UNDERSTANDING CLINICAL NURSING EDUCATION: AN EXPLORATORY STUDY

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LEARNING HOW TO BETTER SUPPORT CLINICAL EDUCATION

ABSTRACT

Clinical experiences are recognized as a critical aspect of nursing education, highlighting the importance of the perspectives of those providing clinical instruction. The aim of this mixed methods descriptive study was to discover the knowledge and guidance needs of preceptors and clinical faculty who provide clinical instruction to Bachelor of Science in Nursing (BSN) students. Fifteen clinical faculty and 17 preceptors were surveyed using a questionnaire developed and piloted by the researchers. Although preceptors and clinical faculty reported a high level of knowledge and confidence in their ability to guide student nurses, they also identified the need for additional support for their teaching roles. Analysis of the qualitative data provided insights into what helped and what hindered clinical instruction, as well as what could enhance clinical instruction. The development, implementation, and evaluation of formal education and mentorship processes for preceptors and clinical faculty are recommended in order to meet these knowledge and guidance gaps. Further research is also needed to explore how to clinical instruction could be tailored to the capacity of those engaged in the experiences and to clinical environments

INTRODUCTION

Instruction in clinical environments is widely acknowledged as a core component of nursing education (Ard et al., 2008; Brown et al., 2008; Tanda & Denham, 2009). The student learning that occurs in the clinical environment builds the foundation for the ongoing development of student nurses' critical thinking and decision-making skills (Ard et al., 2008; Phillips & Vinton, 2010; Tanda & Denham, 2009) as well as developing their professional practice competency. The perspectives of the clinical experience predominately represented in the literature are those of student nurses and academic faculty, not from individuals engaged in

direct clinical instruction (AUTHOR, 2012). In spite of the importance of clinical education, a clear understanding about how to effectively support individuals who are engaged in clinical instruction is lacking. Uncovering the knowledge and guidance needs of preceptors and clinical faculty is a first step toward enhancing the effectiveness of clinical instruction. In our local setting we wondered if we were adequately meeting the information and guidance needs of those providing clinical instruction. We wanted to take a closer look at the experiences of preceptors and clinical faculty.

LITERATURE REVIEW

Within the literature individuals engaged in clinical instruction are identified by diverse titles and various roles. In this paper, we categorize the individuals engaged in clinical instruction into two distinct groups - preceptors and clinical faculty. A preceptor is described internationally "as the person who acts as a clinical support for undergraduate nursing students during clinical placements" (McCarthy & Murphy, 2010, p.235). We expand on that definition to include in their role the provision of direct clinical instruction to students. We defined clinical faculty as nurse educators who work for an educational institution and provide both direct or indirect supervision, and evaluation of students in the clinical environment, as well as support preceptors who are working with students.

While the literature presents more information about preceptors' perspectives than clinical faculty's perspectives of clinical instruction, common challenges for both groups can be identified. These challenges include complex workloads (Butler et al., 2011; Foley et al., 2012; McCarthy & Murphy, 2010), inadequate communication (Hawthorne et al., 2009; Lui et al., 2010), deficits in formal support for their roles (DeWolfe et al., 2010; Scroczynski et al., 2013),

and diverse student needs (Larocque & Luhanga, 2013; Taniqama et al., 2012). Demanding workloads are identified as one of the biggest challenges for both preceptors and clinical faculty. Preceptors report limited time available to fully engage with student nurses, which also increases the need for clinical faculty to be more present and involved with students (Andrews & Ford, 2013; Butler et al., 2011; Chen et al., 2011; Foley et al., 2012; Hawthorne et al., 2009; McCarthy & Murphy, 2010; Richards & Bowles, 2012; Shahsavari et al., 2013; Taniyama et al., 2012). Ineffective communication between preceptors and clinical faculty can lead to preceptors being excluded from clinical instruction and the student evaluation process (Hawthorne et al., 2009; Lui et al., 2010; Taniyama et al., 2012) and deficits in the information clinical faculty receive about the clinical agency (Taniyama et al., 2012; Whalen, 2009). Preceptors also report deficient communication from nurse colleagues (Chen et al., 2011; Liu et al., 2010), and supervisors (Duffy, 2009) about their effectiveness as a preceptor.

Both preceptors and clinical faculty believe they are inadequately prepared for their roles, leaving them to rely on previous experiences (Yonge et al., 2008) and to learn their teaching roles through trial and error (Andrews & Ford, 2013; Gazza & Shelenbarger, 2010). Preceptors identify gaps in their own understanding of educational theory, such as how to help students learn, the various learning styles, and different teaching modalities (DeWolfe et al., 2010; Scroczynski et al., 2012). Both preceptors and clinical faculty find it challenging to work with students who are exhibiting knowledge gaps (Larocque & Luhanga, 2013; Taniyama et al., 2012) or who appear to lack initiative (Kalischuck et al., 2013; Raines, 2012; Taniyama et al, 2012). Clinical faculty also find it challenging to work through understanding students' and preceptors' perceptions about students' practice in order to determine if there are concerns that need to be addressed (DeWolfe et al., 2010; Foley et al., 2012).

Preceptors are looking for more supportive mentoring from their clinical managers, nursing peers and clinical faculty, such as constructive feedback about how they are working with students (DeWolfe et al., 2011; McCarthy & Murphy, 2010; Martensson et al., 2013). Clinical faculty value networking with their peers and want more opportunities to discuss challenges and to learn new educational tools and tips from their colleagues (Heshmati-Nabavi & Vanaki, 2010).

Although, the literature offers some insights into what preceptors and clinical faculty might find supportive, it does not provide insight into preceptors' and clinical faculty's perceptions about whether they feel confident in their knowledge about how to guide student nurses in these complex clinical environments. Gaining a greater understanding of how to better support clinical instruction and how to address challenges has relevance to school accreditation processes, the teaching experience for preceptors and clinical faculty, the student learning experience, and potentially to the quality of care received by patients. In our teaching intensive university, resources and the workload assigned to faculty demonstrate a commitment to student learning as a priority. Most of our nursing faculty are involved in clinical instruction and work closely with preceptors in our geographic region. Over the last five years, we have had an increase in the numbers of new faculty and have not had a formal orientation process in place for preceptors. We have only been able to provide our preceptors with a preceptorship manual and some impromptu guidance, leading us to wonder if we were adequately meeting the information and guidance needs of those providing clinical instruction. A closer look at the experiences of preceptors and clinical faculty's experiences was warranted.

RESEARCH DESIGN

The aim of this study was to gain an understanding of how to better support clinical instruction by discovering the knowledge and guidance needs of preceptors and clinical faculty who provide clinical instruction to Bachelor of Science in Nursing (BSN) students. A pilot mixed methods descriptive design was conducted through a questionnaire developed by the researchers. A sample of the questions is provided in the appendix. The questionnaire consisted of: (1) ten Likert scale style questions asking individuals to rate their perceptions about whether they had the information they needed to work with nursing students; (2) two questions asking individuals to rate on a scale of one to ten their perceptions about their knowledge and confidence in working with student nurses; (3) open-ended questions inquiring about supports and challenges in working with student nurses; and (4) demographic questions.

The Likert style questions were designed to uncover the extent to which preceptors and clinical faculty had the knowledge and support they needed to work with student nurses, and to what degree they understood their role and the processes to follow if they had concerns, (see Appendix). We based the questions from the challenges identified within the literature and from questions posed to the researchers during their previous interactions with preceptors and clinical faculty in their teaching roles; thus the questionnaire was considered to have content validity. Factor analysis of this part of the questionnaire identified one common construct (which we are calling information) with a KMO of 0.81, $p < .01$, suggesting construct validity. The internal reliability of our questionnaire was supported with a Cronbach's alpha of .881.

After ethical approval had been obtained from the university and the health authority, data collection began. Faculty teaching in the BSN program received a questionnaire in their university mailbox inviting individuals who were involved in clinical instruction to participate in the study. Preceptors were recruited to participate in the study through the distribution of

questionnaires through clinical leaders on their units and through information sessions. Clinical leaders on the nursing units were asked to put envelopes into nurses' mailboxes that contained the questionnaire, an invitation to participate, and a self-addressed stamped envelope to return the completed questionnaire. During information sessions on the units, the researchers explained the purpose of the study, invited questions, and distributed envelopes containing the questionnaire to nurses. Respondents could receive a coffee card if they mailed a form in a self-addressed envelope separate from the questionnaire envelope, to maintain the confidentiality of respondents.

We received 15 completed questionnaires from clinical faculty for a 50% response rate and 17 completed questionnaires from preceptors. We cannot determine the response rate of preceptors because we do not have accurate information about how many questionnaires were distributed by the clinical leaders into the Registered Nurses (RNs) mailboxes. Table one provides an overview of the demographic information. Quantitative data were analyzed using S P S S version 18.0 software to examine the means of participants 'confidence in their information, knowledge and guidance of clinical instruction. Qualitative data were hand-coded and analyzed using interpretive descriptive analysis (Thorne, 2008).

RESULTS

Data analysis revealed very similar levels of confidence in information, knowledge, and ability to guide students among preceptors and clinical faculty. Although clinical faculty felt more confident (M = 42.07, SD 4.47) about having the information they need than did preceptors, the mean scores for preceptors still reflected confidence (M = 35.65, SD 7.13). The means of both groups reflect confidence in their level of knowledge, with preceptors rating 7.5 (6 - 9), and clinical faculty 8.6 (6 - 10). Group means also indicate confidence in their ability to

guide student nurses, with preceptors rating 7.8 (5 -10) and clinical faculty 8.7 (6 -10). The information displayed in table two suggests a level of confidence among those providing clinical instruction. The qualitative data provides more specific information about what helped and hindered clinical instruction, as well as more detail about the perceived knowledge and guidance needs.

What Helped

Preceptors and clinical faculty in this study identified the importance of being able to effectively communicate and work with each other, other nurses, and members of the healthcare team. One preceptor identified "open, honest communication with students [and] routine visits with instructors" as important facilitators in their ability to enact the preceptor role. Both preceptors and clinical faculty identified a wide range of people who they called upon for advice and support in their work with student nurses. One clinical faculty suggested that despite "years of experience, [the] ability to bounce ideas off other instructors" was essential. Another clinical faculty identified that the relationship with "other faculty and established relationships with clinical sites and staff" as essential to being able to navigate the clinical area. Still another reported the positive impact that the health care team had upon clinical instruction: "practice teams [that were] enthusiastic, supportive and engaged with students and instructor" were a great asset to furthering clinical instruction.

Participants listed many physical and human supports for teaching student nurses within clinical settings, such as "computer sites on [the health authority intranet] and Google, for meds…textbooks…other RNs and Licenced Practical Nurses (LPNs) - via group think problem solving, other healthcare professionals, physiotherapy, Occupational Therapy, Speech Language, dietary". Clinical faculty identified "program guidelines, policies, resources, minimal semester

requirements, semester concept grid, semester team meetings" that occurred both in clinical settings and at the university as supportive in clinical instruction.

What Hindered

Preceptors and clinical faculty articulated that finding the time to collaborate about an issue on busy clinical units could be challenging, identifying that "communication, or lack of, is one of the biggest [challenges] with students and teachers." Clinical faculty identified that there are challenges both in the clinical settings and the university that inhibit communication. Preceptors and clinical faculty identified that the physical layout of the environment could have a negative impact on communication.Constraints within the clinical environment were identified as the limited physical space, high acuity of the patients, and complex workloads. One preceptor provided an explanation of how the environment negatively impacted how they work with student nurses:

> Space at [the] nursing station, at med carts, in patient rooms is limited. Sometimes there is tension due to crowding. Acuity - often due to instability of patient, unable to explain every step to a student, may have to step in and take on patient management, which may feel threatening or disheartening to a student. Workload - often the patients both the number of individuals and their acuity make it not possible to provide a good learning experience for students. Students now sometimes have to be ignored so staff can get the work done.

Clinical faculty found the clinical environment constricting because of the "absence of designated physical space for debriefing" with students and preceptors. Ironically, the presence of clinical faculty and student nurses contributed to the crowded environment.

Clinical faculty identified that hospital systems and nurses' workload hindered nurses' ability to constructively engage with students. As a result, clinical faculty needed to support both the students and the RNs. Nurses who were struggling with their workload could be impatient with student nurses' questions, creating the need for clinical faculty to invest more in

the development of student- nurse relationships while still attending to “multiple student needs at the same time.”

Perceived Needs

Preceptors and clinical faculty stated they would like more knowledge about teaching students. They reported the need for ongoing development in “questioning techniques, care planning or writing performance appraisals of students”. They also requested support in articulating student progress concerns and resolving conflicts. Both groups wanted quick access to information; preceptors wanted information about the level and capability of the student and clinical faculty wanted a list of available contacts to call when unexpected student issues arose. Clinical faculty articulated a desire to “support preceptors” in a more substantial way, such as coaching preceptors in providing feedback and in working through challenges with students. Preceptors and clinical faculty identified the need for more space and time within the clinical environment to be able to communicate confidentially with students: to assess learning, to discuss progress, and to debrief. They wanted more opportunities to collaborate with peers and health care team members and to learn more about both nursing and teaching.

DISCUSSION

The findings of this study provide insights into preceptors and clinical faculty’s confidence in the knowledge they have about clinical instruction and their ability to guide clinical instruction, despite what they report as challenging clinical environments. The survey we developed and piloted in this study provide practical insights about the impact of clinical environments on clinical instruction and the need for more formal supports.

Both preceptors and clinical faculty in this study found the complexity associated with clinical environments challenged their clinical instruction and their ability to communicate.

Other scholars have identified that the clinical context influences clinical faculty (Heshmati-Navavi & Vanaki, 2010; Hossein et al., 2010) and preceptors (Butler et al, 2011; Foley et al., 2012; Hawthorne et al., 2009; McCarthy & Murphy, 2010) in their ability to deliver quality clinical instruction. Participants in our study identified relationships with others in the clinical environment as key to effective clinical instruction. Although other studies have suggested supportive relationships aide in providing clinical instruction (Andrews & Ford, 2013; DeWolfe et al., 2011; Hallin & Danielson, 2009; McCarthy & Murphy, 2010; Mårtensson et al., 2013; Raines, 2012), our participants pointed to specific relationships with peers, multidisciplinary team members and each other as important. Ongoing research to uncover what constitutes supportive relationships for those engaged in clinical instruction is warranted.

We believe that further research is needed to identify effective models of clinical instruction within the current high acuity, complex, and evolving acute care clinical environments. Creative employment arrangements to reduce preceptors' workload would make the necessary time for clinical instruction more available (Heale et al., 2009; Kalischuk et al., 2013; Richards & Bowles, 2012; Sroczynski et al., 2012). This could include tailoring both the students to clinical faculty ratio and the patients to preceptor ratio to reflect students' learning needs and the capacity of those engaged in clinical instruction. This suggestion would likely be associated with increased cost and would therefore be more difficult for organizations to fund and implement. Equipping those engaged in clinical instruction with enhanced education and mentorship could be an initial and less costly step.

The participants in this study requested formal mentorship to assist them in enhancing their clinical instruction. They identified a lack of formal preparation for their clinical instruction roles and responsibilities, leaving them to fulfill their teaching role through "learning on the job."

This practice reflects the perception that being a good clinician is all that is necessary for effective clinical instruction (Davidson & Rourke, 2012). Unfortunately, this model of clinical instruction for nursing has changed very little over time (Ironside et al., 2013; Phillips & Vinten, 2010), despite changes in clinical environments and the increased complexity of clinical instruction (Forbes et al., 2010; Heshmati-Nabavi & Vanaki, 2010; Hossein et al., 2010). Our findings add to previous research identifying education or training for the role of preceptor and clinical faculty is often lacking (Andrews & Ford, 2013; Butler et al., 2011; DeWolfe et al., 2010; Kalischuk et al., 2013; Mårtensson et al., 2013; Martin et al., 2008; Sroczynski et al., 2012). We suggest that improving clinical instruction requires formal support for both preceptors and clinical faculty. In our setting we have added more formal orientation processes for clinical faculty, assigned mentors to new faculty and developed a comprehensive orientation manual. We are planning workshops to develop teaching competency and understanding of the curriculum.

We agree with previous research that suggests preceptors be provided with education in learning styles (DeWolfe et al., 2010; Sroczynski et al., 2012), conflict resolution, how to be an effective role model, assessment strategies, time management, and generational differences (Mårtensson et al., 2013; Martin et al., 2011; Sroczynski et al., 2012). Additionally, those engaged in direct clinical instruction and supervision require education about key policies and procedures (i.e., how to deal with an unprepared student), a clear understanding of the nursing program (i.e., concurrent theory courses, textbooks, and learning resources available) and all aspects of student evaluation (Davidson & Rourke, 2012). Based on our findings we suggest that formal education and mentorship strategies need to be available for preceptors and clinical faculty regardless, of their years of nursing or teaching experience. We hope the use of the

survey we developed and piloted in this study may provide other researchers with opportunities to gather practical information about clinical instruction.

Although this study is limited by size and represents data from only one teaching intensive university and one health authority in one geographical region in Canada preventing any generalizability, we were able to learn practical strategies in how to provide better support to preceptors and clinical faculty. Concise information sheets about educational processes, brief overviews of students' levels of knowledge and skills, and contact numbers for in-the-moment support, have been developed and provided to preceptor and clinical faculty as a result of this study. Further research is needed to determine if this has assisted in clinical instruction. A formal, more structured and thorough orientation program has also been developed and implemented for all new faculty. Further evaluation is needed to determine if these strategies have enhanced the effectiveness of clinical instruction. Finally, further research is needed to determine appropriate models of clinical instruction in demanding practice settings.

CONCLUSIONS

This study provided important information that is useful in guiding us to support clinical education in our local setting. We have begun the process of developing more formal education and mentorship processes. These processes will need continued evaluation to ensure we are supporting preceptors and clinical faculty in collaborating and providing excellence in clinical education. Challenging clinical environments impact both preceptors and clinical faculty in their efforts to provide clinical instruction. Although research is beginning to identify different models or strategies to enhance clinical instruction (see Scrozynski et al., 2011 for example), further examination of what is feasible in our local setting is needed. We believe that further research is needed to understand effective models of clinical instruction in challenging practice settings.

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Appendix One: Sample of Questions

	1 Strong Disagree	2 Disagree	3 Hard to Decide (neither agree nor disagree)	4 Agree	5 Strongly Agree
I have all the information I need to work with student nurses.	1	2	3	4	5
I do not know where to find the information I need to work with student nurses.	1	2	3	4	5
I feel the University supports my work with student nurses.	1	2	3	4	5
I do not feel supported by the University in my work with student nurses.	1	2	3	4	5
I know the process to follow if a student's clinical practice is unsafe.	1	2	3	4	5
I am unclear what to do if a student's performance concerns me.	1	2	3	4	5
In my role with student nurses, I understand the recourses I can access in the clinical setting.	1	2	3	4	5
I am uncertain what clinical supports I could draw on in my work with student nurses.	1	2	3	4	5
I understand the scope of practice of the students with whom I am working.	1	2	3	4	5
I am not clear about student nurses' level of skills and abilities.	1	2	3	4	5

Section B

In this section we are asking you to **rate your knowledge and confidence level** working with student nurses. In addition, we are asking general questions to gain information about what **supports and constrains** your work with student nurses. Please give us your opinions.

1. On a scale of 1-10 provide a number that best represents your knowledge about how to effectively instruct students in clinical settings. _____

2. On a scale of 1-10 provide a number that best represents your confidence in being a clinical instructor for student nurses _____

3. What **currently supports** you in your clinical work with student nurses?

a) Are there **learning aides available that you use to support students**? Please describe.

b) Are there **supports** within the **clinical environment**? Please describe.

4. What are the **challenges and/or barriers** to **clinical teaching**?

5. **How** would you like **to be supported** in your clinical work with student nurses?

6. What types of **knowledge/education** would enhance your ability to support students in the clinical environment?

7. What would be helpful **resources** to include in an information guide for clinical instructors?

Table One: Demographics

	Preceptors Mean (range) SD= Standard Deviation	**Clinical Faculty Mean (range) SD = Standard Deviation**
Nursing practice	9.5 (1-40) years SD= 10.35	26.7 (2-40) years SD= 10.41
Preceptor experience	5.5 (1-25) years SD= 6.38	
Teaching experience		9.5 (1-23) years SD= 6.39
Age	41.8 (25-65) years SD= 11.22	51 (27-62) years SD= 7.72
Qualifications	Registered Nurse (Diploma- BSN)	Master's Degree
Years since basic nursing education	11 (1-40) SD= 10.35	28.8 (7-40) SD= 10.41
Knowledge (10)	7.5 (6-9) SD= 1.06	8.6 (6-10) SD= 0.97
Confidence (10)	7.8 (5-10) SD= 1.38	8.7 (6-10) SD= 1.09
Information survey (50)	35.64 (24-49) SD= 7.13	41.39 (38-45) SD= 4.47

Table 2: Overview of Results

Survey	Preceptors	Clinical Faculty
Confidence with information (out of 50)	M = 35.65 (SD 7.13)	M = 42.07 (SD 4.47)
Confidence with Knowledge (out of 10)	M = 7.5 (range 6-9)	M = 8.6 (range 6-10)
Confidence with ability to guide students (out of 10)	M = 7.8 (range 5-10)	M = 8.7 (range 6-10)