor's practice yet were unable to confront or challenge the preceptor. Instead they either supervised students undertaking specific tasks or role modelled and retaught the student away from the preceptor. The participants were unable to address the ethical issue of poor nursing practice and maintained the status quo in the clinical area as described by Packford and Polifroni (1992).

The power issues within the preceptor model of clinical teaching are complex and reflect the differing worlds, and the inherent tension, of nursing education and practice. Smyth (1988) argues that the clinical area and the educational institute are both hierarchies and operate on the basis of membership which effectively marginalises those who do not belong. Despite being promoted as a collaborative model between the three major players - the student, preceptor and lecturer - the model is far from balanced, and reflects shades of marginalisation.

Being called the preceptor model in itself denotes the power of the preceptor. As members of the clinical area the preceptors have institutional power (Smyth, 1988). The preceptors influence the lecturers' effectiveness as they require and reward certain lecturer behaviours in the clinical area and sanction

the credibility of the lecturer in the clinical area. The lecturers have no structural authority or power to influence situations or manage resources in the clinical setting (Smyth, 1988). The preceptors' power is also very evident in their relationship with the student and they are inherently very influential. The student spends many hours with a preceptor and the relationship between student and preceptor is fundamental to the student's learning. The preceptor is a constant role model for the student and thus a powerful teacher. If the preceptor chooses not to build a positive, working relationship with the student there is little the student can do to address the situation.

The student - lecturer relationship is also unbalanced as the lecturer has power vested by the educational institution to pass or fail a student. Educational processes are implemented to promote fair and reliable clinical student evaluation. However clinical evaluation has historically been difficult and problematic mainly due to the complexity and variability of the clinical area (Reilly & Oermann, 1992).

It could be said that students have minimal power within the preceptor model, yet the model is designed to promote rather than impede student learning. A survey undertaken by Thompson (1997b), within the same school in which this study is sited, compared 122 students' views on learning within the traditional and the preceptor model of clinical teaching. There was overwhelming support for the preceptor model as students considered it provided a more positive learning environment. Over 75% of the students considered the evaluation process to be fairer to the students in the preceptor model as preceptors were involved in giving feedback to the lecturer. The students also commented on the power of the student-preceptor relationship and, while they highlighted the positive influence of the relationship on student learning and support, they also commented on the negative impact reluctant preceptors can have on student learning.

Just as the student will always be the learner and thus have a lesser status in education the lecturer will always be an outsider within the world of clinical practice. The lecturer role within the preceptor model will always require the lecturer to *be negotiable* as she/he advocates for the philosophy of nursing education within the world of nursing practice which, by necessity, must focus on the philosophy of patient care. The findings of this study suggest that the participants feel more comfortable and accepted by the clinical staff in the preceptor model of clinical teaching. Due to their previous experience in the traditional model of clinical teaching some of the participants were able to compare the two models and reported their increased level of acceptance in the clinical area within the preceptor model.

Summary

This chapter has discussed the central theme that emerged from the data called *being negotiable*. Working as a lecturer in the clinical area constantly requires the lecturers to adapt and accommodate their practice to meet the demands of the clinical area, the patients, the preceptors and the student. The orientating principle underlying this issue is the requirement of the lecturer to function within an area that has a primary focus on patient care rather than student education (Paterson, 1997). The need to *be negotiable* was evident through the four other themes and influenced the participants' effectiveness in the clinical area. The historic difficulties between nursing education and practice contribute to the problem and require the lecturer to acquiesce to clinical demands (Packford & Polifroni, 1992). The participants readily concurred with the theme *being negotiable* and felt it added meaning and understanding to their clinical role. Many of the participants felt that the preceptor model had increased their acceptance in the clinical area. However, the tension between education and practice was still apparent.

The lecturer's lack of power is evident in this theme but closer examination of the power relationships in the preceptor model identify the students as having the least power. A recent research study by Thompson (1997b) carried out in the same setting, however, found that students strongly supported the preceptor model and considered that it positively influenced the learning environment. The students overwhelmingly supported the continuation of the preceptor model of clinical teaching.

In the following chapter a discussion of the overall findings of the study is presented and integrated with literature.

Chapter Nine

DISCUSSION

The findings of this study have identified five themes in relation to the clinical role of the lecturer in the preceptor model of clinical teaching. Focus group interviews with lecturers revealed the following themes: *teaching students, evaluating students, working with preceptors* and *creating a positive learning environment.* These four themes along with a fifth attitudinal oriented theme *being negotiable* comprise the clinical role of the lecturer within the preceptor model in our school of nursing according to the lecturers involved (Table 1).

Table 1

Themes and Sub Themes in Lecturer Role in Preceptor Model of Clinical Teaching

Being negotiable			
Evaluating Students	**Teaching Students**	**Working With Preceptors**	**Creating a Positive Learning Environment**
Lecturer driven	*Contextually driven teaching*	*Building a relationship*	*Consistent link person*
Filtering preceptor feedback	*Teaching the thinking of nursing*	*Supporting preceptors*	*Being visible and credible*
Using a checklist			

The nursing literature abounds with conflict and confusion around the role of the lecturer in the clinical area. Recent studies report that lecturers are unsure of their role in clinical area (Bain, 1996; Forrest et al, 1996; Lee, 1996). However the findings of this study suggest that the participants shared considerable agreement around their role. While there was some variance in teaching behaviours and the participants were not always sure how to undertake facets of their role their main responsibilities of teaching and evaluating students, working with preceptors and creating a positive learning environment were clear to the participants. Several years ago McCallin (1993) undertook a study that included lecturers from the same school as the current study. McCallin's (1993) findings identified that lecturers had difficulty in precisely defining the boundaries of their role as a clinical teacher. The findings of this current study suggest that lecturers are now clearer about their role in the clinical area, which could relate to the introduction of the preceptor model of clinical teaching.

The participants clearly identified primarily as teachers rather than nurses. They consistently reiterated that their primary role was educationally focussed around student teaching and learning, whereas the primary role of the preceptor and clinical staff was patient care. This finding supports Infante (1986). Nehls et al. (1997) claim that lecturers should provide academic guidance and facilitate learning in the clinical area rather than be actively involved in patient care. It could be argued that the participants in this study were *actively* involved in patient care as they worked alongside students in the clinical area. However the purpose of the patient interaction was to provide a base or catalyst for teaching the students, rather than the provision of patient care.

The findings of this study demonstrated a much more active educative and evaluative role than other studies within settings that also utilised a preceptor model of clinical teaching. Lecturers in Crotty's (1993a, 1993b) studies and Clifford's (1993) study summarised their clinical role as liaison and linking

with the clinical area while Carlisle, Kirk and Luker (1997) referred to the lecturers role as facilitating learning. These studies were based within schools that were part of Project 2000 in Britain, upon which the preceptor model adopted by our school was based. The participants certainly undertook activities that reflected liaison and facilitation activities. However, they also actively employed educational strategies such as role modelling, questioning and reflection as they taught and evaluated students in the clinical area. This was evidenced in the themes *teaching students* and *evaluating students.* The participants spent considerable time with the students in the clinical area undertaking educational activities, and this appears to be a major difference between the findings of the current study and the findings of the studies previously mentioned.

The findings of the study suggest several reasons for the difference in focus with other studies. The amount of time lecturers spend in the clinical areas may be a reason. The UKCC recommends that lecturers working within Project 2000 spend 20% of their time in the clinical area. Personal experience identifies that participants in this study spend considerably more time in the clinical area, with some lecturers working up to 4 days per week, 80% of their working week, in the clinical area. This is particularly common when lecturers have between 12-15 second year students undertaking blocks of clinical experience in acute care areas. On average many lecturers would spend 50% of the semester time teaching in the clinical area.

Another reason for the difference may be the strong commitment the school has toward clinical teaching. Lee (1996) argues that the role of the clinical lecturer is contextually driven and the findings of this current study support this belief. Authors suggest that clinical teaching is subsumed under other educational activities in the current climate of nursing education (Wong & Wong, 1987; Myrick, 1991). Despite constraints of cost containment and an increased focus on research activities, the school has made a commitment to

support student learning in the clinical area as an essential and valued component of the undergraduate programme. This is reflected in the lecturer time allowance given to clinical teaching and the articulated commitment to a clinical role for the lecturer in the preceptor model adopted by the school. This supports Baillie's (1994) contention that lecturers are strongly influenced by the philosophy and ideology of the educational institute. The findings also support Clifford (1996) who found that one group of participants, from a college that espoused a positive orientation toward clinical teaching, disagreed with other participants that liaison was the major role in clinical. This group of participants were more likely to insist that students actively work with them.

There appeared to be a clear division between the teaching activities of the lecturers and the teaching activities of the preceptors in this study. The participants considered the preceptors should predominantly teach the students bedside clinical skills, ward routine and day to day practice. This supported students' views that preceptors were in the best position to teach practical clinical skills (Forrest et al., 1996; Nehls et al., 1997; Wills, 1997). On the other hand the participants believed that lecturers should encourage students to develop rationale for practice; relate theory to practice; and develop critical thinking and reflective skills. To some extent this reflects the differing, yet complementary, facets of nursing practice knowledge described by Benner (1985) between the *knowing that* - the objective skills and technical knowledge of practice - and the *knowing how* of practice - the subjective, practical knowing involving problem solving and critical analysis of practice. The participants considered they had the time and the educational knowledge to assist the student to reflect on practice, make meaning of practice and develop critical thinking skills. The educational strategies used by the participants in the current study were questioning and reflection. This finding is not surprising considering there is a strong move within nursing education to teach reflection and critical analysis skills in order to foster an attitude of critical inquiry and reasoning amongst nurses. Dobrzykowski (1994) believes teaching critical

analysis and reflective skills is a responsibility of nurse educators if nurses are to become expert critical thinkers to face and cope with the challenges that currently face all nursing specialties. The findings support recent studies by Ferguson (1996) and Nehls et al. (1996) which also identified a similar educative role for lecturers in the preceptor model. However the findings of the current study are of further benefit to nursing education as the educational strategies used in the teaching process are actually identified and described. Nursing practice is chaotic and abounds with unique, uncertain and ambiguous situations. Teaching the thinking of nursing is an area that requires considerable investigation.

All participants in this study situated their teaching within the clinical context and used the clinical situations and scenarios as a basis for their student teaching. To the knowledge of the researcher this aspect has not been referred to in the literature. The participants felt that this demonstrated to the students that teaching and learning was reality based and applicable within the real world of teaching. Lecturers are often accused of being too theoretical and divorced from the real world of nursing and this criticism had been levelled at education in relation to the preparation of new graduates in New Zealand (Nursing Consensus Conference, 1995). Students value realistic teaching by lecturers according to Forrest et al. (1996) and the participants in this study argue this will not occur if lecturers remain solely within the educational setting.

Evaluating students was identified as the most dominant lecturer role in the clinical area. The evaluation process is a dynamic, continuous process interwoven with the teaching and learning process (Reilly & Oermann, 1992). Nursing faculty are more likely to devolve the teaching of students in the clinical area to the clinical staff and retain responsibility for the student clinical evaluation role (Myrick & Barrett, 1994). The findings of this study support this view. The reasons for this were unclear, although the participants did

acknowledge the clinical skills of the preceptor which supports studies by Forrest et al. (1996) and Nehls et al. (1997) who found that students believed clinical staff were in the best position to teach clinical skills. Conversely, the participants considered they had an in depth knowledge of the curriculum and school evaluation procedures, opposed to that of the clinical staff, and felt responsibility toward the students, school and patients. The finding that student evaluation is *lecturer driven* is not surprising considering that the lecturer role articulated by the school identifies the student evaluation process as a lecturer responsibility (Appendix C).

There is a basic belief that the preceptors' primary role is patient care and clinical staff are awarded no additional time or monetary allowance to undertake student teaching. Many argue that student teaching is a professional responsibility of all registered nurses, however precepting a student does require an active involvement and commitment to teach and support a student over a constant period of time. There are rewards to precepting students for the preceptor and these include increased job satisfaction, increased knowledge base and personal satisfaction (Morton-Cooper & Palmer, 1993). However for the majority of clinical staff precepting students is a responsibility on top of a full patient work load and participants were aware of this, and did not wish to overburden the preceptors. Student clinical evaluation is also known to be complex, subjective and challenging. As educationalists, lecturers have an in depth knowledge of school evaluation expectations and processes. These factors may have contributed to the reason why lecturers have retained responsibility for student evaluation.

Requiring a preceptor to take on the powerful evaluator role could cause conflict in the preceptor-student relationship and threaten the effectiveness of the preceptor's teaching role. Myrick (1988) warns against the *warm body syndrome* which assumes that any nurse can precept a student and accommodate the teaching and the evaluator role effectively. The findings of

the current study support this warning as the participants recognised the aversion some preceptors felt toward failing their preceptees.

The evaluator role is based on power and the participants in this study recognised the imbalance of power in the student - lecturer relationship and the tension this caused students. The literature constantly encourages the development of trust between lecturers and students (Reilly & Oermann, 1992; Hsieh & Knowles, 1990) yet it could be argued that this is not feasible when one considers the lecturer has the power to pass judgement on a student. This aspect should be recognised and addressed within literature on the preceptor model, and may be a valid reason for the lecturer to retain the role of final student evaluation while the preceptor concentrates on the teaching role.

While the lecturer retains the responsibility for the final evaluation of the student the preceptor contributes to this process. The preceptor spends many hours with students and their observations of student performance can contribute to the overall picture the lecturer gains of the student (Ferguson & Calder, 1993). The lecturer also gains information as they work alongside the students and assess their practice and knowledge base. While the participants consistently sought preceptor feedback on student performance the participants then, just as consistently, filtered the feedback and selected and discarded the information at their own discretion.

There were various reasons offered for the filtering of preceptor feedback and, at times, the reasons were unclear but they basically demonstrated a mistrust of the information offered by the preceptors. Often this was due to the newness of the preceptor model and the preceptors' lack of knowledge around school evaluation procedures. Participants spent some time interacting with preceptors and supporting them in their role, however this was often secondary, or incidental, to communicating with preceptors about student learning and

evaluation. The participants also identified a need to ensure that school evaluation documentation was user friendly to the preceptors.

The lecturers developed personal unwritten checklists to evaluate students. While these checklists are related to the clinical evaluation tool it could be argued that there is a lack of reliability and validity in lecturer evaluation procedures. This findings suggests a need to be mindful of the possibility of a covert curriculum as described by Reilly and Oermann (1992) and the need to be overt, to all those involved in the evaluation process, concerning the criteria and standards used in the evaluation process.

Another theme identified in the study involved the participants *working with preceptors.* The participants acknowledged that preceptors were an integral component of the preceptor triumvirate model and therefore had to work with them collaboratively. The majority of preceptors are new to the role and the participants recognised they needed to *support the preceptors*. This supports the findings of many overseas studies including Clifford (1993a), Clifford (1993b), Crotty (1993, 1996) and Carlisle (1997). However these studies offered vague, nebulous descriptions of support and support was often used interchangeably with other terms such as liaison and resource person. The current study is useful in identifying areas that preceptors require support. The need for more preceptor support by lecturers was identified in a study by Thompson (1997a) sited within the same school as the current study. Sixty one preceptors were surveyed regarding their attitude toward the preceptor model of clinical teaching. The findings demonstrated overwhelming support for the preceptor model of clinical teaching as opposed to the traditional model. The findings also showed that only 63% of the preceptors considered they were given adequate preparation for their role as preceptors and only 59% believed that lecturers were available to support them in their new role. The survey did not describe the term *support* although the qualitative data suggested that staff who are newly qualified or new to the role of preceptor require more support

from lecturers. The findings of the current study concur with Thompson (1997a). The participants recognised the need to support the preceptors and suggested this included education around student learning expectations, curriculum processes, giving feedback and documentation. However, the participants were often unsure how to offer or provide the support. Most of the support was offered secondarily as participant communicated student learning needs to preceptors or sought feedback on student performance. The participants were unsure how to teach the preceptors their role. Again, this is an area that is not addressed in the literature.

Several methods have been identified to assist preceptor role development. Literature strongly confirms that preceptors need preparation and support to fulfil their role. Preceptor training should include principles of adult teaching and learning, clinical teaching strategies and methods of performance evaluation (Myrick, 1988). Literature also identifies that preceptor courses require commitment from education and practice agencies and are vulnerable due to cost (Morton-Cooper & Palmer, 1993). The participants of the current study highlighted the difficulty of accessing preceptors and this difficulty needs to be considered in the planning of preceptor training. The manner in which this is addressed, whether by preceptor courses or as part of the lecturer role, needs to be considered if the preceptor model is to work effectively.

The terms *liaison* and *support* are often used interchangeably in preceptor literature as mentioned previously, and are often related to the lecturers building a positive learning environment in the clinical area. Wills (1997) maintains that a major role of the lecturer in the preceptor model should be positively influencing the learning environment in the clinical area. This was supported in the current study as participants worked to *create a positive learning environment* for students.

The difference in the primary roles of the preceptor and lecturer was apparent as the lecturer had to build rapport and communication with the preceptor. Despite their both being nurses, the lecturers were not afforded collegial status and this pervaded many areas of the lecturers' activities and role in the clinical area, as discussed in the previous chapter. This has been well documented in the literature, however there is no literature specifically related to the preceptor model. The findings of the current study suggest that lecturers feel more comfortable working in the clinical area within the preceptor model, however their outsider status remains which requires them to *be negotiable* and adaptable to meet the demands of the clinical area.

The participants were clear that they had a responsibility to *build a relationship with preceptors* in order to support preceptors but this was also necessary in order to share or elicit student information. It was apparent that some of the participants sought to gain the trust of the preceptor but conversely were not always prepared to reciprocate this trust as they filtered and mistrusted preceptor feedback.

The participants considered *creating a positive learning environment* one of their role responsibilities. Learning needs a supportive environment and the attitudes and skills of the lecturer and the clinical staff influences the nature of the learning environment (Reilly & Oermann, 1992). Participants became a *consistent link person* who, as the name suggests, formed a link between the school and the practice areas. This involved being available and able to provided information concerning student experiences and course information. The participants also offered themselves as a resource person and offered information about post registration courses, assisted with assignments, and supplied research and nursing knowledge information to enhance the preceptors' own development. In an effort to break down some of the barriers between education and practice the participants sought to increase their credibility in the clinical area by ensuring they were visible and available to

clinical staff. The results of this study have helped articulate the activities and behaviours related to liaison activities referred to by many studies. This study has also highlighted the considerable time and energy lecturers spend on this role and highlights the need to recognise this as a valid and very necessary responsibility. Of particular note in this study was the firm belief that consistent attachment to the same clinical areas encouraged communication between lecturers and clinical staff.

Charlesworth et al. (1992) and Reilly and Oermann (1992) contend that lecturers need clinical competency to teach in the clinical area. The participants in this study referred to the need to have a basic level of clinical knowledge and understanding about a particular clinical area as this advanced their relationship with the clinical staff and also advanced their teaching with the students. This knowledge and skill level may have related to their previous role as a clinical nurse or developed over time with repeated assignment to the same clinical areas so they became a *consistent link teacher*. This could be related to Benner's (1985) theory of the development of nurses competence in clinical practice. Benner (1985) maintains that nurses move through five levels of competency, from novice to expert level and the skill progression is related to practical knowledge that is gained with time and experience in an area. Based on this premise it could be argued that if a lecturer is required to teach in a wide variety of new clinical areas with little continuity of clinical assignments, they do not develop understanding and knowledge of teaching and evaluating student nurses in that clinical area. They will therefore remain at the novice level. Benner (1985) suggests:

> *any nurse entering a clinical situation where he or she has no experience of the patient population may be limited to the novice level of performance if the goals and tools of patient care are unfamiliar. (p21)*

While this study did not explore the concept of clinical competence the findings suggest there may be a relationship between clinical knowledge and teaching effectiveness. This is supported by Clifford (1993) who found that lecturers who did not work in their area of expertise felt anxious about bridging the theory-practice gap, and about losing their clinical skills.

The issue of lecturers retaining and updating clinical skills remains the topic of considerable debate. It is often suggested that joint appointments between education and practice areas may overcome many issues, including the clinical competence of lecturers, communication and liaison with clinical staff, preceptor support and bridging the theory-practice gap. Lecturers involved in a study by Carlisle et al. (1997) felt that a lecturer-practitioner role would ideally combine clinical knowledge and competence along with educational ability to facilitate clinical learning. There have been few studies that research the efficacy of lecturer-practitioner roles and some studies suggest that nurses who work within these roles have role conflict and ambiguity and may suffer from stress (FitzGerald, 1994). There are currently four joint appointment roles within our school in the undergraduate programme. These roles are all different and individually designed to meet the needs of education and practice. The lecturer-practitioner role is a concept which needs to be researched and evaluated.

This study has identified three role responsibilities, *teaching students, evaluating students and creating a positive learning environment,* which are congruent with the role responsibilities of lecturers working in the classroom arena. *Working with preceptors* is an obvious difference between working in the clinical and classroom areas yet is not adequate, on its own, to account for the complexity and difficulties noted by participants in the current study. In order to cope and function in the clinical area the participants had to adopt a stance of *being negotiable*. Teaching in the clinical area is contextually bound and lecturers had to constantly adjust, adapt and invariably submit to the

demands of the clinical area. Reilly and Oermann (1992) maintain that every clinical area has its own cultural values, norms and expected behaviours. In order to gain some acceptance the participants sought some credibility and recognition from clinical staff by being *visible and credible* in the clinical area. This involved being seen in the ward, willing to take part and able to cope with the reality of the clinical area. Acceptance was always on a visitor status and lecturers maintained the status quo in the area by being helpful but not challenging or disrupting the status quo. Participants in the study at times recognised bad practice but did not overtly challenge clinical staff. They tended to reteach the students or tried to avoid particular staff nurses. According to Smyth (1988) lecturers have minimal power in the clinical area as they are marginalised by the dominant culture of the clinical area and are required to function as outsiders or guests in the area. There are many opinion papers on this topic but few research studies. Lecturers need to acknowledge this covert behaviour and devise strategies to overcome some of the issues. If the preceptor model is to be collaborative this is an area that should be addressed.

The following chapter is the concluding chapter of this research report. This chapter includes the limitations of the study and the implications and recommendations for the school where the study was sited. Also included in this chapter are the implications and the recommendations for nursing education and nursing research. The chapter closes with a concluding statement.

Chapter Ten

CONCLUSION

Limitations of the Study

While personal learning has been considerable throughout the research process there are several limitations within the study.

Due to time limitations of a Master's thesis data saturation was not reached. Despite the non-saturation of data the findings are useful in demonstrating the complexity of the preceptor-lecturer relationship.

In a study design such as that used in this study, there is always the possibility between a mismatch of rhetoric and reality (Clifford, 1993). The lecturers involved may articulate they perform a certain role in the clinical area but there may be discrepancies and differences in actual performance in the clinical area. This mismatch may be overcome by using multiple data collection methods such as observation in addition to interview.

A further limitation was that the study reflects the perception of the lecturers only. As the preceptor model assumes collaboration between the preceptor, student and lecturer there is a need to research the role of the lecturer from the perspective of the other parties involved. Data triangulation methods involving the application of diverse methods to generate and collect data (LoBiondo-Wood and Haber, 1990) would be useful to further explore the role of the lecturer.

The findings of this study cannot be generalised to other populations beyond the school where the study was situated. Although five themes have been identified that comprised the role of the lecturer, the findings are greatly influenced by contextual issues such as the philosophy of the school (Baillie, 1994) and the specifics of the preceptor model implemented (Lee, 1996). The reader must make their own decision regarding the applicability of the findings to other contexts.

Implications and Recommendations

The findings of this study has implications and recommendations for the school within which the study was set. The findings also have relevance for nursing education and nursing research within New Zealand and the international scene.

Implications and Recommendations for the School

The aim of this study was to explore the role of the lecturer in the preceptor model within the school in order to improve the efficacy of the model, clarify the preceptor role and identify issues for staff development and future research.

The findings of the study have identified there are five components to the lecturer role in the preceptor model of clinical teaching. Four of these roles directly relate to educational activities : *teaching students, evaluating students, working with preceptors* and *creating a positive learning environment*. The fifth component is *being negotiable* addresses the need for the lecturer to adopt a stance of adaptability and negotiation when working in the clinical area. The identification of these components are useful in identifying the need for change and topics for staff development.

The findings of the study suggest there are several changes the school should undertake to improve the efficacy of the preceptor model.

Firstly the findings identify that school documentation related to clinical teaching and learning needs to be rewritten so it can be easily interpreted and understood by preceptors and students. This specifically includes documentation relating to student learning outcomes and evaluation criteria.

The findings clearly identify the worth and value of lecturers remaining assigned to the same clinical areas. This must be recognised as a management strategy to promote the efficacy of the preceptor model.

There needs to be recognition and valuing of the lecturer role around creating a positive learning environment. This involves liaison and public relation activities such as being visible and accessible in the ward, being supportive of clinical staff and being available as a resource person and problem solver around educational matters.

The process of student evaluation should be addressed in staff development. The findings raise questions around lecturer reliability related to the use of personal checklists for student evaluation. Improved documentation as suggested previously would assist this process. There is also a need to address the preceptor role in evaluation and explore ways of promoting a more collaborative model of student evaluation. This includes exploring the issue of filtering preceptor feedback.

The use of clinical tutorials as a teaching strategy could also be addressed in a staff development programme.

The findings of the study have already instigated another study within the school that explores the questioning and verbal responding activities that

lecturers employ as they interact with students. The study is based on the tool developed by Mogan and Warbinek (1994). The findings of the current study will also be useful as a foundation to explore other areas of the lecturer's role e.g., areas of satisfaction and dissatisfaction for the lecturers, time allocation and relative importance of lecturer activities and responsibilities and the outsider status of lecturers in the clinical area.

Staff development programmes also need to address methods of assisting the clinical staff to learn their role as preceptors. This includes methods of teaching the students, documentation of student learning and providing constructive feedback. The findings of the current study demonstrated that lecturers were unsure how to support and teach the preceptors. This supported the findings of a study by Thompson (1997a) sited within the same school that demonstrated that preceptors required more preparation for their role and more support from lecturers.

Further research also needs to explore the role of the lecturer from the perspective of preceptors and students to gain consensus around the role of the lecturer.

The role of the lecturer must continue to be explored and refined. The cost of clinical education is rapidly increasing and there will be rationalisation of resources. Questions should be asked by management around the considerable time lecturers spend in the clinical area and the possibility of duplication of roles around teaching students. Further research is urgently needed to ensure the best use of lecturer's time within the preceptor model to promote the highest level of student education.

Recommendations for Nursing Education and Research

The use of preceptorship as a clinical teaching model is increasing in undergraduate education. The findings of this study have contributed to the body of knowledge around the role of the lecturer in the preceptor model of clinical teaching. Several implications for nursing education were raised in this study.

The finding that lecturers worked with preceptors and created a positive learning environment is well supported in the literature (Nehls et al, 1996; Wills, 1997). However these lecturer responsibilities have invariably been described as liaison or support. Nursing educators and researchers need to undertake research that specifically explores these areas in depth rather than research that addresses the issues broadly.

Lecturers in the current study identified that they needed a working knowledge of the clinical area in order to teach the student effectively and to gain credibility and acceptance with clinical staff. This finding offered a different perspective on faculty practice. Choudhry (1992) argues that faculty practice is an essential component of the academic role yet the reality of actually achieving this goal is problematic. Further research is necessary to explore this issue.

Questioning as a teaching strategy emerged in the findings of this study as lecturers sought to promote student critical thinking and clinical judgement skills. This finding supports recent research by Morgan (1991) and Mogan and Warbinek (1994). Further research is needed in the areas of questioning and facilitating reflective thinking to guide the development of the lecturer role as opposed to the preceptor role.

Preparing students to enter the profession of nursing requires high levels of learning in both the classroom and the clinical areas. Nehls et al. (1997) and

Wills (1997) maintain that it is the clinical learning experience that is of the most concern to students. There is an urgent need to examine the effectiveness of the preceptor model of clinical teaching, not just from the perspective of the lecturer but from many perspectives, to ensure the best possible teaching and learning for undergraduate nursing students.

Concluding Statement

This descriptive, exploratory research study has explored the clinical role of the lecturer within the preceptor model of clinical teaching from the perspective of the lecturer. Twelve lecturers took part in the study from one school of nursing. Focus groups were used to collect the data and this method proved beneficial in facilitating group members to share their views and experiences of the lecturer role. The focus groups generated a wealth of rich, in depth data which was particularly beneficial as there was minimal research into the lecturer role within the preceptor model. This method of data collection would be useful in exploring other issues within nursing practice and education about which little is known. The findings of this study have added to the existing body of knowledge around the preceptor model of clinical teaching. The study is particularly relevant as preceptorship becomes increasingly popular within New Zealand and also adds to knowledge within the wider international scene.

Five themes emerged in relation to the lecturer role. Four of the themes had a strong educational orientation: *teaching students, evaluating students, working with preceptors* and *creating a positive learning environment.* The first two themes have not been articulated clearly as lecturer responsibilities in previous research studies. The findings of this study were useful in recognising the strong influence of the philosophical orientation of the educational institute toward clinical teaching. The two latter themes mentioned - *working with preceptors* and *creating a positive learning environment* are more commonly

identified as lecturer responsibilities in the literature. However this study advances the body of knowledge in this area as the findings helped articulate the support that is required by the preceptors, and the activities related to lecturers functioning as a link teacher between the educational and clinical areas. A fifth central theme, called *being negotiable*, was more attitudinal and reflected the difficulties lecturers experienced as they functioned in the clinical practice areas. While this phenomenon has been recognised in the literature the findings of this study are important as they suggest that the tension between lecturers and practitioners may be less within the preceptor model of clinical teaching. New knowledge was also uncovered that advanced understanding around the concept of lecturer's clinical competence. The findings identified that lecturers teaching effectiveness and their relationship with clinical staff was enhanced if they had consistent links with the same clinical area. This enabled the lecturers to advance their clinical knowledge and skill in relation to this area.

The role of the lecturer in the clinical area within the preceptor model is complex and multifactorial. While this study has contributed to the existing body of knowledge in this area it also highlights the need for further research to continue to explore the use of the preceptor model of clinical teaching. Such studies are crucial in order to ensure the best possible preparation of new graduate nurses as they enter the profession of nursing.

'"Come to the edge", he said
They said, "We are afraid".
"Come to the edge", he said.
They came.
He pushed them ...
and they flew!'

Guillaume Apollinaire

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APPENDIX A

Update of Preceptor Role in Clinical Teaching

June 1997

As we gain more experience in the preceptor model of clinical teaching the roles become clearer. While the roles will continue to emerge the following information may be helpful as you undertake the role of a preceptor with students.

Your role is very varied but generally tends to fall into the following domains.

Teaching Role:
work alongside the student in the clinical area
role modelling practice
demonstrating skills
talking your practice out loud (to help the student make sense of what they are seeing)
supervision as student practices new skills
encouraging the student to practice skills - set up opportunities to practice
Research suggests that the preceptor works alongside the student, carrying out the day-to-day practice of nursing - teaching beside skills, client assessment, technical skills etc.

Giving Feedback and Documentation:
Give the student feedback about their practice. Highlight areas they have done well and discuss areas they could improve on. Document their practice in the red books. Weekly written documentation is very useful to guide student learning and increases communication with the lecturer and your feedback is highly valued. Documentation is not easy and you may find it useful to write in relation to areas of nursing practice e.g. time management, communication with nurses and other team members, problem solving in practice, levels of initiative in planning care, knowledge of pathophys conditions re safety issues especially around drug administration, aseptic technique communicating pt data to you.

Relationship with Student:
Get to know your student early in the clinical experience. Students have not all had the same clinical experience and their knowledge and skills will vary. Also their life experience will vary. Take time out to know your student and learn their capabilities and learning needs - this will also guide you as to their safety levels when working with clients. Also tell them about yourself - your past experiences and your way of working in the ward.

Rostering:
Work with the student as many shifts as possible. The student works am/pm shifts four days per week (Mon-Thurs in third year and Tues-Frid in second year).

Negotiate shifts with the student at the beginning of the clinical experience. When you are not rostered on wit the student it is your responsibility to ask another staff member to work with the student.
Once the student has become comfortable with skills commonly performed in your area and the routine of the ward it is important that the student is assigned a patient load (appropriate to level) to encourage comprehensive care, responsibility for practice and clinical judgement.

Assessment:
As you work alongside the student you observe and make judgements about their level of practice. Your input into the student's assessment is therefore very important. The lecturer will ask for regular feedback on the student's performance and will share with you her/his observations.
If you have any concerns about the student please notify the lecturer as soon as possible (see below) even if your concern is intuitive. It is the lecturers role to set up strategies to address issues in student learning and these will be negotiated with you and the student.

Contact with Lecturers:
Please contact the lecturers if you have any concerns at all. The majority of lecturers are available on locator from 0800-1630 for general or non-urgent enquiries concerning their students, although messages outside of these hours can be left on their locators for addressing the following day. Locator numbers are written in the student red books and kept in Charge Nurses office.
If you require a lecturer urgently at any time e.g. for accident or incident please ring the emergency on-call locator as follows:

1. **from an hospital extension dial 93 and the pager number - 1504; from an outside line dial 358 0825 and you will be prompted to key in the pager number - 1504**
2. **then follow the instructions as directed.**

Thank you for your willingness to percept the students. Research shows that preceptors gain satisfaction from seeing their student learn and we hope you also consider this to be a worthwhile model of clinical teaching.

APPENDIX B

Specific Instructions for Students in Preceptor Programme

July 1997

You are expected to meet the usual standards of professional behaviours in the clinical areas and abide by the policies and protocols of your particular clinical area. In addition please recognise the following:

- negotiate your shifts with your preceptor - you are required to work as many shifts as possible with the preceptor. Night duty is to be negotiated with the lecturer as well as preceptor

- contact your lecturer, on voice mail, each Friday to inform them of your shifts for the following week. Inform them if you change shifts. This is to prevent missing clinical appointments with lecturers due to shift changes

- the lecturers will contract time to meet with you at least weekly. You must meet these contracted times with lecturers and be prepared to discuss learning

- keep lecturer informed of any issues or problems in clinical so they can be addressed early

- keep preceptor informed of learning needs to further your learning

- document in 'red book's regularly, at least weekly. These are to be kept updated and available at all times to preceptors and lecturers on the wards

- notify wards and lecturers of absenteeism or lateness promptly

- know how to contact your lecturer. Lecturers do not work set clinical hours and cover students on all shifts. As a general rule lecturers are available on locator from 0730-1630hrs daily, unless otherwise arranged e.g. working pm shifts, part time staff. For non-urgent messages leave a message on your lecturer's locator outside of these hours and she/he will contact you the next day - this would include non-urgent issues such as making assessment appointments, planning learning opportunities, absenteeism

- for urgent lecturer contact there is an emergency locator number and your call will be responded to as soon as possible by a lecturer. This would include clinical accident or incident or whenever you or the clinical staff need to talk to, or see, a lecturer immediately. The pager number for the emergency locator is 1504. To call this number:

1. from a hospital extension dial 93 and the pager number - 1504

from an outside line dial 358 - 0825 and you will be prompted for the pager number - 1504

2. follow the instructions as prompted.

In the preceptor model of learning the preceptor engages in one-on-one teaching with a student in the clinical area. The preceptor teaches clinical skills and knowledge through role modelling and hands-on experience in the clinical area. The relationship between the preceptor and the student is likened to a master craftsman-apprentice relationship as the skilled practitioner enables the learner to develop skills, knowledge and attitudes. The lecturer is involved in promoting the transfer of theoretical concepts to practice and encouraging the development of practice knowledge through working with the student, reflection and discussion. The lecturer has an indepth knowledge of the curriculum and promotes the teaching of curriculum processes. The lecturer's role is also to support you and the preceptor in the clinical area. Assessment is a shared process and is ongoing throughout the clinical experience. As a student you are expected to be involved and active in your learning. Relationships are two way processes and the relationship you build with your preceptor will depend significantly on your input and enthusiasm and this will effect your learning. There is a real need to keep communication open and clear between you, the preceptor and lecturer - if issues are not communicated they cannot be addressed.

APPENDIX C

Role of Lecturer in Preceptor Model

July 1997

There has been some change to the role of the lecturer with the implementation of the preceptor model of clinical teaching. To be effective the roles need to be articulated as clearly as possible to guide those working in the model.

Lecturers experience suggests there are four main aspects to the lecturer role: student teaching, working with preceptors, liaison, assessment. This is supported by literature (Forrest et al 1996). However the lecturer role is diverse and there is a need to be flexible to meet contextual needs. The lecturer is a facilitator of student learning, supporting and building on the bedside clinical teaching role of the preceptor.

Student Teaching:

- transfer of theoretical concepts to practice
- uncovering of practice knowledge
- assist the development of nursing values and beliefs
- promoting the development of practice knowledge
- development of reflective and critical thinking skills
- understanding of wider context of nursing
- identification of student learning needs to promote learning

The above is facilitated through a variety of teaching methods e.g. working alongside students, reflection, questioning, role modelling, dialogue.
It is important to utilise, to the best advantage, the contextual learning to be found in clinical e.g., clients, documentation, staff members, technology, clinical procedures, the 'teachable moments' that arise spontaneously. If these are not accessed the lecturer may as well remain in school and run reflective sessions.

Documentation becomes increasingly important as more people are involved. Please note school guidelines regarding documentation.

Assessment of Students

This often runs concurrently with teaching. It involves:

- informing students re expectations
- working with preceptors to assess student
- using 'standards of clinical practice' as assessment framework
- keeping student informed of progress and any concerns
- planning learning strategies to assist student
- documenting progress in the 'red book'

Working with Preceptors:

Many staff nurses are new to the role of preceptors and want to perform the role well. It is difficult to access clinical staff for preceptor workshops so lecturers will need to support preceptors individually.

- support in learning preceptor role and clear guidelines re roles involved in model
- support with rostering
- encouragement to role model practice and talk practice aloud as teaching strategies
- clear information regarding expectations of students
- assistance with documentation
- involvement in student assessment

Preceptors often find documentation difficult. It may be useful to communication with them via the 'red book':

a) requesting specific feedback re student learning e.g. *time management, knowledge of pathophys, assessment of disturbed pt* etc

b) or give clear guidelines to focus student learning e.g. *knowledge of respiratory conditions not good, please could student care of asthmatic or CORD client. Please note that revision questions are to be completed first.*

Liaison

Lecturers repeatedly comment on the time spent on liaison as significantly more time consuming than in the former model. Liaison also seems to be very broad and depends on contextual needs. The reduction in areas that lecturers have to cover may make liaison more effective.

Primarily the liaison is around student learning:

1. prior to students clinical experience. This is a crucial time and has benefits later in the experience. It involves: contact with Charge Nurse, communicating student numbers, names and dates; identification of preceptors and rostering - often difficult and very time consuming, contacting preceptors and ensuring they are aware of student coming.
2. regular contact with preceptors/CN's re student learning and assessment
3. regular contact with preceptors/CN'S re rostering and student cover

Other liaison activities may include:

- responding to staff needs around education courses available, research, literature
- membership in nursing focus groups, practiced committees
- clinical skills update

teaching in clinical courses e.g. preceptor programmes, new graduate study days

Method to achieve lecturer role:

Make regular appointments to work with student - require that students communicate weekly roster to you by phone. Schedule one or two sessions per week with students of between 1-2 hours (suggest 2 x 1 hr sessions with 2nd years). Work with student and communicate with preceptor. Give clear verbal feedback and written documentation to student about their performance and identify learning strategies. Communicate in writing with preceptor if not available in student documentation.

APPENDIX D

ROLE OF THE LECTURER IN THE PRECEPTOR MODEL OF CLINICAL TEACHING

INFORMATION SHEET

Researcher : Lyn Dyson, Masterate student, Dept of Nursing and Midwifery, Massey University.

Dear Participant,

You are invited to take part in a study which seeks to describe the role of the lecturer in the clinical area within the preceptor model of clinical teaching. The study is in partial fulfilment of a Master of Arts degree at Massey University. The researcher is also a lecturer at a nursing educational institute where the study will take place. The study is supervised by Dr Gillian Eyres White from the Dept of Nursing and Midwifery at Massey University.

Although the study may not benefit you directly it is hoped the study will provide a base for future refinement and development of the lecturer role.

The study and its procedures have been approved by Massey University Ethics Committee and the Auckland Institute of Technology Ethics Committee. The study procedures involve no foreseeable risks or harm to you. Your participation involves two focus group interviews of approximately 40-60 minutes each. These interviews will be tape recorded. The second interview will only be undertaken if information generated in the first interview requires further discussion. The focus groups will be led by an independent person, a nurse, trained in interviewing. The interviewer and the transcriber will be required to sign confidentiality agreements.

Your participation in this study is voluntary; you are under no obligation to participate. A signed consent form will indicate your willingness to participate. You have the right to withdraw at any time - if you do so, you may request that part/all of your contribution be erased and you will be required to maintain confidentiality.

The data will be coded and will be unable to be linked to your name. Your identity will not be revealed in the final report. The study data will be collected by the researcher, kept in a secure place and destroyed after three years. The data will be shared only with the researcher's supervisor for the purpose of data analysis. A final report will be published and available to participants.

Please contact me if you have any questions.

Your sincerely

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July 1997

APPENDIX E

ROLE OF THE LECTURER IN THE PRECEPTOR MODEL OF CLINICAL TEACHING

CONSENT FORM

I have read the information sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I understand I have the right to withdraw from the study at any time and to decline to answer any particular questions.

I agree to provide information to the researcher on the understanding that my name will not be used without my permission. (this information will be used only for this research and publications arising from this research project).

I agree to the interview being audiotaped.

I also understand that I have the right to ask for the audiotape to be turned off at any time during the interview.

I agree to participate in this study under the conditions set out in the information sheet.

Signed: _____

Name: _____

Date: _____

APPENDIX F

CURRICULUM PROCESS : COMMUNICATION

YEAR ONE	YEAR TWO	YEAR THREE
Identifies own strengths and limitations as a communicator. *Begins to explore professional methods of communication with clients in various contexts.* *Articulates own feelings, thoughts and ideas clearly and logically.*	*Continues to develop therapeutic communication with clients.* *Communicates appropriately within the context of nursing practice.*	*Communicates effectively and professionally with individuals and groups.*

* *Communicates Effectively and Therapeutically with Clients* *

STANDARDS FOR NURSING PRACTICE

• Identifies strengths and limitations of own communication. • Recognises his/her role in relation to the quality and nature of the nurse/client relationship. • Differentiates between the content and process of communication.	• Using appropriate communication skills acknowledging different therapeutic client needs and changing environment, e.g. person with disabilities, altered level of consciousness, alternative cognitive functioning.	• Is able to recognise and respond appropriately to the lived experience of clients and families.
• Initiates interactions appropriately. • Uses attending skills when interacting with clients. • Begins to use facilitation skills. • Checks own perception with that of clients. • Uses touch appropriately. • Recognises the appropriate communication skills for the client's situation. • Recognises and responds to obvious client cues.	• Identifies strategies to develop personal therapeutic communication. • Develops a trusting relationship with most clients. • Developing fluency of communication skills within own personal style. • Uses a range of communication modes to ensure effective nurse/client communication. • Shows congruence between communication and action. • Uses communication in a proactive manner. • Recognises and responds to less obvious client cues. • Shows an ability to communicate therapeutically with clients.	• Actively develops therapeutic communication. • Works with the client to create a therapeutic environment. • Uses therapeutic communication skills in a professional manner without direct supervision. • Communicates in a manner that respects the partnership role with clients and families. • Communicates effectively and therapeutically with groups/families and children.
• Terminates interaction/relationship appropriately.		

CURRICULUM PROCESS : COMMUNICATION

YEAR ONE	YEAR TWO	YEAR THREE
Identifies own strengths and limitations as a communicator. *Begins to explore professional methods of communication with clients in various contexts.* *Articulates own feelings, thoughts and ideas clearly and logically.*	*Continues to develop therapeutic communication with clients.* *Communicates appropriately within the context of nursing practice.*	*Communicates effectively and professionally with individuals and groups.*

* *Interacts and Communicates Effectively in a Health Care Setting* *

STANDARDS FOR NURSING PRACTICE

• Keeps current, accurate and legible records. • Demonstrates a development in the use of clinical language.	• Documents and records the care planned for clients. • Maintains records of client's progress.	• Maintains essential written records and communication. • Written plans are consistent with client needs and care given. • Written documentation reflects comprehensive nature of interaction with clients.
• Responds appropriately to clinical staff and colleagues. • Participates effectively in clinical tutorials. • Meets contracted arrangements with client, clinical staff and lecturer.	• Contributes to team discussions on client's care when appropriate. • Communicates relevant information to health care team. • Interacts effectively with health care team.	• Communicates planned client's care to other members of the health care team. • Communicates effectively in an interdisciplinary team. • Uses correct clinical language when appropriate. • Shows an ability to use informatic technology appropriate to clinical setting. • Communicates with individuals and groups in a professional manner.
• Begins to negotiate own clinical experience. • Responds appropriately to guidance from lecturer.	• Negotiates own clinical experiences. • Articulates own learning needs to clinical staff and lecturers. • Discusses own practice appropriately with lecturer.	• Assumes responsibility for communicating learning needs to clinical staff. • Able to discuss own practice with clinical staff and peers.

BACHELOR OF HEALTH SCIENCE (NURSING)

CURRICULUM PROCESS : COMPETENCY		
YEAR ONE	**YEAR TWO**	**YEAR THREE**
Begins to assess clients effectively using nursing knowledge. ***Begins to implement appropriate nursing interventions safely.*** ***Beginning to understand the interdependence of knowledge and practice.*** ***Recognises own strengths and limitations.***	***Prioritises nursing care in a safe and effective way, demonstrating effective problem solving methods.*** ***Developing ways to integrate knowledge and practice.*** ***Assesses own and peers' performance against a given criteria.***	***Demonstrates a professional nursing practice base which recognises the interdependence of theoretical knowledge, practice wisdom and established practice standards.***
STANDARDS FOR NURSING PRACTICE		
• Participates in and recognises the need for ongoing assessment of clients. • Uses a problem solving format as a basis for nursing practice. • Recognises relevant sources of data collection, e.g. client appearance, notes, information from relatives. • Draws conclusions about client's health status from assessment data, e.g. nursing diagnoses.	• Client care is based on ongoing assessment. • Can use a nursing knowledge as a basis for practice. • Collects sufficient information to formulate client's needs/problems. • Incorporates all appropriate data in assessment, e.g. clinical tests. • Identifies individual client need from data.	• Undertakes specified detailed assessments when appropriate. • Can use nursing knowledge to guide your nursing practice and problem solving in a deliberate manner, that is dynamic rather than linear. • Rapidly assesses clinical safety needs. • Analyses, prioritises and acts on all data using multiple ways of knowing. • Proposes nursing diagnosis consistent with assessment and individual client.
• Identifies appropriate nursing care requirements with assistance from an experienced clinician/lecturer.	• Prioritises care accordingly to known information. • Plans appropriate nursing care requirements with client, when appropriate.	• In partnership with client, develops realistic outcomes of client care. • Plans client care within an appropriate time frame.

• Implements nursing care in collaboration with the client when possible or appropriate. • Nursing practice demonstrates the expected knowledge for level of programme, e.g. application of bioscience. • Performs technical skills safely recognising underlying principles of practice. • Nursing care effectively assists client to maintain comfort, dignity and well-being. • Recognises the elements of caring within nursing practice, e.g. knowledge base, skill development. • Performs nursing care within an appropriate time frame. • Aware of the link between own emotional well-being and caring.	• Determines and carries out a plan of care that is safe and competent, in partnership with the client when possible and appropriate. • Nursing care and decisions are based on sound rationale using knowledge and experience. • Performs technical skills competently recognising contextual influences. • Applies holistic concepts to client care. • Organises nursing care within an appropriate time frame. • Begins to adapt nursing practice according to situations/clients. • Is aware of own emotions and their effect on self and on client's care. • Responds rapidly and appropriately to factors that effect client safety. • Demonstrates caring while implementing nursing practice.	• Nursing care is developing adequately to be at the expected level of a newly registered nurse by the end of the third year. • Effectively manages situations which call for non-collaborative decision making. • Nursing care and decisions are based on sound clinical judgement. • Uses knowledge and skill to empower client. • Able to nurse safely within a dynamic and complex client environment. • Manages nursing care within an appropriate time frame. • Consistently demonstrates caring in nursing practice. • Responds effectively and safely in an emergency or time constrained situation.
• Utilises nurse lecturers to validate client care. • Evaluates effectiveness of care implemented.	• Utilises clinical staff/nurse lecturers to evaluate/validate client care. • Evaluates and reviews client status in response to care given. • Able to determine appropriate criteria to measure the effectiveness of client care.	• Checks the validity of own evaluations. • Utilises valid criteria to measure nursing actions and decisions, utilising other health care professionals and the client.

BACHELOR OF HEALTH SCIENCE (NURSING)

CURRICULUM PROCESS : THINKS CRITICALLY WITHIN NURSING PRACTICE

YEAR ONE	YEAR TWO	YEAR THREE
Uses information to support arguments on issues and statements, presents ideas in a logical and clear way. *Uncovers assumptions inherent in own ideas.*	*Analyses information gained from the use of criteria and appropriate frameworks.* *Analyses discrepancies between ideas from self, others and societal norms.*	*Uses critical thinking abilities to continually develop, refine, enhance and validate nursing practice.* *Demonstrates appropriate reflection on, and reasoned judgement about, nursing practice.*
STANDARDS FOR NURSING PRACTICE		
• Developing reflective skills, e.g. - can provide a comprehensive description of selected nursing activities - begins to tell insightful stories about experiences within own practice - begins to recognise the difference between own and client's reality in nursing situations	• Uses reflective skills to enhance nursing practice, e.g. - identifies values and beliefs that underly practice - identifies alterative nursing actions following reflection - explores own practice though dialoguing, journalling, drawing, etc. • Begins to show creativity within nursing care, e.g. - lateral thinking in planning and delivery of care - shows initiative in nursing practice	• Engages in praxis and reflective practice, e.g. - demonstrates insights into own performance - acknowledges different nursing approaches - analyses the culture of nursing - appreciates the complexity of practice - critically analyses the impact of own practice on client and families • Utilises reflection to enhance practice
• Uses a problem solving format as a foundation for nursing practice. • Begins to use nursing and other frameworks as the basis for nursing practice. • Uses Christensen's contextual determinants to understand client and nurse behaviour.	• Uses theoretical frameworks that are appropriate for different clients. • Uses nursing and other theories to enhance practice.	• Articulates nursing and other theoretical concepts/knowledge which guide nursing practice. • Recognises the contribution different nursing theories make to practice. • Practice reflects an understanding of multiple ways of knowing. • Critically analyses the impact of own practice on client and families.

• Recognises the strengths and weaknesses of own practice. • Can cite examples to support self-assessment.	• Can identify changes in own practice. • Critiques own practice using criteria. • Recognises sociopolitical factors that impact on the practice of nursing. • Shows an ability to think in an autonomous manner.	• Refines own practice in recognition of developing knowledge. • Critically evaluates the quality of nursing care within the social/political context. • Assumes responsibility for own clinical judgement and action.

BACHELOR OF HEALTH SCIENCE (NURSING)

CURRICULUM PROCESS : VALUING IN NURSING PRACTICE

YEAR ONE	YEAR TWO	YEAR THREE
Identify own values and beliefs, how they relate to own judgements and behaviour, and how these differ from others' judgements and behaviour.	***Identify, respect and develop ethical reasoning in relation to the differing values and beliefs of individuals and groups within the moral and ethical conflicts that arise from nursing practice.***	***Respect, be aware and be able to act on recognised and understood value systems of self, individuals and groups and the moral and ethical conflicts that arise from nursing practice.***
STANDARDS FOR NURSING PRACTICE		
• Recognises how own values and beliefs impact on client care. • Identifies the dominant values that underpin health care. • Recognises obvious moral/ethical dilemmas in nursing.	• Respects client's culture, values and beliefs without inflicting own values on client. • Nursing care responds to how client perceives his/her problem(s) and treatment. • Shows awareness of value dilemmas in the use of technology. • Recognises the impact institutional values have on client's care. • Recognises the differing values and beliefs involved in ethical issues. • Promotes client individuality.	• Uses an ethical framework to address ethical dilemmas. • Advocates appropriately for client when client's values/wishes conflict with the practice setting. • Maintains client/family as centre of practice. • Nursing practice reflects respect for differing values, when in conflict with own values and beliefs.
• Demonstrates respect for clients and family, and maintains client dignity. • Recognises the wishes and ability of client and family to participate in decision making and nursing care. • Plans care taking into account client's wishes where possible. • Facilitates client's and family's participation in nursing care. • Nursing action reflects an awarenss of client's rights.	• Shows awareness of the cultural, spiritual and moral influences that affects client's health. • Negotiates with client their involvement in own care. • Promotes client's awareness of rights.	• Practises nursing in a manner that is culturally safe for clients and their families. • Works with client to create an environment that is culturally safe. • Involves client in the decision making process and supports his/her decision. • Nursing practice promotes partnership with client and family. • Makes informed value judgements and ethical decisions when faced with dilemmas or conflicts. • Recognises ethical decisions may involve a multi-disciplinary approach. • Nursing practice demonstrates humanistic issues related to client's rights.

• Recognises specific cultural needs of clients.	• Nursing practice reflects sensitivity for cultural needs of client.	• Recognises ethical decisions for clients are based on their cultural values. • Advocates for client to facilitate cultural needs.
• Shows a willingness to care.	• Begins to recognise the reality of client's experience. • Demonstrates a caring attitude.	• Cares effectively for client without relying on a positive response. • Values the family's involvement in individual care. • Nursing care reflects the reality of client's experience. • Nurses clients holistically. • Maintains a caring focus in nursing, including complex and challenging situations. • Practice consistently reflects a genuine caring attitude.
• Demonstrates respect for colleagues and peers.	• Values the worth of input of other health professionals.	• Actively supports colleagues in practice.

BACHELOR OF HEALTH SCIENCE (NURSING)

CURRICULUM PROCESS : PROFESSIONALISM IN NURSING PRACTICE

YEAR ONE	YEAR TWO	YEAR THREE
Identifies influences in New Zealand society that affect health care and nursing practice. *Explores and accepts responsibility for own actions and learning.*	*Practises nursing reflecting a value of the worth of individuals.* *Interacts appropriately with other health professionals.* *Reflects on the concept of power in nursing practice and health care and begins to develop the role of client advocate.*	*Assumes professional accountability for practice in contemporary society.*
STANDARDS FOR NURSING PRACTICE		
• Practices in accordance with relevant legislation, e.g. - Privacy Act - Medicines Act	• Shows awareness of legislation that impacts on his/her practice, e.g. - Mental Health Act • Practices in accordance with relevant legislation and health agency policies, e.g. - Informed consent - IV policy	• Practices in accordance with relevant legislation, e.g. - Nurses Act
• Practises nursing within codes and standards of practice with guidance, e.g. - Begins to recognise the complexities related to maintaining client confidentiality	• Accepts responsibility for practising within professional codes, e.g. - Discusses issues of client confidentiality with others	• Practises nursing complying with professional codes of practice, e.g. - Uses professional judgement within issues of confidentiality
• Recognises issues which impact on health and health care, e.g. - Health costs, private vs public health care - Demonstrates an understanding of the role and practice of nursing within a specific setting	• Is aware of issues which impact on health and health care, e.g. - Shows awareness of factors which cause conflict in a nursing context - Recognises the scope of own nursing practice - Takes action to effect change when and as appropriate (client centred)	• Actively engages in issues in relation to own professional practice, e.g. - Shows an ability to deal appropriately with conflict in a nursing context - Able to fulfil responsibilities when there is a risk of incurring the disapproval of others - Is aware of how to effect change within a nursing context

• Shows a commitment to developing practice knowledge, e.g. - Shows a commitment to learning by seeking opportunities for learning and for practising skills - Shows an awareness of own learning needs and develops learning contracts in practice	• Shows a commitment to developing practice knowledge, e.g. - Shows a commitment to improving own knowledge, skills and nursing practice - Recognises how nursing research can enhance practice - Utilises data to substantiate a realistic self-evaluation of practice	• Shows a commitment to developing practice knowledge, e.g. - Able to articulate personal values and beliefs about nursing - Consistently monitors own performance against quality assurance criteria - Utilises research as a basis to his/her nursing practice - Alters practice in response to self-evaluation • Demonstrates accountability for own practice.
• Promotes the partnership philosophy in caring with clients and family with guidance, e.g. - Shows awareness of power within the nurse client relationship	• Promotes the partnership philosophy in caring with clients and family, e.g. - Develops the ability to empower the client - Encourages and supports client's ability to self-care when appropriate	• Promotes the partnership philosophy in care with the client and or family, e.g. - Promotes the value of client/family centred care within the health care system - Practises nursing in a way that empowers the client
• Maintains professional behaviour and attitudes in nursing, e.g. - Meets contracted time arrangements - Enthusiasm and commitment to practice - Takes responsibility for personal health as a nurse.	• Maintains professional behaviour and attitudes in nursing, e.g. - punctuality within practice	• Maintains professional behaviour and attitudes in nursing, e.g. - Meets all contractual arrangements