Clinical Nurse Educators' experiences working with Students with Mental Health Disabilities

by

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COMMITTEE APPROVAL

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Abstract

Little research has focused on clinical nurse educators' experiences working with students with mental health disabilities. Yet, clinical nurse educators play an important role in helping students with disabilities succeed in nursing school. This exploratory qualitative study used a phenomenological approach to explore seven nurse educator's experiences working in clinical practice with students who self-disclosed a mental health disability. A mental health disability was defined as any condition of the mind that makes it more difficult for the person to perform activities and interact with the world around them. Using conflict as a lens, intrapersonal, interpersonal, and intergroup conflicts were used to identify potential organizational development initiatives.

Purposeful sampling was used to select participants from one small Canadian college. Unstructured, open-ended interviews generated data that was analyzed using Braun and Clarke's model of thematic analysis. Eighteen themes were discovered in the data which were synthesized into seven cluster themes. The findings included: creating safe learning environments fostered positive educator-student connections; vulnerability was experienced by students, patients, and educators; nurse educators felt invisible to parts of the educational institution; measuring student learning in clinical practice was challenging and complex; the nurse could not be separated from the educator; competing educator responsibilities created conflict; and teaching support for nurse educators was found in many places. The findings informed thirteen recommendations for practice using Amy Kates and Jay Galbraith's STAR model as a framework. These recommendations related to strategy, structure, rewards, processes, and people practices focused on mitigating, transforming, and resolving conflicts that

are experienced by nurse educators when they work with students with mental health disabilities in clinical practice.

Keywords: Nurse educators; Nursing students; Disabilities; Conflict; Clinical; Mental health

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Chapter One: Introduction

Students with mental health disabilities are increasingly attending post-secondary education (Condra et al., 2015). Despite an increased awareness of disability and accommodation strategies in post-secondary institutions, students often fail to complete their education (Quick, Lehmann, & Deniston, 2003). Within post-secondary nursing education, past research focused on experiences of students with disabilities, teachers' knowledge about disability law, and accommodation strategies (Levey, 2014; Lombardi & Murray, 2011; Maheady, 1999). Themes that emerged from the literature included timing of disability disclosure (Ashcroft & Lutfiyya, 2013), nurse educator-student relationships (Maheady, 1999; White, 2007), conceptualization of disability (Evans, 2005; Marks, 2007), support availability (Sowers & Smith, 2002; Tee et al., 2010), and collaboration amongst support services (Griffiths, Worth, Scullard, & Gilbert, 2010). While some of this research captures the narratives of clinical nurse educators, there is a continued need to directly explore their experiences in greater depth because of their integral role in helping students with disabilities succeed.

Exploring clinical nurse educators' experiences of conflict when working with students with mental health disabilities can enlighten policy and practice recommendations to support students and educators in clinical practice. Conflict, in this context, transcends interpersonal conflict and also includes experiences of intra-personal, intra-group, and inter-group conflict. Cumulatively, clinical nurse educators' experiences of conflict are functional because their narratives can be used as "instrument[s] of social change and influence" (Rahim, 2015, p. 10) as they potentially identify leverage points for change. The costs of ignoring these conflicts include staff turnover, student attrition, increased conflict, and low job satisfaction for staff (Gormley, 2007; Helminen, Coco, Johnson, Tururen, & Tossavainen, 2016; Schriner, 2007).

Furthermore, the educational institution and its clinical educators are at risk for medical malpractice, for example, they can be held legally accountable for errors their students make (Cowherd v Fraser Valley Health Region, 2001). They are also at risk for lawsuits related to Canadian Human Rights Act violations, for example, unjustified discrimination against students with disabilities (Kelly v University of British Columbia, 2012). Thus, this inquiry explores clinical nurse educators' experiences of conflict in order to better understand their lived reality and make recommendations to support clinical practice education.

Mental Health Disability

The World Health Organization (2011) defines disability as "an umbrella term for impairments, activity limitations and participation restrictions, referring to the negative aspects of the interaction between an individual and that individual's contextual factors" (p. 4). Disability can be related to conditions present at birth, injury, or associated with disease; it can also be progressive, static, or intermittent (Centers for Disease Control and Prevention, 2017). Even though the World Health Organization does not differentiate between mental and physical disabilities, this research is focused upon clinical nurse educators' experiences working with students with mental health disabilities. This definition of mental health disability was adopted because this study takes place within the context of human rights law.

The Clinical Environment

The clinical practice environment is the inquiry's focal point because it is the most challenging teaching situation for nurse educators (Condra et al., 2015; Ikematse et al., 2014). Clinical practice is a mandatory educational component of nursing programs in which students learn to apply their knowledge in complex "real world" settings. The clinical environment presents a different set of challenges than classroom settings (Heelan, Halligan, & Quirke, 2012)

because its physical, emotional, mental, and environmental factors are "not amenable to modification to accommodate certain disabilities" (Parker, 2014, p. 47). These factors contribute to the dynamic, complex, and chaotic teaching experiences which often result in latent and manifest conflicts for educators.

Conflict from Clinical Nurse Educators' Perspective

Researching clinical nurse educators' experiences of conflict in the educator-student relationship can identify leverage points for organizational development (OD) which is defined as the "planned development, improvement, and reinforcement of the strategies, structures, and processes that lead to organizational effectiveness" (Cummings & Worley, 2013, p. 2 as cited in Senior & Swailes, 2016, p. 296). Thus, conflict can be viewed as a diagnostic tool to identify and prioritize OD initiatives. Using this lens, conflict is categorized by its source using Rahim's framework (2015) into intra-personal, inter-personal, intra-group, and inter-group conflict. This classification was chosen because it dovetails nicely with an OD approach to increasing organizational effectiveness.

Intra-personal conflict.

Intra-personal conflict occurs when an individual is "pushed or pulled in opposite directions" (Rahim, 2015, p. 67) and is manifested as role conflict or role overload. Role conflict originates from incongruent external pressures (inter-role conflict) or internal dissonance within the person (intra-role conflict) (Rahim, 2015).

Clinical nurse educators experience inter-role conflict between their dual professional responsibilities as Registered Nurses (RN) and educators. The RN role emphasizes the provision of safe, appropriate, and ethical care (British Columbia College of Nurse Professionals, 2018c; Canadian Nurses Association, 2017) whereas the clinical educator role prioritizes learner

centered education (Camosun College, 2016). If an unsafe student performs a skill, patient safety may be compromised. However, if the student is not allowed to perform a skill, student learning is compromised. Thus, an avoidance-avoidance conflict is generated whereby both activities possess negative consequences (Rahim, 2015).

Intra-role conflict results from a clinical educator's incompatible beliefs, attitudes, or values (Rahim, 2015). For instance, a belief that students with certain disabilities are not capable of becoming RNs is incompatible with a student-centred approach to teaching. In clinical practice, educators' intra-role conflicts can be manifested as assessor bias (Helminen et al., 2016) thereby setting the stage for unconsciously discriminating against students with disabilities.

Role overload exists when individuals are "required to perform more work than they can [accomplish] within a specific time period" (Rahim, 2015, p. 70) or they "believe they do not possess the skills or competence necessary to perform an assignment" (Rahim, 2015, p. 70). In Ashcroft and Luftiyya's (2013) study, clinical nurse educators allocated more time to monitor students with mental health disabilities resulting in role overload as they could not meet the needs of their other students. Additionally, nurse educators may believe they do not have the skill set to work effectively with students with mental health disabilities (Evans, 2005; Griffiths et al., 2010) which can generate intra-personal conflict as this belief is incongruent with their image as competent educators.

Inter-personal conflict.

In the clinical environment, inter-personal conflict can exist between educators and students during the evaluative process especially if students perceive grading as being subjective and unfair (Clark, 2008; del Prato, 2013). The tension within the educator-student relationship is

amplified by the clinical placement's defining characteristics of physical, mental, and emotional stress; and its environmental factors (Parker, 2014).

Intra-group conflict.

Intra-group conflict exists when group members have different opinions regarding its goals, functions, or activities (Rahim, 2015). Personal differences in how to accommodate students often originates in how disability is conceptualized, i.e. as a medical or a social model of disability. A medical model of disability views students with disabilities as inherently flawed and a risk to patient safety (Levey, 2014; Marks & McCulloh, 2016). It focuses on deficits and portrays students with disabilities as being "unable to function as well as a person without a disability" (Levey, 2014, p. 329). Because these students are blamed for their inability to meet a course's learning outcomes, accommodation is viewed as an unfair competitive advantage over other students who are not disabled (Debrew, Lewallen, & Chun, 2014; Levey, 2014; Walker, Dearnley, Hargreaves, & Walker, 2013).

A social model of disability focuses on environmental factors with "an explicit rejection of the notion that being disabled is negative and that disability is a deficiency and/or abnormality" (Marks & McCulloh, 2016, p. 10). Thus, a "student's success is highly dependent on the availability [and creativity] of accommodations, not the type or severity of disability" (Marks & McCulloh, 2016, p. 10). A holistic approach shifts the narrative from solely focusing on the student to examining environmental factors and utilizing the student's strengths.

Marks and McCulloh (2016) implore nurse educators to critically reflect upon how the medical or social model of disability informs their admission criteria, academic standards, and accommodation process in order to strengthen support for students with disabilities. This intra-

group conflict can be unconsciously misplaced or displaced into the educator-student relationship.

Inter-group conflict.

Clinical nurse educators affiliate with the nursing department which interacts with other departments and services in the educational institution. Conflicts can occur between departments and services due to differences in priorities (safety, learning, monetary) or the conceptualization of disability. Collaboration between different services and departments is necessary to support the success of students in clinical practice (Griffiths et al., 2010). Thus, inter-group conflict trickles down and influences the educator-student relationship.

Situating Conflict within Organizational Design

Educator-student relationships do not happen in a vacuum as they are embedded within systems. These systems consist of "external structures and discourses [that] shape perspectives and opportunities" (Gubrium, Hill, & Flicker, 2014, p. 1611) which provide leverage points for change. Using Galbraith's STAR Model, the systems can be differentiated into strategy, structure, process, people practices, and rewards (Kates & Galbraith, 2007). This organizational design framework was chosen because of its simplicity and versatility to visualize growth opportunities using conflict as the catalyst for change. For instance, Rahim (2015) noted that sources of intra-personal conflict typically originate from the organizational structure. Focusing on processes could identify opportunities to explore alternate dispute resolution methods or increased collaboration amongst support services. Ultimately, conflict in the system can identify areas to change the organizational design to help mitigate, resolve, or manage tensions within the system.

Legal Context

Educational institutions in British Columbia must accommodate students with disabilities unless they can prove undue hardship is endured (Canadian Charter, 1982; Canadian Human Rights Act, 1985; Human Rights Code, 1996). The BC Human Rights Code (1996) states that physical or mental disability must not be the grounds for discrimination unless there is a bona fide and reasonable justification. Thus, disability rights are protected under law and universities/colleges must provide reasonable accommodations to students with disabilities.

Once students have declared their disability, the educational institution must provide accommodation unless it can demonstrate undue hardship according to the Canadian Human Rights Act (1985). The concept of undue hardship was elaborated by the Supreme Court of Canada when it "articulated a non-exhaustive list of six factors that … [consists of] safety, cost, interference with a collective agreement, size of the employer's operations, employee morale, and the interchangeability of the workforce and facilities" (Jurczak, 2013, p. 1). In health care settings, hospitals and educational institutions have used safety as a central factor to justify why they have not accommodated a person's disability (Kelly v University of British Columbia, 2012).

The standard for safety cannot be absolute safety as a "certain level of risk may be acceptable" (Jurczak, 2013, p. 5). In the courts, there is a high standard for safety and a low risk tolerance for employees working with vulnerable populations (British Columbia [Superintendent of Motor Vehicles] v British Columbia [Council of Human Rights], 1997; Vancouver Coastal Health [St. Mary's Hospital, Totem Lodge] v. British Columbia Nurses' Union, 2011). However, Gordy v Painter's Lodge (2004) defines "a goal of reasonable safety [as] a contextual one that must [take] into account the nature of the employer's business" (para. 89). For nurses,

the question becomes "what would a reasonable and prudent nurse do under the circumstances" (Canadian Nurses Protective Society, 2004)? In other words, did the nurse provide competent and evidence informed care? In the context of post-secondary education, the question becomes much more complex because mistakes and errors are part of the learning process. Thus, educators accept a level of risk when working with students in clinical practice because they must provide opportunities for students to succeed or fail in their learning experiences. This risk is required because educators must use convincing evidence to establish a safety argument in court as "'anecdotal or impressionistic evidence' concerning the magnitude of risk will invariably be insufficient" (Lynk, 2008, p. 10) to establish this argument.

Clinical nurse educators are acutely aware of the dance between patient safety and student learning when working with students with mental health disabilities (Ashcroft & Luftiyya, 2013). This dance creates conflicts for clinical nurse educators as they navigate the complexities in the educator-student relationship. These conflicts can be represented as intra-personal, inter-personal, intra-group, and inter-group conflicts because educator-student relationships exist within an educational and health care context. The legal context places additional pressures on the relationship because the courts have placed the onus on educational institutions to provide "cogent evidence to establish a safety argument" (Lynk, 2008, p. 10). Schools must explore all options to provide accommodations for students (Kelly v University of British Columbia, 2012) otherwise students can claim discrimination based upon their disability. Exploring the clinical nurse educator's experience of conflict in the educator-student relationship potentially illuminates this dance between patient safety and student learning and may identify leverage points for change.

Assumptions

It is important that the researcher identify biases, assumptions, and preconceptions related to the phenomenon of interest. This process acknowledges the researcher's impact on the research process and data analysis. The assumptions and preconceptions below originate from the researcher's experience as a RN and as an experienced nurse educator who has taught students with mental health disabilities in clinical practice. I have felt joy, sorrow, frustration, despair and everything in between while bearing witness to their successes and failures. Assumptions that I bring to this research include:

1. All conflict has meaning.
2. Understanding, mitigating, and managing conflict may result in positive outcomes.
3. Teaching students with mental health disabilities in clinical practice can be an emotional experience.
4. Teaching in clinical practice can sometimes be a balancing act between student learning and patient safety resulting in ethical dilemmas.
5. Providing accommodations in the clinical area is challenging and often not feasible.

Research Questions

Nurse educators' experiences teaching in clinical practice are not well represented within the scholarly literature. Past research has focused on educators' experiences in the classroom or on student experiences in nursing education. Thus, the primary research question is:

1. What is the experience of nurse educators working in clinical practice with students who have self-disclosed a mental health disability?

Two further questions that deepen the study are:

2. For nurse educators, what is their experience of the intersection between patient safety and student learning when working with students with mental health disabilities in clinical practice?
3. For nurse educators, what is the experiences of "a duty to accommodate" when working with students with mental health disabilities in clinical practice?

Chapter Two: Literature Review

The primary research question was:

1. What is the experience of nurse educators working in clinical practice with students who have self-disclosed a mental health disability?

Two further questions deepened the study were:

2. For nurse educators, what is their experience of the intersection between patient safety and student learning when working with students with mental health disabilities in clinical practice?
3. For nurse educators, what is the experiences of "a duty to accommodate" when working with students with mental health disabilities in clinical practice?

MEDLINE (EBSCO and OVID), CINAHL Complete, and ERIC databases were searched for articles that included key search terms of nurs* student*; disab*; and educator, faculty or teacher. These databases were chosen because they effectively covered the academic journals related to nursing education. Articles were hand-searched for other references to ensure data saturation. This literature search reinforced the dearth of research related to this topic in nursing education. The search was extended to include educator experiences in other clinical practice programs such as medicine, physiotherapy, occupational therapy, social work, and dentistry. Few articles were located that addressed clinical educators' experiences working with students with mental health disabilities.

Based on the research question, the literature review is presented as five categories that provide insight into nurse educators' experiences working in clinical practice with students with mental health disabilities. The categories are: educators' experiences of disability and

accommodation; concerns for patient safety in clinical practice; clinical nurse educator teaching style; student disclosure of disability; and clinical practice evaluation.

Educators' Experiences of Disability and Accommodation

Nurse educators' experiences working with students with mental health disabilities is partly informed by their direct experiences with disability and accommodation (Ashcroft & Luftiyya, 2013; Christensen, 1998; Levey, 2014). A medical conception of disability focuses on disability as a deviance requiring remediation (Levey, 2014; Marks & McCulloh, 2016). Ryan and Struhs (2017) compared the attitudes of nurse educators, nursing students and disability officers towards the inclusion of persons with disabilities in the nursing profession. Even though the sample size was small, the data suggested that nurse educators were the least supportive for persons with disabilities becoming RNs (Ryan & Struhs, 2017). Ryan and Struhs (2017) reported that some nurse educators had "negative and sometimes openly hostile attitudes towards the inclusion of people with disabilities in nursing" (p. 84). In clinical practice, nurse educators have described students with disabilities as burdens who increased their workload (Persaud & Leedom, 2002; Sowers & Smith, 2004; Tee et al., 2010) and increased the risk to patient safety (Marks & McCulloh, 2016; McNish, 2003; Sowers & Smith, 2004). Lombardi believed that educators may resist working with students with disabilities because they do not have the skill set to teach these students effectively (Lombardi, Murray, & Dallas, 2013)

Not all nurse educators had negative attitudes towards students with disabilities (Ashcroft & Luftiyya, 2013; Ney, 2004). Ashcroft and Luftiyya (2013) interviewed 17 clinical nurse educators who believed students with disabilities had the potential to become competent nurses. Their willingness to work with these students was cautiously tempered in what the authors called

a wary challenge. This wary challenge denoted the educators' concerns related to balancing patient safety with student learning.

Aaberg (2012) measured 132 nurse educators' implicit bias towards individuals with visible disabilities. Eighty-six percent of these educators had a moderate to strong preference for able bodied individuals. Aaberg suggested the bias towards ableism is related to nursing's historical focus on performing physical tasks. Thus, disability was viewed as a limitation to performing nursing tasks safely. This stigma associated with visible disabilities may extend to mental health disabilities resulting in beliefs that students with mental health disabilities cannot deliver safe and competent care (Marks & McCulloh, 2016; McNish, 2003; Sowers & Smith, 2004).

In reference to clinical practice, some nurse educators have stated that accommodating students with disabilities is not feasible (Levey, 2014), accommodation lowers academic and clinical standards (Sowers & Smith 2004), and it provides an unfair advantage over other students (Levey, 2014). Marks and McCulloh (2016) raised concerns about the conflation of genuine accommodation requests and requests based upon personal circumstances. This conflation can lead to frustration if accommodations are perceived as being used strategically by unproductive and slothful students. Boston University's Provost Jon Westling voiced this frustration when he critiqued the "advocacy movement [for going] beyond the search for reasonable accommodations to declare every deficit a disability" (Selingo, 1997 as cited in Beilke & Yssel, 1999, para. 2). He believed the advocacy movement was responsible for diluting academic standards (Elswit, Geetter, & Goldberg, 1999).

Insufficient education related to disability law and principles of universal design may limit nurse educators from providing students with necessary accommodations. Levey's (2014)

integrative review exploring nursing educators' attitudes towards students with disabilities recommended a) increasing awareness training and sensitivity towards students with disabilities, b) increasing knowledge about disability law, and c) utilizing teaching strategies that use universal design principles. Lombardi et al. (2013) highlighted similar recommendations so that nurse educators see students with disabilities as being "teachable" rather than focusing on their perceived deficits. As more students with disabilities enter nursing programs, there will be greater need for nurse educators to understand disability law and how to support and accommodate these students (Meloy & Gambescia, 2014; Neal-Boylan & Miller, 2017; Quick et al., 2003). To achieve these ends, Lombardi and Murray (2011) emphasized the need for collaboration within the educational institution. Extending this idea of collaboration further, Griffiths et al. (2010) and Tee et al. (2010) stressed the need for collaboration between the educational institution and health authority/hospitals to support educators and their students with disabilities.

Concerns for Patient Safety in Clinical Practice

When describing their experiences working with students with disabilities in clinical practice, nurse educators have cited patient safety as a primary concern (Aaberg, 2012; Arndt, 2004; Symes, 2014). Arndt's (2004) opinion is based upon personal dialogues with clinical nurse educators but there is no reference to a systematic collection or analysis of this data. Aaberg's (2012) argument is built upon an inference that a traditionally situated curriculum discriminates against students with physical disabilities because it views them as defective and more likely to make errors. Symes' (2014) dissertation found that clinical nurse educators' greatest barrier to providing accommodation in clinical practice was a concern for patient safety.

This perception was not explored in greater depth due to the study's non-experimental survey design and the instrument used.

Although nurse educators believe there is a relationship between disability status and medical errors and patient safety, "no research study has systematically documented" this finding (Marks, 2007, p. 73). Marks (2007) used the Institute of Medicine's 1999 report, "To Err is Human", to argue that errors result from the health care system's design. This reasoning oversimplifies the complexity of supervising students in clinical practice. Ikematse et al. (2014) argued that clinical nurse educators may prevent nursing students from committing errors. Therefore, the perception of risk may be founded on the frequency of errors and near misses[1] which leads clinical nurse educators to believe students with disabilities may pose a greater risk to patient safety.

Marks (2007) would argue that "nursing students with disabilities [do not] pose an inherent risk to the public that is distinctly different from that posed by any other student" (p. 73). It is through accommodation and management of these students that risk is mitigated and patient safety is maintained. However, accommodation and management have limitations which suggests that at some point, students with disabilities may pose a risk to public safety. The question is whether or not this limit occurs before or after the line of undue hardship and how this matches the experiences of clinical nurse educators when they work with students with

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[1] A near miss is "a patient safety incident that did not reach the patient" (Canadian Nurses Association, 2017, p. 24). For students, near misses are often discovered by educators and not reported as they can be considered to be a part of the learning experience. Therefore, near misses tend to be under-reported.

mental health disabilities in clinical practice. Luhanga (2018) and Luhanga, Larocque, MacEwan, Gwekwerere, & Danyluk (2014) and Murphy and Brennan (1998) wondered how nurse educators could maintain patient safety while respecting the rights of students with disabilities to learn in clinical practice. Mossey, Montgomery, Raymond, and Killam (2012) believed that a clinical nurse educator's concern for patient safety should always trump a student's right to learning because RNs must address unsafe, non-compassionate, unethical, or incompetent practice (CNA, 2017).

Clinical Nurse Educator Teaching Style

A clinical nurse educator's teaching style and attitude towards disability can act as a barrier to student learning (Maheady, 1999; Marks, 2007; Ridley, 2011; Yssel, Pak, & Beilke, 2016). Nursing students in Gignac-Caille and Oermann's (2001) and Pagana's (1988) studies saw the clinical instructor as a source of threat to their learning and success. Mahat (1998) and del Prato (2013) found negative or unsupportive relationships made students feel incompetent and increased their stress which negatively impacted learning. Gillespie (2002) noted that clinical educators who grilled students with questions, criticized them, or watched them like a hawk also disconnected themselves from students and increased the students' stress.

A positive educator's attitude towards disability and accommodations can help students with disability succeed in school (Bradshaw, 2006). Cederbaum and Klusaritz (2009) and Gillespie (2002) noted the importance of the educator-student relationship in clinical practice. Factors that helped build a positive educator-student connection were trust, respect, compassion, commitment, mutuality, self-determination, and empowerment (Cederbaum & Klusaritz, 2009; Froneman, du Plessis, & Koen, 2016; Gillespie, 2002). Disrupting the educator-student connection can undermine the relationship and impede learning as evident in McGregor's (2005)

textual reanalysis of Shannon's story. "Shannon experienced disconnecting relations" (McGregor, 2005, p. 507) because the relationship was built upon the clinical teacher's power and the student's fear. Thus, Shannon's personal and professional growth was minimized ultimately resulting in a course failure. McGregor's study highlighted the importance of connected clinical nurse educator-student relationships to create learning spaces permitting students to be vulnerable in the learning process.

Researchers have advocated for increased educational preparation and support to help nurse educators learn how to teach students with mental health disabilities (Brown & Sorrell, 2017; Grassley & Lambe, 2015; Levey, 2014; Lombardi & Murray, 2011; Marks, 2007). A prevalent theme in the literature found an expectation that RNs should know how to teach nursing to students (Dobbs, 2017; Grassley & Lambe, 2015; Weidman, 2013; Williams & Taylor, 2008). Nurse educators consistently emphasized that teaching was different than practicing hospital nursing and they received little preparation to prepare for a teaching role (Brown & Sorrell, 2017; Grassley & Lambe, 2015; Poindexter, 2013). To describe their socialization into nursing education, they used phrases such as sink or swim, being thrown into the deep end of the pool, and feeling like they were drowning (Anderson, 2009; Schoening, 2013). Furthermore, a lack of knowledge and experience working with students with disabilities negatively impacted their confidence to competently perform their roles and responsibilities as nurse educators (Persaud & Leedom, 2002).

Student Disclosure of Disability

In the literature, research related to disclosing a disability focused upon students' experiences. From a clinical nurse educator's perspective, disclosure provides more information that allows the educator to individualize support for each student. When students did not

disclose their disability in Ashcroft and Luftiyya's (2013) study, the clinical nurse educators became frustrated because they felt ill-equipped to support student learning.

Students do not disclose their disabilities to teachers because of their fear and anxiety of being judged and discriminated against (Morris & Turnbull, 2006; Ridley, 2011; Sanderson-Mann & McCandless, 2006). Ultimately, students desired to be treated like other students and not defined by their disability (Barnard-brak, Lechtenberger, & Lan, 2010; Neal-Boylan & Miller, 2017; Nielson, 2011). Morris and Turnbull (2006) also found that students did not disclose their disability in clinical practice because they believed it was not advantageous to their learning.

Clinical Practice Evaluation

The World Health Organization (2016) developed a list of eight core competencies for nurse educators to "improve nursing education … and the quality of nursing services" (p. 6). One of these competencies centered upon assessing and evaluating students (World Health Organization, 2016) which is challenging for clinical nurse educators to perform in the clinical environment. Physical assessments can be objectively measured and evaluated (Isaacson & Stacy, 2009) whereas affective and cognitive domains are more challenging to measure and evaluate in a clinical setting (Dolan, 2003; Fitzgerald, Gibson, & Gunn, 2010; Isaacson & Stacy, 2009; Jervis & Tilki, 2011). Another challenge encountered in clinical evaluation is that "academic student learning outcomes … do not describe actual clinical behaviours" (Prichard & Ward-Smith, 2017, p. 81) making it difficult for nurse educators to quantify a student's performance in clinical practice.

Many of the clinical practice learning outcomes involve higher order thinking skills such as application, analysis, evaluation, and synthesis (Dobbs, 2017). Measuring and evaluating

higher order thinking skills becomes a subjective art because they are reliant upon the evaluator's interpretation of the learning experience. Elliott (2016) claimed that an educator's "subjectivity is one of the greatest complexities of assessment" (p. 252) because their bias, assumptions, and preconceived notions affect their ability to remain objective (Docherty & Dieckmann, 2010; Hughes, Mitchell, & Johnston, 2016; Isaacson & Stacy, 2009; Luhanga et al., 2014; Prichard & Ward-Smith, 2017). For instance, some clinical educators adjusted individual students' learning outcomes based upon environmental cues such as the hospital unit's acuity (Isaacson & Stacy, 2009; Luhanga et al., 2014). As a result, nurse educators may lack confidence in their student assessments and evaluations because of the subjectivity inherent in their clinical evaluation (Hughes et al., 2016). Correspondingly, clinical nurse educators may avoid situations where their credibility and judgement are called into question (Dobbs, 2017), for example, they may not fail a student for fear of having their grades overturned by the educational institution (Brown, Douglas, Garrity, & Shepherd, 2012; Dobbs, 2017; Docherty & Dieckmann, 2010; Hughes et al., 2016; Prichard & Ward-Smith, 2017).

Summary

This literature review presented information on clinical nurse educators' experiences working in clinical practice with students with mental health disabilities. Nurse educators' experiences with disability and accommodation and their pedagogy influenced student-educator relationships which in turn influenced whether or not students would disclose their disabilities. Clinical nurse educators were concerned about patient safety when they worked with students with disabilities. This concern resulted in a tension between creating a space for student learning and protecting the patient from harm. Finally, clinical evaluation is challenging because of its subjective nature in clinical practice. Overall, working with students with mental health

disabilities in clinical practice is a complex, challenging, and potentially rewarding experience for nurse educators.

Chapter Three: Research Methodology

The purpose of this phenomenological inquiry was to explore the experiences of nurse educators working in clinical practice with students with mental health disabilities. By placing the spotlight on clinical nurse educators' experiences of conflict, leverage points were identified that could be used as catalysts for change. The primary research question was:

1. What is the experience of nurse educators working in clinical practice with students who have self-disclosed a mental health disability?

Two further questions that deepened the study were:

2. For nurse educators, what is their experience of the intersection between patient safety and student learning when working with students with mental health disabilities in clinical practice?
3. For nurse educators, what is the experiences of "a duty to accommodate" when working with students with mental health disabilities in clinical practice?

Recommendations from this inquiry may contribute to the educational institution's organizational development to support students and educators in clinical practice.

Methodological Framework

A qualitative research approach was used to explore the meaning clinical nurse educators ascribed to their experiences because of the assumption that social phenomena are complex, interwoven, and irreducible (Marshall & Rossman, 2016; Yilmaz, 2013). This approach is identified by its ontological, epistemological, and methodological underpinnings. Qualitative inquiries have a relativist ontology as they accept the notion that multiple realities exist for a single phenomenon experienced by different people (Yilmaz, 2013). Thus, the methodological

approach needed to be based on the "recognition of the subjective, experiential life-world of human beings" (Sloan & Bowe, 2014, p. 1293) and be able to describe their experiences in depth. The idea that knowing and "understandings are created through interaction between the knower and the unknown or subject" is congruent with a subjectivist epistemology (Yilmaz, 2013, p. 315). Finally, the methodological assumptions were emergent and inductive as the purpose of the study sought to describe the clinical nurse educators' experiences (Yilmaz, 2013). For these reasons, the inquiry's methodology used a phenomenological approach because it explored the lived experience of nurse educators working in clinical practice with students with mental health disabilities.

Phenomenology explores, describes, and analyzes individual lived experience in order to illuminate meaning of a phenomenon (Amos, 2016; Englander, 2012; Marshall & Rossman, 2016, p. 17). Exploring the lived experience of clinical nurse educators is key to understanding the meaning they ascribe to working with students with mental health disabilities. Martin Heidegger developed interpretative phenomenology because he advocated for "the utilization of hermeneutics as a research method [and founded interpretative phenomenology] on the ontological view that lived experience is an interpretive process" (Dowling, 2007, p. 133). Heidegger emphasized that people are self-interpretative beings (Sloan & Bowe, 2014; Wojnar & Swanson, 2007) and they could only be understood within the cultural, social and historical context in which they live (Wojnar & Swanson, 2007).

The goal of interpretative phenomenology is to gain insight as to how a person makes sense of a given phenomenon. It also does not assume that researchers can consciously strip away previous knowledge because they "actively co-create interpretations of phenomenon" (Wojnar & Swanson, 2007, p. 175) with their research participants. Therefore, Heidegger argued

that phenomena cannot be studied objectively (Sloan & Bowe, 2014). Researchers must expose and discuss their biases rather than attempt to eliminate them (Fade, 2003) in the research process. By being aware of their biases, researchers can recognize their influence in how they understand and interpret phenomena (Tuohy, Cooney, Dowling, Murphy, & Sixmith, 2013). Because they are actively involved in the research process (Amos, 2016), they co-create meaning with participants through dialogue in a process that uses their pre-existing values and ways of seeing the world to interpret and understand their experiences (Ho, Chiang, & Leung, 2017; Tuohy et al., 2013). The study's phenomenological approach also provides space for definitions to emerge from this act of co-creation.

Research Design

Brief overview.

A phenomenological approach was used to explore three research questions: what is the experience of nurse educators working in clinical practice with students who have self-disclosed a mental health disability?; for nurse educators, what is their experience of the intersection between patient safety and student learning when working with students with mental health disabilities in clinical practice?; and for nurse educators, what is the experiences of "a duty to accommodate" when working with students with mental health disabilities in clinical practice? Transcription of interview dialogues provided data for thematic analysis resulting in a greater understanding of clinical nurse educators' lived experiences.

Data sources and data.

Participants were nurse educators who worked in clinical practice with students who had self-disclosed a mental health disability. The clinical nurse educators were employed by a

small Canadian post-secondary educational institution that was publicly funded. They were all currently teaching in a nursing program that prepares students to graduate as RNs.

Clinical practice was defined as experiential learning that occurred in a naturalistic environment, i.e. a clinical environment. Students and clinical educators were typically assigned educator-to-student ratios between 1:6 and 1:8. A clinical environment was defined as an acute care hospital setting which included specialty areas such as maternity, paediatrics, cardiology, neurology, medical-surgical areas, rehabilitation, and mental health/psychiatry. It did not include critical care areas such as intensive care, emergency or the post-anaesthetic recovery unit.

For the purpose of this inquiry, students with mental health disabilities were defined as those students who had self-disclosed their mental health disability to the educator. A mental health disability results in the "partial or complete disturbance in the person's thinking, feeling, and behaviour which may also result in recurrent or persistent inability or reduced ability to carry out activities of daily living, self-care, education, employment and participation in social life" (Chaudhury, Deka, & Chetia, 2006, p. 95). In this study, examples of mental health disabilities included, but were not limited to, disordered thinking, difficulty remembering facts, problems with concentration, trouble with multi-tasking, impulsiveness, ineffectual coping with stress, and feeling emotionally numb.

Sample.

A purposive sampling strategy was used to seek out the seven participants who volunteered for the study. Miles and Huberman (1994) recommended the consideration of six different attributes when creating an inquiry's sampling strategy (as cited in Curtis, Gesler, Smith, & Washburn, 2000). The sampling strategy should:

1. be relevant to the methodology and the research question,
2. generate rich data on the phenomenon being studied,
3. enhance the finding's generalizability,
4. produce believable descriptions and explanations,
5. be ethical, and
6. be feasible. (Miles & Huberman, 1994 as cited in Curtis et al., 2000)

The sampling strategy utilized in this study was relevant to the methodology and research question, generated rich data, and was feasible and ethical. The aim of the research was to explore the lived experience of a specific group of clinical nurse educators and did not intend to generalize the results to a larger population. Thus, a phenomenological approach to the research questions met five of the six recommendations.

The study's sampling strategy sought out experientially rich descriptions because phenomenology explores lived experience to generate understanding and meaning (van Manen, 2014). To identify the correct sample, it asked: does this person "have the experience that I am looking for" (Englander, 2012, p. 19). Purposive sampling recognizes that some people have richer experiences than others and can provide more rich data to understand the phenomenon (Given, 2008a; Marshall, 1996; Streubert Speziale & Carpenter, 2003). Therefore, the sampling strategy focused on clinical nurse educators who had worked with students who self-disclosed a mental health disability. The sample originated from a single educational institution because of the desire to maintain consistency of the educational institution's organizational context. This consistency allowed organizational development recommendations to be formulated.

All clinical nurse educators at the educational institution were invited to participate in the study through an e-mail, attached hereto as Appendix A, delivered via an e-mail list server

from the Chair of the Nursing Department. The invitation described the inclusion criteria to the study. The inclusion criteria were 1) experience as a nurse educator, 2) taught students who self-disclosed a mental health disability in clinical practice, and 3) taught in clinical practice which was defined as an acute care hospital setting including specialty areas such as maternity, paediatrics, cardiology, neurology, medical-surgical areas, rehabilitation, and mental health/psychiatry. This broad approach allowed the phenomenon to be explored without introducing bias in the sampling strategy such as a belief that only experienced clinical nurse educators had something of value to offer the study. Potential participants responded by e-mail to the invitation and I e-mailed those persons who met the inclusionary criteria to arrange a time and location for an interview.

Marshall (1996) and van Manen (2014) suggested that the sample size should allow enough data to be collected to adequately answer the research questions. Other scholars determined sample size by the concept of data saturation (Braun & Clarke, 2006; Fade & Swift, 2011) which is the point at which additional data does not add anything substantial to the overall analysis. Corbin and Strauss (2008) explained this concept from a cost-benefit perspective whereby data saturation is the point where the cost of collecting and analyzing any additional data outweighs the benefits. Van Manen (2014) did not agree with the concept of saturation because phenomenology "looks not for sameness or repetitive patterns" (p. 353) but may seek out a unique theme that is only seen once in the experiential data. He suggested the sample size should "gather enough experientially rich accounts that make possible the figuration of powerful experiential examples or anecdotes that help to make contact with life as it is lived" (van Manen, 2014, p. 353). The initial plan was to interview between six to ten participants. After the

seventh participant was interviewed, no further participants were sought out because no new themes were identified and enough data had been collected to answer the research questions.

Research site.

Participants were employed at a single post-secondary educational institution. Interviews took place at either the educational institution or at a local café. The location was mutually agreed upon and considerations for site selection included confidentiality, anonymity, privacy, distractions, and ambient noise level. Participants were provided a choice over the interview location to ensure that they felt safe and comfortable during the interview process. All interviews except one took place in private offices at the educational institution.

Ethical considerations.

To ensure this research was conducted in a manner that maintained the respect for human dignity, ethical approval was sought out before commencing research. Formal ethics approval was obtained from Royal Roads University's Research Ethics Board and Camosun College's Research Ethics Board. Recruitment and data collection did not commence until after both organizations provided formal ethics approvals to engage in this inquiry.

Participants were asked to execute an acknowledgement of their informed consent as a preliminary step to the interview. The informed consent document, attached hereto as Appendix B, outlined: the purpose; participant involvement; foreseeable harms and benefits; conflicts of interest; privacy, confidentiality, and anonymity within the study; and how the research results would be reported. Time was provided to participants to read the informed consent document and ask questions related to the research process. Participants signed the document to acknowledge their informed consent and I gave them a copy of the signed document for their

records. They were notified that they could withdraw from the study at any time without repercussions.

In order to maintain the confidentiality and anonymity of participants, students, and patients, I was the only person who could link personal identifiers with the research data. Pseudonyms were provided to participants and any contextual identifying clues in the data were removed. Additionally, participants were provided input as to the interview location if they desired further anonymity in the study. Participants were also instructed that all documentation would be kept strictly confidential unless a pattern of incompetent or impaired practice that posed a significant risk to public safety was discovered which would be reported to the appropriate authority. They were also asked to respect student and patient confidentiality and not answer questions in a manner that students or patients could be identified.

Data security measures ensured the list containing the participants' identities was locked/encrypted and that only I had access to this information. I locked/encrypted all data related to the analysis process. The data, which includes transcripts of the data, will be kept for five years at which point the data will be destroyed or erased. This is in compliance with the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans guidelines regarding the retention of research data (Interagency Secretariat on Research Ethics, 2005).

It was anticipated that participants may experience emotional duress during or after the interview. If significant duress was experienced, the interview would have been suspended or terminated and the participant would have been referred to an appropriate support service. No participants displayed significant duress during or after the interviews and the support services were not required.

Data collection.

I interviewed participants to collect data for this inquiry. Creswell (2014) described interviewing as the primary means for collecting phenomenological data. Interviews were chosen because of their ability to uncover the meaning of the phenomenon and answer the research questions (Kvale, 2007). Exploratory interviews with an open structure were used to allow for spontaneity within the interview process (Kvale, 2007). I field tested the interview protocol to ensure it addressed the research questions. The interview protocol with its key questions is attached hereto as Appendix C.

I audio recorded and transcribed the interviews in order to begin the process of data immersion. This is congruent with van Manen's (1990) perspective that language is the key to understanding meaning of an experience. "Lived experience is soaked through with language" (van Manen, 1990, p. 38) allowing for recollection and reflection. I also took notes during the interviews in recognition of the importance of non-verbal communication (Smith & Osborn, 2003). These notes included descriptive and reflective notes of what I saw, heard, experienced, felt, and thought during and after the interviews which complimented the data analysis (Groenewald, 2004). The process of note taking and the use of a back-up recorder protected against mechanical or technical failure of the primary recording device which did not occur during the study.

Data analysis.

The process for data analysis will be discussed in two parts: transcription and thematic analysis.

Transcription.

Transcription is a key phase of data analysis and it is considered an interpretative act (Bird, 2005 as cited in Braun & Clarke, 2006) because rendering oral language into written language requires two abstractions: the lived experience to the audio recording and then a further transformation into written form (Kvale, 2007). Even though transcribed documents are "impoverished decontextualized renderings of interview conversations" (Kvale, 2007, p. 94), they can be used to illuminate the meaning of what was said. In this sense, they are tools that help interpret meaning contained within the clinical nurse educators' experiences of working with students with mental health disabilities.

The approach to transcription is dependent upon the purpose of analysis and the study's methodology (Braun & Clarke, 2006). The approach should be guided by the research question and the theoretical underpinnings of the research methodology (Fade & Swift, 2011). Two approaches to transcription are naturalism and denaturalism. Naturalism is when every utterance is transcribed whereas denaturalism removes these idiosyncratic elements of speech such as pauses, stutters, and involuntary vocalizations (Oliver, Serovich, & Mason, 2005). In phenomenological data analysis, Colaizzi emphasized the need to understand the essence of what was being communicated and did not believe a verbatim transcript was necessary (Edward & Welch, 2011). In other words, he believed it was the interview's substance that was most important. Thus, I transcribed participants' interviews verbatim with the exception of incorrect grammar and involuntary vocalizations because I was more focused on the interview's content rather than how the content was communicated.

Thematic analysis.

Thematic analysis is "a method for identifying, analyzing, and reporting patterns (themes) within data" (Braun & Clarke, 2006, p.6). It is an interpretative act involving the researcher's active involvement because themes do not passively emerge or become discovered in data (Smith & Osborn, 2003). They need to be actively extracted from the data through a "process of generation, reduction, and reconfiguration" (Connolly, 2003, p. 104) that is dependent upon the researcher.

An exploratory approach to thematic analysis was used to ensure data analysis was a process of discovery (Guest, MacQueen, & Namey, 2012). The analysis was data driven using codes emerging from the data rather than using pre-existing codes. Because "data are not coded in an epistemological vacuum" (Braun & Clarke, 2006, p. 84), bracketing was used to help guard against bias. This practice recognized and acknowledged my impact on the research process and data analysis (Fade & Swift, 2011; van Manen, 2014). Bracketing helped identify assumptions, preconceptions, and biases about the phenomenon of interest.

The approach to thematic analysis used Braun and Clarke's (2006) guidelines of analysis presented in their paper, using thematic analysis in psychology. In the last phase, I added a member check so that this process became quite similar to Colaizzi's framework which is applicable for Heideggarian phenomenological research (Dowling, 2007). The added step was important because Heideggar's phenomenology is interpretative and this step added credibility to the findings (Tuckett, 2005).

Braun and Clarke's (2006) guidelines consisted of six phases. They were: data immersion, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report. My data collection, transcription, data immersion,

coding, and theming phases were not a linear process. They evolved simultaneously throughout the research process beginning with the initial interview and culminating with the production of the final report.

The first phase consisted of data immersion and familiarization as I transcribed audio recordings of the interviews. Listening to the audio recordings several times in addition to multiple readings of the transcripts helped with data immersion (Braun & Clarke, 2006; Guest et al., 2012; Smith & Osborn, 2003). It was an active process whereby I read and listened for meanings and patterns. These observations were recorded and became part of the audit trail (Fade & Swift, 2011).

The second phase systematically generated initial codes for the data. To identify a code, significant statements were identified from the data. These statements, which could be represented as words, sentences, or paragraphs, were then interpreted as codes ensuring that the original description was still evident in the interpreted code. A list of significant statements was maintained as well as a code book describing the name and definition of each code. Significant statements were identified as a "feature of the data … that appears interesting to the analyst, and refers to 'the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon'" (Boyatzis, 1998, p. 63 as cited in Braun & Clarke, 2006, p. 88).

After coding the third transcript, I re-coded the first two transcriptions to compare the results to their initial coding. This code-recode procedure demonstrated that there was a slight code drift as several significant statements were not included in the initial coding and several new codes emerged. This procedure was incorporated as part of the coding process to ensure dependability of the data.

Searching for themes was the third phase in Braun and Clarke's (2006) guideline. As I analyzed the codes, I began the process of sorting them into themes. It was at this point in time that relationships between codes and themes and different levels of themes began to be recognized. Numerous thematic maps were drawn to identify potential relationships within the data.

The fourth phase refined the themes that were developed in the third phase. This phase focused on determining a theme's meaningfulness. Using Patton's (1990) dual criteria, I examined a theme's internal homogeneity and external heterogeneity (as cited in Braun & Clarke, 2006). Codes within a theme must "cohere together meaningfully" (Braun & Clarke, 2006, p. 91) in addition to the theme being distinct from other themes. A thematic map of the analysis was generated in this phase.

The fifth phase involved identifying the theme's essence and providing it with a clear name and definition. For each theme, I wrote a "story" about its essence and how it connected to the broader research questions. For this inquiry, the prevalence of themes or codes did not represent its "keyness" in the analysis. Another way of stating this is that the importance of a theme was not informed by its quantifiable nature (Braun & Clarke, 2006; van Manen, 2014). Similarly, prevalence did not indicate which themes to discard (Fade & Swift, 2011). Once a theme was re-situated back into the data, the theme's "keyness" presented itself within the experiential data (van Manen, 2014).

The final phase began by integrating the themes together to create an exhaustive description of the phenomenon. This exhaustive description was shared with the research participants as a member check to gauge the credibility of the analysis and findings. No changes were made to the exhaustive description after this step. Finally, I wrote an account representing

the meaning people ascribed to their experiences to conclude the thematic analysis process. I used vivid extracts to represent the themes and ensure the data supported the themes (Braun & Clarke, 2006).

In order to aid the thematic analysis process, MAXQDA, a qualitative data analysis software program, was utilized to store the transcribed interviews, track significant statements, and maintain an accurate codebook. The software was not used to quantify data which would have been incongruent with this inquiry's qualitative approach. Hence, MAXQDA was used as a tool to aid in the initial organization of data. Using MAXQDA helped me immerse myself within the transcripts whereby I saw the transcripts as a whole and not reduced to just words or phrases. Despite its benefits, I quickly resorted to printing the significant statements on paper so that I could move them around on a desk when I was theming data. This approach allowed a more holistic view of all the data at a single point in time.

Rigour and trustworthiness.

"Rigour lies in devising a systematic method whose assumptions are congruent with the way one conceptualizes the subject matter" (Reicher & Taylor, 2005, p. 549 as cited in Braun & Clarke, 2006, p. 27). Lincoln and Guba's (1985) criteria of credibility, confirmability, dependability, and transferability were used to examine the study's rigour and trustworthiness.

Lincoln and Guba (1985) argued that credibility was the most important criteria for establishing trustworthiness. Credibility is defined as the 'fit' between participants' views and descriptions and the researcher's presentation of them (Tobin & Begley, 2004; Yilmaz, 2013). Congruent with a relativist ontology, the 'fit' needs to be a credible one and "not the only credible one" (Pringle, Drummond, McLafferty, & Hendry, 2011, p. 23). To achieve credibility, strategies included the generation of thick descriptions, investigator triangulation, triangulation

of different theories, member checks, audit trails, accurate transcription, seeking out negative cases, and using a journal to aid in bracketing by being critical reflexive throughout the research process (Braun & Clarke, 2006; Fade, 2003; Tobin & Begley, 2004; Tracy, 2010; Yilmaz, 2013). I identified and acknowledged my biases, assumptions and preconceptions related to the phenomena of interest and the research process throughout the study's duration. The goal was to be critically reflexive and understand and acknowledge my own subjectivity within the data collection and analysis. Prior to the commencement of the study, I reflected on my assumptions, beliefs and preconceptions about working with students with mental health disabilities in clinical practice, which are listed in chapter one of this study.

Confirmability demonstrates that the findings are "not figments of the inquirer's imagination but are clearly derived from the data" (Tobin & Begley, 2004, p. 392). To fulfill this criterion, an audit trail was created to demonstrate that my decisions were logical.

Dependability was achieved through an audit trail (Tobin & Begley, 2004). This ensured that the "process of research [was] logical, traceable, and clearly documented" (Tobin & Begley, 2004, p. 392). I used a code-recode procedure to increase the study's dependability by re-coding transcripts to ensure the results were similar and that there was no code drift (Yilmaz, 2013).

Transferability relates to the generalizability of the findings (Tobin & Begley, 2004). However, the aim of phenomenology is to understand how people construct meaning of their experiences (Dowling, 2007). With this understanding, phenomenological results cannot be generalized because they are unique to a specific sample and context. A thick description was created so that readers could "make their own determinations about transferability" (Given, 2008b, p. 886).

Summary

In this chapter, I described my intentionality in designing and implementing a research study using a phenomenological approach designed to explore how nurse educators experience working in clinical practice with students with mental health disabilities. The purposive sampling strategy was designed in a manner that did not create researcher bias within the sample. Data was collected using unstructured open-ended interviews which were then analyzed using a model described in Braun and Clarke's (2006) paper, Using thematic analysis in psychology. Significant statements were identified and then coded and themed to produce an exhaustive description of the nurse educators' lived experience working in clinical practice with students with mental health disabilities. A member check was added in the final phase to increase the credibility of the research findings. The chapter concluded with a discussion of the study's rigor and trustworthiness.

Chapter Four: Findings

The purpose of this study was to explore the experiences of nurse educators working in clinical practice with students with mental health disabilities. These experiences can be fraught with conflict as educators navigate intrapersonal dilemmas, interpersonal conflicts with students, and inter-group conflicts with other departments within the educational institution. Competing professional duties, maintaining patient safety, creating effective student learning environments, and human rights regulations co-exist to create a complex clinical practice environment. A phenomenological approach was used to explore three research questions focused on understanding the meaning of clinical nurse educators' lived experience. Its philosophical underpinnings assumed a constructivist paradigm where knowledge is socially constructed as it was experienced. Reality existed as subjective interpretations that were unique and true for each individual experiencing it. Using an emergent research methodology, three questions were explored. The primary research question was:

1. What is the experience of nurse educators working in clinical practice with students who have self-disclosed a mental health disability?

Two further questions that deepened the study were:

2. For nurse educators, what is their experience of the intersection between patient safety and student learning when working with students with mental health disabilities in clinical practice?
3. For nurse educators, what is the experiences of "a duty to accommodate" when working with students with mental health disabilities in clinical practice?

Braun and Clarke's (2006) model of thematic analysis was used as the foundation for data analysis. I began the research process by bracketing my assumptions, preconceptions, and

biases related to the research questions. After interviewing the participants, I transcribed the interviews and identified and coded significant statements within the data. Codes were analyzed and grouped into cluster themes which were in turn analyzed and synthesized into emergent themes that accurately reflected the data set. These emergent themes became the basis for the exhaustive description that was then validated by the participants.

Participants

Seven participants were interviewed for this study. To maintain participant confidentiality and anonymity, specific descriptions of participants could not be forthcoming as details related to their tenure, background, clinical practice area, ethnicity, age, and educational background would identify the participants. They were assigned gender neutral pseudonyms to protect their confidentiality and anonymity within the study. Herein, the participants are referred to as Alex, Devon, Kelly, Morgan, Quinn, Shay, and Taylor and the feminine pronoun is used when referring to their experiences.

The participants worked as registered nurses in hospital and community settings before teaching at the educational institution. Most of the participants had taken graduate level education and all of the participants had more than two years of teaching nursing students in clinical practice. They were all passionate about teaching and facilitating student success in the clinical environment. In their experiences with students who disclosed mental health disabilities, ineffectual coping with stress was the most common disability but they also discussed experiences that included students who had difficulty remembering facts, problems with concentration, and impulsiveness.

Cluster and Emergent Themes

Every interview was transcribed so that significant statements were identified. During the analysis of the significant statements, 18 cluster themes emerged from the data. These cluster themes represented the lived experience of nurse educators working in clinical practice with students who have self-disclosed a mental health disability. The cluster themes were further analyzed and synthesized into seven emergent themes that are defined and supported with transcript excerpts. The seven emergent themes were:

1. Safe learning environments foster positive educator-student connections,
2. Vulnerability is experienced in every part of the system,
3. Nurse educators are invisible to parts of the educational institution,
4. Measuring student learning in clinical practice is challenging and complex,
5. One cannot separate the nurse from the educator,
6. Competing responsibilities create conflict in clinical practice, and
7. Teaching support for nurse educators is found in many places.

Table 1 lists the emergent and cluster themes related to the experiences of nurse educators working in clinical practice with students with mental health disabilities.

Table 1

Themes representing the experiences of nurse educators working in clinical practice with students with mental health disabilities

Emergent themes	Cluster themes
Safe learning environments foster	• Diversity in learner abilities, including mental health abilities, is supported • Valuing a strengths-based approach supports learning

positive educator-student connections	• Trust is at the center of the educator-student relationship • Providing feedback mindfully contributes to a safe learning space for students with mental health disabilities
Vulnerability is experienced in every part of the system	• Students are vulnerable once they disclose a mental health disability • Patients are vulnerable because they are the focus of nursing care • Nurse educators are vulnerable in their roles as teachers and evaluators
Nurse educators are invisible to parts of the educational institution	• The Centre for Accessible Learning (CAL) is omnipotent • A difference in priorities results in misunderstandings and conflict
Measuring student learning in clinical practice is challenging and complex	• A nurse educator's subjective lens is used in clinical evaluation • Evaluating emotionally safe care begins with a measurable learning outcome
One cannot separate the nurse from the educator	• Assessing a student's mental capacity supports learning and safety goals • Ethical and legal duty to act as patient advocates
Competing responsibilities create conflict in clinical practice	• There is not enough time to meet all students' learning needs • Balancing the needs of students and patients • A challenge of maintaining professional objectivity in the face of empathic support

Teaching support for nurse educators is found in many places	• Unit staff are an extension of nurse educators • Collaborative learning within the educational institution

Safe learning environments foster positive educator-student connections.

Participants described a pedagogical approach to working with students with mental health disabilities that valued safe learning environments for students. These safe environments fostered positive educator-student connections allowing participants to support student learning. Safe learning environments are a fundamental need to manage conflict constructively because they promote honest communication, expression of one's vulnerability, open mindedness and facilitate relationship building which is a central focus of conflict resolution (LeBaron & Pillay, 2006). Destructive manifest and latent conflicts can occur if students do not feel safe resulting in decreased communication, disengagement, and other defensive behaviours. Safe learning environments were cultivated by being inclusive, valuing trust, working from a students' strengths, and being mindful when providing student feedback.

Diversity in learner abilities, including mental health abilities, is supported.

When participants spoke about their experiences working in clinical practice with students who had self-disclosed a mental health disability, they were adamant that these relationships were initially approached as any other educator-student relationship. They focused on developing safety within the relationships and connecting with students rather than labelling them based upon their ability, maturity, gender, or past performances. As Alex described, "I am with the student regardless of whatever label they've got. I'm just there with them and we're developing our relationship as two people." Similarly, Devon did not assume that the presence

of a mental health disability required additional support. "I try and give them all the same level of support up front and when situations arise and they need more support I then try to give them more" (Devon). By not stereotyping students with mental health disabilities and being open to supporting individual learning needs, she demonstrated that she valued inclusivity.

Morgan recognized that not all of her students disclosed their mental health disabilities. "I approach all students assuming there is some anxiety though I am sure there are some that don't but I think that is a safe approach to come from until proven otherwise" (Morgan). She focused on supporting students based upon their need for support and not the presence of mental health disabilities. This inclusive approach signaled acceptance and a willingness to work with every student which could help develop positive educator-student connections. Morgan further explained her approach:

> They have no need to disclose [their disability] and so whether or not they have a mental health diagnosis or undiagnosed, they are all in the melting pot of a class … but it really doesn't matter in a lot of ways because I am still trying to support them toward success. (Morgan)

Valuing a strengths-based approach supports learning.

Many participants described working from a strength-based approach to develop positive educator-student relationships. A strengths-based approach focuses on "discovering, affirming, and enhancing the capabilities, interests, knowledge, resources, goals, and objectives of individuals" (Cederbaum & Klusaritz, 2007, p. 423) which can help create safe learning environments. For Alex, this approach created the foundation of her relationships with students. She stated, "I do value relationships and how to be in relationship that brings out the best in everybody."

When starting a new clinical rotation, Quinn and Kelly focused on their students' past successes as a means to empower students and reduce anxiety. Their strengths-based approach created a safer learning environment for students by not focusing on the unknown and could be experienced as encouraging and supportive.

When Devon worked with a student who exhibited anxiety in clinical practice, she encouraged him to recognize his successes in order to increase his self-efficacy. When this student became overwhelmed and could not practice safely, Devon focused on his strengths and knowledge base to reduce his anxiety so that he could practice safely. She re-affirmed his capabilities which in turn strengthened their relationship. Devon stated she could see him becoming overwhelmed. Furthermore, she said:

> He was frozen at that point, he couldn't think about what to do next so I just stopped him … and I said, "You do know what to do, tell me what you do know, let's walk through this, what do you know just by seeing?" and then I said, "Okay, where do you think you go from here?" (Devon)

Trust is at the center of the educator-student relationship.

Lewicki and Tomlinson (2014b) believed trust was at the heart of a relationship. When trust exists between individuals, it "makes conflict resolution easier and more effective … [by shaping] emergent conflict dynamics" (Lewicki & Tomlinson, 2014b, p. 126). In order to develop trust in their relationships with students, participants invested time and energy into these relationships to connect with students. They believed trust played a central role creating safe learning environments for students to take risks and be vulnerable in their learning. Quinn and Shay reflected on how their students opened up and disclosed information about their mental health challenges once they felt supported and trusted their teachers. Quinn said:

> Once she realized I was going to be a support for her and try to encourage her how to develop strategies to be in clinical, she started to feel more comfortable with me. That was sort of where the shift occurred and after that, I did find that she was quite open. (Quinn)

Taylor believed in the importance of developing trust to strengthen her relationships with students. To support her student who repeatedly compromised patient safety, a learning contract was developed that outlined strategies and requirements needed to pass the course. However, Taylor believed the learning contract "put a big barrier up between the two of us … which could be why I wasn't able to support her learning." She believed the student perceived the learning contract as an act of betrayal that "dug us into a deeper level that wasn't a good level, it didn't bring us closer to be able to tackle the issues or … give a more trusting relationship. It actually did the opposite." The distrust created by the learning contract disconnected the educator-student relationship resulting in an adversarial relationship.

Providing feedback mindfully contributes to a safe learning space for students with mental health disabilities.

Many participants were mindful of how they provided feedback to students who had mental health disabilities. They recognized that they could not "be part of an interaction without shaping, moving, directing, and being affected by it" (Bishop, Picard, Ramkay, & Sargent, 2015, p.126). Hence, their ability to reflect and communicate played a central role in their understanding and management of conflict in the educator-student relationship. Their self-awareness created safety within the relationship by ensuring they approached conversations with compassion, respect, and sensitivity. This sense of safety helped build trust which in turn strengthened the educator-student relationship. Shay described her mindful engagement as a spark that was always present and affected the way she approached and communicated with her

student who had anxiety. She recognized her ability to constructively pause between a stimulus and her response so that she maintained a safe learning environment.

> [There was a] little spark or something in me that was there when interacting with the student where I felt like I had to put more thought into how to construct the sentences, in conversation that we would engage in, how I would say it, how I would respond, or what I would respond with if things occurred. (Shay)

Similarly, Quinn was "keenly conscious" of how she gave feedback to her student who had multiple mental health challenges. She further explained:

> It really is because of the severity of the reaction she had [to previous feedback], I had to be extremely cautious and I was very aware of it more so than I have been in general. Every time I went to talk to her, I put on my delicate gloves. 'How is she today?' I was very sensitive to how she was. (Quinn)

When she provided student feedback, Devon was mindful of the hospital unit's physical surroundings because she recognized the need for privacy. Devon believed privacy provided a safer environment to have these "very delicate conversations."

Vulnerability is experienced in every part of the system.

Participants discussed the following themes of vulnerability: students are vulnerable once they disclose their mental health disability; patients are vulnerable and can feel powerless because they are the focus of nursing care; and nurse educators are vulnerable in their roles as teachers and evaluators. While not all participants used the term vulnerability, they expressed it as "feeling powerless" (Shay), "objectified" (Taylor), "unsafe" (Quinn), "scared" (Kelly), and "inadequate" (Devon). Vulnerability is defined as experiencing "uncertainty, risk, and emotional exposure" (Brown, 2015, p.34) which can possibly lead to being exposed to harm. The Oxford

dictionary defined vulnerable as susceptibility to being wounded or hurt (Oxford University Press, 2018b, para. 1) which could include moral attacks and criticism (Merriam-Webster, 2018, para. 2).

Students are vulnerable once they disclose a mental health disability.

Students are vulnerable once they disclose their mental health disabilities because they risk discrimination and harassment from their teachers and peers. If a teacher divulges this information to colleagues, the student is potentially placed into a position of further harm by creating a bias towards the student from future educators. Thus, sharing information can set the stage for educators to experience intra-personal and interpersonal conflict. For example, educators may learn their student has a disability but believe persons with disabilities are unsuited for careers in nursing.

Devon and Kelly worked with students who felt discriminated against by previous educators once they disclosed their mental health disabilities. The participants acknowledged that these were second-hand accounts from students. Kelly described her student's experience. "I have had students who had anxiety who said, 'I had a really negative experience with an instructor who said I shouldn't be a nurse'" (Kelly).

Not all educators negatively judge and discriminate against students with mental health disabilities. Despite being vulnerable, Morgan's student disclosed her mental health disability which provided a starting point for them to work together. To minimize the student's vulnerability, Morgan kept information related to the mental health disability confidential between herself and the student. "I reassure them that it doesn't go on their evaluation. It stays between them and me" (Morgan). Likewise, Quinn justified not discussing her student's progress in meetings designed to support student success because she feared it could

disadvantage them in the future. "I needed to maintain confidentiality for this student to keep her safe … I didn't want everyone to know" (Quinn). This fear may be justified as Shay described how she knew about a student's mental health disability prior to meeting that student in person. Shay stated, "prior to that student coming to me, I had already known [of the disability] because of conversations that were taking place during meetings. I was already aware that that student had mental health issues."

Patients are vulnerable because they are the focus of nursing care.

Patients risk suffering or harm due to the actions of nursing students. They are vulnerable because of their dependence upon health care providers for care and their loss of identity within the health care system (Irurita, 1999). For instance, in Berglund, Westin, Svanstrom, and Sundler's study (2012) patients suffered when provided inappropriate care that led to harm or feelings of being powerless, invisible or objectified during care. Even though participants believed they bore witness to patient vulnerability and suffering, it is important to recognize that patients did not explicitly verbalize any suffering caused by inappropriate student care. When participants believed patients suffered or were harmed due to the actions of their students, they experienced intra-personal conflict due to their inability to advocate for or protect the patients.

Quinn believed her student's actions were egocentric and largely driven by her mental health disability. By focusing so much on her own needs and objectifying the patient as a means to an end, the student could not practice patient-centered care resulting in patient suffering. She stated:

> I felt concerned because when she wasn't stable, she was so focused on herself and how the world was perceiving her it didn't seem to me that she was focusing on her patient.

> She was interpreting everything through, "What did they think of me?" … It was all about her. (Quinn)

Taylor's experience was similar in that she perceived her student's word choice implied the provision of incompetent nursing care. Taylor believed the patient's feelings of powerlessness and vulnerability intensified because it appeared he was not being provided safe and competent care.

> She would say very inappropriate things in front of the patient which would completely, from my perception, would have the patient lose confidence in her abilities. She would say "I don't know what I'm doing" and we were doing a dressing on a foot and she would say "I have no idea what I'm doing." (Taylor)

Devon expressed her feelings working with a struggling student whose mental health disability affected the quality of nursing care. She believed the student's unsafe practice placed her vulnerable patients at increased risk for harm and suffering. "She was not only technically unsafe but she was also I felt emotionally unsafe towards the patients … I felt horrible for them because they are so vulnerable" (Devon). Devon believed this student became so anxious administering an intra-venous (IV) medication that she could not register the pump's beeping alarm. Despite wanting the alarm turned off, the patient was powerless to silence it. This experience highlights patient vulnerability and dependency upon others to meet their needs.

> The entire time the IV pump was beeping and she wasn't silencing it … I was waiting for her to ask for help. Another student came over to silence the pump and the patient looked directly at me and mouthed thank you and he just shook his head and I could tell that experience was distressing for him. (Devon)

Nurse educators are vulnerable in their roles as teachers and evaluators.

Participants described their vulnerability as feelings of inadequacy and fear. To reduce their sense of vulnerability, participants could have become defensive and escalated the conflict. The source of their vulnerability was rooted in their sense of identity and who they are as professionals. For instance, one participant felt ill-prepared when she transitioned into her educator role fearing that she would be found out as an imposter. Even though she was an expert in nursing, she believed she did not have the skill set to be an effective educator or to teach students with mental health disabilities (Devon). This insecurity in their teaching skills was also evident when several participants described their fear of being confronted by administration if they failed a student with mental health disabilities.

When she started to teach in the nursing program, Devon noted, "we never were really taught how to teach" (Devon) resulting in feelings of inadequacy and incompetence. She described an experience early in her teaching career. "It rocked me as well as I really felt like I didn't know what I was doing" (Devon). Further increasing her sense of vulnerability, Devon hesitated to ask for help because she did not want to be seen as incompetent by her peers. She noted:

> I guess when you're just sometimes not sure that you have done the right thing, there is not a handbook that tells us exactly what to do in each situation and so it is sometimes difficult to stand up in front of your peers and say what you have done and hope that you did it right. (Devon)

Several participants feared confrontation with administration if they failed a student with a mental health disability in clinical practice. They referred to a newspaper article in which a recent story suggested human rights violations occurred within their nursing department. Quinn

stated, "I think that I am quite afraid now of failing a student because of that" newspaper article. Similarly, Shay feared "backlash" and "retaliation" is she failed a student with a mental health disability. Participants commented on their colleagues' attempts to reduce their vulnerability with administration by passing students that did not meet the learning outcomes. This avoidance behaviour limited communication between educators and administration which ultimately polarized the conflict. Alex partially attributed this behaviour to a lack of trust in the system. "Instructors are reluctant to put it out there because they don't feel like anyone will have their back. … so I see that. I don't think there is trust in the system" (Alex). Alex believed people's reputations could be harmed if they attempted to fail students with mental health disabilities. Mayer (2012) noted that the higher the stakes in a conflict, the more it could feel unsafe. In this scenario, the possibility of being accused of committing a human rights violation would be considered high stakes which likely contributed to people's defensive reactions to minimize their vulnerability.

Conversely, Taylor and Devon felt confident failing students regardless of a student's disability status if the student did not meet the course's learning outcomes. "I have got a good process … and I'm really comfortable in my process so that part doesn't matter" (Taylor). To reduce their vulnerability with administration, they focused on using rigorous processes when working with struggling students with mental health disabilities rather than worrying about the final grade being overturned.

Nurse educators are invisible to parts of the educational institution.

Several participants experienced a feeling of being invisible within the educational institution. They believed they were deprived opportunities to collaborate with the Centre for Accessible Learning (CAL) and administration which potentially compromised student learning

and patient safety. These experiences resulted in feelings of powerlessness, frustration, and anger that influenced their teaching in clinical practice. Power appeared to be a central concept within this theme. Power can often be leveraged to attain goals but it can also escalate conflict thereby "decreasing communication, encouraging negative attributions, and make cooperation more difficult to achieve" (Mayer, 2012, p. 86).

The Centre for Accessible Learning (CAL) is omnipotent.

Two participants strongly believed CAL had too much power and authority over how students should be accommodated at the educational institution leaving them feeling invisible and powerless. Shay and Kelly's experiences accommodating students in theory courses informed their view that CAL is a powerful department. They believed CAL and the educational institution valued students' rights over their rights as educators. Kelly stated, "Students can get whatever accommodations they want and we just have to suck it up because we have to be inclusive." Their working relationship with CAL could be described as adversarial and non-collaborative as evident in Shay's description, "I get told what to do right. Instead of having an equal natural discourse about something, it's authoritative." Kelly's anger expressed this sentiment as "It's basically, bend over, that's their response. Get fucked and too bad." Often, rights-based approaches to conflict resolution such as this can lead to adversarial relationships and zero-sum solutions producing winners and losers (Bishop et al., 2015).

Ultimately, these experiences created feelings of powerlessness for Shay and Kelly when working with CAL. Shay stated "I feel like powerless … I feel powerless with CAL." Shay elaborated that she was hesitant to fail a student with a mental health disability who was registered with CAL. She wondered if she could "actually fail them?" She explained:

> What if I do and then you know, a human rights thing and I didn't do this certain thing or I didn't tick this certain box or write this certain word … and then the next thing you know I get in trouble or they get the pass regardless or both. … What's the point? It does feel a bit hopeless. (Shay)

A difference in priorities results in misunderstandings and conflict.

The majority of participants believed the educational institution's administration[2] had different priorities than nurse educators in clinical practice. For participants, this perceived difference in priorities is lived as if they were invisible to administration resulting in feelings of frustration and powerlessness. Quinn described her belief that administration was not focused on patient safety which she considered a priority in nursing care. She believed:

> You are trying to assess if this student is safe in this clinical practice experience and they are meeting the learning outcomes and you determined for XYZ reasons and now someone else is arguing that you're not passing them. They are not looking at that patient safety piece. (Quinn)

Many participants believed administration prioritized its beliefs and values of student success regardless of their concerns about a student's competence. They suggested that administration did not understand the complexities of nursing and student evaluation in a clinical environment. Kelly stated, "they don't understand nursing. They don't understand the clinical environment that the students are entering, the acuity, the workload." Even though Alex

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[2] Administration was defined as persons who had power over the nursing department and included persons in the Dean's office that administer the nursing department and the Vice President of Academics' office that oversees grade appeals.

considered herself an expert in nursing and nursing education, she believed administration would discount her expertise in a student's grade appeal. "I don't feel that [my experience] even enters into it at the college. … I don't think my experience would have any bearing whatsoever" (Alex).

Morgan suggested administration viewed the nursing program as the same as other programs because it did not understand its clinical practice component. Hence, changing a grade only had implications on paper and did not affect patient care. "It's just another program like the woodworking program and they just want us to have those students succeed and so grades get changed" (Morgan). This act made her feel that nursing as a profession was being dismissed. To Morgan, the act of changing a grade implied the educational institution knew what was best to deliver safe and competent nursing care. However, she believed administration and nurse educators prioritized student learning and patient safety differently. She believed administration prioritized success of all students who met the entrance requirements whereas she prioritized safe and competent care which meant all students might not be successful in the nursing program.

> Interviewer: Do you think everybody that has been admitted into the nursing program is capable of graduating as a registered nurse?
>
> Morgan: No, no just because they meet the admission requirements does not mean they have what they need to complete the nursing program.
>
> Interviewer: Does administration have similar beliefs?
>
> Morgan: No, and I think that is a huge challenge in our program that we are being managed instead of being understood as a professional entity. (Morgan)

On the surface, it appears as if their difference in priorities can only result in misunderstandings and conflict. This conflict centers upon what each party considers important,

in other words, it is a value-based conflict (Mayer, 2012). Nurse educators perceive themselves to be experts in nursing education. However, administration perceives itself as being the expert in policies related to fairness and rigour in evaluation. These priorities could co-exist if educators and administrators collaborated on a shared vision of what student success meant. Both groups would learn from the other which would also provide an opportunity to recognize and acknowledge the expertise nurse educators and administrators bring to the relationship.

Measuring student learning in clinical practice is challenging and complex.

Participants believed they could not objectively measure student learning in clinical practice. Challenges in assessing and evaluating students in clinical practice were mainly attributed to the subjectivity inherent in student assessment and evaluation processes and an inability to measure emotionally safe care. These challenges were especially poignant when students struggled to meet learning outcomes and provide safe and competent care. Objective criteria are essential to being able to determine the progress towards and the achievement of goals (Constantino & Merchant, 1996) or educational learning outcomes. When outcomes or procedures are viewed as being unfair by one party, conflict can occur (Fisher et al., 2011). Thus, the participants' belief that evaluation was subjective opened the door for students to complain about unclear and unfair evaluations (Kelly; Taylor).

A nurse educator's subjective lens is used in clinical evaluation.

Participants voiced frustration at the subjective component within student evaluation. In an ideal world, learning outcomes are objective and designed to measure a student's performance in a course. However, the process of using learning outcomes in clinical practice is subjective because of the human element involved in it. This subjectivity makes it difficult to situate a student's progress within a course which is essential when determining if a student passes or fails

a course. Participants were cognizant that this subjectivity was a source of inter-personal conflict with students. For instance, Quinn worried that if she gave students a failing grade based upon her subjectively interpreted data, they could "drag her through the mud" causing emotional distress and potentially damaging her reputation.

To complicate matters, clinical learning environments are chaotic and complex. They provide unique opportunities to learn which makes it challenging to standardize a course's learning outcomes. Shay took the learning context into consideration when deciding which data to use in her students' evaluations. Her beliefs, values, and assumptions coloured the manner in how she interpreted data adding a subjective component to her evaluations. She explained the effect this subjectivity had on her evaluation.

> Every single situation is so complex and so different that it's really difficult to use that as evidence to fail a student because it can be argued, I could even argue for them, I do argue for them, when I am evaluating them "Should they really know this?" (Shay)

For Quinn, measuring the application of knowledge became subjective because the depth of ability or integration was open to interpretation and dependent upon the evaluator and learning context. Examples of learning outcomes that she had to navigate as an evaluator included:

1. Demonstrate abilities in time management.
2. Integrate knowledge of pathophysiology and pharmacology in a nursing practice setting.
3. Establish and maintain caring relationships in dynamic healthcare environments. (Camosun College, 2018)

To emphasize her point that evaluating a student's practice was subjective, she stated:

> It's supposed to be objective, yes or no, but the language of the learning outcomes isn't like "Did you pass this test?" It's like "Did you integrate or apply knowledge?" … The language of the learning outcomes is really open to interpretation too … one could argue either way using a variety of subjective evaluative processes. I feel as if relying on the learning outcomes themselves, you could spin that however it suits your needs. (Quinn)

Evaluating emotionally safe care begins with a measurable learning outcome.

Two participants mentioned their challenge evaluating student provision of emotionally safe patient care in clinical practice. Their evidence was the absence of a clear learning outcome associated with it and it was difficult to articulate within an evaluation. They believed this oversight omitted a key aspect of practicing as a RN. Both participants considered the provision of emotionally safe care to be woven into BCCNP's (2018c) Professional Standards of Practice and the CNA's (2017) Code of Ethics to provide safe, compassionate, competent and ethical care. When Alex and Devon narrated some of their experiences with students with mental health disabilities, they expressed instances when students jeopardized patients' emotional safety but they had no means of documenting this experience. Both participants found it challenging to measure and evaluate their concerns using the learning outcomes. Alex described the challenge of evaluating emotionally safe care as "consistently muddy" (Alex) due to its difficulty in objectively measuring it. When Devon was asked how she evaluated her student's emotionally unsafe care, she responded: "It is a really hard thing to evaluate" (Devon). Thus, measuring the provision of emotionally safe creates the potential for conflict because it is a subjective evaluation that is open to interpretation.

One cannot separate the nurse from the educator.

During the interviews, participants described numerous roles they occupied when working with students with mental health disabilities. Beyond the expected roles of teacher and evaluator, participants identified two roles that originated in their professional identity as RNs: assessor of mental capacity and patient advocate. With regards to assessing mental capacity, RNs are governed by a practice standard whose principles include "nurses determine the client's capacity to give consent" (BCCNP, 2018a, para 10). Thus, they are expected to be able to assess an individual's cognitive ability to make decisions.

Devon believed her nursing skills and knowledge were second nature to her. "I think that is in our blood. I think it is hard to separate that" (Devon). Each day, participants assessed their students' mental capacity to make decisions utilizing their specialized knowledge related to mental health nursing. They also acted as patient advocates because they felt it was their ethical and legal duty as RNs to "prevent or minimize patient safety incidents" (CNA, 2017, p. 8) within the clinical environment.

Assessing a student's mental capacity supports learning and safety goals.

All participants were experienced RNs who had achieved a level of unconscious competence in their practice (Gullander, 1974) which meant their nursing assessments were second nature and could be performed without making serious conscious effort. It is within this context that participants assessed their students' mental capacities. Any condition or factor that affects cognition has the ability to potentially impair a student's decision-making capacity. Therefore, the goal of these assessments was to determine the student's functional capacity and whether or not they needed support or supervision to provide safe patient care. Quinn noted how a student became the subject of her nursing assessments. "I was also assessing her constantly as

a nurse would assess a patient. 'Is she stable today? Is she safe today?'" (Quinn). Using her knowledge about mental health nursing, Quinn determined support was required to maintain student and patient safety in clinical practice. "I knew something was off and I didn't feel comfortable just leaving her, … I was prioritizing making sure she was safe and that the patients were safe" (Quinn). Devon also assessed the mental capacity of each of her students at the beginning of every shift. "I always meet with my students outside of the elevator at first … [to] get a good view of what they look like that morning and does anyone need to stay behind and talk for a minute" (Devon). Besides supporting learning and safety, these assessments can strengthen the educator-student connection because they can be interpreted as acts of caring. Alternatively, they could weaken the relationship and result in conflict if the student interprets it as a means to decrease their independence.

Ethical and legal duty to act as patient advocates.

As RNs, participants were legally bound by their professional and ethical responsibilities. While classroom teachers may prioritize student learning, participants prioritized patient safety and acted as patient advocates when working with students with disabilities in clinical practice. Even though participants had strong convictions to prioritize patient safety, they still had to navigate the inter-role conflict created by their dual roles as educators and RNs. Morgan believed her professional (BCCNP, 2018c) and ethical responsibilities (CNA, 2017) as a Registered Nurse took precedence over her teaching responsibilities. "My nursing commitment, as a professional BCCNP commitment, my responsibility there comes before my teaching commitment. … The patient has to come first" (Morgan). Thus, the goal of safe, competent, compassionate, and ethical care is placed ahead of student learning.

Devon described herself as a patient advocate because she had "an ethical and legal obligation to provide safety for the patients. They can't advocate for themselves so that's our job" (Devon). Similar to Devon's experience, Taylor prioritized patient advocacy because of the patient's vulnerability to harm and suffering. "My job when I am out there is safe practice for the patient first, that's how I look at it, to make sure they [students] are practicing safe for the patient first" (Taylor).

Competing responsibilities create conflict in clinical practice.

When working with students with mental health disabilities in clinical practice, participants felt pulled in many directions resulting in intra-personal conflict. Experiences of role overload were most evident when they attempted to fulfill multiple, and sometimes conflicting, responsibilities leading to feelings of frustration and inadequacy. Inter-role conflict occurred when participants struggled to simultaneously accommodate student learning and maintain patient safety. Participants felt caught between their professional duties as RN and educators. These conflicts often occurred in the context of students struggling to meet learning outcomes which sometimes included students with mental health disabilities. By providing empathic support for students, the participants also struggled to evaluate them objectively and maintain professional boundaries. Being able to reflect continuously on their practice was critical to navigating these conflicts effectively.

There is not enough time to meet all students' learning needs.

Participants worked with groups of six to eight students in clinical practice which created tensions as they attempted to multitask competing priorities. The tensions originated from the clinical practice group's size and was exacerbated by the presence of a student who struggled to meet the course's learning outcomes. Devon experienced this tension as "constantly [feeling]

like [she was] never available enough" (Devon). She believed the group sizes were too big as "one or two students probably don't get as much teaching as they could use on a given clinical shift" (Devon).

Reflecting on an experience working with a student who had a mental health disability, Quinn believed this particular student required extra support to practice safely and competently. In order to provide this student with extra support, Quinn limited her availability with other students in the group. Her action was consistent with Devon and Taylor's experiences when they were faced with similar circumstances. Thus, one student's learning came at the expense of other students' learning needs. Quinn acknowledged the constant juggling required to support her students but felt this experience was different due to the amount of time and support the student required. She explained:

> It was some days where my other students didn't get as much of my time. There were occasions I had to say no to another student that wanted to do a skill because I was prioritizing making sure she was safe and that the patients were safe so that did affect my ability to spread my time evenly amongst all the students. (Quinn)

Further compounding this impression of time scarcity, Shay commented on her frustration of teaching students dispersed throughout different hospital units. For Shay, the geographic dispersal of her students over a large area limited her availability even further as she had to factor in travel time when trying to multitask competing priorities. She reflected, "… then my thought is that I need to be there for them but how do I split myself [amongst] different units that are very far apart" (Shay).

Balancing the needs of students and patients.

Several participants experienced tension when student learning appeared to happen at the expense of patient safety. Participants experienced inter-role conflict as they felt pulled between their duties of teaching and advocating for patient safety. There were many times when the needs of students and patients co-existed peacefully but when this tension existed, it was because these needs opposed one another. Morgan and Devon pondered how to create a learning space while maintaining patient safety. In this excerpt, Devon recognized the need to create space for student learning and evaluation but she struggled when she believed her student's unmanaged stress and anxiety negatively impacted patient safety. Devon wondered out loud when patient safety should override student learning.

> You have to let students go a certain amount to be able to assess and evaluate their clinical performance before you can deem that they are not safe but then … I replayed in my head, "Should I have cut it off sooner? Should I have stopped that student?" (Devon)

In order to create a learning space that allowed student learning and patient safety to co-exist, Taylor and Devon constrained their students' scope of practice. "I put a plan together because she has the right to come to practice … [and] I put limits on her practice as well, and she had to prove to me that she could do ABCD" (Taylor). This restriction ensured that her student had space to learn which was safe and appropriate for everyone.

A challenge maintaining professional objectivity in the face of empathic support.

Participants grappled to maintain their professional objectivity when they provided empathic support to students with mental health disabilities in clinical practice. Relativist ontological and subjectivist epistemological orientations assume reality is subjective and knowledge is socially constructed (Yilmaz, 2013). Beliefs in these orientations challenged

participants to evaluate their students objectively. Empathic support strengthened participant-student relationships thereby making it harder for participants to assess and evaluate their students without bias. Shay described this conflict as a "catch 22" when she worked with students with mental health disabilities. "If they express more to you then you run the risk of having your evaluation of them being skewed and taking on that worry or burden or that responsibility" (Shay). Shay feared making the student's mental health struggles worse if she provided critical feedback to help them improve.

Devon faced a difficult decision when she needed to fail her student in clinical practice. She empathized with her student's predicament but ultimately Devon gave her an unsuccessful course grade because she felt it was her professional responsibility. Being a reflective practitioner, Devon was able to examine her practice allowing her to navigate this type of inter-role conflict. She explained the tension in this situation:

> My heart went out to her and I really liked her as a person and I didn't want her to fail. The safety piece came into play and I knew that I would not want her to care for one of my loved ones. (Devon)

Quinn's empathic support came at a cost of eroding her professional boundary to help meet the student's needs. She reflected on the difficulty of maintaining a clear professional boundary.

> I wanted to maintain professional boundaries. I'm your instructor but I am also concerned about you. It was difficult separating that at times. I imagined that if she did call me in the middle of the night, I would have taken her call. (Quinn)

Teaching support for nurse educators is found in many places.

Participants experienced teaching and learning challenges when working in clinical practice with students with mental health disabilities. They experienced role overload when they

felt they could not be everywhere at once or when they believed they did not have the knowledge to perform their role as educators. In order to navigate these challenges, they sought out support from hospital staff, colleagues, and individuals with specialized knowledge in supporting students with mental health disabilities. These supports provided participants with information, strategies, and resources to work more effectively with their students. Without these supports, their experience of intra-personal conflict would have intensified and likely increased the participants' sense of isolation.

Unit staff are an extension of nurse educators.

One of the teaching and learning challenges experienced by participants involved an inability to continually support and supervise all of their students. Spending more time with one student meant not being available to teach or supervise other students. To compensate for this time scarcity, the majority of participants used unit staff as an extension of themselves to identify unsafe student behaviours or assess and supervise select students. This strategy supported participants by providing an extra layer of teaching oversight that generated additional assessment data on student performance. Devon and Alex had similar experiences when staff approached them about concerns regarding their student's unsafe actions. "The staff came to me expressing their concern about his safety" (Alex). Shay and Devon actively sought out additional assessment data on their students. "I would often go to the nurses at the end of the day and ask, 'How did the student do that day? Is there anything of concern that I need to know about?'" (Devon).

Taylor sought out a different kind of teaching support from unit staff. She drew upon their expertise to assess her student's practice because she believed her presence exacerbated her

student's anxiety. Taylor stated it was the staff's support that helped her student pass the course. Taylor described the challenge within this situation:

> I couldn't get in to assess her in a way that I needed to assess her. I came up with the strategy of her working with the nurses that I knew were really competent and that would ask her questions and that would bring her along gently and took myself a little out of the scenario. (Taylor)

Collaborative learning within the educational institution.

Many of the teaching and learning challenges faced by participants required additional teaching support from the educational institution. The challenges were quite varied: ethical dilemmas, knowledge gaps related to mental health disabilities, inquiries related to policies, and determining strategies that best support students and participants. Participants collaborated with colleagues and experts in order to navigate these complex educational challenges. Hence, they navigated this intra-personal conflict by seeking out new knowledge. It was important to have a safe work environment that participants felt safe enough to ask for assistance. An inability to be vulnerable would have resulted in missed crucial conversations (Lencioni, 2002) that could have been critical to educator and student success.

Quinn and Taylor reflected on their team leader's ability to support and strategize learning plans for their struggling students. Devon and Morgan mentioned their colleagues as a knowledge source to navigate challenging situations. "I have certainly gone to peers and asked for feedback on how to manage a situation or for ideas for future similar situations" (Morgan).

Morgan and Taylor identified knowledge gaps and actively sought out specialized knowledge within the educational institution to complement their teaching practice. "I have gone to a couple of [counsellor's] talks on mental health and I have gone to the Centre for

Teaching and Learning for a teaching course that they offered" (Morgan). Taylor visited the instructors in CAL who "for the most part I have found them supportive. They have given me some literature and some tips to help support students" with mental health disabilities. As a resource for teaching in clinical practice, it is noteworthy that CAL was visibly absent from other participants' stories despite CAL's expertise working with students with disabilities. This omission suggests that participants did not recognize CAL as a resource, the nursing department segregates itself from other departments, or participants somehow perceived CAL as a threat.

When Morgan started working in the nursing program, she believed faculty meetings helped her learn how to navigate challenging experiences in clinical practice. Morgan explained, "I found the team meetings sometimes have been incredibly helpful just in talking about unidentified student concerns and how different people have approached it. I think initially as a newer educator I found that very helpful." She emphasized the meetings were more beneficial to her as a new faculty member because she "didn't study to be an educator" (Morgan). Conversely, Devon experienced confusion during these meetings because too many people shared their experiences or interjected their opinions. "I find that with the team meetings there are just so many opinions that it gets convoluted for me" (Devon). Similarly, Shay identified the need to have a skilled facilitator at the meeting. "We would need to have someone to facilitate it otherwise we run the risk of it getting convoluted or defaulting into something non-constructive. It has to be rooted in good practice" (Shay). Shay believed collaboration requires skill in order to maximize the participants' learning.

Exhaustive description of the lived experience of nurse educators working in clinical practice with students who disclosed mental health disabilities

Nurse educators display considerable compassion and dedication towards working in clinical practice with students who disclose mental health disabilities. They strive to create safe learning environments for all their students by being inclusive, focusing on students' strengths in an appreciative manner, and providing mindful feedback that is considerate to a student's well-being. These educators invest time to develop trusting relationships because they believe trust is the foundation of the educator-student relationship.

Vulnerability is a central concept experienced by students, patients and nurse educators. Students with mental health disabilities are vulnerable once they disclose their disabilities as they risk judgment and discrimination. Patients are vulnerable because they are the focus of nursing care and cannot protect themselves from harm. Lastly, nurse educators are vulnerable because they lack formal preparation for teaching and they do not feel administration supports their grading decisions.

Compounding their sense of vulnerability, nurse educators feel invisible with CAL and administration. Their relationship with CAL is strained because they feel they are denied opportunities to collaborate and design strategies for student success. They feel their priority for safe and competent nursing care is superseded by administration's priority for student succession.

Nurse educators find the process of evaluating students in clinical practice challenging because of its subjective nature and the difficulty in quantifying specific measurements such as provision of emotionally safe care. Evaluation is influenced by their own beliefs, assumptions,

and biases making it difficult to evaluate students' performances to standardized learning outcomes.

Nurse educators perform many roles when working with students with mental health disabilities in clinical practice. They assess their students' mental health capacity using their knowledge of mental health nursing. This action adds a safety net for students and patients as it helps to ensures the right level of supervision is provided. They also act as patient advocates because they have a legal and ethical obligation to protect patients from harm.

Nurse educators face competing responsibilities within the clinical practice environment as they attempt to fulfill multiple, and sometimes conflicting, responsibilities. They experience time scarcity to meet all of their students' needs. Tension also occurs when they attempt to ensure safe patient care while providing student learning opportunities. Finally, the danger of empathically supporting students can result in increased subjectivity of students' evaluations.

Nurse educators seek support from many different sources. For instance, unit staff help assess and evaluate students in clinical practice because nurse educators feel like they cannot continually be present with their students. Ideally, mutual and collaborative learning occur within the educational institution allowing for knowledge transfer between nurse educators, colleagues, and content experts within the institution.

Summary

In this chapter, the findings for the research question, how do nurse educators in clinical practice experience working with students with mental health disabilities, were discussed and presented as seven emergent themes. Excerpts from the participants' transcripts were used to illustrate each theme.

Chapter 5: Discussion of Findings

The purpose of the inquiry explored the experiences of nurse educators working in clinical practice with students with mental health disabilities. The primary research question was:

1. What is the experience of nurse educators working in clinical practice with students who have self-disclosed a mental health disability?

Two further questions that deepened the study were:

2. For nurse educators, what is their experience of the intersection between patient safety and student learning when working with students with mental health disabilities in clinical practice?
3. For nurse educators, what is the experiences of "a duty to accommodate" when working with students with mental health disabilities in clinical practice?

Using conflict as a lens, a phenomenological approach was used to explore the research questions. A lived experience is best explored from the meaning imbued by the person sharing the experience. Thus, seven clinical nurse educators were interviewed and this data was transcribed and analyzed. Eighteen themes were discovered in the data which were synthesized into seven cluster themes. The cluster themes were:

1. Safe learning environments foster positive educator-student connections,
2. Vulnerability is experienced in every part of the system,
3. Nurse educators are invisible to parts of the educational institution,
4. Measuring student learning in clinical practice is challenging and complex,
5. One cannot separate the nurse from the educator,
6. Competing responsibilities create conflict in clinical practice, and

7. Teaching support for nurse educators is found in many places.

This chapter will situate the findings in the relevant literature; provide implications and recommendations for practice and research; and discuss the limitations of the study.

Experience of working in clinical practice with students who self-disclosed a mental health disability

During interviews, participants told me narratives of their experiences working in clinical practice with students who self-disclosed mental health disabilities. Participants believed students with mental health disabilities could be successful in clinical practice which is a belief supported by clinical nurse educators' in Ashcroft and Luftiyya's (2013) study. In Ryan and Struhs' (2017) study, some nurse educators did not believe that nurses should have disabilities while other researchers reported negative attitudes of nurse educators towards students with disabilities in nursing school (Persaud & Leedom, 2002; Sowers & Smith, 2004; Tee et al., 2010). Even though participants in this study believed students with mental health disabilities could become RNs, one of the study's participants suggested that not all students who entered nursing school would become RNs (Morgan). Her belief was that regardless of a student's mental health ability, there would be some students who would fail to meet the learning outcomes to graduate the nursing program.

Aaberg's (2012) study of implicit bias towards individuals with visible disabilities suggested that nurse educators have a bias towards able bodied students because the presence of a disability indicated the student was deficient or broken. Aaberg attributed this ableism to historical beliefs of the importance of being able to complete hands-on physical skills in nursing. While nursing still emphasizes physical and sensory requisite skills and abilities, the College of Registered Nurses of British Columbia (CRNBC) (2015) also identifies cognitive, behavioural,

inter-personal and communication requisite skills and abilities. Thus, perceived impairment in any of these areas could result in similar discrimination as found in Aaberg's study. Participants in this study did not assume students with mental health disabilities required more support than other students suggesting they did not have a bias against students with mental health disabilities.

Gillespie (2002) described the student-teacher connection in clinical practice as a means to stay focused on student learning and create safe learning environments. It focused on egalitarian relationships that placed trust, respect, communication, and mutuality at the core of the relationship. Froneman et al. (2016) added compassion, caring, curiosity, and commitment as qualities to strengthen the student-teacher relationship. Participants highlighted a similar pedagogical approach to teaching students that emphasized developing relationships based upon inclusion, trust, respect, empowerment, and mindfulness. They stressed that they approached relationships with all students, regardless of mental health abilities, in this manner. Overall, they created safe learning environments by supporting student diversity, utilizing students' strengths to overcome obstacles, fostering trust in their relationships, and reflecting inward to act from a place of compassion.

In the literature, clinical nurse educators reported being frustrated when students did not disclose their mental health disabilities because it hindered their ability to support students (Ashcroft & Luftiyya, 2013). Similarly, participants also voiced this frustration and recognized that students may not disclose their disabilities. Two reasons that students do not disclose their disabilities include fear of discrimination or a perception that it is not as advantageous as disclosing their disability within a classroom setting (Morris & Turnbull, 2006; Ridley, 2011; Sanderson-Mann & McCandless, 2006). To compensate for students not disclosing their disabilities, several participants used the principles of universal design to teach clinical practice

so that students did not have to disclose their disabilities. This approach to teaching is consistent with Heelan et al. (2015) proposal to apply universal design principles to clinical practice. The focus is on designing "learning with the learning requirements of all potential learners in mind and recogniz[ing] that every student is an individual with different ways of learning, motivations, and experiences that need to be considered" (Heelan et al., 2012, p. 470).

The perils of an unsafe learning environment can result in student-teacher disconnection as evidenced by McGregor's (2005) study. Her findings noted relationships built upon fear and power created unsafe clinical learning environments resulting in the withdrawal of students from the student-teacher relationship. Taylor experienced this disconnection when she placed her student on a remedial learning contract. The purpose of the learning contract was to provide the student with clear strategies to meet the course's learning outcomes (Gallant, MacDonald, & Higuchi, 2006). She believed the learning contract generated mistrust, fear, and anger because the student felt unsupported in her bid to become a RN. Taylor perceived this to be a key turning point in their relationship resulting in inter-personal conflict. This reaction may be contrary to the nursing students' reactions in Gallant et al. (2006) study when they were placed on remedial learning contracts in clinical practice. Most of these students expressed surprise followed by appreciation for additional support but the findings did not elaborate on the other reactions experienced by these students. Gallant et al. suggested the initial surprise could hint at a student's lack of insight into their clinical competence. Thus, a learning contract could be experienced as a threat to a student's self-image as a competent individual or to their future as a RN resulting in anger.

Bernard Mayer (2012) believes "human needs are at the core of all conflicts" (p. 11) which include a "sense of who we are and our place in the world" (p. 25), "fundamental concerns

about safety and security, … food, shelter, and clothing" (p. 27), and identifying what is important to the person. When a person's core human needs are threatened, a fight or flight response is often triggered potentially escalating the conflict (Picard, 2016). Ideally, to prevent this escalation learning contracts are created collaboratively between students and nurse educators (Lewicki & Tomlinson, 2014a). An integrative approach allows students and nurse educators to teach each other about their needs and create opportunities for mutual problem solving. Sharing control over this process is a means to re-distribute power in the relationship so that problem solving is a mutual activity. This approach can create buy-in from students as they are provided an opportunity to voice their needs, desires, concerns, and fears (Fisher, Ury, & Patton, 2011) resulting in a more sustainable agreement if they feel heard and respected. Conversely, a learning contract only developed by the educator without student participation could be viewed as coercion as it uses the threat of failing to ensure student compliance. Hence, differences in the philosophical foundations for developing learning contracts yields important differences in the process and outcomes.

Participants were challenged to maintain their professional objectivity while providing empathic support to students. Shay's assessments were influenced when she empathized with her students' experiences with mental health disabilities. She also felt guilty because she believed she could "make them worse off" if she were to provide them with a negative evaluation. These experiences are consistent with research that has indicated an educator's evaluative objectivity is influenced by their relationships with students (Cleland, Knight, Rees, Tracey, & Bond, 2008; Prichard & Ward-Smith, 2017). For instance, educators found it harder to negatively evaluate students whom they liked (Cleland et al., 2008) creating intra-role conflict in the form of assessor bias.

It has been noted that student assessment and evaluation in clinical practice are subjective because educators are interpreting student behaviours within a complex learning environment (Docherty & Dieckmann, 2010; Dolan, 2003; Hughes et al., 2016; Isaacson & Stacy, 2009; Prichard & Ward-Smith, 2017; Walsh & Seldomridge, 2005). Participants struggled with their subjectivity in the assessment process especially when assessing cognitive and affective domains of learning. They believed learning outcomes were situated within a clinical context that made it challenging to apply them universally to all students. Participants also commented on the difficulty of measuring the provision of emotionally safe care because of its subjective nature and the difficulty in operationalizing it as a learning outcome. This last point is congruent with Prichard and Ward-Smith's (2017) point that most learning outcomes do not describe actual clinical behaviours because they are based upon academic student learning outcomes.

Participants voiced feelings of uncertainty and vulnerability in their role as nurse educators. Devon commented that she was not taught how to teach resulting in feelings of inadequacy and incompetence. Brown and Sorrell (2017), Grassley and Lambe (2015), and Poindexter (2013) looked at the inadequate preparation nurses received in their transition into nurse educator roles. Their findings support this theme and refutes the belief that RNs should know how to teach nursing because they are content experts in nursing which was evident in the works of Dobbs (2017), Grassley and Lambe (2015), Weidman (2013), and Williams and Taylor (2008).

Most participants felt they required more knowledge and skills to support students with mental health disabilities in clinical practice. They sought support from colleagues, team leaders, and content experts within the educational institution. This support provided them with validation from others, knowledge related to mental health disabilities, and teaching strategies to

navigate educational challenges. Barriers to receiving support included the need to maintain student confidentiality and ineffective support in faculty meetings. Student confidentiality is challenging as collegial support can create bias towards the student with future educators (DeBrew et al., 2014) and confidential information is subject to the Freedom of Information and Protection of Privacy Act (1996) and the Personal Information Protection Act (2003). Participants echoed these points as their rationale for not sharing student information at faculty meetings. Furthermore, participants noted the need for skilled facilitation during meetings to support students; otherwise, they felt the meetings became ineffective and confusing.

Collaboration between key departments within the educational institution is highlighted in Griffiths et al. (2010), Lombardi and Murray (2011), and Tee et al. (2010) studies. Increasing education related to disability law, accommodations, and principles of universal design is required as more students with disabilities enter nursing programs. Only one participant accessed CAL and several participants approached the counselling department to learn more about supporting students with mental health disabilities. Collaborative learning between CAL and clinical nurse educators is encouraged to support students with mental health disabilities in clinical practice. It encourages people to work together towards a shared goal in a process that involves mutual learning. Griffiths et al. (2010) emphasized that learning needs are mutual highlighting the need for disability service advisors to understand the demands and expectations within clinical practice. Two participants described CAL's approach as authoritarian when they accommodated students in their theory classes. Their experiences made them feel powerless and angry which inhibits their ability to engage in future collaborative learning with CAL. This is congruent with a rights-based approach to conflict resolution whereby an adversarial relationship is developed resulting in a zero-sum solution, i.e. CAL was "right" to make them accommodate

students and the participants were "wrong" to claim academic freedom on how to teach their courses.

Participants also described their vulnerability in terms of feeling powerless, unsafe and scared in reference to their relationship with the educational institution. They believed the educational institution prioritized student learning and did not value their expertise in assessing and evaluating students who failed a course. This sentiment is present in the literature and has been cited as a reason why nurse educators do not assign failing grades to failing students (Brown et al., 2012; Dobbs, 2017; Docherty & Dieckmann, 2010; Hughes et al., 2016; Prichard & Ward-Smith, 2017). Several participants felt vulnerable failing a student with a mental health disability because they feared being reprimanded for violating human rights laws. However, two participants felt confident failing students because they felt secure in their teaching processes as well as their ability to assess and evaluate students. They believed they did everything to support students including how they garnered support, assessed and evaluated students, and strategized for their success.

Conflict with administration partly originates in the participants' inter-role conflict as RNs and educators. An RNs, they have professional (BCCNP, 2018c**)** and ethical (CNA, 2017) duties to ensure safe, competent and ethical care for patients but as educators, their priority is providing student-centered learning. Participants believed administration did not prioritize patient safety because it placed priority on student succession. This conflict reflects a difference in values between participants and administration. Silver (2003) noted nurse educators' values are likely to be more aligned with the nursing profession than the educational institution's values. This is evident in the findings by the participants' strong voice advocating for patient safety within the learning experience. Additionally, British Columbia's nursing's regulatory

body states that when conflict occurs between ensuring patient safety and student learning, "public protection comes first" (CRNBC, 2012, p. 4**).** The participants' experience of the intersection between patient safety and student learning is explored below in greater depth.

A final theme experienced by participants working with students with mental health disabilities was not evident in the reviewed literature for this study. In clinical practice, nurse educators provide regulatory supervision for students. Hence, participants focused on teaching nursing students to provide patient care. When Devon mentioned nursing was in her blood, she meant that her nursing assessments happened instinctively and without much thought. Thus, she assessed her students every clinical shift to ascertain the need for increased support or supervision to maintain patient and student safety. Other participants also assessed their students in this manner using their expertise in nursing and mental health to make this determination. Although it did not occur within the narratives used for this study, participants had the power to withdraw students from practice based upon their assessments of the students' mental health.

Experience of the intersection between patient safety and student learning when working in clinical practice with students with mental health disabilities

When participants' experiences of the intersection between patient safety and student learning was explored, they emphasized their legal mandate to protect patients from harm. As described above, participants may experience inter-role conflict due to their roles as RNs and educators. Mossey et al. (2012) believed a clinical nurse educator's concern for patient safety should precede student learning which is substantiated by the CRNBC (2012) Practice Standard Regulatory Supervision of Nursing Student Activities, that nurse educators must prioritize public safety ahead of student learning. A clinical nurse educator's failure to meet these practice

standards can result in "reprimands, suspensions, limits/condition on practice, or cancellation of [their] registration" (BCCNP, 2018b, para. 2).

In previous research, clinical nurse educators voiced concern about patient safety when working with students with disabilities (Aaberg, 2012; Arndt, 2004; Symes, 2014). Aaberg (2012) pointed out that errors are made by nurses including those nurses who did not have disabilities. Marks (2007) further argued that the risk to public safety does not increase because of a student's disability. The risk increases due to inappropriate supervision and management of student learning (Ikematse, 2014; Marks, 2007). Likewise, participants clearly indicated their belief that patient safety concerns were not exclusive to students with mental health disabilities. Their concerns reflected unsafe or incompetent care that was associated with students not meeting required learning outcomes.

The standard of care within clinical practice is a goal of reasonable safety (Jurczak, 2013). Determining reasonable safety is contextual and dependent in part on whether or not individuals work with vulnerable populations. As a result, for nurses the safety standard is high and the risk tolerance is low (Gordy v Painter's Lodge, 2004). Nurse educators working with students in clinical practice must abide by these standards and supervise students to ensure a low risk tolerance is maintained. However, they must also use convincing evidence to determine if a student poses a risk to patient safety because anecdotal or impressionistic evidence is insufficient to prove this risk (Lynk, 2008). This evidence can only be attained by providing students with opportunities to demonstrate their competency. It is within this learning space that inter-role conflict occurs for nurse educators as they potentially place patients in harm's way to acquire convincing evidence of a student's performance. Devon felt terrible allowing her student the opportunity to provide patient care in order to acquire evidence that her student was unsafe.

Even though she prevented physical harm from occurring to the patient, this experience left a lasting impression on Devon. She wondered if she did not stop the student early enough because she believed the patient exhibited emotional duress during the student's care.

The majority of student learning occurs within the context of safe patient care. Marks (2007) believed they can co-exist harmoniously because the supervision of students mitigates the risk to patient safety. It was this concept of supervision that created conflict for participants as they bore the responsibility of maintaining patient safety. For instance, Devon experienced doubt and worry as to whether or not her supervision adequately protected patients.

Participants experienced role overload supervising students. They struggled to meet the students' learning needs while ensuring the provision of safe and competent care. This finding is consistent with Luhanga's (2018) study of nurse educators and their experiences supervising groups of six to ten nursing students in clinical practice. The clinical nurse educators "felt responsible and accountable for patient safety and quality of care as well as supervising students' learning" (Luhanga, 2018, p. 130). Essentially, students missed learning opportunities because they could not supervise all students continuously. However, the presence of one at-risk student reduced the clinical educator's available time even further due to their concerns for patient safety. Clinical nurse educators in Persaud and Leedom (2002), Sowers and Smith (2004) and Tee et al. (2010) studies raised concerns that working with students with disabilities decreased their availability to support all students. Participants emphasized that it was the presence of at-risk students which limited their time and not the presence of a student's disability. They also noted that larger student group ratios and geographical spread of students worsened their experiences of role overload because these factors further reduced their available time. Luhanga's (2018) clinical nurse educators also agreed that an educator-to-student ratio of 1:8

was too high and expressed concerns related to educator availability, decreased student learning, and increased risk to patient safety.

To help navigate their experiences of role overload, participants asked unit staff to report unsafe student practices. This strategy was effective because participants had established trusting relationships with them. Hence, participants discovered a means to be in multiple places at once by utilizing staff to help assess their students' knowledge, skills, and attitudes. Even though these assessments were considered supplemental, they helped participants determine the level of confidence they had in their own assessments. This is consistent with Langan's (2003) findings that clinical nurse educators expected unit staff to teach and evaluate nursing students.

A final means to navigate role overload is to limit a student's scope of practice. Patient safety can be maintained by providing constraints around a student's practice such that they only perform nursing care that they are likely to perform competently. Two participants used this technique which enabled them to scaffold student learning. They recognized that students learn at different paces and some students required more time to learn than others. This technique reduced their experience of role overload by ensuring their students were likely to succeed which was less time intensive than if the students were unsuccessful.

Experience of "a duty to accommodate" in clinical practice

During their entire experiences as nurse educators, no participant had ever been approached to legally accommodate a student with a disability in clinical practice. Thus, the experience of "a duty to accommodate" when working with students with mental health disabilities in clinical practice could not be directly explored. The absence of accommodation in clinical practice is curious when considering the difference between classroom and clinical practice environments. Accommodations are proven to support learning for students with

disabilities in the classroom (Schreuer & Sachs, 2014). And yet, students identified clinical practice as the primary source of their stress due to its unpredictability, high expectations for patient care, and fear of making mistakes (Beck, Hackett, Srivastava, McKim, & Rockwell, 1997; del Prato, Bankert, Grust, & Joseph, 2011; Pagana, 1988). Parker (2014) suggested educators should expect "dysfunction [to] be exacerbated by the demanding physical, mental, and existential environmental factors" (p. 47) faced by nursing students in clinical practice. If this were true, one would expect more students to seek accommodations in clinical practice.

The participants had an accumulated teaching experience in clinical practice of over 50 years. The fact that no accommodation requests occurred during this time period is curious as each participant identified teaching many students with mental health disabilities. This observation suggests the existence of a gap in support services for students with mental health disabilities. Collaboration with CAL or counselling at the educational institution was rarely mentioned in the interviews. Collaborating with the health authority was not mentioned by any of the participants. Research has recommended active collaboration between all stakeholders in order to support student success in clinical practice (Condra et al., 2015; Griffiths et al., 2010; Jackson, Henderson, Edwards & Raines, 2011). Stakeholders include students with mental health disabilities, nurse educators, administrators, disability service providers, counsellors, and the health authority. The idea that only clinical nurse educators need increased education related to disability law, accommodation, and principles of universal design is a fallacy. Hence, mutual learning should be prioritized for all stakeholders within the system.

Recommendations for practice

The STAR model (Kates & Galbraith, 2007) is the framework used to present the recommendations for practice. The categories in the model are strategy, structure, processes,

rewards, and people practices. Recommendations were designed to help mitigate, resolve, and manage tensions that arise when nurse educators work in clinical practice with students with mental health disabilities. Thus, "conflict [became] an instrument of social change and influence" (Rahim, 2011, p. 10). Recommendations sought to "minimize the dysfunctions of conflict [while] enhancing the constructive functions of conflict" (Rahim, 2011, p. 46). This approach to conflict management encourages organizational learning. Due to similarities in Camosun College's Registered Nurse and Practical Nurse programs, recommendations may be applicable to both departments.

Strategy.

Strategy is how the educational institution will achieve its goals and vision. It prioritizes actions and provides boundaries on what it will and will not do to achieve its goals and vision. Camosun College's strategic plan identifies four corner posts: the student experience, supporting people in an engaged community, creativity and innovation, and sustainability for the environment and society (Camosun College, 2016) attached hereto as Appendix D.

- Recommendation #1: All stakeholders discuss and design shared values and goals around what it means for nurse educators to work in clinical practice with students with disabilities. These shared values and goals need to be communicated to all stakeholders. Discussion topics should include, but not limited to, student and patient safety, risk tolerance, student learning, equity versus equality in teaching, collaboration, and confidentiality.

Structure.

Structure consists of the educational institution's organizational hierarchy including the identification of key roles. Key roles within Camosun College's nursing department include:

team leaders who manage and support clinical nurse educators; a placement coordinator who liaises between the health authority and the nursing department; and clinical nurse educators who work directly with students. Collaboration with CAL and counselling is done on an individual educator basis.

- Recommendation #2: Create a liaison role within the nursing department to coordinate and collaborate with support services and the health authority. Responsibilities within the liaison role include: provide continuity of care for students as they progress through the nursing program; provide input into a student's clinical placement; disseminate knowledge related to working with students with disabilities; provide information about clinical practice to other departments or support services; coordinate accommodations with the health authority; and identify areas for improvement within the system.
- Recommendation #3: Create a permanent committee within the nursing department to help support and strategize learning plans for at-risk students. Committee members should work collaboratively with students and clinical nurse educators to develop mutually agreed upon strategies. The committee would also research evidence informed practices related to working with at-risk students and compile a report that highlights the committee's key recommendations. The report would focus on aggregate findings such that it would not violate student confidentiality.
- Recommendation #4: Consider utilizing smaller educator-student ratios when a student is identified as requiring more support from the clinical nurse educator.

Processes.

Processes examine how information and work flows between different departments and roles within the organization. It also highlights how decisions are made within the organization. Due to confidentiality concerns, different departments at the college tend to work in isolation from one another.

- Recommendation #5: Design a case management system that allows individual stakeholders to come together to collaborate with students. With the student's consent and participation, stakeholders share information and updates to individualize learning plans. The student is an active participant in this process.
- Recommendation #6: Consult students with disabilities to ascertain their needs related to learning in a clinical practice environment.
- Recommendation #7: Generate a collaborative report from all stakeholders that collates recommendations for teaching students with disabilities in clinical practice. Student confidentiality is maintained through the use of aggregate data.

Rewards.

Rewards looks at how the organization measures success and what incentives are used to guide behaviours to reach this goal.

- Recommendation #8: Create opportunities for stakeholders to discuss how one measures success when nurse educators work in clinical practice with students with disabilities. Discussion topics should include, but not limited to, attrition and retention, outcomes of success, and program specific versus college wide metrics of success.

- Recommendation #9: Create a certificate of accomplishment for the completion of educational modules on inclusion, disability law, and the principles of universal design.

People practices.

The people practices include developing the competencies that people require in order to carry out the organizational strategy.

- Recommendation #10: Create mutual learning opportunities within the educational institution for support services to learn more about the stressors in clinical practice. These opportunities should include experiential learning such as site visits to the clinical practice placements.
- Recommendation #11: Create educational modules (that includes asynchronous and synchronous learning opportunities) on the principles of universal design, disability law, and accommodations for all clinical nurse educators. Implement these modules to all clinical nurse educators in conjunction with integrating them into the onboarding of new clinical nurse educators.
- Recommendation #12: Create an on-boarding program to support RNs as they transition into an educator role. This program would consist of modules that introduce the theory of adult education.
- Recommendation #13: Create a community of practice that supports nurse educators in clinical practice.

Recommendations for future research

This study explored the experiences of nurse educators working in clinical practice with students with mental health disabilities. Five areas that I suggest for future research consideration are:

1. More research on collaborative learning partnerships within the educational institution. By embedding this research question into the system of the educational institution, key stakeholders can be identified and they can create shared values that would benefit everyone. The result could be partnerships that are built upon the strengths and capabilities of each stakeholder.
2. Additional research on accommodations in clinical practice for students with mental health disabilities because previous research has focused on accommodating students with learning or physical disabilities. Research on experiences working with students with mental health disabilities can be expanded and explored to identify accommodation strategies that are effective for students. The result would be an ability to individualize support for students with mental health disabilities.
3. More studies should explore partnerships between educational institutions and health authorities to accommodate students with disabilities, especially mental health disabilities. As mental health disabilities rise within the student population, this will become a more pressing issue. Effective partnerships could result in a greater number of environmental accommodations rather than focusing on the individual student.
4. Further exploration of clinical nurse educators' experiences of inter-role conflict because this appeared to be one of the central conflicts experienced by participants in the study. Further exploration of this topic may provide guidance to help nurse

educators navigate this conflict when working with students in clinical practice. The result could be more role clarity which would potentially decrease job stress and increase job satisfaction for nurse educators.

5. Research clinical nurse educators' experiences with their own mental health challenges. Understanding this topic in greater depth could increase opportunities for organizational support related to clinical nurse educators' mental health challenges.

Limitations of the study

The limitations of this study are primarily derived from its methodological approach. This was an exploratory study using a phenomenological approach. As a result of the qualitative methodology used, there were a number of intrinsic limitations.

The small sample size, consisting of seven clinical nurse educators, and the focus on one educational institution limited the ability to generalize the findings to a wider population of nurse educators. However, the intent of the study was never meant to generalize the findings to a broader population. The goal of the study was to delve deep into their experiences to understand how they created meaning when working with students with mental health disabilities in clinical practice. Even though the sample size was small, the emphasis focused on generating thick descriptions of their experiences to obtain rich data.

The sampling strategy introduced the possibility of self-selection bias within the study. Participants volunteered for the study because they had an interest in the research topic. Most participants had experience in mental health nursing or took mental health courses to complement their teaching competency. Thus, a bias could have been introduced because of their specialized knowledge related to mental health disabilities and their conceptualization of disability, i.e. they believed in a social model of disability.

The researcher knew all of the participants in the study which could contribute to a Hawthorne effect. While the collegial relationships may have encouraged open discourse, the participants may not have been completely open about their experiences for fear of judgment.

Personal Reflections

While conducting this research, I was surprised by how much the findings resonated in me. I became a nurse educator almost 15 years ago and have taught over 250 students in clinical practice. Each year, I have worked with numerous students who have disclosed mental health disabilities because it affected their learning in clinical practice. Feelings of joy were often overshadowed by feelings of frustration and helplessness as I watched students struggle to meet a course's learning outcomes. Over the last few years, I have become increasingly frustrated by my inability to reconcile student learning and patient safety leading me to feel alone and isolated as I struggled with my own experiences of vulnerability. As I listened to participants describe their experiences, I felt awestruck and inspired by their vulnerability and willingness to share their stories with me.

This research had a profound impact on me. First, the importance of an educator's biases, assumptions, and preconceptions was evident in the participants' stories. Because the academic literature reviewed for this study often highlighted negative experiences or challenges working with students with mental health disabilities, I expected to hear them describe predominantly negative experiences. What I did not expect to find was inspiration within their stories as their words moved me to aspire to become a better teacher. Their teaching was based upon student-centered approaches that saw the potential growth and success in every individual. They prioritized relationships, safety, and trust as foundations to their practice. I found myself

re-discovering my passion for teaching and re-connecting with my values of connection and inclusivity when working with students in clinical practice.

Second, the participants highlighted challenges they faced when working with students with mental health disabilities in clinical practice. They described the complexity of being a Registered Nurse teaching clinical practice while employed by an educational institution. As they told their stories, I felt a deep sense of comradery as I have had similar experiences assessing students, feeling vulnerable, and struggling to simultaneously meet patient safety and student learning needs. By having the courage to describe and name their experiences, it felt as if they shone a light onto these important issues. I felt a profound sense of responsibility as I bore witness to their stories. It felt as if this research project was one step on a much longer journey.

Summary

This study explored experiences of nurse educators in clinical practice working with students with mental health disabilities. It further highlighted nurse educators' experiences of conflict between patient safety and student learning and their experiences of "a duty to accommodate" when working with students with mental health disabilities in clinical practice. The lived experience of seven nurse educators was explored. The findings included the following seven emergent themes: 1) safe learning environments foster positive educator-student connections, 2) vulnerability is experienced by every part of the system, 3) nurse educators are invisible to parts of the educational institution, 4) measuring student learning in clinical practice is challenging and complex, 5) one cannot separate the nurse from the educator, 6) competing responsibilities create conflict in clinical practice, and 7) teaching support for nurse educators is found in many places.

The use of conflict as a tool provided an opportunity to identify organizational development initiatives to help support nurse educators in clinical practice when they work with students with mental health disabilities. Organizational development initiatives have the potential to mitigate, transform, or resolve conflicts that are experienced in educator-student relationships. New knowledge highlighted the importance of creating a shared vision and values for all stakeholders working with students with mental health disabilities. These stakeholders needed opportunities for mutual learning and collaboration related to disability law, accommodation, principles of universal design, and the demands of clinical practice. Increased understanding of how information was siloed in the institution helped identify roles and strategies to further support students with mental health disabilities. Finally, it was evident that nurse educators needed support to meet the challenges of teaching students in clinical practice.

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Appendix A: Invitation to Participate in the Study: Clinical Nurse Educator experiences working with Students with Mental Health Disabilities

You are invited to participate in a research project that explores nurse educators' experiences in clinical practice working with students with mental health disabilities. Your contribution is being solicited because your valuable experience will enrich the study's results which will ultimately generate recommendations to support nurse educators in clinical practice. This study is being completed as part of my requirement for a Master of Arts in Conflict Analysis and Management at Royal Roads University.

The research involves a 60-90 minute interview and if required, a second interview or meeting to review the credibility of the findings may be requested. The interview questions will refer to your experiences as a nurse educator working with students with mental health disabilities in clinical practice. I do not expect there to be harm associated with participating in this study. You will be asked to share some personal and confidential information, and if you feel uncomfortable talking about a topic, you do not have to answer the questions.

All of the information that is collected will remain anonymous and confidential. Any recorded and published material from this research will not identify you, and any quotes used from your interview will not be attributed to you through use of your name or personal identifying information.

To demonstrate appreciation for the time participants have given to the study, participants can choose to receive a ten dollar gift certificate from either Starbucks or Bolen Books.

My credentials with Royal Roads University can be established by telephoning Dr. Marnie Jull, Thesis Coordinator for Master of Arts in Conflict Analysis and Management, XXX-XXX-XXXX ext. XXXX. If any concerns or questions arise about this inquiry, please contact me at the number or address below.

Thank you for your time,

Ryan Russell, B.Sc., B.S.N., M.A. (candidate)

Phone: (XXX) XXX-XXXX

E-mail:

Appendix B: Informed Consent

Clinical Nurse Educator experiences working with Students with Mental Health Disabilities:

A Phenomenological Research Project

Informed Consent for Participants

My name is Ryan Russell, and this research project is part of the requirement for a Master of Arts degree at Royal Roads University. My credentials with Royal Roads University can be established by telephoning Dr. Marnie Jull, Thesis Coordinator for Master of Arts in Conflict Analysis and Management, xxx-xxx-xxxx ext. xxxx or contacting the Royal Roads Research Ethics officer at: email; xxx-xxx-xxxx ext. xxxx.

Invitation and purpose:

This document constitutes an agreement to participate in my research project, the objective of which is to explore how nurse educators experience working with students with mental health disabilities in clinical practice. In particular, attention will be directed at the educator's experience navigating student learning and patient safety in these experiences.

You are being invited to take part in this research because your experience as a nurse educator can contribute much to our understanding of this complex process.

Nature and expected duration of participant involvement:

The research involves a 60-90 minute interview. If required, a second interview or meeting to review the credibility of the findings may be requested.

Nature of questions to be asked:

The interview questions will refer to your experiences as a nurse educator working with students with mental health disabilities in clinical practice.

Any foreseeable harms and benefits (including any financial costs or benefits and/or inconveniences to the participants):

I do not expect there to be harm associated with participating in this study. You will be asked to share some personal and confidential information, and if you feel uncomfortable talking about a topic, you do not have to answer the questions. You do not have to provide a reason for not responding to a question or for refusing to take part in the interview.

To demonstrate appreciation for the time participants have given to the study, participants can choose to receive a ten dollar gift certificate from either Starbucks or Bolen Books.

Participation in this study will benefit the scholarly literature by helping to explore this complex process. Camosun College and other educational institutions with a clinical practicum will also benefit as this project will shine a light on ways to support educators in clinical practice.

Conflicts of Interest:

The researcher received financial remuneration from Camosun College to complete the Master of Arts degree in return for studying a topic of interest to the organization. Camosun College has

no financial interest in the study's outcome, and they will not have access to any of the data. The college will have access to the final report which is a public document.

Statement about how information obtained will be recorded:
Interviews will be audio-recorded and I will be making hand-written notes during the interview process. Any recorded and published material from this research will not identify you, and any quotes used from your interview will not be attributed to you through use of your name or personal identifying information.

Privacy, confidentiality, and anonymity:
All documentation will be kept strictly confidential. The use of pseudonyms will be used to identify participants in order to protect their anonymity. Data collected will be kept on a password protected computer or encrypted USB drive. Notes and other hard copy information will be secured in a locked cabinet. Material containing identifying information will be kept in a locked cabinet that is separated from any materials generated in the study including interview transcripts, publication, and manuscripts.

All data will be held for a period of five year after the successful defense of this study. At this point in time, records and documentation will be destroyed by erasing data or shredding documents.

How the research results will be published, and how participants will be informed of the results of the research:

In addition to submitting my final report to Royal Roads University in partial fulfillment for a Master of Arts degree in Conflict Analysis and Management, I will be sharing my research findings with Camosun College. The findings will also be presented in the publication of journal articles and conference presentations.

Participants may request and shall receive a copy of a summary of the finalized thesis report. They will also have access to the full thesis through the Royal Roads University library.

Consent to participate:

I have read the above, and I understand that publications and manuscripts arising from this research may incorporate direct quotes, but that no direct quotes from my interviews or any research conversations will be accompanied by identifying information other than my pseudonym.

Withdrawal from project:

I have had a chance to ask any questions that I had about the study and may do so at any time during the study. I understand that my participation in the study is completely voluntary and I may choose to stop participating at any time. If I choose to participate, I are free to withdraw from the study at any time without prejudice. This decision to not continue participating will not influence my relationship or the nature of my relationship with the researcher or with staff of Royal Roads University either now or in the future. In the advent that I withdraw from the study,

all associated data collected will be immediately destroyed wherever possible unless I choose to have the data remain as part of the study.

CONSENT

Your signature below indicates that you have reviewed this document and that you have understood the intended use of data collected during the interview.

I agree to participate in one or more interviews and in that context to be audio recorded for this study:

☐ Yes ☐ No

Please initial _____ Please initial _____

I have read this paper about the study. I know the possible risks and benefits. I know that being in this study is voluntary. I choose to be in this study. I know that I can withdraw at any time. I know that it is my choice to be audio taped. I have received, on the date signed, a copy of this document containing 3 pages.

Name: (Please Print): _____

Signed: _____

Date: _____

Appendix C: Interview Protocol

(For the interviewer)

Project Name:

Date and time: Place:

Participant number: Interviewer:

1. Exploratory interviews with an open process will be used to collect data. This open process will allow flexibility and spontaneity in the process allowing participants the opportunity to express and explore their experiences working with students with mental health disabilities in clinical practice. Sometimes, the interviewer may need to use prompts to help participants delve deeper into their experiences or clarify assumptions or the use of jargon. This approach is congruent with a phenomenological approach in which the interviewer and participant co-create meaning of their shared experience.

2. Foremost, the interviewer will bear in mind the research question when asking interview questions. The interview is intended to explore participant's experiences related to the research questions. The questions below are meant to be used as guides and are not intended to create a rigid structure that the interview must follow.

3. Participants will be provided a choice as to the interview location. A private office can be used at the place of employment but if the participant desires a greater degree of anonymity, a coffee shop or restaurant could be used as an alternate setting.

4. Informed consent will be obtained from the participant. The participant will understand the meaning of informed consent, its limitations, and provided an opportunity to ask questions before the interview commences. The participant will understand that withdrawal from the inquiry can occur at any time without penalty.

5. The interview:
    a. Thank-you for taking the time to meet with me. The purpose of this research is to explore nurse educator's experiences working in clinical practice with students who have self-disclosed a mental health disability.
    b. The interview should take approximately 60-90 minutes. If at any point in this interview, I ask you about something you don't wish to discuss, please let me know and feel free not to discuss it. If at any point you would like to stop or take a break, please let me know and we'll stop and reassess whether or how we want to continue. This is as much your process as mine. I really want you to feel comfortable guiding and shaping our shared conversation about your experiences.
    c. I will be audio recording our conversation because I believe what you have to say is very valuable and I don't want to lose any part of it. Before we start, I would like to review the informed consent that you signed earlier and provide an opportunity for you to ask any questions you might have about the consent or the interview.

Introductory questions

1. How long have you been a registered nurse?
2. Where have you worked as a registered nurse?
3. How long have you worked as a nurse educator?
    a. How long have you taught at Camosun College?
4. Where do you teach students in clinical practice?

Guiding questions

1. What is your educational approach to teaching in clinical practice?

a. Can you explain more about _____?
b. What informs or influences your decision to use this educational approach to teaching in clinical practice?

2. More specifically, can you think of a time when you were working with a student who self-disclosed a mental health disability.
    a. What happened in this experience?
    b. How were you personally affected by this experience?
        i. How did this experience resonate in your body?
        ii. How did if affect your relationship with the student?
    c. Did you experience any patient safety concerns in this experience?
        i. What specific concerns did you have?
        ii. What does patient safety mean to you?
            1. How do you measure it when you are teaching in clinical practice?
        iii. What did you experience in this/these situations?
        iv. What factors do you think contributed to your experience?
            1. How did _____ influence your experience?
    d. Was this a unique experience or are there other similar experiences?
        i. What made these experiences different/similar?
    e. Have you experienced a concern for patient safety when working with students <u>without</u> mental health disabilities?
        i. What makes these experiences similar or different to working with students with mental health disabilities?

3. Can you think of a time that you had to legally accommodate a student with a mental health disability in clinical practice, i.e. they are officially registered with CAL for clinical practice?
    a. How many times has this occurred?
    b. If so, what was this "legal accommodation" experience like?
    c. What made this experience different from an experience of a student who self-discloses a mental health disability but is not "legally" registered with CAL?
        i. How did _____ influence your experience?
4. Reflecting on your specific experiences working with students with mental health disabilities, what, if any, recommendations would you make to support nurse educators in clinical practice when working with students with mental health disabilities?
    a. Why are these recommendations important to you?
    b. Do you have specific examples from your experiences that highlight the need for "specific recommendation"?
        i. Can you describe these experiences?

Summary:

1. Some of the main points I heard in our conversation are …..
2. Before we end this interview though, is there anything you would like to add that you think is important for me to hear about your experiences working with these students in relation to the College's organizational design?
3. If needed, are you willing to participate in a follow-up interview or be willing to answer follow-up questions?
4. On a final note, would you like to receive a copy of the research outcomes?

Closure:

I just want to thank-you for sharing these experiences with me and being so open and generous with your time and thoughts. Thank-you.

6. If required, prompts will be used to encourage depth and clarify meaning within a participant's narrative. For example, prompts could include:

   a. Can you tell me more about "_____"?
   b. Can you provide an example of "_____"?
   c. What would that look like?
   d. What does "_____" mean to you?
   e. How did "_____" make you feel?
   f. Ideally, what would you like to happen?

Appendix D: Camosun College's Strategic Plan 2016-2021

Camosun College's vision statement is "Inspiring life-changing learning." Its mission statement is "We build a better future for our community with relevant, innovative, and applied education." To fulfill this vision and mission, Camosun College's strategic plan is developed upon four corner posts. These corner posts are:

Corner Post 1: The student experience

Goal #1: Ensure we have an environment in which student learn to learn; are engaged in community; and acquire skills and knowledge that effectively supports them in building their future.

Goal #2: Develop a strong, college-wide service philosophy and culture that puts students at the centre of everything we do.

Corner Post 2: Supporting people in an engaged community

Goal #1: Recognize and celebrate diversity within the college community.

Goal #2: Build on the support for the Indigenous peoples and communities in BC.

Goal #3: Build internationalization opportunities for the college.

Corner Post 3: Creativity and innovation

Goal #1: Actively engage the college community in recognizing and building on innovation and creativity.

Corner Post 4: Sustainability for the environment and society

Goal #1: Provide leadership and support on key social, environmental, and economic issues impacting the college.