Exploring Perceptions of Staff Registered Nurse Preceptors for Undergraduate, Pre-licensure Nursing Students

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Dedication

I dedicate this dissertation to my loving husband, David; his unconditional love and support has been my foundation through this journey. And to my son Jake, who spent many days and nights watching from afar while I worked endlessly to achieve my dream. I hope I have made you both proud.

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Abstract

Staff nurses are increasingly called upon to accept more responsibilities and roles in addition to provider of patient care, including that of preceptor. Aside from dealing with demands of high acuity patients, working long hours with inadequate staffing, and carrying heavy workloads, nurses may view teaching and supervising students as an additional burden, time-consuming, and not part of their role. The purpose of this dissertation was to explore staff nurse experiences as preceptors to undergraduate, pre-licensure nursing students. Emphasis was placed on exploring RN's perceptions of the role, specifically the preparation for, support in, and understanding of what the role entails. The following question was used to guide the study: What are staff nurses' experiences with precepting undergraduate, pre-licensure nursing students? A naturalistic inquiry within an interpretive paradigm guided this qualitative exploratory study. The sample consisted of nine licensed registered staff nurses with experience as preceptors in tertiary care settings in Northeast Tennessee. Most participants were currently working in or had worked in the role of preceptor for undergraduate nursing students within the past six months. All nine participants were female. Most participants were between the ages of 30-39. Participants were licensed as registered nurses anywhere from 2 to 14 years. Participants attended one of two focus groups lasting between 60-90 minutes each. A semi-structured interview guide assisted in data collection. Transcripts were analyzed using conventional content analysis. Findings suggest that while preceptors perceive information about teaching and learning styles to be beneficial, they did not perceive a formal class essential to preparing them for the preceptor role. Preceptors perceived most support from their co-workers and least support from nurse managers. Faculty seemed to be silent partners. The primary role function is Protector, with Socializer and

Teacher as secondary role functions. Preceptors have a strong empathetic drive to protect students from negative experiences, to protect patients from harm, to protect their own professional identities, and to protect the nature of the nursing profession itself. Preceptors perceived students with overconfident attitudes as unsafe. Findings have significant implications for development of professional values in practice and education.

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List of Abbreviations and Symbols

Accreditation Commission for Education in Nursing (ACEN)

American Association of Colleges of Nursing (AACN)

American Association of Critical Care Nurses (AACN)

American Nurses' Association (ANA)

Analysis of Variance (ANOVA)

Bureau of Labor Statistics (BLS)

Bachelor of Science in Nursing (BSN)

Centers for Medicare and Medicaid Services (CMS)

Cumulative Index to Nursing and Allied Health Literature (CINAHL)

Collaborative Institutional Training Initiative (CITI)

Commission for Collegiate Nursing Education (CCNE)

Commitment to the Preceptor Role Scale (CPR)

Education Resources Information Center (ERIC)

Healthy Work Environment (HWE)

International Council for Nurses (ICN)

Institute of Medicine (IOM)

Institutional Review Board (IRB)

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

Knowledge, skills, and attitudes (KSA)

Nasogastric (NG)

National League for Nursing (NLN)

National League for Nursing Accrediting Commission (NLNAC)

National Patient Safety Goals (NPSG)

Nursing Professional Values Scale (NPVS)

Primary Investigator (PI)

Preceptor's Perceptions of Benefits and Rewards Scale (PPBR)

Preceptor's Perceptions of Support Scale (PPS)

Quality and Safety Education for Nurses (QSEN)

Registered Nurse (RN)

Self-Determination Theory (SDT)

Statistical Package for the Social Sciences (SPSS)

Tennessee Research and Creative Exchange (TRACE)

Chapter I: Introduction

Gone are the days when nurses were responsible only for following physicians' orders. In today's healthcare system, nurses face many challenges in their work places. Staff nurses are increasingly called upon to accept more responsibilities and roles in addition to provider of patient care. An added responsibility experiencing recent resurgence is that of preceptor. A preceptor is defined as a staff nurse who works with an assigned undergraduate, pre-licensure nursing student in a one-on-one relationship over a period of time, including days, weeks, or months, for the purposes of nursing education, including on-site supervision, clinical teaching, and some responsibilities for assessment and evaluation (Carlson, Wann-Hansson, & Pilhammar, 2009; Chickerella & Lutz, 1981; Fitzgerald & McAllen, 2007; Morton-Cooper & Palmer, 2000; Orhling & Halberg, 2001; Udlis, 2008).

Historically, nurses in America were trained under an apprenticeship model, consistent with other professional disciplines in the later 19th and early 20th centuries (Baer, 2012). In this model, nursing students were trained at the bedside primarily in hospital settings where they followed the lead of an already trained nurse, learning rituals and adopting skills without questioning (Allen, 2010; Baer, 2012). This method of nursing education continued until the era of World War II, when nurses experienced increased respect and autonomy as members of the military through the camaraderie they developed with other soldiers (Allen, 2010). As a result, nurses began to sway from the stringent nature of hospital training and desire an education inside an academic institution. Even so, it was not until 1965 when the American Nurses' Association (ANA) introduced their first position statement on the education of nurses, saying that "the education for all those who are licensed to practice nursing should take place in institutions of

higher education" (ANA, 1965, p. 107). Within the position statement, the ANA recognized the importance of educating nursing students in the theoretical foundation, scientific background, and emerging nursing research relevant to autonomous nursing practice. This transition from hospitals to classrooms meant that nursing students spent less time in a clinical setting and more time in the classroom.

As healthcare advanced and nursing education changed, the roles and responsibilities of students, faculty, and staff nurses were transformed. According to Myrick (1988) as nursing education became university based, faculty often found themselves relegating their clinical competence to the shadows in order to maintain research and publication requirements needed to secure tenure. Myrick says that a primary concern resulting from this movement was the introduction of ill-prepared new nurses into the clinical environment. She also asserts that faculty members were left scrambling to find ways to research, publish, teach, and ensure that nursing students were clinically competent to enter practice. In the mid-1970s, the response was a new clinical model, called the preceptorship, where faculty assigned a student to a nurse for a pre-determined amount of time, often during the later or last semesters of the academic program (Chickerella & Lutz, 1981; McClure & Black, 2013; Myrick, 1988).

According to Tanner (2006), clinical nursing education has gone essentially unchanged over the past 40 years. Preceptorships have remained a staple in nursing education curricula. Reporting on a survey of baccalaureate nursing programs, Chappy and Stewart (2004) noted that among Commission for Collegiate Nursing Education (CCNE)-accredited schools of nursing, 75.8% use preceptorships as part of their clinical education. Altmann (2006) conducted a similar survey consisting of undergraduate baccalaureate schools of nursing accredited by the National

League for Nursing Accrediting Commission (NLNAC), now known as the Accreditation Commission for Education in Nursing (ACEN). She found that 85.9% used structured preceptorships. Although these studies do not take into account the many other schools of nursing, such as associate degree programs, which can be accredited by the ACEN, it seems that the use of preceptorships remains prevalent among undergraduate nursing programs.

Despite its prevalence, the preceptor role and model have some problems. A primary contributing element is that there is no standardized definition for preceptorship and as such, schools of nursing implement these experiences in a multitude of different ways. Both accrediting bodies for schools of nursing, the CCNE and the ACEN, offer only vague statements with regard to preceptors. Standard 2.4 from the ACEN (2013) says "preceptors, when utilized, are academically and experientially qualified, oriented, mentored, and monitored, and have clearly documented roles and responsibilities" (p. Baccalaureate-2). The CCNE (2013) says in Standard IIE, "when used by the program, preceptors, as an extension of faculty, are academically and experientially qualified for their role in assisting in the achievement of the mission, goals, and expected student outcomes" (p. 11). They elaborate further and say:

> The roles of preceptors with respect to teaching, supervision, and student evaluation are clearly defined; congruent with the mission, goals, and expected student outcomes; and congruent with relevant professional nursing standards and guidelines. Preceptors have the expertise to support student achievement of expected learning outcomes. Preceptor performance expectations are clearly communicated to preceptors and are reviewed periodically. The program ensures preceptor performance meets expectations (CCNE, 2013, p. 11).

Although schools of nursing must provide documentation to support these standards, the standards are open to the interpretation of schools of nursing based on individual institutional philosophies and curricula. This can lead to a significant amount of confusion among schools of nursing using preceptors and those staff nurses serving as preceptors. Some nurses may be considered eligible for precepting with one school and ineligible with other schools. There are also differences in nursing curricula that must be taken into account. Even though accreditation guidelines say that preceptors should be oriented, mentored, monitored, and should have clear expectations of their role, all of these processes can vary from school to school. Adding to the frustration is that preceptors may be responsible for several students at various points in the curriculum, during any one semester, from different schools of nursing. Staff nurses may or may not receive training or compensation through their employers. Additionally, staff nurses often lack the advanced education required to effectively assess and evaluate nursing students. Altmann (2006) reported that most preceptors received only 2.5 hours of orientation to the role. Consequently, nurses who serve as preceptors often report role ambiguity, role conflict, and role overload (Omansky, 2010).

Next, although the experience of precepting takes place outside the walls of the academic institution with staff nurses serving as "an extension of the faculty" (CCNE, 2013, p.11), it is viewed in nursing primarily as an academic endeavor. This is evidenced by the lack of attention given to the role by national and international organizations outside of nursing education. The ANA, the International Council for Nurses (ICN), and even state boards of nursing responsible for the regulation of nursing practice do not address the specific preceptor role of the staff nurse. Additionally, extensive variations in implementation of preceptorships exist both nationally and

internationally. This literature is discussed in Chapter II. Based on the information in the previously cited studies by Altmann (2006) and Chappy and Stewart (2004), it is clear that preceptorships are still quite prevalent in nursing, are a significant part of nurses' work environments, and therefore warrant more attention.

The confusion and inconsistencies surrounding the role of preceptor is worrisome. Particularly considering the current national focus on the relationship between nurses' work environment and the ability to provide quality nursing care. Nurses' work environments have become so complex that the ANA (2013) and the American Association of Critical Care Nurses (AACN, 2005) have stepped up to the challenge making healthy work environments (HWEs) a top priority. The AACN provides six standards necessary for a HWE. These are skilled communication, true collaboration, effective decision making, appropriate staffing, meaningful recognition, and authentic leadership (AACN, 2005). The ANA (2013) says that a healthy work environment is one that is "safe, empowering, and satisfying" and that the work environment "plays a large role in the ability to provide quality care" (Healthy Work Environment, para. 1).

The focus on a HWE is of utmost importance as the nursing profession has entered a critical period. For some time, nursing leaders have anticipated a national nursing shortage. In fact, it is projected that jobs for registered nurses (RN) will increase by 26% between 2010 and 2020, with an estimated need for more than 700,000 new nurses (Bureau of Labor Statistics, 2012). It should also be noted that approximately 13% of newly licensed nurses have changed jobs after only one year of work and 37% report a desire to change jobs in the near future (Kovner et al., 2007). Further, it is estimated that the cost of replacing a single nurse is approximately $88,000 (Krsek, 2011). These statistics suggest that recruitment and retention

efforts are still major issues for healthcare organizations, even in the face of a nursing shortage and a focus on quality care.

A healthy work environment and retention are inextricably linked. Ritter (2011) says that a healthy work environment is "crucial to job satisfaction, best practices, and retention" (p. 29). This is substantiated by Cohen, Stuenkel, and Nguyen (2009) in their longitudinal, descriptive study examining registered nurses' perceptions of their work environments, demographic factors, and elements that affect retention. Nurses who perceived supervisory support, and those who perceived a work environment where innovation was respected, were more likely to stay (Cohen et al., 2009). Staff nurses supported in their roles of teacher and preceptor may have increased levels of job satisfaction and experience professional growth (Bizek & Oermann, 1990; Henderson, Fox, & Malko-Nyhan, 2006); however, this support is often lacking (Landmark, Hansen, Bjones, & Bohler, 2003; McCarty & Higgins, 2003; O'Callaghan & Slevin, 2003). Additionally, federal organizations, such as the Centers for Medicare and Medicaid Services (CMS) have enacted recent changes in reimbursement guidelines requiring evidence of the provision of quality nursing care (CMS, 2012; Hall, 2008), adding another level of accountability to the already multi-faceted responsibilities of nursing work.

Undeniably, these are valiant attempts to address the connection between a healthy work environment and quality nursing care. However, there is extant and emerging research findings that indicate nurses, when serving in the preceptor role, often experience negative emotions and may demonstrate negative behaviors, including anxiety, anger, frustration, self-doubt, fear, and feelings of responsibility for allowing certain students to enter professional practice (Hrobsky & Kersbergen, 2002; Luhanga, Myrick, & Yonge, 2010; Luhanga, Yonge, & Myrick, 2008a,

2008b). This is particularly true if the learning needs of the student are high, as with those students who demonstrate incompetent or unsafe practice during the precepted experience (Lusk, Winne, & DeLeskey, 2007). These emotions and behaviors can have significant effects on the professional socialization of newly licensed nurses entering practice (Duchscher, 2009; Duchscher & Cowin, 2004; Price, 2008) and can even alter the way nurses themselves view the profession (Murray, 2008). These emotions and behaviors are not consistent with a healthy work environment.

In an attempt to prevent the previously cited consequences, and to support current nursing initiatives, it seems fitting that nurses should have the opportunity to offer input that is aimed at tending to their own needs in the work environment. It seems then, that in conjunction with the continued rise in the use of preceptors, the inattention to the role by nursing and healthcare organizations, and the varied methods of implementation among schools of nursing in light of an increasingly complex healthcare system may actually be supporting an unhealthy work environment. Attention should be directed toward ensuring nurse preceptors understand and are comfortable in the role so their overall work environment is supported.

Problem Statement

In addition to dealing with demands of high acuity patients, working long hours with inadequate staffing, and carrying heavy workloads, nurses may view teaching and supervising students as an additional burden, time-consuming, and not part of their role (Bowles & Candela; 2005; Grant, Ives, Raybould, & O'Shea, 1996; Grindel, Bateman, Patsdaughter, Babington, & Medici, 2001). Nevertheless, staff nurses may be expected to serve as preceptors without having the opportunity to have their voices heard or to ask questions (Happell, 2009; Yonge, Krahn,

Trojan, Reid, & Haase, 2002). Failure to recognize and address the impact of preceptorships on nurses' work environment can be serious. Left unattended, work discomfort can have deleterious consequences on nurses' overall well-being, work performance, and satisfaction, and can include discontentment, distrust, apathy, and decreased provision of quality care (Bowles & Candela, 2005; Murray, 2008; Paris & Terhaar, 2011). Nurses may even leave the profession (Paris & Terhaar, 2011). Increased responsibility without remuneration or input can lead to negative emotions and behaviors consistent with an unhealthy work environment that can ultimately have an effect on the provision of quality care. However, little is known about how preceptors actually perceive and understand the role of preceptor.

Purpose

The purpose of this dissertation is to explore staff nurse experiences as preceptors to undergraduate, pre-licensure nursing students. Emphasis is placed on exploring RN's perceptions of the role, specifically the preparation for, support in, and understanding of what the role entails.

Research Question

The following question was used to guide the study:

1. What are staff nurses' experiences with precepting undergraduate, pre-licensure nursing students?

Assumptions

I made the following assumptions:

1. Nurses have many roles and responsibilities in the work environment.
2. Study participants had in-depth knowledge about the research topic.

3. Study participants could clearly articulate their perspectives.

Philosophical Framework

Use of naturalistic inquiry within an interpretive paradigm is best suited to guide this study. According to DePoy and Gitlin (2005), naturalistic inquiry uses "inductive and abductive forms of reasoning to derive qualitative information" (p. 322). The authors say that this type of research begins with a shared experience (DePoy & Gitlin, 2005). Participants in the study had the shared experience of serving as a nurse preceptor to undergraduate, pre-licensure nursing students.

Sandelowski (2000) says that in naturalistic inquiry, there is no pre-selection of variables, no manipulation of variables, nor is there an *a priori* commitment to a single theoretical view. Additionally, it is acknowledged that there are multiple realities that exist, that these realities are based in the person's individual experiences, and that meaning is derived through the person's environments (DePoy & Gitlin, 2005; Sandelowski, 2000).

Research within an interpretive paradigm is conducted to gain a deeper understanding of phenomena through the perceptions of those in the experience (Weaver & Olson, 2006). The interpretive paradigm is often regarded as congruent with a social constructivist worldview, where subjective meanings develop based on the individual's experience (Creswell, 2007; 2009). In social constructivism, meanings given to experience are formed through interaction with others (Creswell, 2007; 2009). Nursing is an inherently social profession as nurses interact with a multitude of persons daily. As such, the meaning that nurses ascribe to a particular phenomenon is likely shaped by interactions in their work environments. This underlying framework provides support for the use of focus groups to collect data.

Delimitations

This study was delimited in several ways. Only staff nurses who have at least one year of nursing experience were considered for this study. Nurses who have less than one year of experience often experience periods of overwhelming adjustment to the demands of the nursing profession (Martin & Wilson, 2011) and were therefore excluded from this study. Data were collected from nurses working at health care agencies in the South. Registered nurse preceptors working in these agencies may not be representative of registered nurse preceptors elsewhere.

Significance to Nursing

This study is significant to nursing. Staff nurses serve on the front lines, dealing not only with their daily nursing workloads, but also with extra demands of students and faculty members. Preceptorships are still widely used by schools of nursing as part of the nursing education experience. There is also a call to action by the ANA and the AACN to create healthy workplace environments for nurses. In order to see this to fruition, the role of precepting should not be discounted. However, extant research findings regarding the role of preceptors are limited. These study findings add to the overall amount of nursing knowledge on the topic and may provide insight into additional strategies that can benefit clinical nursing education and support both recruitment and retention efforts within healthcare organizations.

Chapter II: Review of the Literature

As noted, the purpose of this dissertation is to explore staff nurse experiences as preceptors to undergraduate, pre-licensure nursing students with emphasis on exploring RN's perceptions of the role, specifically the preparation for, support in, and understanding of what the role entails. The purpose of this chapter is to provide a broad overview of what is known about clinical nursing education. It is an organized systematic review starting with a brief discussion of the traditional model of clinical nursing education, defined below, and moving into a discussion of the preceptorship model. The method of the literature search and the resultant outcomes of that search are described first. The chapter concludes with a summary of the review.

Method of Literature Search and Databases Used

The literature search was conducted using a variety of methods. On-line databases, including CINAHL, ERIC, PubMed, The Cochrane Library, and PsycINFO were searched. I also searched ProQuest and TRACE databases for relevant theses and dissertations. Descendency searches of previously identified relevant literature were also conducted by hand. Keywords used during the literature search included staff nurse, clinical experience, clinical nursing education, nursing education, preceptor(ship), and a variety of combinations of these words and phrases. Initially, a 10-year limit was included for all areas of the review; however, this limit failed to provide enough relevant information for the literature related to the traditional model of nursing education. Therefore, the time restriction for that part of the review was removed. Even with the time restriction removed, the number of sources related to the traditional model of nursing education was only slightly increased. After generating pertinent

literature lists, literature was separated into research articles and opinion/anecdotal articles. There are 26 articles included in this chapter spanning from 1996 to 2011.

I have organized the germane literature under the major category of clinical nursing education. There are two sub-categories for clinical nursing education including (a) traditional model and (b) preceptorship model. The preceptorship category is further delineated into the following: (a) preceptors' perceptions, (b) preparation for preceptors, and (c) support for preceptors.

Review of the Literature

Clinical Nursing Education

Pre-licensure clinical nursing education courses provide a wide range of interactions with nurses and utilize a variety of clinical education models. One of the most common is the traditional model. The traditional model consists of one faculty member, employed by the educational institution, who works with a group of about 6-10 students on a hospital unit or clinical site that matches the faculty member's clinical expertise (Mannix, Faga, Beale, & Jackson, 2006). The traditional model is mentioned to a much lesser extent in the recent literature, but is important to include here as there are elements that overlap with preceptorship and inclusion of this information adds to the understanding of the problem. The initial search, with a time restriction of 10 years, generated only 13 articles for review, which reflects that the model is waning and far from cutting edge. Therefore, the time restriction for this aspect of the review was removed and the literature reflective of the traditional model includes some older, classic works.

In addition to the traditional model, the preceptorship model is frequently used in nursing education. As defined in Chapter I, p**r**eceptorship is the one-on-one, teaching/learning experience between nurse preceptor and undergraduate, pre-licensure nursing student working during the nurse's regular work schedule over a pre-determined amount of time for educational purposes (Chickerella & Lutz, 1981; Happell, 2009; Morton-Cooper & Palmer, 2000). The preceptorship model is the most prominent model in the recent literature. The initial literature search for *preceptorship* and *nursing* yielded over 1700 results. Due to the voluminous amount of literature, here I enforced a time constraint of 15 years.

Throughout the review, I also noted an inconsistent use of the terms "mentor" and "preceptor". The semantic nature of these terms predisposes authors to frequently interchange them. Although this review uses some articles where mentor is reported, I chose to use the term preceptor. I ensured that where the word mentor was used, the authors' definitions were consistent with the definition of preceptor used for this study. I did so by validating that authors were focused on the short-term, education experience between undergraduate, pre-licensure nursing students and staff nurses. When discussing studies where the word mentor was used, I keep with the authors' choice of terminology.

All abstracts were read for relevancy. Inclusion criteria were that the reference (a) was written in English, (b) focused on the education of pre-licensure nursing students, and (c) focused on my population of interest, i.e. the needs and/or perceptions of staff nurses serving as preceptors to undergraduate, pre-licensure nursing students and/or the preceptorship(s) of undergraduate, pre-licensure nursing students. An exception was made for the article written by

Henderson, Fox, and Malko-Nyhan (2006), in which the authors focus on preceptors for new graduate nurses employed as new staff.

Traditional model. This model is also referred to as a "faculty-supervised practicum" (Budgen & Gamroth, 2007). In this model, the faculty member is in a supervisory role to work in a practice area with a group of students (Mannix et al., 2006). Implementation of this type of model can vary depending on unit capacity and curriculum requirements (Budgen & Gamroth, 2007). Following is an amalgamation of information from five research studies about the traditional clinical model that provides a foundational understanding of the problem.

The traditional clinical model is purported to provide support for staff nurses and students (Budgen & Gamroth, 2007). Faculty members are ostensibly available and "accessible for discussions with clinicians about patient care needs and student learning needs" (Budgen & Gamroth, 2007, p. 274). However, this is not substantiated through my literature review. In sharp contrast, staff nurses report faculty members are unavailable and difficult to reach when necessary, and feelings of resentment in staff nurses often result (Levett-Jones, Parsons, Fahy, & Mitchell, 2006). Feelings of anxiety and vulnerability among nursing students are also reported (Holmlund, Lindgren, & Athlin, 2010). Consequentially, learning opportunities may be stifled because of faculty unavailability and this is an identified limitation of this model (Budgen & Gamroth, 2007). Nonetheless, staff nurses expect faculty to be available during these experiences (Grant, Ives, Raybould, & O'Shea, 1996). It is clear that a relationship exists between faculty and staff nurses during the traditional clinical experience. However, based on the literature, nursing faculty and staff nurses have differing perceptions about what benefits faculty members provide to staff nurses during the traditional experience.

One viable explanation is that faculty and students involved in traditional clinical experiences may be perceived as temporary systems intruding into a larger, permanent system (Paterson, 1997). Faculty members have described experiences of territoriality, separateness, and defensiveness as consequences of being a temporary system (Paterson, 1997) and being perceived as guests (Budgen & Gamroth, 2007). These consequences required nursing faculty to engage in "courting and negotiating behaviors" (Paterson, 1997, p. 202) with staff nurses, often leading to feelings of personal conflict that the faculty had somehow exposed students to an unspoken "ideal-reality dichotomy" in nursing (Paterson, 1997, p. 202). Paterson goes on to say that continued dialogue and committed effort are necessary, but may prove difficult as faculty are marginalized as they attempt to minimize the consequential effects of their presence. This can result in limited learning opportunities for students as staff nurses resign themselves to minimal interaction with faculty and students (Budgen & Gamroth, 2007).

Within this small body of reviewed research, the authors make general recommendations to enrich the traditional clinical experience for all involved; however, there are no identified studies that test these recommendations. For example, it is recommended that researchers focus on how outcomes for patients, students, and staff are affected by this model (Budgen & Gamroth, 2007; Paterson, 1997) and how nursing faculty credibility among staff nurses affects interactions with faculty and students (Paterson, 1997), but this research has yet to be done. Much of what is described above regarding support, behaviors, and perception is paralleled in literature about the preceptorship model. The reviewed studies are informative and add to our understanding, but more research is needed specifically to address the effectiveness and potential feasibility of suggested strategies. Moreover, the wide gaps in the date range suggest that we, in nursing, have

not made significant progress in research focused on the traditional clinical setting. This literature is summarized in Table 1.

Preceptorship model. For purposes of this review, preceptor refers to a staff nurse who works with an undergraduate, pre-licensure nursing student in a one-on-one relationship for the purposes of nursing education, including on-site supervision, clinical teaching, and some responsibilities for assessment and evaluation (Carlson, Wann-Hansson, & Pilhammar, 2009; Fitzgerald & McAllen, 2007; Ohrling & Halberg, 2001). The remainder of this section focuses on the preceptorship model and builds on what has been previously mentioned above regarding the traditional model of clinical nursing education. I start by providing information about general preceptor perceptions. I then move into a discussion about preceptor preparation and preceptor support, with special emphasis on support for assessing and evaluating student performance. Table 4 in Appendix A summarizes the 21 studies discussed below.

Preceptor perceptions. It is posited that preceptorships can provide nurses with a sense of professional development, intellectual stimulation, and personal growth through reflection and critical analysis of their own practice (Grindel et al., 2001; O'Callaghan & Slevin, 2003). Even so, these benefits may be outweighed by particular areas of concern to nurse preceptors, including evaluation of student clinical performance. There may be a perceived lack of consideration given by faculty to preceptors' recommendations and feedback, especially if a student's clinical performance is deemed to be of concern by the preceptor (Charleston & Happell, 2005; Happell, 2009). As such, it is imperative to first understand what preceptors, themselves, think and believe about precepting.

Table 1. ***Summary of Traditional Clinical Education Literature***

Author (Year)	Design & Method	Theoretical Framework	Instrument/ Data Collection	Focus or Study Aim	Population	Results/Findings
Bugden & Gamroth (2007)	Literature Review	None identified	Electronic databases	Practice education models in nursing		Authors described 10 practice education models in nursing literature, including key features, benefits, and limitations of each
Grant, Ives, Raybould, & O'Shea (1996)	Descriptive survey	None identified	26-item Likert-type questionnaire	To investigate RN attitudes to their role as teachers of nursing students and to identify support the nurses need to carry out the role.	N = 304	Nurses with more education, nurses who had volunteered, and nurses informed of university expectations were more likely to report that teaching is part of their role. These nurses also found teaching more satisfying. Nurses with more years of nursing experience and prior experience teaching nursing students were more likely to report feelings of adequacy in the teaching role.
Holmlund, Lindgren, & Athlin (2010)	Qualitative descriptive	None identified	Open-ended questionnaire	To explore what situations baccalaureate nursing students focus on during group supervision sessions, and what group supervision means to nursing students during their clinical training	N = 51	Three categories, including being a nursing student, encountering demanding situations, and becoming a nurse, and eleven subcategories were identified as foci of nursing students. The meaning of group supervision was described in three categories. These are satisfaction of being together, new understanding and insights, and hesitation and discomfort.
Levett-Jones, Parsons, Fahy & Mitchell (2006)	Description of QI project	None identified	Focus groups, personal interviews, surveys	Quality improvement project to enhance nursing students' clinical placement		Five themes identified as concerns, claims, and issues: (1) communication breakdown between the university and clinicians, (2) mentorship, (3) preparation for clinical placements, (4) clinical competence, and (5) graduates' readiness for practice.
Paterson (1997)	Exploratory descriptive/ Ethnography	Symbolic interactionism	Observations, interviews, concept mapping, and document review	To explore and describe what takes place in the realm of clinical teaching in nursing education.	N = 6	Consequences of being a temporary system (1) territoriality, (2) separateness, (3) defensiveness, and (4) patterns of intergroup communication. Effects were minimized by clinical faculty through behaviors of courting and negotiating with clinical staff.

Smedley (2008) conducted a phenomenological study about becoming and being a preceptor. After interviewing seven participants and analyzing data, the author said seven themes emerged and were categorized into two broad areas: (a) issues related to learning to be a preceptor and (b) issues related to being a preceptor. The seven themes are as follows: (a) developing knowledge about adult learning, (b) increasing awareness of various learning styles, (c) changing attitudes toward students and new graduate nurses, (d) changing teaching and learning approaches in the clinical environment, (e) experiences with culturally and linguistically diverse learners, (f) experiences with the age of the learners, and (g) differences in teaching registered nurses and students.

Within these themes, preceptors reported that the relationship with students was important to the preceptorship, as was the need for self-reflection. Preceptors were empowered in their role through the acquisition of knowledge, skills, confidence, and positive attitudes towards students. Development of knowledge, particularly about adult learning, was described by preceptors as empowering, enlightening, and permitted them to be more focused on the student's needs. Preceptors' positive attitudes towards students increased their awareness of the preceptor role, increased patience, and revealed a need for self-reflection as a nurse. Students who were culturally or linguistically diverse and the differences in student attitudes were reported as challenges to preceptors.

Charleston and Happell (2005) further focus on the relationship between preceptor and students in their grounded theory study designed to examine mental health nurses and undergraduate nursing students' perceptions of preceptorships in mental

health settings in Australia. The authors used individual interviews to collect data from nine mental health nurse preceptors. Analysis was conducted using Strauss and Corbin's procedures for grounded theory. The ability to attain a sense of connectedness with the student was reported as the core issue central to the preceptorship relationship. Preceptors wanted consistent, purposeful, holistic experiences for the students and needed to make connections to achieve this and reported frustration when connections could not be made or if inconsistency was perceived. Time was identified by the preceptors as a significant factor contributing to the ability to achieve connectedness. The category of actuality was identified as encompassing the components of the preceptorship in which preceptors serve to assist students. These components were acknowledged by preceptors as important to their overall domain of being a preceptor and include directing, managing, protecting, decision making, socializing, supporting, and encouraging. Through these actions, preceptors are able to achieve the connectedness with the student. A third category, augmentation, was also discussed. Within this category, preceptors acknowledged the need to formalize the preceptorship process to decrease disorganization and inconsistency. Preceptors also articulated the need to feel prepared and valued in their role and suggested that support from other nurse preceptors and universities would be helpful.

Ohrling and Hallberg (2001) conducted a phenomenological study in Sweden to explore the meaning of preceptorships through the lived experiences of nurses. Through hermeneutic interpretation, the authors report two themes, eight sub-themes, and four

dimensions identified in the text. The two themes identified as the meaning of preceptorship were identified as (a) sheltering the students when learning and (b) facilitating the students' learning. Within the theme of sheltering, preceptors reported conferring with colleagues, faculty, and students to guide the development of the preceptorship experience. By doing so, students were sheltered to some degree as preceptors gauged the learning process. The authors reported that this suggests the preceptor took responsibility for "widening the student's experience" (Ohrling & Hallberg, 2001, p. 533). Preceptors also discussed the value of observing and listening to the students, referred to as *valuing dimensions*. Based on the preceptors' statements, the authors pointed out that it was the preceptor who set boundaries for the student by evaluating competence level, and by doing so, minimized the risk of course failure and patient discomfort. Within the theme of facilitating student learning, preceptors reported that communication with students and task-oriented learning were used as teaching strategies. Preceptors reported they deliberately thought about how students would advance through the preceptorship. Communication was often used to help students navigate through tasks, provision of pep-talks, and reflect on previous experiences.

The importance of facilitation was repeated in another phenomenological study by O'Callaghan and Slevin (2003). In this study from Ireland, the authors explored the lived experiences of registered nurses facilitating supernumerary nursing students. Supernumerary refers to the student's status in his or her educational program and is congruent with the term pre-licensure nursing student. Using semi-structured interviews,

the authors collected data from the sample (n = 10). The authors described six themes that emerged from the data. Participants reported that facilitation of student learning was accomplished by using their own experience as a learning resource. Participants also reported that the experience provided them with opportunity to develop their own learning and professional practice. The amount of student interest was described as essential, and students who appeared uninterested were perceived as difficult to deal with and as an unnecessary waste of time. Study participants also conveyed a feeling of being ill-prepared for their role and cited a lack of support from the school of nursing as part of the source of this feeling.

The brief review of the previous studies revealed that preparation and support are two key elements of the role with which preceptors are concerned. These findings are also in line with Omansky's (2010) integrative review of the nursing preceptor literature. Using the role episode model, Omansky concluded that preceptors experience role ambiguity, role conflict, and role overload. She said all of these are associated with a lack of understanding about and recognition for the role. Specifically, it was noted that managers and colleagues viewed the preceptors as having additional help as opposed to additional responsibilities and as a result, workload issues were not taken into consideration when making patient assignments. Further, she noted conflicting perceptions between preceptors and clinical instructors of what was most important in the preceptorship experience. According to the author, clinical instructors considered the student evaluation most important, whereas preceptors considered being a role model

most important. This ambiguity resulted in additional stress for preceptors trying to function in an already ill-defined role. Omansky is quick to note that the similarities in the extant literature cross international boundaries. In fact, regarding role overload, she says "this role overload stress was reported from every country where studies were found" (Omansky, 2010, p. 701).

The cumulative findings of these studies guided the development of the remainder of this section of my literature review. A lack of preparation and lack of support were clearly elucidated as prominent issues for preceptors, and as such, I further explored these areas to determine if more specific information or issues could be discovered. The outcomes of this more in-depth exploration of the literature are described below.

Preparation for preceptors. One area in which there is much variation is regarding the preparation of preceptors. In an opinion article, Edmond (2001) says that staff nurses should be the ones to best facilitate clinical learning, role transition, and professional socialization of students and novice practitioners and their ability to do so is documented in research (Carlson, Pilhammar & Wann-Hansson, 2010b; Kowalski et al., 2007). However, simply because a nurse is an expert clinician does not mean that he or she will make an expert preceptor. Preparation is necessary for any role. Reporting on a process improvement project, Kowalski et al. suggest that a lack of preparation is a reason for burnout and dissatisfaction with nurses working as preceptors. It is often expected, though, that nurses will assume this role without incentive or adjustment to workload (Happell, 2009; Yonge, Krahn, Trojan, Reid, & Haase, 2002). As such,

preceptors should have clear responsibilities provided in order to help prepare them for this role (Rogan, 2009). The following discussion reveals current research findings focused on the preparation of nurse preceptors.

In Sweden, Carlson et al. (2009) used ethnography to describe strategies and techniques used by preceptors (n = 16) to teach undergraduate nursing students. Data sources included field notes, observations, and focus group interviews. Three categories were found as important techniques for preceptors. These include (a) adjusting the level of precepting, (b) performing precepting strategies, and (c) evaluating precepting. The authors also describe seven subcategories in their findings. Based on the findings of their study, preceptors think it essential to have a first meeting with the student prior to the initiation of the preceptorship. This allowed the preceptor to develop some idea about the student's abilities so that the level of precepting could be appropriately adjusted. Further, preceptors expressed the importance of creating a trusting relationship to enhance the feeling of security for the student. By doing so, preceptors reported that the preceptorship was enhanced. These two components supported the use of the preceptors' reported teaching strategies of demonstrating, questioning, reflective thinking, and assessing. Results from this study indicate that nurse preceptors use methodical strategies and techniques to facilitate student learning during preceptorships. What is not known from this study is how much, if any, preparation was provided to the preceptors prior to assuming the role. The authors recommend that to support preceptor role development, information about pedagogical strategies should be provided and that

preceptors should be given the opportunity to create learning opportunities that meet the requirements of the academic institution.

In her descriptive study, Rogan (2009) used Mercer's Role Attainment Theory to examine the type of preparation nurse preceptors believe is required to complete their job. She also researched differences in perceptions about preceptor preparation based on years of nursing experience, area of practice, or years of preceptor experience. Study participants (N = 75) completed The Preparation of Nurses Who Precept BSN Students Survey. This instrument asks participants to rate 33 content areas pertaining to preceptor preparation as "essential", "useful", or "not needed". Study results indicated that preceptors (n = 71) overwhelmingly identified role responsibilities as the most essential content element. Setting priorities and organizing workload (n = 70) and preceptor roles (n = 68) were the second and third most essential content elements, respectively. Only descriptive statistics are reported. In her discussion on study implications, Rogan (2009) suggests that preceptor preparation focus on teaching/learning strategies, adult learning principles, communication, values and role clarification, conflict resolution, assessment needs of the preceptee, and evaluation of preceptee performance with the desired outcome of "cultivation of a greater sense of comfort in the preceptor role" (Rogan, p. 566). She also asserts that nurses with adequate preparation can enhance their current practice and therefore become better role models for preceptees.

Zahner (2006) used repeated measures design in a pilot study to determine the effectiveness of a web-delivered preceptor course for nurses who work in public health

settings (n = 13). As reported by the authors, the study was conducted over one semester with measurements taken before the course (Time 1), throughout the course (Time 2), and at the end of the semester (Time 3). Time 1 knowledge was assessed using a mailed survey consisting of nine knowledge questions. Four on-line video vignettes were used to illustrate important concepts in the interactions between preceptor and preceptee in these types of health settings, and nine modules were used to provide course content. The same nine questions from Time 1 were provided among a total of 36 knowledge questions included in module quizzes completed throughout the nine modules (Time 2). Participants were allowed the entire semester to complete the course. At the end of the semester, participants complete the same nine knowledge questions for the Time 3 measurement. Repeated measures ANOVA indicated statistical significance in knowledge over time (F = 55.603, df = 2, error df = 11, $p < .0001$). The difference between Time 1 and Time 2 was statistically significant (t = -10.25, $p < .00001$). The difference between Time 1 and Time 3 was also statistically significant (t = -4.95, $p <$ .0003). Zahner reports that study participants were satisfied with the individual modules and the format of the web-based delivery system. She does note, though, that the time it took for the participants to complete the course was an issue (M = 34.51, SD = 16.42, Range = 10 – 80 min).

Heffernan, Heffernan, Brosnan, and Brown (2009) described a comprehensive evaluation study of a preceptor course in the workplace in Ireland, where preceptorship is a required part of nursing education and practice. Nurses serving as preceptors must

complete a preceptorship course. The initial course is 16 hours, provided in two 8-hour days, and contains information about changes in nursing education nationally and internationally, clinical learning environments, principles of assessment and feedback, learning theories, clinical support networking, and competency among a few other broad topics. After two years of precepting, a required 4-hour update course is required. The pedagogies of choice for these courses include lecture, discussion, group work, and interactive forum. This study consisted of two phases. In Phase I, the authors transcribed over 520 evaluation forms and conducted three small (n = 12, n = 12, n = 12) focus group interviews. The transcribed data were analyzed using thematic analysis. Four themes emerged during Phase I and included the following: (a) Theme 1: the importance of preceptor characteristics, (b) Theme 2: the demonstration of preceptor characteristics, (c) Theme 3: the specific knowledge demonstrated by preceptors, and (d) Theme 4: specific skills demonstrated by preceptors. Those findings were used to construct a new 74-item, Likert-type questionnaire used during Phase II. The internal consistency of the final instrument was $\alpha = .919$. This questionnaire was administered to preceptors (n = 191) and students (n = 208) and results were analyzed. Findings related to Theme 1 indicated that students consider being supportive of students and being approachable as the most important characteristics preceptors should have. Preceptors also rated support and approachability as important, but rated communication skills as of highest importance. In Theme 2, preceptor confidence and knowledge were reported by students as being consistently demonstrated. Being approachable and being supportive were ranked by

students third and fourth, respectively, in Theme 2. Interestingly, preceptors ranked being supportive of students as their best demonstrated characteristic and being approachable as their least demonstrated. In Theme 3, both students and preceptors ranked the understanding of the role of the student and the importance of orientation to the clinical area as highest. In Theme 4, there was a noted difference in ranking between preceptors and students regarding communication skills. Preceptors ranked their communication skills as lowest, whereas students ranked it as highest. Further, students rated preceptors' ability to challenge them as very low, whereas preceptors ranked it much higher. These results suggest that preceptors and students differ in their perceptions of preceptorships. Of significant importance is the differing perceptions regarding preceptors' ability to challenge thinking. This difference in perceptions beckons a need for further exploration of nurses' preparation as preceptors. The authors suggest that preceptor preparation requires support networks and consistent education updates with follow up evaluations.

In Australia, Henderson, Fox and Malko-Nyhan (2006) conducted a longitudinal, descriptive study to evaluate nurse preceptors' perceptions of a 2-day educational workshop and subsequent organizational support to prepare them for their roles. In their study, preceptors were used for new graduate nurses hired as new staff. I included this research because the population was similar to my specified population, with the exception that the students had already graduated from the educational institution. Furthermore, there are excerpts of transcripts in the article where participants directly

refer to both new graduates and students. Therefore, it can be surmised that participants considered both when discussing their role as preceptor. The authors conducted focus group interviews (n = 36) with preceptors who received preceptor training in a local tertiary care setting. They reported that the program is open to all registered nurses with at least one year of experience and who demonstrate interest in and aptitude for the role. The preceptor preparation course consists of a 2-day workshop where preceptors primarily receive information about preceptor roles and responsibilities, preceptee needs, adult learning, effective teaching and performance assessments, and strategies for effective preceptorships. Six focus groups were conducted 2 to 3 months and four at 6 to 9 months after the workshops and lasted for about one hour. Nurses who could not attend focus groups were provided with one-on-one interview sessions lasting approximately 30-45 minutes. Study results indicate that preceptors are satisfied overall with being a preceptor, with the personal growth that takes place as a preceptor, and with perceived learning opportunities from others. There were, however, some negative perceptions and feelings, such as frustration, reported. These also include the perceived lack of time needed to serve as an effective preceptor, perceived lack of support from the educator in facilitating learning opportunities, and perceived lack of organizational support for the role of preceptor. Preceptors also reported that a support network was desired and the authors suggest that these results indicate the importance of organizational support for preceptors.

There is wide consensus in the literature that preceptors need some type of preparation. What is less clear is the best practice for preparing preceptors. The studies described here provide initial insight into various preparatory methods for preceptors, including teaching strategies, and preceptors generally reported satisfaction with the processes. Even so, the notion of support, or the lack of support, permeates the literature. The incongruence between preceptors' reported satisfaction with preparatory methods and lack of support suggests that preparation and support are intricately interwoven and perhaps more so, that we do not understand the amount or type of support required or requested by preceptors in order to sustain them in their roles.

Support for preceptors. As early as 1990, research on support for nursing preceptors can be found. Although the study by Bizek and Oermann (1990) will not be specifically discussed in this review, I mention it here to demonstrate the lack of progress nursing has made with this aspect of preceptorship. Even now, one of the most common reports from preceptors is that they feel unsupported by faculty and other nursing administrators (Landmark, Hansen, Bjones, & Bohler, 2003; O'Callaghan & Slevin, 2003). Nonetheless, nurses still express desire to assist in educating students and want their professional judgments considered in the student evaluation process (Levett-Jones et al., 2006), so continued efforts should be made to support them. The following research studies describe current attempts to elucidate information about support for preceptors.

Yonge et al. (2002) used a descriptive, exploratory research design to study the nature of stress in the preceptor role and to identify the kind of support needed to make

the experience valuable. Using a Likert-type survey designed by the authors, preceptors were asked about the levels of stress in the preceptor role ranging from (1) nonstressful to (5) extremely stressful. The authors report that 75% of respondents indicated some level of stress as a preceptor, but none indicated it was extremely stressful. The most common sources of stress were the sense of having added responsibilities at work and the extra time required of the preceptorship. It was also reported that preceptors felt responsible for students' work, including any mistakes that might have occurred, and that this also increased stress levels. Additional stress was reported if students were ill-suited for the clinical area, lacked confidence or lacked skills. Based on the study results, the authors recommend that nursing faculty use strategies designed to lessen preceptors' burdens, screen students for suitability for placement, and assess the suitability of the preceptor as well. Aside from the general recommendations already mentioned, discussion about the kind of support required to enhance this experience is lacking.

Landmark et al. (2003) conducted a qualitative descriptive study to gain insight into, and identify, what participants experience in the role of clinical supervisors of nursing students. Data were collected in three focus groups (n = 20), each of which lasted 90 minutes, and were analyzed using content analysis. Three areas of importance were identified and include: (a) didactics, (b) role functions, and (c) organizational framework. Regarding didactics, nurses reported a need to support students in making the connection between practice and theory; however, they also recognized that they, themselves, needed supervision in order to be competent in their role. Novice nurses, in

particular, reported an inability to support students through reflection on practice as they, themselves, had little experiential knowledge. The authors did not provide a definition of novice nurses. When discussing role function, nurses reported feeling that the role was not adequately recognized by others. Additionally, nurses reported that professional self-confidence and self-awareness influenced their ability to adequately supervise nursing students. Within the area of organizational framework, nurses indicated a need for communication from faculty members about expectations. Not only were expectations about student performance needed, but expectations were needed regarding the responsibilities and the demands of being a clinical supervisor to students. The authors suggest that these findings indicate a need for clarification of the role of the nurse in the clinical supervision of students.

In Sweden, Carlson, Pilhammar, and Wann-Hansson (2010a), conducted an ethnographic study designed to describe conditions for precepting in a clinical context. The authors used observations, focus groups, and field notes as data sources to collect information about preceptor-student relationships, obstacles and support for preceptors, organization and routines for precepting. Study results identified three themes to describe conditions for precepting: (a) the organizational perspective, (b) the collaborative perspective, and (c) the personal perspective. Time was a repeated element throughout the study. Nurses reported that precepting often presented an added responsibility on top of their clinical work, particularly if nothing was known about the student prior to his or her arrival. Furthermore, nurses reported feeling stressed and

inadequate for the role because of time shortage; and they stressed the importance of feedback from students and faculty members. Nurse preceptors found collegial support from their co-workers to be invaluable in creating a positive learning experience for students. This support was enhanced by the shared initiative to find learning opportunities and the temporary handing over of the preceptee to other nurses, which also allowed the preceptor to find additional time. The authors found that although time was a repeating element in all conditions, nurse preceptors value personal satisfaction, growth, and competence over monetary or other material incentives.

In their descriptive survey research from the United Kingdom, Pulsford, Boit, and Owen (2002) aimed to glean information about mentors' perceived levels of support in undertaking the role, and factors that would allow them to carry out the role more effectively. The total sample for this study was n=198. Survey results indicated that most participants had been a mentor for 0-5 year (n = 32) or 6-10 years (n = 35). Results also suggested that participants perceived the most support for their role from their colleagues (n = 67) and the least amount of support from their managers (n = 23). Participants indicated they would like more support from faculty in higher education institutions (n = 36). According to the authors, nurses serving in the role of mentor to nursing students must attend annual updates provided by the higher education institutions. Although most participants reported attending an update within the past 12 months (n = 35), the next highest report was that participants had never attended an update (n = 21). The most frequently reported reason for non-attendance was staff

shortages (n = 47). Only two participants indicated lack of interest as the reason for non-attendance. The most preferred method of receiving information from updates was in the form of written information (n = 54) and newsletters (n = 53). Responding to a question about what would make their role easier or more fulfilling, participants reported a desire for more time to undertake the role, more support from management, partnerships with higher education institutions, more appropriate use of student placements, better ways to document student performance, more motivated students, and extra pay.

Hyrkas and Shoemaker (2007) conducted a study to explore the relationships between preceptors' perceptions of benefits, rewards, support and commitment to the preceptor role. The study was a replication of studies conducted in the 1990s by Dibert and Goldenberg (1995) and Usher, Nolan, Reser, Owens, and Tollefson (1999). The authors used a descriptive, correlational survey design to collect data in two phases. The first phase consisted of nurses who had attended a preceptor workshop and were assumed to serve as preceptors for newly hired nurses. The second phase involved targeting nurses working as preceptors for undergraduate nursing students at a local university. The total sample was 82 preceptors. I have included this study as some of the participants served as preceptors for both newly hired nurses and undergraduate nursing students. The authors used a four-part questionnaire consisting of the Preceptor's Perceptions of Benefits and Rewards (PPBR) Scale, the Preceptor's Perceptions of Support (PPS) Scale, the Commitment to the Preceptor Role (CPR) Scale, and a demographic sheet. The authors reported that a positive correlation between the two sub-

scales, PPBR and CPR, existed ($r = 0.52$, $p < 0.001$, $n = 70$). That is, the more preceptors perceived benefits and rewards, the more they were committed to the role. They also reported a positive statistically significant correlation between perceptions of support and commitment to the role ($r = 0.42$, $p = 0.01$). The authors used nonparametric tests to determine the differences between scale scores and participants' educational preparation, graduation year, attendance at preceptor workshops, age, workplace, and type of nursing. No statistically significant correlations were found between preceptors' years of nursing experience and scores on the PPBR, PPS, and CPR scales. Additionally, no statistically significant relationships were found between the number of experiences as a preceptor, number of each type of preceptorship and scores on the PPBR, PPS, and CPR scales. The relationships between educational background and scores on the scales, and age and the scales did not result in statistical significance. There were, however, statistically significant differences among preceptors according to graduation year, workplace, and type of nursing work. Nurses who graduated between 1981and 1990 ($M = 74.60$, $SD = 6.97$) rated the benefits and rewards of preceptorship higher than those who graduated in 1991 or later ($M = 69.25$, $SD = 6.85$). Nurses working in homecare or nursing home settings ($M = 77.80$, $SD = 3.42$) also assessed benefits and rewards of preceptorship as higher than nurses working in other settings. Preceptors of undergraduate nursing students assessed support higher than other preceptors ($M = 68.64$, $SD = 14.51$, $p = 0.04$). The differences were found in the following PPS Scale items: "support from the nursing coordinator, other staff not understanding of preceptor programme [*sic*] goals, related

workload, and time for patient assignments" (Hyrkas & Shoemaker, 2007, p. 519). The authors assert that results from this study confirm the commitment of preceptors to their role, particularly when benefits and rewards are available. Further, they suggest that a positive perception of support helps to maintain the nurses' commitment to the preceptor role. The authors report that study findings were congruent with the aforementioned studies by Dibert and Goldenberg (1995) and Usher et al. (1999).

Luhanga, Dickieson, and Mossey (2010) aimed to "explore and describe preceptor role support and development within the context of a rural and northern mid-sized Canadian community" (p. 3). Using a qualitative exploratory descriptive design, the authors conducted semi-structured individual interviews and focus groups to collect data from nurse preceptors (n = 22) about both the support for and the preparation of preceptors. Data were analyzed using content analysis. Four prominent themes were identified and include (a) accessible resources, (b) role complexity, (c) partners in precepting, and (d) role development. Communication with nursing faculty, especially in a timely fashion, was identified as essential for the preceptors, but lack of communication and support from the university were reported as barriers. Regarding their roles as preceptors, nurses stressed the importance of being able to facilitate student success through fostering critical thinking, competence, confidence, and organizational skills. Of significant importance is the recognition by preceptors of their role in evaluating students' performances. This element of precepting was viewed by preceptors as a "substantial component" of their role, but there was mixed responses regarding feeling

prepared and supported to carry it out, particularly if a student was unsafe or in jeopardy of failing the course. Preceptors stressed the need for clearer role expectations and guidance in and support for student evaluation. As has been previously discussed, time was also a factor for preceptors in this study. In fact, the authors report that preceptors described "the nature of preceptorship as time-intensive as they worked to fulfill their preceptorship responsibilities in addition to their regular practice responsibilities" (Luhanga et al., 2010, p. 10). Although preceptors requested the development and implementation of a preceptor selection process, including formal education geared toward understanding the preceptor role, there were several barriers cited. These included scheduling issues, heavy workload responsibilities, and competing priorities during work. The authors recommend using flexible, creative strategies to prepare and support nurse preceptors. Further, they say that faculty members should be cognizant and proactive in assisting preceptors with student evaluation.

The importance of support for nurses who precept is clearly noted in the literature. It is reported that nurses often experience stress in their role as preceptor and that support from a variety of sources is desired. Collegial support from co-workers is reported as invaluable and the most frequent source of support. Nurses report a need for more support from nurse managers and faculty members. Several authors suggest strategies for faculty, such as screening students, communicating about student expectations, and clarifying preceptor role expectations, that can provide support for nurse preceptors. A

particular area of concern for preceptors is in the assessment and evaluation of students. The remainder of the literature review addresses this topic.

***Support during student assessment and evaluation*.** One particular area of noted concern among preceptors is in dealing with the assessment and evaluation components of students. As I reviewed the literature, I noted that in studies focused on this aspect of the preceptorship, there were reports from nurse preceptors of feelings and perceptions that seemed to be reflective of discomfort. This was especially true if the student was unsafe or incompetent. The following discussion focuses on this specific aspect of preceptorship.

While reviewing grades for a preceptorship experience, Seldomridge and Walsh (2006) reported an observation of "unusually large number of high grades and very few average grades" (p. 171) when compared to faculty-led clinical experiences. This observation led them to question why this discrepancy existed. The authors conducted a descriptive study to compare clinical grades for students in two different preceptorships, community health and leadership/management, among cohorts from 1997 to 2002. Results of that study revealed 95% of students in preceptorships between these dates received grades of either an A or a B, and the remaining 5% of students received a grade of C. The authors point out that grades of C or better were needed in order for students to successfully complete the course. No statistically significant differences were found when comparing group means or in the pattern of distribution. The authors make several assertions for the high grades in preceptorships. They say that the extent of preceptors'

orientation often includes only the receipt of information about the course from faculty through hand-delivered, regular, or electronic mail. It was further noted that, as a result of inadequate preparation and lack of recognition, preceptors may simply find it easier to provide passing grades as opposed to expending more time and energy to defend a failure. The relationship that develops between preceptor and student may also have an effect on grading, according to the authors. They assert that part of the reason preceptors serve in the role is an attempt to enhance the student's experience of transition into practice. This desire to be supportive may in actuality lead to "generosity in grading" (Seldomridge & Walsh, 2006, p. 172). To provide clarity to this aspect of precepting, the authors say faculty should provide preceptors with specific information about course objectives and student evaluations, ensuring that all have the same expectations of the student performance.

Preceptors' perceptions of unsafe student clinical performances are the focus of Hrobsky and Kersbergen's (2002) qualitative descriptive study. They used semi-structured interviews to collect data from four participants. The authors report identification of three prominent themes: hallmarks of poor performance, preceptors' feelings, and the liaison faculty role. Some of the reported hallmarks of poor performance include students not asking questions, being unenthusiastic about nursing, and demonstrating unsatisfactory skill performance. Hrobsky and Kersbergen state that preceptors reported feelings of fear, anxiety, and self-doubt in wondering about whether the student would fail if observations were reported to faculty members. In their analysis,

the authors reported that these preceptor statements reflected self-esteem issues, especially when trying to communicate this to faculty. Preceptors also identified three liaison faculty roles that they found beneficial during preceptorships. These are listening, being supportive, and following up after the preceptorship. Hrobsky and Kersbergen go as far to say that assessing unsatisfactory clinical experiences is demoralizing for and even "poses threats to preceptors' self-confidence" (p. 552). The authors recommend that preceptor preparation must be strengthened and include information about liability and accountability issues. They also recommend that faculty and preceptor relationships be strengthened through frequent dialogue about role expectations and clinical outcomes.

Luhanga, Yonge, and Myrick (2008a), Luhanga, Yonge, and Myrick (2008b), and Luhanga, Myrick, and Yonge (2010) report on various aspects of the same study focused on the assessment and evaluation of incompetent and unsafe students in a preceptorship. Using grounded theory, the authors explored "the psychosocial processes involved in precepting a student with unsafe practice" in an attempt to identify "effective management and coping strategies that preceptors use" (Luhanga et al., 2010, p. 266). An unsafe practice in the clinical setting was defined as "any act by the student that is harmful or potentially detrimental to the client, self, or other health personnel" (Luhanga et al., 2008a, p. 1). Data were collected from 22 preceptors through semi-structured interviews and analysis was conducted using Glaser's (1978) constant comparative analysis. Five major categories were revealed: (a) hallmarks of unsafe practice, (b) factors that contribute to unsafe practice, (c) preceptors' perceptions and feelings, (d)

issues related to grading and (e) strategies for managing students with unsafe practices (Luhanga et al., 2010). The authors identified "promoting student learning *while* [*sic*] preserving patient safety" as a core category (Luhanga et al., 2010, p. 266).

Luhanga et al. (2010) say "preceptors have a moral obligation to evaluate students accurately" (p. 268). They also suggest that preceptors must be experts in their areas of practice, and that they must assign or recommend failing grades to students who demonstrate less than satisfactory clinical performances. However, it was noted that this is an area in which preceptors report feelings of fear, anxiety, self-doubt, anger, lacking in confidence, and frustration (Luhanga et al., 2008a; 2008b). As a result, some nurse preceptors had not failed students because "they had given the benefit of the doubt to the students who were less than competent" (Luhanga et al., 2008a, p. 267). Other reasons that preceptors did not assign failing grades to incompetent and unsafe students were (a) personal feelings of guilt and shame, (b) reluctance to cause the student to incur additional costs, (c) complacency about the extra workload, (d) lack of appropriate evaluation tools, and (e) feeling pressured to help produce nurse graduates due to the nursing shortage (Luhanga et al., 2008a). In fact, failing a student was so stressful for one preceptor that she refused to precept thereafter (Luhanga et al., 2008b).

These feelings may be explained, in part, by preceptors' perceptions of accountability. Preceptors recognized that it is their responsibility to intervene when situations presented in which patient safety could be compromised (Luhanga et al., 2010). Further perpetuating the problem were the perceptions that students are ill-prepared for

the clinical setting with regard to skill demonstration (Luhanga et al., 2008b); and preceptors reported a lack of time to work with the student as a contributing factor to their reluctance in assigning failing grades (Luhanga et al., 2008a; 2008b). If an error occurred, and the student was dishonest about the situation, preceptors found it even more difficult to trust the student (Luhanga et al., 2010); yet, failing grades were still not assigned (Luhanga et al., 2008a; 2008b).

In the rare instances when a failing grade was assigned to an unsafe student, some preceptors experienced relief (Luhanga et al., 2008b). Contributing to the feeling of relief is supportive faculty who are communicative with the preceptors, offering advice and guidance in these situations (Luhanga et al., 2008b). Preceptors felt it is important to provide honest feedback to students and their faculty members (Luhanga et al., 2010). In order to do so, preceptors expect faculty to be more available, especially when unsafe situations arise (Luhanga et al., 2008b). Preceptors also indicated they were more likely to fail students if needed when faculty were more supportive (Luhanga et al., 2008b). Although it is the faculty member who ultimately assigns the grade for the preceptorship, most preceptors expect their input to faculty to be taken seriously and feel belittled and betrayed if their recommendations to fail a student are not respected (Luhanga et al., 2008a). It was reported that in a few cases, preceptors recommended failing a student and instead, faculty members assigned a passing score (Luhanga et al., 2008a).

This presents quite a conundrum. It is asserted that by not assigning failing grades or otherwise addressing unsafe preceptee practice, preceptors are negligent in their

responsibilities (Luhanga et al., 2008a). However, if nursing faculty expect preceptors to accurately evaluate students, then faculty should engage in behaviors that demonstrate support. Unfortunately, most preceptors reported infrequent visits or even no contact with faculty members during preceptorship experiences (Luhanga et al., 2008b). Although the authors make general recommendations for both faculty and preceptors in dealing with unsafe or incompetent students, there is no identified research reporting specifically on the effectiveness of these strategies.

Summary

In this chapter, I reviewed a total of 26 research articles focused on clinical nursing education; five dealing with the traditional model and 21 with the preceptorship model. Within the body of research, several important issues are elucidated.

It is clear that lack of time is one of the limitations reported by preceptors to cause excess stress during preceptorship experiences (Carlson et al., 2010a; Henderson et al., 2006; Pulsford et al., 2002). It is reported as a primary problem when workloads are heavy, as nurses identify themselves as nurses first and as preceptors second, therefore preceptor responsibilities are relegated to becoming a less important priority (Carlson et al., 2010a). This sense of accountability and responsibility is viewed by preceptors as critical, especially if students are deemed unsafe or incompetent (Luhanga et al., 2008a; 2008b; Luhanga et al., 2010). Research indicates that poorly performing students are often a significant source of stress, leading to feelings of self-doubt, fear, anxiety, anger, and frustration for preceptors (Luhanga et al., 2008a; 2008b; Luhanga et al., 2010).

Preceptors often feel unsupported in their roles and express needs for this support from faculty, colleagues, and administrators in healthcare organizations. They are often expected to assume the preceptor role without incentive or adjustments to workload. It is well documented that precepting can be source of professional development and self-esteem for nurses, promoting critical reflection of their own practice (Grindel et al., 2001; O'Callaghan & Slevin, 2003), but these rewards are intrinsic as the recommended workload reduction and additional pay are not yet the norm. Preceptors also say they feel ill-prepared to assume the role (Luhanga et al., 2008a; 2008b; O'Callaghan & Slevin, 2003). There are no identified studies describing implementation of decreased workloads for preceptors or other strategies designed to alleviate this problem, nor are there studies that describe testing interventions to determine best practices and pedagogical methods. This begs the question of why one would choose or continue to be a preceptor.

My study differs from the extant literature. First, I addressed the perceptions of preparation and support in the preceptor role. Focus group questions targeted to address support and preparation in the role provided additional insight into the role of preceptor and allowed for a deeper examination of the role. This builds on what we already know about preceptors' needs in regard to these areas. Second, I focused specifically on preceptors' understanding of what their role entails. This area has not yet been singularly addressed in prior research. Even though there are several suggestions for interventions that aim to improve the preceptor experience, without understanding the role functions from the preceptors' perspectives, implementation of such strategies may be fruitless.

Third, through this study, I attempted to begin understanding preceptors' motivation to serve. By doing so, it is possible that information for development of novel clinical strategies can be revealed, leading to further research in this very important area of nursing education and practice.

Chapter III: Methodology

To recall, the purpose of this dissertation is to explore staff nurse experiences as preceptors to undergraduate, pre-licensure nursing students. Emphasis is placed on exploring RN's perceptions of the role, specifically the preparation for, support in, and understanding of what the role entails. In this chapter, I provide a description of the research design and methodologies. I also discuss sample and setting, recruitment procedures including consent, instruments, data collection, and data analysis procedures. The chapter concludes with a discussion of ethical considerations.

Research Question

As stated in Chapter I, the following question guided the research study:

1. What are staff nurses' experiences with precepting undergraduate, pre-licensure nursing students?

This question served as the driving force for the research design and method. Using this question as the foundation for the study, I aimed to explore the experience of preceptorship as told by staff registered nurse preceptors for undergraduate, pre-licensure nursing students. Specifically, I examined their words, conversations, and interactions for understanding about their overall perception of the preceptor role with emphasis on the preparation for, support in, and understanding of what the role entails.

Research Design and Data Collection Strategy

Research Design

Creswell (2007) offers several reasons for conducting qualitative research. Among these are the need to explore a problem, the need to identify variables that can be measured, when existing theories do not fully capture the complexity of the problem, and when quantitative measures do not fit the problem (Creswell, 2007). As seen in the literature review, there is little research or theory basis regarding the precepting role as experienced by the RN. Exploratory research should be used when little is known about a topic, the topic has not been previously studied, the participants have personal experience in or about the topic, and participants can talk about the topic (Wood & Ross-Kerr, 2011).

Although little is known about the preceptor role as it is perceived by those who do it, what is known is that there is much variation in the way that preceptorships are implemented, thereby leading to confusion and possible negative emotions experienced by preceptors. Moreover, the term *precepting* is also used interchangeably with the term *mentoring* and is often used to describe the orientation process of newly hired graduate nurses. This adds to the lack of clarity about what is known about preceptorships. Taken together, it appeared there was adequate need and the time was right for further exploration of the preceptorship experience from the perspective of staff registered nurses serving in the role for undergraduate pre-licensure nursing students.

Data Collection Strategy

Focus groups are defined as semi-structured, informal group sessions with a moderator or facilitator conducted to collect data on a specific topic occurring in a social context (Carey & Smith, 1994; Duggleby, 2005). A distinguishing factor of focus groups is the interaction that occurs between participants (Kitzinger, 1994). Krueger and Casey (2009) say that group influence is a reality in life and focus groups support this type of natural environment. Focus groups are appropriate when researchers need a deeper examination of perceptions, feelings, and thinking about issues, with the inclusion of rich details (Asbury, 1995; Carey & Smith, 1994; Krueger & Casey, 2009). In addition, group interaction supports a "candor and spontaneity" that cannot be achieved through individual interviews (Carey & Smith, 1994). The group interaction that occurs as a result of focus group research, allows participants to address issues that are important to them, in their own words, bringing their own priorities to the forefront (Kitzinger, 1994). This is less easily accomplished in one-on-one interviews. I sought to understand, in-depth through nurse preceptors' own words, the experience of being a preceptor to pre-licensure, undergraduate nursing students. Preceptorships are inherently social experiences requiring those involved to interact with each other and a multitude of others inside and outside the clinical agency. Because of the social nature of preceptorships and the shared experiences of those involved, it was possible to glean information from focus groups that would not otherwise be accessible in one-on-one interviews. Therefore, focus groups were the optimal method for data collection in this study.

Group characteristics are important to consider when planning focus groups. It is recommended that the group is homogenous or "having something in common" but with "sufficient variation among participants to allow for contrasting opinions" (Krueger & Casey, 2009, p. 66). The groups were homogenous in that they consisted of nurses who share the experience of serving as preceptors for undergraduate nursing students. In addition, all participants were preceptors in hospital settings. The homogeneity can be beneficial to participants who may experience embarrassment or other negative emotions or if there are viewpoints inherent to their own culture as co-participants can offer support (Kitzinger, 1994).

Kitzinger (1994) and Krueger and Casey (2009) note that although homogeneity is important in focus groups when the topic addresses shared experiences, differences between members are equally important. The heterogeneity of the group allows for variant and differing opinions and viewpoints to be elucidated (Kitzinger, 1994). When dissent occurs, some participants may be silenced or censored (Carey & Smith, 1995; Kitzinger, 1994; Kitzinger, 1995). This effect can be ameliorated through a strong facilitator exploring these divergent opinions (Kitzinger, 1994). It can be surprising to group members to realize that there are those with shared experiences but differing perspectives. The facilitator can capitalize on this by encouraging participants to "theorise [*sic*] about why such diversity exists" (Kitzinger, 1994, p. 113). Efforts to secure sufficient variation for the groups for this study included inviting participants from

(a) differing healthcare organizations, (b) various nursing units, and (c) working different shifts. Participants attended the session of their choice.

The recommended size for noncommercial focus groups is between five and eight, particularly when the participants have expertise in a specific area (Krueger & Casey, 2009; Krueger, 1995). Although smaller focus groups are preferred when participants have had intense or lengthy experiences with the topic of interest (Krueger & Casey, 2009), it is recommended that researchers oversample when conducting focus groups (Morgan, 1995).

The number of focus groups must also be considered. The term, *saturation*, is found in literature associated with qualitative research methodologies. Saturation refers to the point at which new information is no longer generated or when the facilitator can anticipate what will be said (Asbury, 1995; Krueger & Casey, 2009). The number of focus groups required for saturation will vary, but a general rule is to conduct three or four with each category of individual (Asbury, 1995; Krueger & Casey, 2009). Although I conducted only two focus groups, I achieved saturation. The transcripts reflect many of the same or similar phrases and words spoken by individual participants. Each category and subsequent codes are supported by multiple participant phrases and descriptions. Additionally, the methods used for data analysis, including constant comparison and taking memos, support data saturation (Bowen, 2008). These methods are described below.

Sampling and Recruitment

A non-probability snowball sampling method was used. According to Wood and Ross-Kerr (2011), convenience sampling is required for an exploratory descriptive study. Furthermore, the amount of information about the problem is lacking, again supporting the need for non-probability sampling (Wood & Ross-Kerr, 2011).

Most participants were recruited from tertiary care facilities in Northeast Tennessee. Research fliers were sent via e-mail communication to select faculty/peer colleagues in the Northeast Tennessee areas who had access to hospital settings where potential participants were employed. These colleagues were in non-supervisory roles with regard to potential participants and distributed fliers to potential participants, shared study information, and informed potential participants of how to contact me as the PI. I also hand-delivered research fliers to several area hospitals and spoke to potential participants about the study. I also provided research fliers to potential participants in local schools of nursing. Information on the flier (Appendix B) acknowledged the recruitment strategies of light refreshments during the focus groups and a $20.00 gift card for each participant at the end of the focus group session. The inclusion of incentives keeps with recommendations for recruitment for focus groups (Morgan, 1995). When participants contacted me, I asked them to invite others who were known to them by sharing information about the study. All participants self-referred.

During the initial contact, I gathered information from the participant, including name, address, e-mail address, and a contact phone number. I entered the information

into a password protected computer file and used it to send out a personalized follow-up letter (Appendix C), information sheet (Appendix D), and provide a reminder phone call and e-mail one day prior to the scheduled focus group as recommended (Krueger & Casey, 2009; Morgan, 1995). This information was kept confidential in a password protected file accessible only by me as the primary researcher.

Originally, I planned to conduct three focus group sessions; two in my local geographic area and one approximately 100 miles away. However, recruitment was particularly challenging. After four weeks of recruitment, from approximately September – October, 2013, I received only 11 contacts, all of which were within a 25-mile radius of my geographic area, although I did have a few from as far as 50 miles away. I received no contacts from interested persons in the area farther away, but I attribute this primarily to my lack of physical presence in the area hospitals.

As a result of limited responses and after consultation with committee members, I submitted a Form D (Appendix E) requesting to change the number of focus groups from three to two. Many authors recommend a minimum of three groups, but the overall number of groups is based on the purpose of the study and data saturation (Asbury, 1995; Krueger & Casey, 2009). Several authors have noted the challenges of conducting focus groups with nurses, and specifically, that nurses are often difficult participants to recruit for research studies because of perceived lack of benefit, alterations in work schedules, distance from work settings, perceived coercion, fear of speaking out about focus group topic, and the perception that participation was a burden (Clark, Maben & Jones, 1996;

Happell, 2007; Howatson-Jones, 2007; Shaha, Wenzel & Hill, 2011). I do not know if the limited participation in my study was the result of one of these or if there was some reluctance based on fear of a lack of confidentiality due to the nature of the focus group method, but participants who completed the sessions did not appear to have any concerns.

The final sample consisted of nine licensed registered staff nurses who had experience as preceptors in tertiary care settings in Northeast Tennessee. Most participants (*n*=7) were currently working in or had worked in the role of preceptor for undergraduate nursing students within the past six months. Two participants indicated that their most recent precepting experience had taken place more than six months in the past. Certain questions posed during the focus group required participants to reflect back on an experience. According to Krueger and Casey (2009), questions addressing reflection should be based on a fairly recent experience. Nurse preceptors who had one year or less of experience as a registered nurse were excluded from this study, due to the occurrence of their own on-going professional socialization (Martin & Wilson, 2011). Study participants were also required to read, write, speak and comprehend English as the informed consent and the demographic survey were written in English and the focus groups were conducted in English.

Setting

The settings for the focus groups were off site from preceptors' places of employment to avoid feelings of unnecessary worry or coercion regarding speaking out about a topic related to their work. Both sessions were held in classrooms on the campus

of an educational institution in Northeast Tennessee to serve as a neutral location for study participants. Participants had the choice to attend any of the three focus group sessions initially scheduled; however, only two sessions received any volunteers. Each session lasted between 60 and 90 minutes, per recommendations (Asbury, 1995; Krueger & Casey, 2009).

Human Subjects Considerations

Prior to participant recruitment, human subjects protections was assured through completion of the Collaborative Institutional Training Initiative (CITI) on-line and institutional review board (IRB) approval from The University of Tennessee, Knoxville. Once I secured IRB approval, I began recruitment using the previously described convenience sampling method. Recruitment procedures are described below. Study participation was completely voluntary. Prior to attending the focus group session, participants were sent an information sheet and a copy of the informed consent statement for review. Once on site for the focus group session, each participant was provided with an Informed Consent statement, which I then read aloud. This included the explicit understanding that the participant retained the right to withdraw from or not contribute to the study and that responses on questionnaires would be maintained confidentially as described in the Informed Consent statement.

Safeguards to Confidentiality in Documents and in Group Meeting

I labeled focus group sessions alphabetically as Group A or Group B and participants numerically. These alphanumeric labels were written at the top of the

demographic survey. Attached to the demographic survey with a paperclip, participants received a place card with the corresponding alphanumeric label. I asked participants to place this card in front of them during the focus group session. This allowed tracking of group communication while taking field notes during the focus group and provided a way to maintain anonymity and confidentiality for any verbatim quotes used in publications. All names used by participants in their conversations are reported using pseudonyms. Only I, as the primary researcher, and my dissertation chair have complete access to the demographic surveys and the transcripts. Furthermore, I made participants aware that participation or lack of participation would not influence their employment status. Before each focus group session began, I also reminded participants that research is confidential and to refrain from communicating with others about their participation in the study.

Anticipated risks to participants were minimal; however, they did exist. There was potential for study participants to experience bothersome feelings or emotions during the focus group process. Participants had the option to not complete part of or any part of the research study, including withdrawal without penalty. Additionally, there was a risk of loss of confidentiality as the focus group sessions were audiotaped and I used these audiotaped sessions for transcription. Participants may also have inadvertently communicated about the study or their involvement with others. It is also possible that participants knew others in the focus group from work or other outside activities. I specifically addressed this potential issue by including a brief statement reminding

participants of the importance of maintaining confidentiality as professional nurses in practice. I included this statement written on both the information sheet and the informed consent statement, and verbally during the informed consent process. I took every safeguard to maintain confidentiality of study participants, including keeping all computer and audio files on a password-protected computer system, keeping the recording device in a locked cabinet in my personal office when not in use, and keeping paper documents, including demographic surveys and transcripts, locked in a file cabinet.

Instruments

I used two written instruments to collect data for this study. First, participants completed a PI-developed demographic questionnaire (Appendix F). Information on the demographic questionnaire included age, gender, years of nursing experience, years of preceptor experience, nursing and general educational history, current area of nursing practice, educational level of precepted nursing students, number and types of nursing students precepted per year, preceptor preparation, and faculty availability.

To support the conversational nature of focus groups (Kitzinger, 1995), focus group moderators used a semi-structured focus group interview guide (Appendix G). As recommended, the questioning route was sequential in order to evoke conversation among the group and keep the group on track (Asbury, 1995; Krueger & Casey, 2009). This process included the use of (1) an opening question, easy and quick to answer; (2) introductory questions, open-ended to get participants thinking and encourage conversation; (3) transition questions, to logically move the conversation into key

questions that drive the study; (4) key questions, to drive the study; and (5) ending questions, bringing closure and reflection (Krueger & Casey, 2009).

The interview guide was slightly modified after the first focus group and after the debriefing with the moderator. Specifically, in response to the original opening question: *Tell us your first name, how long you have been a nurse, and why you became a preceptor*, we noticed that responses were much longer than anticipated, and that participants immediately digressed into discussion about their own personal experiences as new nurses or students and their motivation to precept. This made it somewhat difficult to move into the introductory question. We also recognized that the original key question about preparation did not lend itself to in-depth discussion among participants; instead, participants offered simple, straight-forward answers. Additionally, preparation was specifically addressed on the demographic questionnaire. As a result, the following changes were made: (1) the original opening question was deleted, (2) personal introductions were completed at the very beginning of the second focus group, (3) the introductory question became the first question in the second focus group and was expanded to include preceptor motivation, (4) the original question about preparation was removed, and (5) a question addressing preceptors' thoughts about confidence was added at the end. These slight modifications to the interview guides are typical in focus group research (Krueger & Casey, 2009).

Procedures

Data Collection

Data collection occurred during two focus groups held in October 2013. Both groups took place on Saturday mornings, one week apart. The first group lasted 53 minutes and the second group lasted 90 minutes. There were three participants in the first group and six in the second.

There were two moderators used for this study. Moderators must be respectful, understand the topic, communicate clearly, open and not defensive, and able to get useful information (Krueger & Casey, 2009). For the first focus group session, the facilitator was Dr. David Schumann, a Ph.D.-prepared faculty member at The University of Tennessee, Knoxville in the College of Business Administration. Dr. Schumann was initially scheduled to conduct both focus groups; however, as a result of scheduling problems, he was unavailable for the second focus group session.

The second focus group was facilitated by Ms. Janel Seeley, a Ph.D. candidate at the University of Tennessee, with extensive experience in conducting focus group research and recommended by Dr. Schumann. In order to maintain reliability for the second group, I sent a copy of the audio-recording from the first focus group session and debriefing to Dr. Schumann and Ms. Seeley. I also sent copies of the original and revised semi-structured interview guides to both. Ms. Seeley listened to the first audio-recorded focus group session and consulted with both myself and Dr. Schumann to answer any pre-existing questions.

As the primary researcher, I served as the assistant for both focus groups. This allowed the moderator freedom to focus on conducting the group while I handled group logistics, such as managing the audio recorders and taking notes (Asbury, 1995; Krueger & Casey, 2009). These notes were helpful in data analysis (Krueger & Casey, 2009).

Prior to focus group questioning, I, as the PI, conducted the informed consent process. I provided each participant an informed consent (Appendix H). I read the informed consent statement aloud and audiotaped the reading. Once all informed consent statements were signed and collected, participants completed the demographic questionnaires. Demographic questionnaires were then collected, and focus group questioning began. Each focus group was recorded using a digital audio recorder and an additional back-up audio recorder. Using the semi-structured interview guide, the moderator facilitated discussion among participants. Occasionally, participants needed prompting by the moderator for clarification of thoughts and ideas. At the end of each group, the moderator offered a brief summary of major points and ideas brought out during the group and sought confirmation of these ideas. After each focus group session concluded, a short debriefing session between the moderator and the PI took place and was audio recorded. The debriefing gave the moderator and PI an opportunity to immediately reflect on the group and document important details for analysis and future groups (Krueger & Casey, 2009). All recordings were transferred from the digital recorder onto password protected audio files kept in my possession at all times. This transfer of information took place within 24 hours of the end of each focus group. Once

the transfer was complete and the adequacy of the file was verified, recordings from the digital and back-up audio recorders were deleted. Recordings were transcribed onto password-protected paper documents within one week after the focus group.

Data Analysis

Demographics

Demographic data were analyzed using descriptive statistics including percentages, means, frequency counts, and measures of central tendency. These data were used for informative purposes only during this study. SPSS Version 21 was used to analyze these data.

Transcripts and Field Notes

When conducting analysis of focus group transcripts, many authors stress the importance of considering the group interaction (Asbury, 1995; Carey & Smith, 1994; Duggleby, 2005; Kitzinger, 1994; Kitzinger, 1995; Krueger & Casey, 2009; Morgan, 1995; Morgan, 2010). In fact, there are three levels that should be considered during analysis. These are the individual level, the group level, and a comparison of individual data with group data (Carey & Smith, 1994; Duggleby, 2005). These authors say that researchers who fail to analyze data without considering the group effect "will incompletely or inappropriately analyze their data" (Carey & Smith, p. 125). Although the content of the group sessions and the group dynamics and interactions provide many areas for analysis, this study focused on the conversations and interactions among the participants to seek for an understanding of the role of the preceptor. As such, a

conventional content analysis approach was used to analyze the data. This specific methodological approach is described below.

As suggested in the literature, the importance of group interactions and dynamics were not discounted. In order to ensure that individual and group dynamics were accurately represented and included in the data analysis, I kept field notes for each session and recorded a debriefing between myself and the facilitator at the end of each session. These field notes and debriefings are important to capture what Carey & Smith (1994) say cannot be captured in transcripts; that is, richness of data and subsequent meaning. While taking field notes, I noted aspects of both individual and group dynamics including, but not limited to, satire, joking, laughing, body language and touch, changes in vocal tone, eye contact, and so on. I also attempted to diagram communication patterns and pathways, taking note of which participants were more or less active. These diagrams of group interaction were useful in analyzing data, especially when looking to compare individual and group patterns. Kitzinger (1995) calls this "talk between participants" and says that true focus group reports include some information representative of group interactions, rather than isolating single quotations out of context.

I used conventional content analysis to examine the data. This method keeps with the inductive process used in naturalistic inquiry. Content analysis is defined as "a research technique for making replicable and valid inferences from data to their context" (Krippendorff, 1989, p. 403). Conventional content analysis is typically used when the research design aims to describe a phenomenon (Elo & Kyngas, 2007; Hsieh & Shannon,

2005). It is prescribed and sequential, and should be concurrent with data collection (Krueger & Casey, 2009). Data are analyzed according to the meaning attributed to the phenomenon by a particular group or culture (Krippendorff, 1989). This methodical, continuous approach improved data collection for the next focus group (Krueger & Casey, 2009). The content and process of the first focus group session was used to slightly modify the process for the second group. By doing so, the second focus group session was improved. Qualitative content analysis uses codes generated through in-depth evaluation of data sources (Hsieh & Shannon, 2005; Kondracki, Wellman, & Amundson, 2002; Morgan, 1993). Data sources included transcripts, demographic surveys, memos and field notes taken during each focus group session.

I transcribed each audio-recorded focus group session verbatim onto a word processing document. I kept paper transcripts for each session in a locked file in my possession. I labeled transcripts with the pre-determined focus group code and read them for accuracy and completeness. Data analysis began at the conclusion of each individual focus group, and continued through and beyond data collection. More in-depth data analysis took place after data collection concluded with both focus groups.

I read transcripts over and over to become immersed in the data and gain a "sense of the whole" (Tesch, 1990 as cited in Hsieh & Shannon, 2005, p. 1279). I then read transcripts again to identify and highlight words in the text that appear to reflect the participants' perceptions of the preceptor role (Hsieh & Shannon, 2005). This is known as manifest content (Kondracki et al., 2002). As I continued to read, I made notes of first

impressions, thoughts, and initial analyses as recommended (Hsieh & Shannon, 2005). This allowed me to develop my initial codes and is referred to as open coding (Elo & Kyngas, 2007). Part of identifying manifest content also includes frequency counts of words in texts and emerging codes (Kondracki et al., 2002; Krippendorff, 1989; Morgan, 1993). I included these in my analysis and they helped guide development of categories. As codes continued to emerge, I began to develop categories in which codes were sorted and linked. From these categories, definitions codes, categories, and subcategories were developed and are reported (Hsieh & Shannon, 2005).

I also examined the text for latent content. Development of latent content includes delving deeper into the meaning of the text (Kondracki et al., 2002). According to Kondracki et al., analyzing data for latent content can provide insight into new constructs and add significant meaning to the text. Examples of the latent content are seen in the analysis of the functions of the preceptor role. Finally, as the data warranted and as suggested, I addressed relevant extant theories in the discussion section of my study report (Hsieh & Shannon, 2005).

Rigor

Creswell (2009) describes several strategies that are useful to enhance rigor in qualitative studies. To enhance reliability, transcripts were read and re-read to ensure accurate transcription. Creswell (2007) also suggests keeping detailed field notes and using high-quality voice recording equipment. I used both of these procedures during data collection. I also used constant comparison during data analysis to ensure that codes

are interpreted accurately. Constant comparison involves returning to original definitions of codes throughout the analysis process to ensure that as the researcher codes passages, the meanings do not shift (Creswell, 2009).

Intercoder agreement, or cross-checking, is another technique used during analysis for reliability. My dissertation chair served as a second reader throughout the entirety of the dissertation process. Both I and my dissertation chair independently coded selected text passages. Once coded, these results were compared. Similarly-coded passages support intercoder agreement (Creswell, 2009). Reliability is further supported if one person is primarily responsible for analysis, participates in as many groups and debriefings as possible, and communicates regularly with other team members (Kidd & Parshall, 2000). As I am the primary researcher, I was responsible for these elements.

I also included member checking. Hsieh and Shannon (2005) say that one of the challenges with this type of analysis is failure to "develop a complete understanding of the context, thus failing to identify key categories" (p. 1280). Member checking is defined as a "technique whereby the investigator checks out his or her assumptions with one or more informants" (DePoy & Gitlin, 2005, p. 206). As suggested by DePoy and Gitlin, this process is critical to the overall understanding of the text interpretation and should be conducted throughout the process of data collection. Once focus group transcripts were analyzed and as recommended by Creswell (2009), I sent e-mails to study participants with a brief summary of the results to ensure accuracy of interpretation. I asked for feedback from these participants and used it to help guide final data analysis.

I received two responses. Both respondents indicated their agreement with the initial draft of analysis.

To support validity, field notes, memos, demographic surveys, and interview transcripts served as multiple sources of data that were triangulated. Acknowledging bias is also purported to support validity in qualitative research (Creswell, 2009; Krueger & Casey, 2009) and the safeguards described above decreased this risk.

Data Safeguards

As is standard practice, all data collected through this study is confidential. No quoted comment is identifiable as alphanumeric labels were used to protect the participants' identity and their right to confidentiality. Furthermore, group identity is unidentifiable as groups were labeled alphabetically. Any name of a person contained in any of the text passages was converted to a pseudonym. Consent forms and completed study instruments will be kept in the office of my dissertation chair for three years after the study is completed. Only I, my dissertation committee, and the IRB have access to these forms. Further, any information entered into computer databases remains in my possession at all times and is password protected. Participants were notified of confidentiality during the informed consent process and reminded of it at the beginning of each focus group. Anonymity will be maintained any time study results are disseminated to audiences either through written publications or oral presentations. Participants were assured that their employer will not have access to these data, and that responses do not permit identification; however, study results may be reported. Study

participants were also explicitly notified that any information collected on the demographic questionnaire or in the audiotaped focus sessions may be used in future research endeavors.

Summary

This chapter has provided information on this qualitative exploratory research design and methodologies. I have discussed sample and setting, recruitment procedures including consent, instruments, data collection, and data analysis procedures. Focus groups were used for data collection. Analysis was conducted using a conventional content analysis method. Use of best practices during data collection and analysis supported the reliability and validity of the study, thereby increasing transferability of study findings.

Chapter IV: Findings

The purpose of the study was to explore staff nurse experiences as preceptors to undergraduate, pre-licensure nursing students. I collected and analyzed the data from two focus groups consisting of licensed registered staff nurses practicing in tertiary care settings. The following question guided the study:

1. What are staff nurses' experiences with precepting undergraduate, pre-licensure nursing students?

Emphasis was placed on exploring first-hand perceptions of the role, specifically the preparation for, support in, and understanding of what the role entails. In this chapter, I report findings based on content analysis of qualitative data.

The findings are reported based on the area of emphasis, beginning with preparation for the role, moving into support in the role, and ending with understanding the role. These areas of emphasis serve as the major headings for the findings. Under each major heading, a broad definition is provided, synthesized from information, descriptions and words of the participants. Within each major heading, categories and sub-categories are identified and described using participants' words or phrases that capture the overall meaning of that area.

Findings

Demographics.

All participants (*N*=9; 100%) were female. Most participants (*n*=5; 55.6%) were between the ages of 30-39. Participants were licensed as registered nurses with

experience ranging from two to 14 years (M = 7.78; SD = 3.563). Four participants (44.4%) held baccalaureate degrees in nursing and four (44.4%) had master's degrees in nursing. Only one participant (11.1%) had an associate degree in nursing. A majority of the participants (n=5; 55.6%) had between 6-10 years of precepting experience and seven (77.8%) participants reported having had formal training as a preceptor. Eight participants (88.8%) reported experience precepting three or more students per year and five (55.6%) reported that their most current student was from a baccalaureate nursing program. Most participants (n=7) were currently working in or had worked in the role of preceptor for undergraduate nursing students within the past six months. Two participants (22.2%) indicated that their most recent preceptor experience took place longer than six months prior to the focus group session and indicated that they were currently employed as full-time nurse educators. All participants' preceptor experiences occurred in tertiary care settings. A detailed description of the sample is provided in Table 2.

Group Differences and Similarities

During the focus groups, I took field notes and attempted to diagram communication pathways. I also noted body language among group members. These data sources provided insight into the group dynamics of both focus groups. Names of participants reported below are pseudonyms.

Focus Group A consisted of three participants: Alicia, Anna, and Lisa. This group was small and as a result, discussion among participants was limited. Most

Table 2. *Sample Characteristics*

Characteristic	**N**	**%**
Age		
50+	2	22.2
40-49	1	11.1
30-39	5	55.6
18-29	1	11.1
Highest level of nursing education		
Diploma	0	0
Associate degree	1	11.1
Baccalaureate degree	4	44.4
Master's degree	4	44.4
Post-master's degree	0	0
PhD or DNP	0	0
Academic degrees earned		
Associate degree in nursing	3	33.3
Associate degree in another field	1	11.1
Bachelor's degree in nursing	6	66.7
Bachelor's degree in another field	2	22.2
Master's degree in nursing	4	44.4
Additional Master's in nursing	0	0
Master's degree in another field	0	0
Doctorate in nursing	0	0
Doctorate in another field	0	0
Years of nursing experience		
1-5	1	11.1
6-10	6	66.7
11-15	2	22.2
16-20	0	0
20+	0	0
Years of preceptor experience		
1-5	2	22.2
6-10	5	55.6
11-15	2	22.2
16-20	0	0
20+	0	0
Current or previous employment unit		
Medical-surgical	5	55.6
OB/Labor & Delivery	1	11.1
Pediatrics	0	0
ER	0	0
Psychiatric/Mental health	0	0
Surgery/PACU/Recovery	0	0
ICU	1	11.1
Stepdown/Telemetry/Transitional/Progressive Care	1	11.1
Other (reported as Cardiac Cath Lab)	1	11.1

Table 2. *Continued.*

Characteristic	N	%
Number of students precepted per year		
1-2	1	11.1
3-4	4	44.4
5+	4	44.4
Educational level of most current student		
LPN	0	0
Diploma	0	0
Associate degree	3	33.3
Baccalaureate degree	5	55.6
RN-to-BSN	1	11.1
Formal training or preparation as preceptor		
Yes	7	77.8
No	2	22.2
Notification of student arrival		
Same day	0	0
< 1 week	3	33.3
1-2 weeks	4	44.4
3-4 weeks	2	22.2
> 4 weeks	0	0
Faculty availability		
Yes, faculty are in the building	3	33.3
Yes, faculty are not in the building, but are available by phone, text or e-mail	6	66.7
No, faculty are not available	0	0

conversation was initiated by the moderator in the form of questions or statements aimed at having the participant further explain their comments. Two of the group members knew each other, and as a result they were more talkative and dominant during this focus group session. The third participant appeared reticent and made much less eye contact with the other participants and the moderator.

Focus Group B consisted of six participants: Susan, Chelsea, Dianne, Felicia, Kendra, and Rhonda. As a result of the larger group size, interaction was much livelier. Participants spoke freely between each other, vocal intonations were much more varied, and laughter abounded. They seemed to establish an almost immediate rapport. There

was also a noted difference in the role of the moderator. Rather than moving through the interview guide systematically, the moderator simply guided the conversation when necessary. For example, participants in this group tended to include conversation about precepting new employees and the moderator would refocus the groups' attention back to the precepted student. There was no single participant in this group who was dominant. Conversation in this group flowed easily from participant to participant.

Participants in both groups were supportive and respectful of each other even when there was dissent or disagreement. Additionally, participants used body language to convey agreement with each other. Every participant was noted to have nodded her head in support or agreement of another's statement. There are also several episodes noted in the transcripts of participants verbally agreeing with each other. However, the way in which this occurred varied between the groups. In Focus Group A, verbal agreements were quiet, even whispered at times. In Focus Group B, the verbalization was markedly different. In fact, one participant was noted to even cup her hands around her mouth and in effect, yell her comment. I noted other participants nodding their heads, laughing, pointing at her, and saying "Yeah, yeah!" Although different between groups, this type of camaraderie and support was consistent throughout the duration of both. The empathetic nature of participants' behaviors and comments during the focus groups lends significant support for the finding, discussed below, that co-workers are viewed as a source of support during preceptorships. Individual participant characteristics are provided in Table 3.

Table 3. *Individual Participant Characteristics.*

Focus Group	Participant	Age	Highest level of nursing education	Years of nursing experience	Years of preceptor experience	Formal preceptor training	Precepted within the last six months
A	Alicia	30-39	Associate's	11-15	11-15	Yes	Yes
	Anna	40-49	Baccalaureate	6-10	0-5	Yes	Yes
	Lisa	18-29	Master's	6-10	6-10	Yes	No
B	Chelsea	30-39	Master's	6-10	6-10	Yes	Yes
	Dianne	50+	Baccalaureate	6-10	6-10	Yes	Yes
	Felicia	30-39	Master's	11-15	11-15	No	No
	Kendra	30-39	Master's	6-10	6-10	No	Yes
	Rhonda	50+	Baccalaureate	6-10	6-10	Yes	Yes
	Susan	30-39	Baccalaureate	1-5	1-5	Yes	Yes

Preparation for the Preceptor Role

Participants described preceptor role preparation as a formal education process provided in a classroom setting at their respective places of employment. The process includes participation in a brief course where specific information is provided regarding teaching and learning styles. When asked about their perceptions of whether or not their preceptor class prepared them for their roles, most participants (n = 7, 78%) answered with a simple "yeah" or "yes". Participants reported that these classes were a requirement at their respective place of employment for all RNs who serve in the preceptor role. Only two participants reported not having had the preceptor class. Participants believed the preceptor course content about teaching and learning styles to be most influential to their role for two reasons: (1) the insight it gave them in working with students, and (2) the insight it gave them in their own and their co-workers' nursing practice.

Teaching and learning styles: "It keeps me grounded". Those who had participated in a formal precepting class recognized the importance of understanding the information and its application to each individual student situation. Lisa stated "…it really helped me as [*sic*] some insights as to different ways of learning and different ways to communicate." Alicia reiterated: "…I have to remember that not everybody is a hands-on learner….I have to make adjustments in the way I precept different people based on their learning styles, it keeps me grounded…."

Additionally, participants thought that understanding teaching and learning styles also aided in their ability to reflect on and be aware of not only their own practices, but those of their co-workers as well. They thought this awareness helped them to assess from afar the practices of co-workers who are precepting students, and intervene when necessary. For example, Alicia said

> ...we had a nurse, who is no longer with us, and she hated students, and I don't know why she agreed to take students, but she would make them so miserable and take pleasure in seeing them struggle and fail, until it, you know, it was just like, you know, 'I think you need to step aside and you know, let me take them for a little while'….

Alicia added "…there's [*sic*] some nurses that are really good at precepting, and I think there are those who are really good nurses that are not prepared to precept." Lisa spoke from her experiences: "…you know it as soon as you see it…the student is trailin' [*sic*] behind and the nurse is 15 feet in front of 'em [*sic*], walkin' [*sic*] as fast as they can

go…." Lisa went on to express her rationale for why this occurred: "I think part of it could be a lack in [the nurse's] own knowledge, and…a lack of confidence in your own knowledge and a lack of confidence in your own skills."

Support in the Role

Participants perceived support from RN co-workers and faculty positively but differently. Support is seen as a *helping* function when coming from RN co-workers and as a *validating* function when coming from faculty. However, they perceived support from their nurse managers as a *mechanical* function. Participants reported that support was actively sought from RN co-workers, faculty, or a nurse manager when needed. Co-worker support was most sought out and most available, with lesser opportunities for support from faculty and least from nursing administration. Figure 1 depicts the three sources and attributes of support described below.

Co-worker support: "We are a team". Registered nurse co-workers are seen as the primary source of support for preceptors. There is a strong sense of teamwork where participants and their co-workers work together to provide the best experience for the preceptee. For example, one participant said "…I think we're a good group to offer things." Another said "…we're lucky with that, that we work good together…so we have a good team." Others agreed: "…and we do, we work really well together", "…we work so well together…" and "We all pretty well work as a team." Participants described effective teamwork that is best accomplished through (1) sharing the responsibility and (2) problem-solving.

Sharing the responsibility. Sharing the responsibility includes offering and seeking out skills for the student to perform. For example, Anna said

> I'll ask my friends, "Hey, you have a catheter or an NG tube or needle we can stick?" You know, "When we get caught up here, we'll do that, don't do it, let us do it"…and I'm the same way if they [other RNs] have a preceptee.

Sharing the responsibility also meant that preceptors and their RN co-workers functioned as a group to ensure the student reaps as many benefits as possible. This was reflected in the following statements

- "…it seems like the students really enjoy working with someone else [another RN] temporarily just to see their organizational skills";
- …that's important too because people pick up on the skills from people that they're with, and in order for that student to find out who they want to be as a nurse, it might be good to put 'em [*sic*] with different people so they can take from each person maybe a good attribute that they have; and
- "When the whole floor knows -when our two units know- that we're getting students, then it helped [sic] everybody work together and be more adept to taking students."

Problem-solving. Participants spoke about seeking out co-workers when they experience problems with students or when they were unsure about how to handle a particular situation. This process is often reciprocal in nature in that some participants themselves told of being sought out for support by co-workers who were precepting a student.

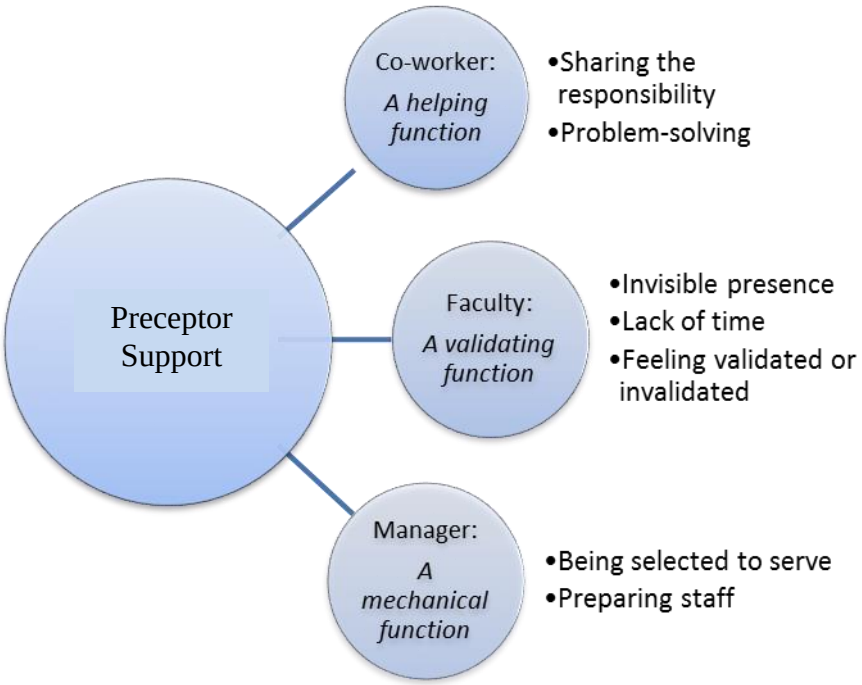


Figure 1. Sources and attributes of preceptor support systems.

Anna recalled being asked by a co-worker what to do with a student who was having difficulty inserting an intravenous line. She said "…we were allowed to go to the Sims [simulation] lab…we both went with her…and I think with both me and my co-worker doin' [*sic*] that, I think she felt more confident." This was repeated by Susan, who said "I feel like people seek me out to ask me questions." Chelsea described her experience of dealing with a student with performance deficiencies. When asked what she did in that situation, she replied, "…I talked to one of my mentors. You know, someone who precepted me, you know to get advice about kinda [*sic*] how to handle the situation, um, and she was a big help." The necessity of co-worker support, particularly with students who have performance deficiencies, was validated by Kendra who described her experience: "We talked with her…I was shift leader at the time, but another shift leader, you always want to have one additional person in there with you whenever you talk…hopefully it's one that [has] precepted with them as well."

Faculty support: "It's there if we need it". Faculty support is seen as a validating function that occurs as a result of interactions between the preceptor and the faculty member. Interactions were often limited because of a lack of time, and as a result, preceptors perceived faculty support as an invisible presence with gaps in communication. Preceptors could feel either validated or invalidated in their assessments of student issues based on the response of the faculty member.

An invisible presence. The amount of faculty support, both expected and received, was mixed. Dianne said

> I think that the support is there by faculty if we need it, but it's just not necessarily something, you know, because there's not that communication, on-going communication between that student's faculty member and the preceptor, [then] It's not really the first person that we run to when there are issues.

She continued: "We don't see them very often, and so you kind of just handle, you know, as you would a regular hospital situation." Some participants expressed an assumption that faculty would not be present during the experience. Kendra stated

> I always felt when I had a student, I wouldn't see the instructor anyway…I would just feel like the instructor's hovering anyway and I wouldn't appreciate her being there…because you're like "I don't need you in my way too", just let me work with the student.

Dianne agreed: "…it's like once you're in the hospital, that's it, you're here, and this is where we're gonna work from, you know." It was also mentioned that faculty sometimes did not leave contact information: "It's not like they leave a phone number or anything like that…I haven't had 'em [*sic*] ever leave me any contact information with me when they've left a student with me." Lisa offered a different perspective: "I feel like I get really good support from the instructors. You know, all I gotta [*sic*] do is call, and they're like 'OK, I'll be down there'."

Lack of time. The lack of time was seen as a major barrier to engaging in communication with faculty. Felicia, who has held both roles, expressed: "…it's time, on both ends, it's time to communicate…I would love to tell the faculty member details

about the student, and as a faculty member I would love to touch base with the preceptor, but it's time." Kendra chimed in

> …and as a staff member, you thinkin' [*sic*] 'I don't have time to sit down to talk with your instructor' and talk about how you're doing, I have to, you know, I have five patients to take care of…I can e-mail her on my day off.

Susan mentioned that her schedule prohibited her communication with faculty and information was simply passed on to faculty

> I leave by 7:30 [a.m.]; I don't see anybody, so I'm kind of out of the loop in that way. I deal with my student, that kind of thing, but then I'm gone before any kind of actual faculty are back in the building while I'm there.

In some instances, when problems with students arose, participants did not consult faculty members or they consulted faculty after the problem was addressed. Chelsea explained

> …I didn't want to bring it up to her faculty member just right away, I mean, so um, but we ended up talking to her faculty member later on, um but basically to tell her that we had worked everything out, you know, and you know, it worked out fine.

Dianne said "I would contact my education department. I'd contact the person that knows the legalities of it…" Anna said "Straight up, I would talk to the student; I mean, you got to go to that first person…and then I would talk to the instructor…." Recalling an issue with a student who was noncompliant with organizational policies, Rhonda stated "I

mentioned it to him…and uh, he did it a couple more times, and then, I only had to say somethin' [*sic*] to the instructor…."

Feeling validated or invalidated. Most participants described positive interactions with faculty and reported that concerns were, in fact, validated by the faculty person. Alicia recalled her experience in dealing with a student who demonstrated behavioral problems during the preceptorship

> …I had really tried to muster all the niceties I could muster, and I called the instructor, who I have worked with on multiple occasions, and said, "I don't feel like I'm doin' [*sic*] her any good, and I don't feel like she's doin' [*sic*] me any good…we need to make an adjustment", and they did put her with someone else.

When asked about the instructor's response, Alicia said

> Well, the instructor's response was that she understood that she was a difficult student…there had been some issues, and that they were working to address those issues…that made me feel like, that it was, you, not just me, because that was my biggest thought, was you know "Did I do something wrong to make her the way she is towards me?" It made me know that I, it wasn't just me and the clinical experience.

This sense of validation was repeated by Lisa. She spoke about working with a student whose performance was inadequate to the extent that a failing grade was necessary. Recalling her communication with the faculty members, she said "…they'll call me, they have my personal number, you know, they communicate, but as far as any

problems…the instructor probably already knows, they have a good idea, and you're just confirmin' [*sic*] what they already know."

Although most participants reported positive interactions with faculty, Felicia's assessment of a particular student's performance was not validated by faculty; her expectations for support were not met. She described her experience of having a student practice outside his scope as a student

> …and so reporting this not just to faculty, but to the dean of this program, I expected the student to be dismissed from the program, because you know, practicing out of your scope of practice is a huge issue…but they didn't act as serious as I thought they should have. He was written up, and had to redo some clinical hours, and I see him in the hospital, and he's a practicing nurse now and it's all I can think is "What in the world is he gonna [*sic*] do when people are not watching him?"

Managerial support*:* "They picked me". Participants perceived support from nurse managers as a mostly positive, but mechanized action. The mechanical nature of managerial support involves two processes. These are (1) being selected to serve as a preceptor and (2) preparing staff for the arrival of students. When preceptors perceived communication with managers as unilateral or apathetic, the resulting perception of support decreased.

***Being selected to serve*: *Recognition of individual strengths*.** A majority of participants (78%) reported having been selected by nurse managers or administrators to

serve in the role as preceptor. Participants perceived this selection as recognition of good nursing practice which leads to acceptance of the role. Susan explained: "I guess I'm preceptor because I'm good at time management skills…so I guess they picked me to do, uh, preceptin' [*sic*] a lot." She goes on to say "I never really volunteered for stuff…so that was just somethin' [*sic*] my clinical leader picked up on…." Kendra reported: "…the reason I was asked [was] because I get along with everybody, and I welcome everybody with open arms, and that's why they chose me…so they picked me as a welcomer!" Chelsea said "The manager keeps puttin' [*sic*] 'em [*sic*] with me, [I] must be doin' [*sic*] somethin' [*sic*] right!" Lisa stated: "…my manager doesn't come right out and say, 'hey you're doin' [*sic*] such a good job', but the students always get put with me…." When asked how being selected as a preceptor made her feel, Anna responded enthusiastically with "Oh that makes me proud, it really does, and um, apparently, I mean, not to toot my own horn, but I have a following."

Preparing staff for student arrival. Participants also perceived positive support when managers communicated and involved staff in the anticipated arrival of students. Kendra detailed this

> I know that my manager, any time that we're about to get a lot of students…my manager meets with us prior to the students coming and says "Listen, these are potential employees, make sure you welcome them, and teach 'em [*sic*] this and do this and that", and just tells us it's gonna [*sic*] happen…so we kind of got like an orientation to the fact that we're getting students and that's helpful.

Alicia and Anna also reported positive communication from managers. Anna stated: "…my nurse manager, she speaks out to people on our floor that she feels would be really good…"

Two preceptors described different experiences with their respective managers. Dianne decided not to engage in precepting for a few months after an experience with a newly hired nurse left her feeling unsupported from her nurse managers. When questioned about her return to precepting, she said

> Um, they came to me and said, "Dianne, you have a student!"…unfortunately, that is probably how it goes the majority of the time. You are told you have a student, you know, it's not like 'Ok, the students are comin' [*sic*] in, it's August!' and most of the time it's just that we are told "This is your student".

Sometimes managers were perceived as apathetic. Lisa acknowledged

> …as far as management and administration, um, I wouldn't say that they, they don't give really great support, it's just like they're neutral. Do you know what I'm sayin' [*sic*]? They're not negative towards it, but they're not positive…it's just a very neutral, just like "Ok, you're preceptin' [*sic*], ok", not negative or positive, just neutral.

The perception of unilateral communication, lack of choice, and apathy toward involvement in precepting contributed to a shared sense of low perceptions of managerial support.

Understanding the Role

Preceptors' motivation to precept appeared to emanate from a strong empathetic drive to protect students and the nature of nursing. As such, *Protector* is the primary role function described by these participants. Preceptors want to protect the student and the profession of nursing. Their effectiveness as a protector is predicated on certain behaviors that are demonstrated when they engage in the secondary role functions of *Socializer* and *Teacher* and through the use of resources, including aspects of preparation and support to varying degrees. Figure 2 depicts the relationship of the preceptor's primary and secondary role functions and associated behaviors.

Motivation to precept: "That's how I wanted to be treated". Preceptors' motivation to serve in the role stems from empathy. This empathetic, protective nature drives preceptors to engage in a variety of behaviors that are directed at benefiting the student and preserving the nursing profession. This empathy is the result of the participants' own experiences as students or as new nurses. These experiences were reported to have been the significant driving factor in the initial decision to accept and continue in the precepting role. As already noted, most preceptors did not volunteer for precepting. However, they willingly accepted the role and continue in it. Precepting appeals to these preceptors' empathetic nature and their desire to effect change in the nursing profession by allowing them to treat others (i.e. future nurses) the way they themselves wanted to be treated.

Anna explained: "…while I was in nursing school, I did have some bad experiences with [staff] nurses with students…I'll never forget being treated differently as a student; so, I wanted to make a difference." She said: "I want to make people comfortable…", and added

> I try to treat everybody just like a colleague…I want them to succeed…and I want to change that, that whole thing that nurses eat, eat their young. You know, I don't want that to be around, in future generations…if you teach 'em [*sic*] the right way to begin with, I think things, you know, it'll be ok when they get some experience.

Anna provided an example of how she accomplished this with the student

> …I'll go in and see you set up everything, but I'm gonna turn my head when you, you know [perform], 'cause [*sic*] I don't like for somebody to stand over me…I'm seein' [*sic*] that you're doin' [*sic*] everything right, but you know...if you can't get it, tell me…but I cannot stand for people to be over my shoulder…I just wanna [*sic*] give people a little space to do their thing.

She then added "That's how I want to be treated…and uh, that's how I want to treat people."

Lisa also described this sentiment

> I had a horrible experience while I was doing my internship whenever I was in nursing school; it almost made me want to quit nursing before I ever got started. So, um, I wanted to make it better, I knew there had to be a better way.

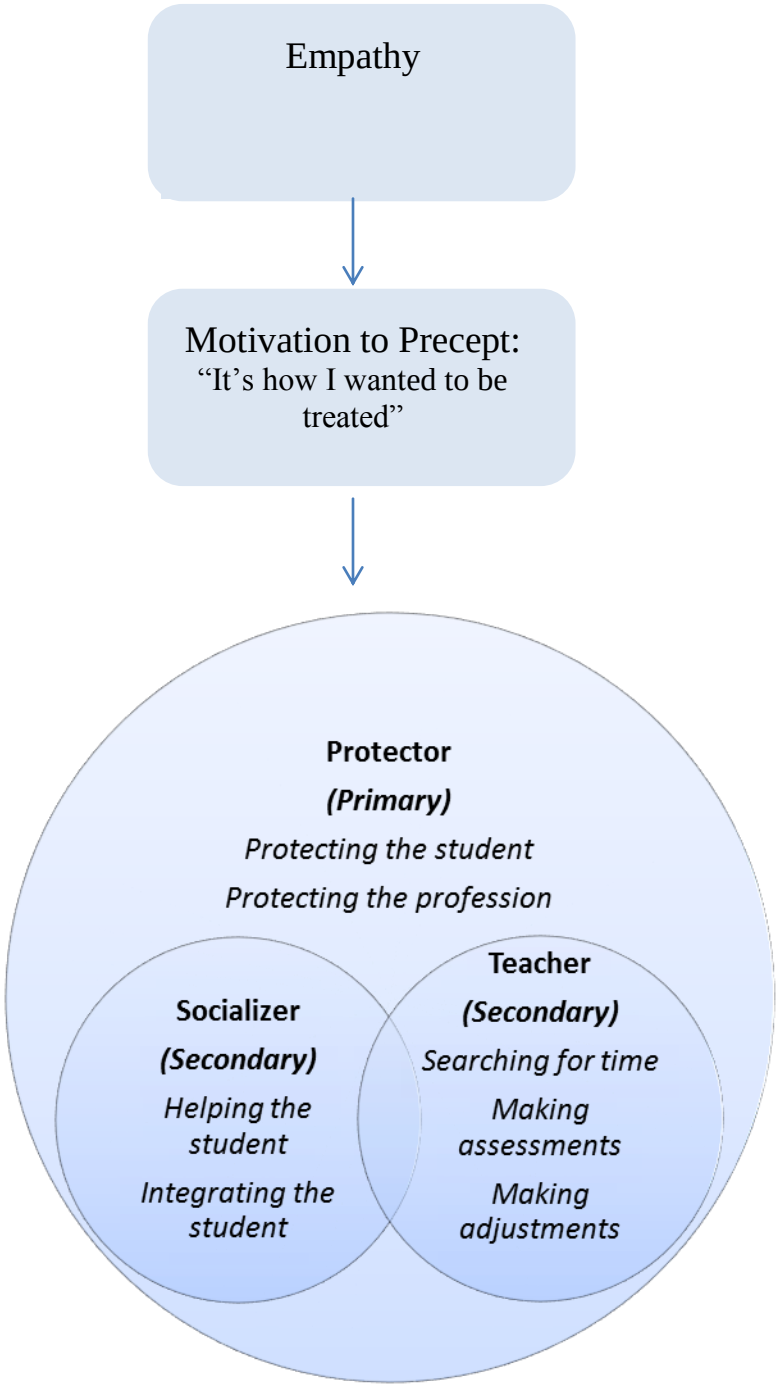


Figure 2. Preceptors' primary and secondary role functions and associated behaviors.

She expressed the desire to always be at her best as a preceptor

> …it helps you realize how much you do and how much you don't know, and how you have to teach your students the correct way. You don't want to show them bad habits that maybe you've picked up over the course of your practice…you have to be, be at your best, at your best, you have to show them best practices.

Dianne also recalled her negative experience as a preceptee:

> … my preceptor was like, sittin' *[sic]* at the desk, "You gotta [*sic*] hang that blood, Dianne!", you know and "No, that's not how you do it!", and so everybody knew that I didn't know how to do it and stuff like that.

She acknowledged: "I understand the scare factor, and I know, and I personally didn't have really good preceptor experience, and so I wanted to be able to offer a better experience." Dianne further reflected on what she wants to do as a preceptor

> I feel like, as a preceptor, I wanted my preceptee to, to learn, there's certain things you need to be educated on – time management, procedures, critical thinking, things like that – but also at the same time, and maybe this was probably wrong, but I wanted to impart to them a passion for the profession…and to be proud of this profession and know that it makes a great difference.

Alicia and Susan offered more detailed negative personal experiences. Alicia said

> I got into the preceptor experience because as a brand new nurse I had a very miserable experience and thought that maybe I'd picked the wrong career and I don't want other new nurses to feel the way I felt.

She mentioned the phrase "nurses eat their young" and said

> …when I started my internship…many years ago, [there] was a group of nurses on night shift that had been nurses for 20 years. They were very unreceptive to having a newer nurse…and I felt very uncomfortable asking any questions because everything I was told, "You went to nursing school, figure it out." And as nurse, I don't ever want someone to feel like they can't come to me and ask me for help or ask me for guidance. Because I don't want anybody to feel the way I felt, like I was stupid...I would leave and cry all the way home, thinking that I have picked the wrong career choice and that I wasn't cut out to do this. And I just want the students to know that it's ok to ask questions.

She indicated that the relationship between herself and preceptees helps her in her own practice

> …when you have those fresh eyes on that situation…you have to stop and say "You know how did I get to this point?" The preceptor role for me, kind of help brings me back to where I need to be as a nurse sometimes.

Susan's story illuminated her experiences as a student and as a new nurse. She recalled being a student

> I had a day, um, on the unit that I'm on now, on step-down, and the preceptor I was with that day made me hate that unit, and I was, I was like "I will never work on this floor". I was like, "I hate this". She made me hate that day.

Subsequently, Susan was hired to work in that unit, and she recounted an experience as a new nurse that affected her

> …I had one lady [a nurse] make me cry, one of my first few nights on the unit…everything I did was, was wrong, "I could've done this better, I could've done this better"…and just, just chewed me out basically…and I had to go in the break room and cry…it made me not want to come back…I was like, "I will not do this to someone else…there is no way"…I felt miserable…and I knew from that first day, that I would not do that [to] somebody else, regardless of what the mistake was.

She then described her motivation to precept

> …I was just willin' [*sic*] to explain things to our newbies…I felt like some people wouldn't take time with me and I wish that they'd taken time with me...I think once they noticed I was more willin' [*sic*] to do that, then I kind of got branched out into that role…because I needed that help, so I helped others; not because I volunteered for it. I know how it is to, to get out there and be scared to death, and then need help, and not be sure what to do, and then you have somebody that like wants to 'eat your young' and then not have somebody that's willin' [*sic*] to help you, and then I didn't want to be that person…I didn't want to be that person to a

> newbie, at all, to our new grads, I love 'em [*sic*], so I didn't want 'em [*sic*] to be scared…yeah, yeah, that's what I didn't want them to feel like at all.

Although most participants offered descriptions of negative past experiences, there were two participants who described their motivation to precept as stemming from positive experiences of enjoyment in the role itself and personal qualities that influenced the decision to assume the role, with no mention of past experiences. For example, Rhonda said "…I enjoy the youngsters as they come up and I like to be there in the beginning…." Felicia reports that students were funneled to her by her co-workers

> …I was that person that everybody put all the nursing students to 'cause [*sic*] they didn't want to fool with the nursing students, and I had patience with 'em [*sic*], and I enjoyed 'em [*sic*]…they picked up, "Well Felicia takes time with them, they're comfortable with her, she steps back in the middle of her busy day."

Overall, however, the descriptions of past experiences provide a preponderance of evidence the root of the majority of preceptors' motivation to accept and continue in the role. Their empathy is the force that drives them to protect.

Primary role function: Protector. As a protector, preceptors engage in behaviors that aim to minimize or eliminate negative experiences for the student while maintaining patient safety, their personal values, and the integrity of the nursing profession. This primary role function can be separated into two broad categories: *Protecting the student* and *Protecting the profession*.

Protecting the student: "Take 'em under my wing". As a protector of students, preceptors assume responsibility for and nurture the student's professional and personal growth. They shelter the student and encourage them through gentle communication. Preceptors' protective nature for students is rooted in their desire to change the perception that nurses "eat their young". Preceptors willingly put themselves in a position to protect the student from situations where this might arise. They do this by engaging in behaviors that support beginning the professional socialization process for students and by teaching the student. Socializing and teaching are discussed below. Alicia described the protective nature of the relationship with her students as one similar to a mother and child

> I am…maybe more experienced, and the preceptor [*sic*] is more like my child that I want the best for them…you want to build that relationship and help them become the best that they can because you know that later in life, they are gonna [*sic*] be the future that's gonna [*sic*] be taking care of us when we're older.

She went on to say that she felt compelled to "take them under my wing and you know, protect them like they were one of mine." Lisa also mentioned the need to protect

> The students would be just so scared…they didn't know if they could breathe, move, or anything… and just to be able to take 'em [*sic*] under your wing and show 'em [*sic*] stuff, and get 'em[*sic*] interested and get 'em [*sic*] engaged.

The patience conveyed through gentle communication is an essential characteristic of protecting the student. Anna provided an example of how she achieves this and encourages the student

> Certain people will sit back and watch you fail, knowing that you're doing something wrong, or knowing that there's an easier way to do something, they will sit back and just watch you fail…and I am the buffer…this is not the way we're gonna [*sic*] be, you know, we're gonna [*sic*] do it this way, we're gonna [*sic*] do it the right way, and we're gonna [*sic*] leave those other people in the corner.

Lisa recalled an episode in which a student performing a procedure could have potentially harmed the patient. Through this discussion, her patience for the student is evident:

> …I took over, and I went through it with her, I didn't just say 'get out of the way', you know, I said 'Here's what we've got to do'…I think once I talked to her and she realized the full scope of what one tiny mistake can mean for a patient, I mean it hit her so hard, she started cryin' [*sic*]…I said 'If you need to, go outside, get you some fresh air, just shake it off, and then you know, let bygones be bygones, you learned a lesson and then you come back, we'll get started again'.

Protecting the profession: "Nobody knows everything". Preceptors' commitment to nursing is strengthened through precepting and the protection that it allows. Preceptors place high value on protecting certain professional qualities including

humility, patient safety, and lifelong learning. Consequentially, preceptors engage in behaviors in and out of preceptorship experiences to ensure high standards of nursing care are met and maintained.

Of particular interest is the finding that preceptors perceive students with overconfident attitudes as potentially unsafe. Preceptors perceived students to be overconfident when students did not seek appropriate guidance for processes or procedures. Preceptors also perceived overconfidence or resistance when students were unreceptive to constructive criticism or correction. Alicia called this a "know-it-all" attitude. The idea of overconfidence and resistance is discussed in more detail below. In contrast, preceptors did not view inexperience negatively. Preceptors were consistent in their ability to be patient and communicative with students who were perceived as unsafe or incompetent. This allowed them to intervene so that high standards of care were maintained and the patient was protected. Anna spoke of a student she precepted who, after two failed attempts, went on to successfully pass the licensure examination and work alongside her

> She had the anger issues of having to repeat that twice, and when I would try to show her things, "I know it, I already know, I know, I know", so the first day she got out on her own…this person who knew it all last week was begging for my help, and you know I didn't throw it up in her face…she came back to me two or three weeks later and she said, "Thank you for not bein' [*sic*] ugly to me"…I'm not that person, but never ever think that you know everything, because you don't.

Kendra also spoke about an overconfident student: "…she thought she could do no wrong, she was too confident, *too* confident and she didn't want to seek resources or help and things and just assumed she could do it, when she couldn't, which was unsafe." Describing how she handled the situation, she said

> We talked with her and said "I understand you feel like you know how to do things, but you're in training right now, so you need to keep staff with you and you need to check with everyone before you do anything".

Lisa described an experience of intervening to protect a patient when a student demonstrated uncertainty while performing a procedure. She said: "…just let me take over from here, and 'you need to watch what I do', and so I went through the steps and showed her...."

Preceptors take this responsibility seriously as they perceive students as a direct reflection of themselves. They are protective of their own professional image and are concerned about how a student's performance may reflect the preceptor's image. Felicia described a situation where during a period of illness, she was a patient in a healthcare facility. She reported a feeling of disappointment when a former student she had precepted, now a licensed registered nurse, failed to perform to the standards she had taught: "…she didn't lay hands on me…and I was very disappointed, I was like 'What did I do wrong? Doesn't she remember anything that we went over?'…." Chelsea offered two examples of how a student's performance is perceived as a reflection of the preceptor. She first discussed a student whose performance was less than stellar: "I felt

like it was a reflection on me too, like maybe I didn't do something right…that's one of the challenges, is, you know, really making sure that I'm doing a good job for that nursing student." She then recalled a more positive experience with a former student who went on to become a co-worker

> [A] couple Christmases ago, it was me and a girl that I precepted and we were the two nurses in the unit, and um, we had a code, and after the code, I was like "That's a reflection of me! I did something! I did something good!"

Dianne agreed: "…to see somebody that I precepted precepting somebody else and doing well, then I know I did my job." Kendra also reflected this sentiment: "…it just shows how precepting is a big responsibility, because no matter what you do it reflects on you, and everybody sees it too."

Because preceptors perceive students as reflections of themselves, they want to protect their professional identity and essential values associated with nursing. They are committed to maintaining high standards of practice with dedication to lifelong learning and humility. This was conveyed by several preceptors. Anna and Alicia voiced the importance of continued learning and self-responsibility. Alicia said: "Fourteen years later there's still days that I ask questions, and we use each other as sounding boards, because things are changing at all times, and we're learning to adapt, and nobody knows everything." She also noted: "I want to be held accountable for what I do." Anna echoed this and said: "That's very scary as a new nurse, to come out and act like you know everything, 'cause [*sic*] you don't, I mean, people learn every day." The level of

humility and professional dedication that preceptors have was best elucidated by Dianne who said

> I feel like anything that I have learned it has been because the nurses in the units have poured into me, you know, and taken that time, and I've sought things out. Every day I've looked at it like, "You know there's something to learn. I've got something to learn today. I don't know everything I need to know for this day."

Secondary role function: Socializer. In the secondary role function of a socializer, preceptors' assist the student in beginning to understand professional norms. They help the student begin to socialize to the profession and to the area in which the student is assigned. Preceptors accomplish this by participating in the behaviors *helping the student* and *integrating the student*. Because preceptors are driven by empathy, they may perceive a need to step in and protect the student from less desirable interactions with other nurses so that the student's beginning social process is a positive one.

Helping the student: "Let me". Helping the student is a latent process that stems from the preceptor's empathy. In helping the student, the preceptor recognizes the student's needs and then seeks permission early on to direct or redirect the student's actions or remove the student from negative socialization experiences through use of the phrase "let me". This is often done when explaining the logistics of the unit or the department or when an intervention by the preceptor is needed and helps the student begin to identify with professional norms and unit expectations. Anna provided an example: "If we get a new employee or a student, 'Here let me show you where you put

your lunch, let me show you where to hang your jacket up'…it's just the basic things…just basically being nice." Susan echoed: "…I would kind of reach out and be like, 'Well here let me show you how this works…." Felicia described what a co-worker said about why students were placed with her: "She steps back and says, 'Let me show you how this works' and 'If this comes up, let me show you what to do'."

Some students may be introduced to professional socialization through less than desirable experiences. During these experiences, the preceptor's empathy motivates them to help the student by intervening when necessary. Alicia recalled the need to step in to protect a student and remove her from a nurse who took pleasure in watching the student fail: "It was just like, you know, 'I think you need to step aside and you know, let me take them for a little while'. " Here, the preceptor protects the student from negative interactions with another registered nurse. Alicia recognized the need to intervene in order to minimize possible deleterious effects on the student's professional identity and to positively support the student's professional socialization.

Integrating the student: "We didn't mesh". During the process of socialization, preceptors found themselves assessing the student's attitude or motivation and then making a determination about whether the student would be a good fit with the unit. The resultant assessment led preceptors to make decisions about how much the student should be integrated, or socialized, into the environment. Some preceptors referred to this process as "meshing".

Kendra described her perception of precepting, in part, as having a very social nature

> …I get along with everybody, and I welcome everybody with open arms…I like introduce 'em [*sic*] to everybody and say like "Come out to eat with us!", so it was more of not really teachin' [*sic*] 'em [*sic*], but more of like "Make 'em [*sic*] part of the team", even though as a preceptor I wanted to teach and everything, but I feel like my main purpose when I was asked to do it was to make sure they don't leave.

Some participants reported difficulties integrating the student into the unit because they may not be well-suited to that particular nursing environment. Susan said: "…that's hard to say that, but you know, you can tell when somebody's not meant to be for the unit, and then somebody's meant more for med[ical]-surg[ical], and somebody's meant more for, you know…" When asked about how she could tell, she replied

> Their panic level, I guess…and how quick they are to know, "Oh, well this heart rate's doin' [*sic*] this. Do I need to call the doctor now?"…and too, if my student can ask me somethin' [*sic*] before I have to be like, "Hey, should you call the doctor about this?"…just how quick they are to pick up on stuff."

Felicia agreed: "Right, right, a good nurse, a good nurse but for one patient…it's just they can't um, they can't deal with time management." Kendra related this problem to personalities

> …is it their personality? Like, are they just so lackadaisical about everything?...is that just your personality?...are you just, like, that lazy?...I mean, I know intelligent people who are lazy…they know somethin's [*sic*] goin' [*sic*] on but

> they don't feel like dealin' [*sic*] with it, so they don't…you can't train that, you can't train people not to be lazy.

Rhonda saw the inability to mesh as potentially related to the students' motivation for entering the profession

> I mean, why did they get into nursing? Did they lose a job? Did they want to be nurses from the get-go? I think it makes a huge difference with these students, as to why they're in nursing in the first place.

Other participants specifically referred to this process of socializing the student as "meshing". Alicia said

> I found that our personalities just didn't mesh, and you know, it got to the point that I had to call the instructor and ask that she please take that student away from me, because our personalities did not mesh.

Anna also discussed her experience

> One challenge that I had is a, not a difficult student, but we didn't mesh well…and she was assigned to me, and I knew that she was assigned to me, but just our personalities didn't mesh, and we had to, you know, we finally just had to sit down and we just had to have a conversation, and after that it was better, but she wasn't one that I recommended to be hired for a job in my unit, because she just…she didn't…it wasn't her place, you know, that she just didn't mesh well with the environment at all…and that's hard.

Although both preceptors' responses were different, both responses were attempts to protect the culture of their particular nursing unit.

Secondary role function: Teacher. In this secondary role function, preceptors attempt to impart professional nursing knowledge to the student. Preceptors recognized that procedural skills were important to provide for the student, and they accomplished this with the support of their co-workers; however, they also acknowledged there were many other aspects of nursing to be taught and one participant alluded to this as the "reality of nursing". They voiced concern about the amount of time they were given to achieve everything they felt needed to be taught, and patient care was their top priority. Therefore, the type and amount of knowledge conveyed to students is individualized and based on a combination of making assessments and making adjustments.

Searching for time: "We're tryin' to do the best we can". Preceptors are acutely aware that time is needed to be effective in their role. However, participants reported that the lack of time to teach everything that needed to be taught was frustrating. This lack of time sometimes causes students to be pushed to the background. While discussing this, Dianne said

> They need that opportunity, the need the clinical, they need the education, but things are so hectic…that really the first priority is maintaining this unit, maintaining the care of this patient or these patients, and you know, sometimes I feel like the students…we're tryin' [*sic*] to do the best we can with them, but they really don't get the time, or the priority.

She stressed: "There's so much you want to teach them, but there's so little time." Susan also chimed in on the lack of time: "…it's so many things I want to tell 'em [*sic*]…you have such short amount of time to squeeze this in…there's so many things that you have to impart to them…." Preceptors indicated that the many other responsibilities they have as nurses contributed to the difficulty of finding time for students. Susan said: "I have a full load, and I'm charge, and I have a student, so that can be a bit overwhelming…the student gets mixed up in the shuffle." Anna mirrored this

> Some days, I mean…you walk into a mess at work, and you gotta [*sic*] get this, this, and this done immediately, and I will tell my student, 'Just follow me for right now and then I'll explain it, you know, when the dust clears.

Rhonda identified technology orientation as a potential contributing factor:

> I see a big difference in precepting now than I did five years ago…now I feel like I'm competing with technology, and teaching them all the computer issues, the scanning correctly and the charting correctly, to save your behind, um, and it's a real struggle to make sure we stay that on top of just teaching the basics of nursing.

Rhonda felt confident that she could teach the skills, but said

> I am not confident that I have the time or that I'm going to be able to fit in all the effort to teach the student what they really want to know, and that just terrifies me…I mean, they're seeing how nursing really is, but what are they really getting out of this?

Making assessments: "You have to evaluate each person". Because time is lacking, preceptors spoke of the importance of assessing a student's skill level, attitude, and motivation for entering the profession. They described it as an iterative process influencing the way they interact with the student and the way they adjust their precepting. Susan said: "You have to evaluate each person that comes through and know their skill set and see what they need to maybe work on more." Lisa related this to teaching and learning styles: "…it helps me realize different teaching methods. Like this may work for this student, but this may not work for this one."

Preceptors are astute when assessing students' attitudes and were quick to express their concerns. For example, when asked to explain the differences she assessed in students, Lisa said: "Um, not necessarily so much ability, but it's more like personalities, you know, more personality. It's not necessarily ability." Anna also expressed her concerns: "Some people, if they have the personality they already know everything, and that's very scary as a new nurse, to come out and act like you know everything, 'cause [*sic*] you don't, I mean, people learn every day." Alicia agreed: "…sometimes the, the mindset of the students that we get is that they know it all, they don't need you there and you're just kind of in their way." Preceptors were quite emphatic that students with overconfident or resistant attitudes were unsafe. Although preceptors acknowledged the importance of assessing students' skill levels, they emphasized the importance of assessing students' motivation. Student motivation and attitude was a driving factor in the participants' needs to adjust their precepting.

Making adjustments: "I'm pushing and pulling". As preceptors assess the students, they adjust their precepting and make adaptations to meet the individual student's needs. The need to adjust was noted by Dianne: "…of course we have various levels of precepting…and you have to approach each one, personally in my opinion, a little differently, and how you need to work with that." Alicia also recognized need for adjusting : "…I have to make adjustments in the way that I precept different people based on their learning styles."

Adjusting was described as an active process that requires significant energy on the part of the preceptor, with the expectation that the student should also actively engage. The process can be invigorating or overwhelming depending on the response of the student. Felicia said

> I guess what I'm trying to say is that they are not proactive, unless you, uh, tell them to go do this task, they are not going to do a task whatsoever…It's great when somebody's there to learn, and they're excited, but it's a little draining when you have to push somebody all day long to learn.

She continued: "I expect them to be scared, but by day three, you shouldn't still have to be pushing them out." This was repeated by Rhonda who said: "If we can understand what their personal goals are, where they feel like they need more education, if there's some way for us to tap into that information, you know we can push them in that direction." Chelsea reflected on her experience of needing to make adjustments for a student who was hesitant to perform: "…it's kinda [*sic*] like I had to pull her to do

things." Dianne mirrored this and said: "It's very hard with younger nurses, you know, to get the younger nurses you know to get them to take the initiative, that its' not going to be handed to them." Anna provided an example of how she makes adjustments in her precepting

> Well, like, if I'm pullin' [*sic*] medications out, I feel like I need to explain what I'm gettin' [*sic*] out and what this medicine's for. Even though you heard it in nursing school…I've got to stop and explain it or try to show where something is…it does slow you down, but that's OK, that's OK, we'll get through it.

Alicia summed up what adjusting means when she said

> Everybody has a different personality, and everybody has a different learning set, and you kind of have to adjust yourself to kind of meet their needs…you take the good, and you take the bad, and you kind of lump it together and you make the best you can out of the situation at hand.

Summary

Findings from the data analysis indicate that preceptors view preparation for the role as a formal process consisting of a preceptor class with a focus on teaching and learning styles. Support for the role is sought and received in varying amounts from RN co-workers, faculty, and managers. Support is perceived as a helping function from co-workers, as a validating function from faculty, and as a mechanical function from managers. The role itself is characterized by the preceptor's strong empathetic drive to protect students and the nature of nursing. This empathetic drive originates from

preceptors' past experiences and serves as the foundation for the primary function of the role: Protector. Preceptors identified two secondary role functions, Socializer and Teacher, which are characterized by certain behaviors that preceptors demonstrate to varying degrees. The degree to which they engage in these behaviors is dependent on the individual student situation. Group interaction findings suggest that preceptors empathize strongly with one another, offering support for the helping function associated with co-worker support. Findings can be used for suggestions for additional research. These suggestions are discussed in the subsequent chapter.

Chapter V: Conclusions and Recommendations

The purpose of this study was to explore staff nurse experiences as preceptors to undergraduate, pre-licensure nursing students. I gathered the data using focus groups and interpreted the data using conventional content analysis. In this chapter, I provide a brief summary of study findings from Chapter IV and place them in context of current literature and practices. I also discuss findings that are new to the literature, implications for nursing practice, implications for nursing education, and study strengths and limitations. The chapter concludes with suggestions for future research.

Summary of Findings

Preparation for the Role

Preparation for the role is extensively discussed in the current preceptorship literature as a necessary element for role performance. There is some consensus among authors regarding the types of information that should be presented, but method of presentation and amount of time spent on preparation are varied. Study participants described preparation for their preceptorship as a formal process that included participating in a class offered by their places of employment. Only two of nine participants reported not having taken a preceptor class. Participants reported that they felt prepared to undertake the roles, and those who had taken the class perceived the most important aspect to be the focus on teaching and learning styles. They offered some support for current recommendations that information about teaching and learning strategies be provided to preceptors (Carlson et al., 2009; Rogan, 2009). Participants also

said that by understanding the information about teaching and learning styles, they were able to integrate it into and reflect on their own precepting practices, and the practices of their co-workers. However, the minimal discussion about benefits of the class or other information gleaned from the class suggests that although participants found the some of the information useful, they did not find the class to be essential in shaping the overall framework of the preceptor role. In-depth discussion about preparation was extremely limited.

My research findings offer some support for the comprehensive evaluation study of a preceptor course conducted by Heffernan et al. (2009), who utilized three focus group interviews (n = 12, n = 12, n = 12) and thematic analysis. The authors reported on the evaluation of a 2-day, 16-hour preparation workshop for preceptors. Information provided to the preceptors included clinical learning environments, principles of assessment and feedback, learning theories, clinical support networking, and competency. According to the authors, preceptors found that understanding the student role and an orientation to the clinical learning environment were of utmost importance for preceptors to demonstrate to students. They also found that preceptors considered communication skills, being supportive of students, and being approachable as the most important characteristics that a preceptor should have. They go on to recommend that preceptor preparation include support networks for preceptors. Their findings and suggestions parallel findings of the current study with regard to the preceptor's primary role function of Protector and the secondary role function of Socializer. In the Protector function,

preceptors are supportive of and nurture the student's professional growth. As a Socializer, preceptors assist the student to become acclimated to the environment of the clinical unit and the culture of nursing. These functions are discussed in more detail below.

Most of the current recommendations for preceptor preparation include focusing on adult pedagogies and evaluation methods. Even though participants found information about teaching and learning strategies useful, it was discussed only minimally. Taken with Heffernan's findings, this could mean that preceptors may not perceive formal preparation as a necessary requirement to serve in the preceptor role. It is possible, though, preceptors in this study simply felt more prepared as a result of their educational levels. Several of the preceptors (n = 4, 44.4%) had Master of Science degrees in nursing and reported prior or current experience as faculty members in nursing education programs. Further research is needed in this area to determine what types of information and methods of preparation best support preceptors in their roles.

Support in the Role

Participants described support in the preceptor role as a three-prong system, sought and received in variable amounts from RN co-workers, faculty, and nurse managers. Participants perceived support from co-workers as a helping function, from faculty as a validating function, and from nurse managers as a mechanical function. Registered nurse co-workers are seen as the primary source of support for preceptors through the processes of sharing responsibility for the preceptee and problem-solving.

Co-worker support. Participants found co-worker support to be of utmost importance and critical to their success in the role. This is consistent with research findings that indicate support from co-workers is desired, is invaluable, and is beneficial to students when preceptors share responsibility (Carlson et al., 2010a; Pulsford et al., 2002). In their ethnographic study designed to describe conditions for precepting in a clinical context, Carlson et al. (2010a) found that preceptors' perception of co-worker support was enhanced when the preceptor and co-worker worked together to find learning opportunities for the student. Study participants in the current study described several experiences that contributed to the sense of shared responsibility and teamwork when students were afforded opportunities to learn from nurses other than the preceptor.

Pulsford et al. (2002), in their descriptive survey, found that preceptors perceived the most support from their RN co-workers and the least support from their managers, as did my sample. Manager support is discussed below. There is a gap in extant literature regarding this specific aspect of preceptor support. There is also no information about specific interventions used to increase support networks between preceptors and their RN co-workers. More research should be directed here so that preceptors enjoy the full benefit of collegial support.

Faculty support. Participants described faculty support as a validating function that is limited because of a lack in time and gaps in communication. This may have contributed to participants' perception of faculty as an invisible presence with the potential to validate or invalidate preceptor assessments or concerns. Prior to the

interview, all participants reported on the demographic survey that faculty members were available in the building or by way of phone, text, or e-mail. However, during focus group sessions, the conversation was decidedly different. Discussing faculty availability, participants reported that they did not expect to see the faculty during the preceptorship and stressed the importance of being able to handle student situations without involving faculty, even though faculty were available. One participant noted that faculty did not leave contact information, which was in direct contradiction to her demographic survey response, and another said that she would not want the faculty member present while working with the student. Only one participant reported that faculty was available in the facility during precepting experiences. Participants did not discuss specifically how much time they spent in any type of communication with faculty. These conflicting reports of faculty availability suggest that preceptors may have varying definitions of faculty availability or accessibility.

Contrary to previous studies suggesting that preceptors desire more communication with and support from faculty (Carlson et al., 2010a; Landmark et al., 2003; Luhanga et al., 2010; Pulsford et al., 2002; Raines, 2012), my study revealed that preceptors do not expect or necessarily want more contact with faculty. Several participants indicated that they themselves served as faculty members in various capacities. This may have resulted in participants feeling more confident in their abilities to precept and handle situations that arise with students without the need to involve

faculty members and may have also contributed to the contradictory statements from preceptors on the demographic survey and in conversation.

Although participants reported few expectations that faculty would be available, they did report that a major barrier was lack of time to communicate. They also expressed the expectation that faculty would validate preceptors' concerns when communication was established. When validation was not given, the perception of support was altered. This is consistent with prior studies. Luhanga et al. (2010) found that preceptors wanted recognition for their role in evaluation of student performance, but that feelings of support and preparation to carry it out were affected if the student was deemed unsafe or in jeopardy of failing. Preceptors have also reported self-doubt, fear, and anxiety about reporting concerns about poor performance to faculty (Hrobsky & Kersbergen, 2002; Luhanga et al., 2008a; 2008b) and it is suggested that this can affect a preceptor's self-esteem (Hrobsky & Kersbergen, 2002). One participant in my study indicated that her concerns about a student's performance were reported to faculty, yet the student was allowed to continue in the nursing program. Similarly, this is found in the literature that faculty may pass a student even when preceptors recommend failure based on poor or unsafe performance (Luhanga et al., 2008a). This is worrisome and suggests a need for serious inquiry into the nature of faculty-preceptor communication and expectations.

Manager support. Perceptions regarding managerial support are also noteworthy. Managerial support includes the processes of being selected to serve as a

preceptor and preparing for student arrival. Support from nurse managers was both the least perceived and least sought or expected. Participants reported a sense of pride when speaking of being selected to serve in the role. Some participants acknowledged feeling valued by their managers when selected as preceptors, lending credence for previous findings about the importance of recognition when serving as a preceptor (Omansky, 2010; Seldomridge & Walsh, 2006). Although preceptors reported feeling pride that they were selected by their managers to serve as preceptors, they also described several situations in which they had no choice about serving as a preceptor. At the same time, others' descriptions of managerial support are also consistent with prior research, including perceptions of manager apathy (Landmark et al., 2003) and lack of managerial support (Pulsford et al., 2002). These situations of unilateral communication, lack of choice, and apathy toward involvement contributed to the stated minimal degree of decreased perceptions of managerial support. Pulsford et al. (2002) say that preceptors indicated a need for more support from managers, but they do not offer recommendations for what form that support should take.

Understanding the Role

Participants described their understanding of the preceptor role as one that is primarily rooted in their own personal prior experiences as a new nurse or nursing student. Six participants reported negative experiences and three reported positive experiences, but all participants described a strong empathetic drive to connect with nursing students and to make a difference in the profession. This is evidenced in the

transcripts by the many times that participants voiced a strong will or resolve by saying "I want to" or "I don't want to". All participants mentioned one or both of these phrases at some time during the focus group sessions.

Participants identified three distinct functions of the preceptor role, all of which emanate from their motivation to take on the role. The names used these functions were derived by the author after data analysis. The primary role function identified by preceptors is that of a protector. Secondary role functions include those of a socializer and teacher. Within each function, there are specific behaviors in which the preceptor engages to varying degrees depending on the needs of the individual student. The following is a discussion of the findings about role functions.

Protector. The primary role function of the preceptor in my study is that of protector. As a protector**,** preceptors assume responsibility for and nurture the student's professional and personal growth. They encourage the student through gentle communication and consider the student to be a direct reflection of them. It is because preceptors are protectors that they engage in the secondary role functions of socializer and teacher. Preceptors have a strong empathetic drive to protect the students from negative experiences, to protect their patients from harm, to protect their own professional identities, and to protect the nature of the nursing profession itself.

Student and patient. The idea of the preceptor as protector is not completely new. In her article describing the implementation of a research-based nurse internship project in Vermont, Boyer (2008) acknowledges that the role functions of socializer,

educator, and role model are essential, but goes on to say that the protector role is the foundation of the preceptor role. Boyer asserts that preceptors protect the patients through ensuring the provision of safe, effective care and protect the student by ensuring the learning environment is safe. Participants in my study validated these sentiments as evidenced by their discussions about intervening to protect patients when a student was incorrectly performing a skill or slowing down to explain nursing actions to the students so that patient care was delivered appropriately.

Participants described the protection of students as occurring when the preceptor took the student "under wing" and shielded them from the reality of nursing. The idea of taking the student under one's wing is also reported by Luhanga et al. (2010) in their qualitative descriptive study. The authors referred to this as serving as a *student advocate* and indicated that preceptors reported a need to ensure students were kept safe in a "complex healthcare environment" (Luhanga et al., 2010, p. 9). This same finding is reported in Ohrling and Hallberg's (1999) phenomenological study exploring the relationship between student and preceptor. Here, the authors called this *exercising control* and reported that students perceived feeling safe when the preceptors took responsibility for the student's learning and the patient's safety.

Nurses have long been considered as patient protectors. Provision 2 of the American Nurses' Association Code of Ethics for Nurses says "the nurse's primary commitment is to the patient whether an individual, family, group or community" (ANA, 2010) and there is current focus on healthcare quality issues including annual National

Patient Safety Goals (NPSG) by the Joint Commission. These goals are designed to address issues of concern related to patient safety (The Joint Commission, 2013, "Facts about the National Patient Safety Goals," para 1). The commitment to patient safety and high quality nursing care cannot be overstated and my study findings support this; however, the findings also suggest that the role function of protector is much more than the obvious patient protection.

Socializer. This function is characterized by helping and integrating the student into the professional role as a result of the preceptor's motivation to protect and connect with the student. Preceptors practice respect for the students, thereby role modeling this professional attribute. Specifically, preceptors in the current study recognized student needs and then sought permission to direct or redirect the student's actions through the phrase "let me". In reference to working with students, the phrase "let me" appeared 10 times in the transcripts. This appeared to be a way for the preceptors to demonstrate professional respect and practice peer-to-peer boundaries while initiating the socialization and team-building process.

Team training is recommended by the Joint Commission (2005) as a potential way to strengthen nursing education. This is a call for collaboration so that the transition to practice is eased for students and new nurses. Recalling from Chapter I, collaboration is one of the AACN's standards needed to enjoy a healthy work environment (AACN, 2005). In order for collaboration and teamwork to be truly effective, the relationships between nurses should be respectful and positive. Moore, Leahy, Sublett, and Lanig

(2013) found that some nurses had considered leaving the profession because of poor nurse-to-nurse relationships. A key finding from their study is that nurses reported the need to be "tolerant and accepting of each other" (Moore et al., 2013, p. 175). Levett-Jones, Lathlean, Higgins, & McMillan (2008) refer to this as "belongingness" and say that the receptiveness of the nursing staff on the first day of clinical placements for students was "like a barometer that foreshadowed how their placements would unfold" (p. 319). According to the authors, students who felt included and welcomed experienced increased levels of well-being and motivation to learn. Brown, Stevens, and Kermode (2012) also report that the clinical preceptor is essential to the student's sense of belonging and inclusion. In fact, preceptors have been noted to be the most significant influence in students' perceptions of feeling like an "insider" on a clinical unit (Rush, McCracken, & Talley, 2009) and are reported to support students' acquisition of professional values and development of professional identity (Brown et al., 2012; Fagermoen, 1997). My study results support these findings. Participants contributed to positive professional socialization processes by approaching the students early in the preceptorship experience, extending a welcoming demeanor, and demonstrating professional values of collegiality and respect throughout.

Ousey (2009) says that some students may struggle to "fit in" with unit. This was also reported in my study. Participants characterized the struggle to fit by the more negative phrase, "we didn't mesh", which was repeated seven times during the focus group sessions. The ability of the student to fit with the group is discussed by Moore et

al. (2013) who say that nurses find that in order to fit, students should be "cheery, outgoing, open-minded, friendly, and humble" (p. 176). Moore et al. also report that nurses found students who displayed a passion for the profession, maturity, and the ability to be confident as likely to be successful at fitting in. On the other hand, students with a "know-it-all" attitude were deemed less likely to fit in with the nursing unit (Moore et al., 2013).

Several of these authors' findings closely parallel results of my study. Particularly, the notions of humility and know-it-all attitudes, or overconfidence, are central to my findings and were discussed above. It is interesting that one of my study participants, using the same verbiage as reported by Moore et al. (2013), stressed how very important it was to her that she imparts a passion for the profession to her students.

It is not known from previous studies how nurses make the determination regarding the students' level of passion, humility, or know-it-all attitude. Future research might be designed specifically to explore the process of how nurse preceptors make these decisions, the resulting actions, and how those actions affect preceptors and students.

Teacher. As teachers, preceptors stressed the importance of assessing a student's skill level, attitude, and motivation for entering the profession. They described the process of teaching as invigorating or overwhelming depending on the response of the student and they used the terms "pushing" and "pulling" to describe the activities associated with making adjustments to their teaching.

Preceptors recognized that procedural skills are important to provide for the student, and accomplished provision of skills with the support of their co-workers. However, they also acknowledged there were other aspects of nursing to be taught. The lack of time to teach everything participants thought needed to be taught was frustrating. Participants said that patient care and unit-specific priorities, technology, and their simultaneous service in multiple roles such as preceptor and charge nurse, resulted in limited time spent teaching students and could be overwhelming. Several authors have noted that lack of time for teaching is a consistent problem reported by nurses serving in the preceptor role (Carlson et al., 2010a; Haggerty, Holloway, & Wilson, 2012; Henderson et al., 2006; Pulsford et al., 2002). Nurses who are overwhelmed with role responsibilities may unintentionally neglect students during the preceptorship (Henderson et al., 2006) and participants in my study did indicate that students may be pushed to the background as a result of patient care priorities. To minimize negative effects, many authors have recommended that preceptors should have decreased workloads and should not be expected to serve in additional roles while precepting (Carlson et al., 2010a; Happell, 2009; Luhanga et al., 2010; Omansky, 2010; Yonge et al., 2002). These recommendations have yet to become the norm in preceptorships. More attention should be directed toward research implementing these types of strategies so that patient care is not compromised and so that preceptor and student benefit from the precepted experience.

Highest priority: Student motivation and attitudes. Despite the known need for skill acquisition, preceptors in my study seemed more concerned with students' motivation and attitudes. Preceptors reported conducting assessments on each student individually and then making a determination about that student's abilities, motivation, and attitude and what actions were required. Participants did not perceive a student's limited skill level to be unsafe per se, but rather they perceived students with overconfident or resistant attitudes as very unsafe. In both focus groups, student attitude and motivation were discussed more frequently than students' skill levels. In Focus Group A, participants spoke of student attitudes for approximately 20 minutes. Focus Group B was much more talkative on the subject, approximately 45 minutes total. Word choices, as well as total time spent directly addressing motivation and attitudes, supports these priorities. The word "motivation" was noted in the transcript 6 times and the words "too confident" or "overconfidence" were found in the transcript 14 times.

Findings related to overconfident or resistant attitudes have been reported in several prior studies. Killam, Montgomery, Luhanga, Adamic & Carter (2010) used Q-methodology to determine views on unsafe nursing students in clinical learning. The authors report findings of three viewpoints of unsafe practice. Each viewpoint has a list of statements that support it. One of the viewpoints is *clinical disengagement*. Within clinical disengagement, students who are not prepared to respect the needs of the patient, those who do not volunteer for clinical learning opportunities, and those who display a lazy, non-interested attitude toward clinical practice were deemed as unsafe. Also, in

their integrative review of the literature, Killam, Luhanga, and Bakker (2011) categorized inappropriate attitudes, inappropriate behaviors and lack of accountability under the theme, *unprofessional image*. Mossey, Montgomery, Raymond, and Killam (2012) also used Q-methodology to identify five typologies of nursing students who engage in unsafe clinical practices. These are (a) the displaced student, (b) the vulnerable student, (c) the unprepared student, (d) the unknowing student, and (e) the distanced student. The authors report that the displaced student represents the consensus viewpoint, whereas the other four typologies represent discrete viewpoints. The consensus viewpoint represents what all participants thought to be unsafe clinical practices. According to the authors, the displaced student may demonstrate dishonesty, repeated patterns of error, may practice outside their scope of practice and are not protective of their patients.

Results of the current study offer some support for prior research findings about students who are deemed unsafe. Preceptors clearly acknowledged their concern about students they deemed to be lackadaisical or resistant to learn; and it was reported that preceptors experienced students practicing outside their scope of practice. Nevertheless, we must consider the role of the preceptor as teacher in a broader context with regard to assessment of student attitudes and motivation. For example, the age of the students in this study who were precepted is not known. It is quite possible that because of generational differences between the preceptor and the student, assessments of attitudes and motivation were less than accurate. Those in the Millennial generation are adaptable to change, technology dependent, and enjoy being part of a team, whereas those from

Generation X prefer an individual approach to work and prefer completing work on their own terms and without supervision (Hendricks & Cope, 2012). Baby Boomers are strong willed and enjoy the recognition that comes with dedication to work (Hendricks & Cope, 2012). These generational characteristics may affect not only the preceptor's assessment, but also the performance of the student. This is important to consider as those in the Millennial generation continue to join the ranks of an already multi-generational profession. There is the possibility that professional and personal values (e.g. time spent on a computer system), as they are perceived across generational lines, do not mesh, thereby contributing to a perceived lackadaisical or overconfident attitude by preceptors. As already noted, current research exists that indicates nursing experience may not be a pre-requisite for the development of professional values (LeDuc & Kotzer, 2009) and nursing students have substantially higher levels of empathy when compared to the general student population (Penprase, Oakley, Ternes, & Driscoll, 2013).

LeDuc and Kotzer's (2009) cross-sectional survey study compared the professional nursing values of students (n = 97), new graduates (n = 46) and seasoned nurses (n = 84) using the Nursing Professional Values Scale (NPVS), which is designed to measure professional values based on the Code of Ethics for Nurses (Weis & Schank, 2000). The mean age for students, new graduates, and seasoned nurses were 26, 26, and 43, respectively. The authors found no statistically significant differences in responses among all three groups. They also found no statistically significant relationship between years of experience and any individual statement on the NPVS. According to the authors,

this indicates that students, new graduates and seasoned nurses all found the Code of Ethics for Nurses important to guide their practice.

Additionally, questions exist about what types of information about attitude and motivation should be provided to preceptors to help prepare them for the role. Further, if the expectation of faculty and nurse managers is that preceptors are, in part, responsible for assessing and assisting in the education of the professional ethos of students, this should be clearly communicated to preceptors. This is addressed in more detail below in the discussion of nursing education implications. Finally, although preceptors in my study perceived assessment of attitudes and motivation imperative for success in their teaching function, it is possible that preceptors elsewhere do not perceive this as equally important or even as part of their teaching function. In their opinion article, Fahrenwald et al. (2005) offer suggestions for teaching core values as identified by the AACN as integrated into the curriculum, but these may be more appropriate for nursing faculty teaching in the undergraduate programs. There is limited information about methods that preceptors use to teach core professional values. More research is warranted so that a better understanding of attitudes and motivation in preceptorship is gained.

New Findings

Many of the findings from this research study support findings from prior studies related to precepting. However, there are two particularly new findings that stand out and warrant specific attention.

Manager support and staff recruitment. An apparently new finding from the current study is the perceived support from nurse managers in preparing staff for the arrival of students as potential employees. This finding is not explicitly identifiable in the literature; however, there is current research about the importance of preceptorships, mentorships, nurse residency programs, and general clinical placements as recruitment and retention strategies (Andrews, Brodie, Andrews, Wong, & Thomas, 2005; Eick, Williamson, & Heath, 2012; Hillman & Foster, 2011; Salt, Cummings, & Profetto-McGrath, 2008).

Understandably, nurse managers are concerned with recruitment and retention of staff nurses. As previously mentioned in Chapter I, approximately 13% of newly licensed nurses have changed jobs after only one year of work and 37% report a desire to change jobs in the near future (Kovner et al., 2007). The topic has been a focal point of nursing conversation for some years. In 2005, the Joint Commission, formerly known as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), put forth recommendations to address critical issues in nursing. One of these recommendations was to establish a culture of retention (JCAHO, 2005). The Joint Commission report stated that when nurses are retained, patient quality improves (JCAHO, 2005). In the same paper, the Joint Commission also recommended that the nursing education infrastructure be strengthened through standardized post-graduate nurse residency programs and emphasis on team-training in nursing education. Nurse residencies were also recommended by the Institute of Medicine (IOM) in the *Future of Nursing: Leading*

Change, Advancing Health report (IOM, 2010). Nurse residencies are similar to preceptorships, and are defined as "structured post licensure programs lasting between 3 months and 1 year" (Pittman, Herrera, Bass, & Thompson, 2013, p. 597). These new nurses are usually paired with a preceptor (Anderson, Linden, Allen, & Gibbs, 2009). Based on my study findings, it seems that, for some, there may be an expectation from managers that preceptors focus on recruiting new staff. It is possible that nurse managers are well-versed in the current recommendations for staffing, recruitment, and retention from the Joint Commission and other agencies, and may see preceptors simply as a means to an end with regard to recruitment of employees and consider recruitment an important part of the precepting role. This perception was reported by one participant in my study, but it was not identified in any current literature as a perceived responsibility in the preceptor role.

Protector of professional identity and integrity. Preceptor as protector of self and professional ethos is relatively unexplored in the preceptorship literature. Although exciting, it is also somewhat unexpected. Professional values are fundamental to the discipline of nursing. The American Association of Colleges of Nursing (AACN, 2008) says that professionalism entails consistent demonstration of core values and involves "accountability for one's self and nursing practice, including continuous professional engagement and lifelong learning" (p. 26). The AACN identifies nursing core values as (a) altruism, (b) autonomy, (c) human dignity, (d) integrity and (e) social justice.

The National League for Nursing (NLN) identifies seven core values inherent to the nursing profession. These are (a) caring, (b) diversity, (c) ethics, (d) excellence, (e) holism, (f) integrity, and (g) patient-centeredness (NLN, 2010). The NLN is a national organization whose mission is to "promote excellence in nursing education to build a strong and diverse nursing workforce to advance the nation's health" (NLN, 2013). Members of the NLN include nursing professionals, and can include individual members of society and agencies who are interested in helping advance nursing education (NLN, 2013). The NLN (2010) says that part of integrity includes "recognizing with humility, the dignity of each individual patient, fellow nurse, and others whom we encounter in the course of our work" (p. 13).

Additionally, Provisions 5 and 6 of the Code of Ethics for Nurses clearly articulate the professional expectations of nurses to preserve wholeness of character and integrity (ANA, 2010). According to Provision 5.3, "nurses have both personal and professional identities…the nurse embraces the values of the profession, integrating them with personal values" (ANA, 2010, Provision 5.3, para 1) and "nurses have a duty to remain consistent with both their personal and professional values.…" (ANA, 2010, Provision 5.4, para 1). Provision 6 of the Code of Ethics speaks to the sustenance of a respectful, moral environment in which nurses work (ANA, 2010). It may be said that those who practice nursing mindfully, with these qualities in place, preserve the nature of nursing while protecting their professional identity.

Fagermoen (1997) defined professional identity as "the values and beliefs held by the nurse that guide his/her thinking, actions and interactions with the patient" (p. 435). In her qualitative descriptive study, Fagermoen used content analysis to explore professional values as they are expressed in the nurse's work. Her findings revealed two major themes: (a) other-oriented values and (b) self-oriented values. Other-oriented values were reflective of a holistic perspective to patient uniqueness and nursing presence and empathic understanding; self-oriented values addressed the cognitive aspect of work, such as problem-solving, and the how nursing work affects the nurse personally, such as personal growth. Fagermoen asserts that other-oriented values are actualized through competent nursing care and self-oriented values are mediated through other-oriented values and the nurses' engagement in the work-setting. Findings from the current study suggest that preceptors are strongly influenced in their daily practice by the core values fundamental to the nursing profession and take great care to preserve and protect their professional identity and the nature of nursing. Because of their strong commitment to professional values and identity, they value these qualities in others, including students.

Although there are no identified research studies that address preceptor as a protector of self or profession, the guiding frameworks mentioned above offer support for the development of professional identity in nursing. For many years, nursing has been considered the most trusted of all professions (Gallup Poll, 2013; Olshansky, 2011). Olshansky (2011) states "trust involves integrity and honesty" (p. 193). Integrity, honesty, caring, and a sense of vocation continue to be well documented in the nursing

literature as qualities that support one's decision for becoming a nurse (Eley, Eley, Bertello, & Rogers-Clark, 2010; Samaniego & Carcamo, 2013).

In her seminal work, *The Nature of Nursing: A Definition and Its Implications for Practice, Research, and Education* (1966), Virginia Henderson says that nurses should "put herself [*sic*] in the patient's boots" (p. 24). She also says that nurses have a unique, complex function that "requires identification with, or understanding of, all kinds of people" (Henderson, 1978/2006, p. 26). According to Henderson, the ability of the nurse to empathize is essential to professional practice. Preceptors in the current study are motivated by empathy to support the students' learning. They are able to step into, and out of, the student's boots. They are acting in what Robinson (2009) calls *servant teaching*. Servant teachers use listening and empathy to support students in a safe, comfortable learning environment where students feel valued and supported (Robinson, 2009).

As noted, a majority of participants stated that students who were overconfident, resistant, or lackadaisical were potentially harmful and unsafe; there is evidence in the literature to support this notion (Killam et al., 2010; Killam et al., 2011; Mossey et al., 2012). Because of this, preceptors did express concern regarding some students' motivation for becoming a nurse. This concern may be justified; however, there is also current research that indicates students who select nursing as a career demonstrate substantially higher empathy scores compared to the general student population

(Penprase et al., 2013) and that experience as a nurse is not necessarily required for high levels of professional values (LeDuc & Kotzer, 2009).

When a student demonstrated an overconfident or resistant attitude, preceptors in the current study were quick to convey to the student the value of humility and lifelong learning. Preceptors were clear in their comments that learning as a nurse was a lifelong process and alluded that this commitment to lifelong learning was, in part, indicative of being a responsible preceptor. They perceived this to be extremely important as they view students as direct reflections of themselves and reported perceptions of disappointment when students did not perform to expected levels of care. It seems that when preceptors perceived a student's qualities as incongruent with their own, they determined that the student was unsafe and warranted some type of direction or intervention designed to protect professional values. This seems to be an attempt by preceptors to protect their professional identity and to protect the values that are so closely associated with nursing.

Findings from the current study suggest that nurse preceptors are deeply committed to quality nursing practice by protecting the student, the patient, their own professional identity, and the nursing profession. As there are no identified research studies addressing preceptors as protector of self and profession, much more research is needed to explore this exciting new area.

Implications for Nursing Practice

Findings from my research study have several implications for nursing practice. Findings from previous studies suggest that preceptors may feel prepared for their role, and yet still report a lack of support. Overall, my findings are consistent with that statement. Taken together, it seems that nurse preceptors may require more support than preparation. Specifically, nurse preceptors may need less preparation in the shape of formal didactic presentation and more support through collaborative efforts that stem from the six standards the AACN identifies as essential for a healthy work environment discussed in Chapter I. Ideally, this would involve a collaboration of staff nurses, managers, and faculty members. Information about teaching and learning strategies and other pedagogical methods should not be ignored, but perhaps a shift in focus is needed. Based on the findings from my research study and previous studies, RN co-workers are the most sought source for preceptor support. Healthcare organizations where preceptorships can be found should actively promote collegial collaboration through some type of support system for registered nurse co-workers serving as preceptors. Voit and Carson's (2012) qualitative descriptive study out of Australia found that staff nurses nearing retirement saw themselves continuing to contribute to the profession "on and off the floor" (p. 1881). The authors stated that part of being "off the floor" included the mentoring of younger nurses. This type of activity and institutional recognition may enhance nurses' work environments, morale, and patient quality, with the potential to

create a mutually beneficial experience for student and nurse thereby supporting recruitment and retention.

Second, it seems that preceptors perceive different role functions, like that of recruiter, that originate from expectation of their nurse managers. This is quite important as it offers additional support that role expectations are not clearly defined across the boundaries of practice and education. It also suggests that nurse managers may have a more in-depth connection to preceptorships than previously thought. In this study, faculty appeared to be a silent partner for preceptors. This is noteworthy considering the perceived levels of support from managers and faculty members seem to be incongruent with some of the literature. More information about the role of the nurse manager in preceptorships is needed. However, in order to ensure healthy work environments are maintained, managers and faculty should work together to clearly elucidate role expectations for nurses serving as preceptors.

Third, the focus on preceptor's motivation as a protector of self and profession must be acknowledged. Participants in this study repeatedly stated that they served in the preceptor role because they wanted to create change, while preserving the nature of nursing. They did not focus on previously identified benefits of precepting, described in prior studies, including professional development, recognition, or monetary incentives (Carlson et al., 2010a; Grindel et al., 2001; O'Callaghan & Slevin, 2003; Pulsford et al., 2002). Instead, participants focused on their personal motivation to serve in the role – the desire to effect change in the profession by treating students the way they, themselves,

want to be treated. It was this empathy and their commitment to professional values that allowed them to become protectors of the student, the patient, their identities, and the profession. There are no identified studies that specifically address preceptors' motivation to serve in the role, nor are there studies identified that address the preceptor as a protector of self or profession. Integrating these findings into role expectations for nurse preceptors may help them continue to develop their professional identities.

Implications for Nursing Education

Implications also exist for nursing education. As stated in Chapter I, preceptorships are used extensively among schools of nursing (Altmann, 2006; Chappy & Stewart, 2004) and Tanner (2006) says that clinical nursing education has gone unchanged over the past 40 years. She asserts that current clinical experiences are reminiscent of the traditional clinical model. The traditional model consists of a faculty member taking a group of students into a clinical area. Tanner says that this model is still consistently used and because of the increasingly complex nature of healthcare, nursing faculty should look to more innovative models of nursing education. Therefore, schools of nursing have a vested interest in developing preceptorships that encourage not only clinical competence, but development of professional identity and values.

The call for development of professional identity and values is most notably demonstrated in The Quality and Safety Education for Nurses (QSEN) initiative. The QSEN initiative started in 2005 driven by a grant funded by the Robert Wood Johnson Foundation (Cronenwett et al., 2007). According to the organization website, "the

overall goal through all phases of QSEN has been to address the challenge of preparing future nurses with the knowledge, skills, and attitudes (KSAs) necessary to continuously improve the quality and safety of the healthcare systems in which they work" (QSEN Institute, 2014). There are six pre-licensure KSA competencies identified by QSEN. These are (a) patient-centered care, (b) teamwork and collaboration, (c) evidence-based practice, (d) quality improvement, (e) safety, and (f) informatics. KSA competencies are based on the cognitive, psychomotor, and affective domains of learning, respectively. Each competency is defined and includes specific outcomes identified as essential for each learning domain.

As previously mentioned in Chapter II, preceptors may have difficulty assessing and evaluating student performance, and may be reluctant to fail a student who demonstrates poor performance. Authors of these studies reported that poor performance was often associated with inability to perform skills (Hrobsky & Kersbergen, 2002; Luhanga et al., 2008b). Participants in my study were quite vocal about students who they considered to be incompetent or unsafe. No participant equated incompetence or lack of safety with inexperience or lack of ability to perform skills. Instead, the perception was that students with overconfident or resistant attitudes were unsafe or incompetent. Some participants indicated that, as a result of overconfidence or resistance, skill performance was secondarily affected because students overstepped their scope of practice.

The affective domain is essential for nurse educators in faculty roles to take into account when developing and implementing preceptorships. Weis and Schank (2002) say that development of professional values begins in formal education settings and has tended to focus on cognitive and psychomotor learning. Schools of nursing are required by accrediting bodies to have methods of evaluation for student clinical performance. Although affective outcomes are often included in clinical evaluations, more value may be assigned to cognitive and psychomotor outcomes as they may be more easily observable. Affective outcomes can be difficult to grade and measure because of a high level of subjectivity (Andrusyszyn, 1989). Cognitive and psychomotor outcomes are critical for safety and success as a nursing student; however, nursing faculty should ensure that affective outcomes are receiving adequate attention. One possible way to do this is to use the value-laden behaviors, such as the demonstration of respect for human dignity described in Provision 1 of the Code of Ethics for Nurses, as a way to measure affective learning (ANA, 2010; Andrusyszyn, 1989). For example, Provision 1.2 says that "an individual's lifestyle, value system and religious beliefs should be considered in planning health care with and for each patient" (ANA, 2010) and faculty could include a statement on the clinical evaluation tool addressing this aspect of care planning. Methods of assessment for attitudes and professional qualities must be clear. Preceptors also need information about how to correct or address issues with a student's professional attitude. Furthermore, preceptors may be under the assumption that they have little recourse for students who demonstrate overconfident or resistant attitudes. It is imperative that

faculty review clinical evaluation tools with preceptors so that all areas of the tool are understood and areas of confusion are clarified prior to the preceptorship experience.

Theoretical Implications

Theoretical implications for my study exist. There is a noticeable shortage in theory-driven literature about nursing preceptorships. This is disheartening considering the voluminous amount of literature about preceptorships. It is beyond the scope of this dissertation to discuss all the theoretical implications for the study; however, some are glaring and are addressed here.

First, results of my study indicate the role of preceptor is still not fully understood. This implies the possibility for the use of role theories in future studies. As noted in Chapter II, Rogan (2009) used Mercer's Role Attainment Theory in a descriptive survey study exploring perceptions about preceptors preparation among nurses who precept baccalaureate nursing students. She found that preparation needs varied among preceptors based on years of nursing experience. Some participants spoke of their preceptor/student relationship in terms of a mother/child relationship. Mercer's theory is specifically targeted to the child-bearing woman and the process of becoming a mother (Mercer, 1985; 2004). If the perception of the relationship between preceptor and student is that it is similar to that of a mother and child, then perhaps Mercer's theory is one that could be more closely examined.

The same can be said for the role episode model developed in the 1960s by Kahn, Wolfe, Quinn, Snoek, and Rosenthal (Van Sell, Brief, & Schuler, 1981). Omansky

(2010) used the role episode model in an integrative literature review and concluded that preceptors experience role ambiguity, role conflict, and role overload. She said all of these are associated with a lack of understanding about and recognition for the role. The role episode model "depicts the interpersonal process between the person being sent expectation (the focal person) and those sending the expectations (role senders)" and "incorporates organizational, personal, and interpersonal factors which affect the role episode" (Van Sell et al., 1981, p. 46). The lack of role clarity reported in previous studies and the findings from my study strongly support the use of the role episode model in future studies. This model has the potential to inform all areas of nursing affected by preceptorships, including managers, faculty, preceptors, and students.

The use of Hildegard Peplau's theory is also one that should be considered in future studies. Peplau's theory focuses on the interpersonal relationship between the nurse and the patient. Peplau (1997) says that much of the nurse's work occurs during the interaction with patients. Peplau asserts that the interpersonal relationship occurs in three phases: (a) orientation phase, (b) working phase, and (c) termination phase; and she acknowledges that within the relationship certain hierarchies of power, authority, and responsibility exist. Numerous studies demonstrating application of Peplau's theory exist; however, most of these are specific to the nurse-patient relationship. Nonetheless, Peplau's theory is certainly applicable to a wide variety of healthcare contexts in which a focus on interpersonal relationships are pronounced. The relationship between preceptor and preceptee is one of these contexts. There are few studies noted in the literature in

which Peplau's theory is applied to the preceptor-preceptee relationship, and even so, the theory itself is not tested (Washington, 2013; Washington, 2012). Much of the discussion in the current study focused on the participants' perceptions of how the relationship with the student developed, including aspects of socialization and teaching. Using Peplau's theory to frame additional studies exploring the interpersonal relationship between the preceptor and student could lead to theoretical expansion and guide development of new clinical education models.

Finally is the need to understand preceptor motivation. The extent to which participants spoke of their motivation to precept strongly points toward using theories that aim to explain the concept of motivation and resultant behaviors and action. Ryan and Deci's Self-Determination Theory (SDT) is a logical option that can be used to frame future studies. Self-determination theory focuses on extrinsic and intrinsic sources of motivation and how those sources interact to cause a person to act in particular situations (Ryan & Deci, 2000). Ryan and Deci (2000) identify three psychological needs that are the foundation of development and maintenance of internalized self-motivation and assert that these needs are "essential for facilitating optimal functioning of the natural propensities for growth and integration, as well as for constructive social development and personal well-being" (p. 68). These needs are autonomy, competence, and relatedness. The theorists posit that if these needs are unsupported, then the person's well-being and the quality of their performance will be negatively affected. The amount of attention that participants gave in discussion about their empathetic drive and

motivation to serve strongly suggests that intrinsic sources are significant in deciding to become a preceptor. In addition, perceptions of co-worker, faculty, and manager support were interconnected to role functions, suggesting that extrinsic sources of motivation also have an effect on preceptor behavior. As there are no studies that focus on preceptor motivation, the possibilities for using theory to expand our knowledge in this area are limitless.

Strengths and Limitations

This study adds to the overall body of nursing knowledge with regard to preceptorships and offers additional support for several previous research studies. I designed the study to ensure rigor was maintained throughout the duration of the project to aid in the reliability and replicability of the design. The new findings should be considered as origination points for new research studies.

This study also has some limitations. First, the sample represents mostly White (n = 8, 89%) female preceptors from hospitals in a semi-urban area of a Southeastern state and may not be representative of nurses elsewhere. I received no contacts from male nurses. The size of the sample and the homogeneity of the members likely are a result of the geographical area in which the study was conducted. As a result, study findings are not generalizable to other geographical areas.

Secondly, study recruitment was a problem. I was able to recruit enough participants for only two focus groups. As mentioned in Chapter III, three groups is often a recommended minimum, but the number of groups is based on the purpose of the study

and data saturation (Asbury, 1995; Krueger & Casey, 2009). I also noted in Chapter III that nurses can be particularly challenging to recruit because of perceived lack of benefit, alterations in work schedules, distance from work settings, perceived coercion, fear of speaking out about focus group topic, and the perception that participation was a burden (Clark, Maben, & Jones, 1996; Happell, 2007; Howatson-Jones, 2007; Shaha, Wenzel, & Hill, 2011). As such, ideally this study should be replicated with a larger sample.

Suggestions for Future Research

Several recommendations for future research exist. It would be beneficial to expand the geographical area of the study so that a larger, more diverse sample is included so that transferability of study findings is improved. Ideally the same questions would be used in a similar format, the number and diversity of samples would be larger, and the focus group facilitator would remain constant.

Furthermore, the same study with a sample of only male nurse preceptors would be quite informative. I received no contacts from male nurses. Nursing is still a female dominated profession. Only about 9.6% of the registered nurses in the United States are men (U.S. Census Bureau, 2013). As such, there is a notable lack of research directed at exploring male nursing students' experiences in preceptorships or exploring male nurses' experiences as preceptors. Research focused on gender differences in the preceptor-student relationship could be very informative and even guide strategies for communicating in the preceptorship, assessing and evaluating student performance, and development of professional core values.

More information is needed regarding preparation for nurse preceptors. Participants did not perceive a formal class on precepting as particularly beneficial for shaping their preceptor role. Comparison studies examining methods of and amount of time spent on preceptor preparation would add to the knowledge base of preceptor preparation.

Additional studies should focus on exploring support as it exists between and among RN co-workers. Preceptors overwhelmingly perceive the most support from their co-workers. Deeper examination of co-worker support in preceptorships could provide us with meaningful information about work environments, professional socialization, and the culture of nursing.

Similarly, much more information is needed about the perceptions of managers' support of nurses in the preceptor role. Based on the findings from prior work and findings from my study, it seems that managers may have very different expectations from preceptors. I have not identified any literature that focuses on nurse managers' perceptions of the preceptor role. Findings from this type of study can provide additional information about role expectations and could help support a clearer definition of what it means to precept.

Finally, results from my study warrant a more in-depth examination into preceptors' motivation for serving in the role. As stated above, participants discussed very different motivational forces for serving in the role than what is suggested from prior studies. Although this may be reflective only of my sample, there are no identified

studies that explore preceptors' motivation to serve. A more thorough understanding of preceptors' motivation can provide insight into the feasibility of strategies designed to promote HWEs. That is, the success of strategies aimed at creating HWEs may rely on better understanding the motivation of staff nurses who serve in the preceptor role.

Conclusion

Through this study, I explored the perceptions of staff registered nurses who serve as preceptors for undergraduate pre-licensure nursing students. I found that preceptors are motivated to serve in the role because of a strong empathetic drive that originates from their personal experiences as nursing students or new nurses. Nurse preceptors identified three functions of the preceptor role and within each function, described behaviors in which they engage to succeed in their role. The extent to which they participate in those behaviors is dictated by individual student situations.

Although many of the findings support previous work in the area of preceptorships, some of my findings were new. These areas are unexplored and have the potential to inform nurse preceptors, managers, and faculty about the complex nature of the preceptor role. Even with the many changes in nursing education, from the apprenticeship model to the current university settings, nurse preceptorships, in one form or fashion, have persisted. However, our understanding of the preceptor role has not kept pace. Consequently, the development of new strategies for preceptorship experiences has also lagged. It is imperative then, that additional research progress rapidly, but

systematically and with rigor so that best practices are identified, implemented, and studied for future nursing generations to come.

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APPENDICES

Appendix A

Table 4. *Summary of Preceptorship Clinical Education Literature*

Author (year)	Design	Theoretical Framework	Instrument/ Data Collection	Aim	Population	Findings
Carlson, Pilhammar, & Wann-Hansson (2010a)*	Ethnography	Symbolic interactionism	Observations, field notes, focus groups	To describe under what conditions precepting takes place from the perspective of precepting nurses.	N = 13 preceptors during field observation N = 16 for focus groups	Three themes to describe conditions are as follows: organization, comprising clinical responsibilities and routines; collaboration, focusing on professional relations and interactions; and personal perspective, comprised of preceptors' experiences, need for feedback and identified benefits. Identified conditions could be limiting or supportive, with time as a repeated limiting condition throughout all categories.
Carlson, Pilhammar, & Wann-Hansson (2010b)*	Ethnography	None identified	Observations, field notes, focus groups	To describe how preceptors mediate nursing as a profession to undergraduate nursing students.	N = 13 preceptors during field observation N = 16 for focus groups	Authors described three roles used by preceptors. These include the administrative role, the caring role, and the medical and technical role. Preceptors stressed importance of clinical competence, professionalism, and confidence in students.
Carlson, Wann-Hansson, & Pilhammar (2009)*	Ethnography	None identified	Observations, field notes Focus group	To describe strategies and techniques preceptors use to teach undergraduate nursing students during clinical practice.	N = 13 preceptors during field observation N = 16 for focus groups	Three categories & seven subcategories emerged. These include (1) adjust the level of precepting, (2) perform precepting strategies, and (3) evaluate precepting; and (1) getting the picture, (2) preconceived expectations, (3) creating a feeling of security, (4) teaching, (5) giving situational feedback, (6) reflecting on action, and (7) assessing.
Charleston & Happell (2005)	Grounded theory approach	None identified	Semi-structured interviews	To examine mental health nurses and undergraduate nursing students' perception of preceptorship.	N = 9	Resultant theory titled "Accomplishing connectedness"; depends on their roles within the following categories: actuality (being preceptor) and augmentation (expanding preceptorship). Preceptors desire a fulfilling experience for students; however, that experience is often fraught with obstacles, such as time issues, student fear, and lack of preceptor preparation. Preceptors also desire to feel valued in their roles.

Table 4. *Continued.*

Author (year)	Design	Theoretical Framework	Instrument/ Data Collection	Aim	Population	Findings
Grindel, Patsdaughter, Medici & Babington (2003)	Descriptive survey	None identified	54-item Nursing Students' Contributions to Clinical Agencies (NSCCA)	To explore benefits and limitations of having undergraduate nursing students on acute care units in adult-health/medical-surgical nursing; To determine differences in perceptions regarding students' contributions between nurses with less practice experience and more seasoned practitioners.	N = 70	Nurses with less than 10 years of experience rates students' overall contributions to the clinical agencies higher than those with 10 or more years of experience. Nurses with more experience were more likely to agree with "Working with students takes too much time", "Problem students can be frustrating", and "Students are not well received by patients". Nurses with less experience were more likely to agree with "Working with students allows for reciprocal learning", "Nurses enjoy teaching students", and "Working with students exposes staff to different perspectives". More experienced nurses also were more likely to identify the instructors as a resource for clinical decision-making.
Hallin & Danielson (2010)	Descriptive cross-sectional survey	None identified	Likert-type survey	To describe RNs perceptions of nursing student preparation and study approaches in clinical education in hospital workplaces; To explore relationships between RNs' personal/ clinical characteristics and their perceptions of students' preparation and study approaches.	N = 142	Strong positive relationships between nurses who want to precept and perceptions of nursing students. No demonstrated relationship between years of experience and perceptions of student preparation. Nurses working in pediatric, emergency, or other specialty units had more negative perceptions of nursing students.

Table 4. *Continued.*

Author (year)	Design	Theoretical Framework	Instrument/ Data Collection	Aim	Population	Findings
Heffernan, Heffernan, Brosnan, and Brown (2009)	Exploratory survey	None identified	Phase 1: Document analysis, focus groups Phase 2: Likert-type survey	To evaluate stakeholder perspective of preceptor preparation and attributes	N = 191 preceptors N = 208 students	Preceptors rated communication as most important characteristic, followed by being approachable, and being supportive of students. Preceptors and students rated maintaining preceptor's own education as less important. Preceptors also rated their best performance as being supportive of students and their least as having an approachable attitude; however, students rated preceptors as less supportive but more approachable.
Henderson, Fox, & Malko-Nyhan (2006)	Longitudinal descriptive	None identified	Focus groups	To evaluate preceptors' perceptions of a program in terms of educational preparation and subsequent support by management in the clinical setting.	N = 36	Preceptors generally satisfied with preparation of course and satisfied with their role as a preceptor. Preceptors reported lack of satisfaction with organizational recognition, lack of time to adequately perform the role, and lack of support from organization.
Hrobsky & Kersbergen (2002)	Qualitative descriptive	None identified	Semi-structured interviews	Explored preceptors' perceptions regarding unsatisfactory clinical performances by students.	N = 4	Preceptors identified "red flags" early in the preceptorship. Preceptors also expressed feelings of fear, anxiety, and self-doubt regarding reporting the unsatisfactory student. Preceptors also identified the need for faculty liaisons to be supportive, listen, and follow up after the preceptorship.

Table 4. *Continued.*

Author (year)	Design	Theoretical Framework	Instrument/ Data Collection	Aim	Population	Findings
Landmark, Hansen, Bjones, & Bohler (2003)	Qualitative descriptive	None identified	Focus group interviews	To describe factors defined by nurses as influential upon the development of competence and skills in supervision.	N = 20	Factors were related to three areas of importance for competency and skill development in students. These areas are didactics, role functions, and organizational framework. Nurses described a gap in application of theory to practice. They also found working with students to be challenging, but reported feelings of being underappreciated and unrecognized. Nurses also reported uncertainty about responsibilities and the importance of seeking information from faculty.
Luhanga, Myrick, & Yonge (2010)**	Grounded theory	None identified	Semi-structured interviews	To explore "the psychosocial processes involved in precepting a student with unsafe practice" and identify "effective management and coping strategies that preceptors use". The article examines the ethical and accountability issues related to two aspects of the preceptorship experience: hallmarks of unsafe practice and grading.	N = 22	Authors report that preceptors felt responsibility for ensuring safe patient care during student preceptorships and identified hallmarks of unsafe care, such as lying, early in the preceptorship. Preceptors identified two ethical dilemmas often encountered: student's right to confidentiality and evaluation of the student. Preceptors expressed a desire to have more information about students' previous performances from faculty before a preceptorship ensued. They also reported on the importance of providing honest feedback; however, were not confident in their own evaluation abilities and therefore, passed students who were less than competent. Preceptors were reluctant to fail students.

Table 4. *Continued.*

Author (year)	Design	Theoretical Framework	Instrument/ Data Collection	Aim	Population	Findings
Luhanga, Yonge, & Myrick (2008a)**	Grounded theory	None identified	Semi-structured interviews	Same as Luhanga, Myrick, & Yonge (2010) This article focuses on grading issues as one of the five major categories revealed during the original grounded theory study.	N = 22	Within category of "grading issues", subcategories include (1) reasons for presenting as an unsafe student, (2) reasons for failing to fail borderline or unsafe students, and (3) the role of the preceptor as a "gatekeeper to the profession". Preceptors report reluctance to assign a failing grades. Preceptors report feelings of belittlement when faculty assigned a passing grade to students that were identified by preceptors as substandard. Preceptors also indicated they passed unsafe students because they lacked experience as a preceptor, were reluctant to cause students to incur personal cost, experienced personal feelings of guilt and shame, were reluctant to assume extra workload, lacked appropriate evaluation tools, and felt pressure to graduate new nurses into the profession.
Luhanga, Yonge, & Myrick (2008b)**	Grounded Theory	None identified	Semi-structured interviews	Same as Luhanga, Myrick, & Yonge (2010) This article explains the processes preceptors use to manage students engaging in unsafe practices and presents preceptors' recommendations for managing unsafe students.	N = 22	Three subcategories identified: (1) strategies for prevention of unsafe practice, (2) early identification of unsafe practices, and (3) dealing with unsafe practice. Prevention strategies: (1) clear expectations at the beginning, (2) familiarization with course expectations, (3) review student's own expectations, and (4) ensure clinical setting is appropriate. Strategies for unsafe students: (1) communicate problem to the learner; (2) develop a plan of action; (3) communicate the problem to the faculty (4) encourage skill practice; (5) questioning and reading assignments; (6) create supportive environment conducive to learning; (7) provide constructive feedback; (8) encourage self-evaluation for the student; (9) maintain high practice standards;(10) seek external help from colleagues and faculty; and (11) remediation and decisions to fail.

Table 4. *Continued.*

Author (year)	Design	Theoretical Framework	Instrument/ Data Collection	Aim	Population	Findings
Matsumura, Callister, Palmer, Cox, & Larsen (2004)	Descriptive, correlational survey	None identified	54-item Nursing Students' Contributions to Clinical Agencies (NSCCA)	Replication of Grindel et al. (2003); To identify staff nurse perceptions of the contributions of students to clinical agencies.	N = 165	Nurses are ambivalent about working with students, and said that students "allow opportunities for mentoring" and 'threaten professional role development". Positive and negative items ranked in the top-scored 15 items. Nurses with master's degrees had higher overall scores compared to other nurses; higher levels of education was negatively correlated with "help lighten the workload". Psychiatric nurses rated overall student contributions higher than those in perinatal areas; and medical-surgical nurses ranked "allow opportunities for mentoring" higher than psychiatric nurses.
O'Callaghan & Slevin (2003)	Phenome-nology	None identified	Semi-structured interviews	To explore and describe the everyday lived experiences of registered nurses facilitating supernumerary diploma student nurses in the clinical area.	N = 10	Nurses believed their role in facilitating students was achieved in many ways including creating an environment conducive to learning, using their own experiential knowledge as a learning resource, role-modeling, and self-reflection. Nurses also reported feelings of being unprepared to assume the role as facilitator, lack of support from nursing management and the school of nursing, and feelings of extra work to already overloaded work schedules.

Table 4. *Continued.*

Author (year)	Design	Theoretical Framework	Instrument/ Data Collection	Aim	Population	Findings
Pulsford, Boit & Owen (2002)	Descriptive survey	None identified	Questionnaire with one open-ended question	To gain an overview of practitioners who act as mentors for pre-registration nursing students in England; to gain information as to mentors' perceived levels of support in undertaking the mentoring role, and factors that would enable them to carry out that role more effectively; and to ascertain mentors' experiences of annual update sessions, and their views as to how updating may be best facilitated.	N = 198	The following were identified by nurses as ways to make their role of mentor easier: (1) time to undertake the role, (2) managerial support, (3) partnerships with higher education institutions, (4) practice learning documentation, (5) appropriate use of placements, (6) students' motivation levels, and (7) extra pay. Nurses reported feeling supported by their work colleagues; however, much less support was reported as coming from their managers and the Higher Education Institutions. They also reported a need for more information prior to student placement, more involvement from faculty, and more feedback following placements. Over half of participants had not been to an update session in over one year, and 20% had never been to an update session citing inadequate staffing of the clinical area as the primary problem.
Rogan (2009)	Descriptive survey	Mercer's Role Attainment Theory	Preparation of Nurses Who Precept BSN Students Survey (modified)	To explore perceptions about preceptors preparation among nurse who precept baccalaureate nursing students.	N = 75	Two primary findings: preceptors want to know what responsibilities are and critical care nurses identified critical thinking as more essential than nurses in other areas. Nurses with more experience identified preceptor responsibilities, preceptor roles, and teaching strategies as essential for preparation. Nurses with less experience identified priority setting, organizing workload, preceptor responsibilities, and setting realistic goals with students as most essential for preparation.

Table 4. *Continued.*

Author (year)	Design	Theoretical Framework	Instrument/ Data Collection	Aim	Population	Findings
Yonge, Krahn, Trojan, Reid, & Haase (2002)	Descriptive, exploratory survey	None identified	Questionnaire	To highlight, from preceptors' perspectives, the nature of stress in the preceptor role and to identify the kind of support needed to make the preceptorship a valuable experience.	N = 295	The most common sources of preceptors' stress are the sense of having added responsibilities and the extra time required when units were busy. Preceptors also reported feeling responsible for students' work habits, nursing care, and mistakes. Students with unrealistic expectations or those who were substandard in their performance also caused much stress for the preceptors.
Zahner (2011)	Pilot test with repeated measures	None identified	Pre-course survey, post-course survey, post-semester survey	To determine knowledge gained over time from an on-line preceptor preparation course and to determine perceptions about course utility and satisfaction.	N = 13	Knowledge levels significantly increased from pretest to posttest, and pretest to post-semester. Participants also reported satisfaction with the preceptor course.

Appendix B

Research Flier



Nurse Preceptors Needed!

Participants Wanted for Group Interviews – Let's Talk!

- Are you a Registered Nurse with one or more years of nursing experience?
- Have you precepted a nursing student within the past 6 months?
- Are you responsible for providing verbal or written feedback on student performance to faculty?

If you answered "YES", you may be eligible to participate



Research Participants Wanted

Study participants will be provided with light refreshments during study sessions.

Those who complete the full group interview will receive a gift card valued at $20.00 at the end of the session.

What: Group Interview Session, 1-2 hours

Where: ***Your choice of one (1) of three (3) sites:***

The University of Tennessee, College of Nursing
1200 Volunteer Blvd., Knoxville, TN

Or

Northeast State Community College
Regional Center for Health Professions
300 West Main St., Kingsport, TN

Or

Northeast State Community College
Kingsport Center for Higher Education
300 West Market St., Kingsport, TN

For more information, contact:

Christy Hall, MSN, RN-BC, PhD Candidate
Principal Investigator
The University of Tennessee, Knoxville
College of Nursing
Telephone: 423.646.9830 or 423.354.5123
E-mail: khall32@utk.edu

THE UNIVERSITY of TENNESSEE KNOXVILLE

Appendix C

Follow-up Letter

Dear _____ (participant name),

Thank you very much for your interest in participating in this research study. This letter is a simple follow-up to our initial contact to serve as a reminder of your selected date, time, and location of focus group session. Enclosed you will also find an information sheet about the study and a copy of the consent for your review.

Your selected focus group session will take place on _____ (date) at _____ (time) in _____ (location).

If you have any questions at all, please do not hesitate to contact me at the information provided below and on the Information Sheet.

Thank you,

Katherine C. Hall, MSN, RN-BC, PhD candidate
The University of Tennessee, Knoxville
College of Nursing

E-mail: khall32@utk.edu
Office: 300 West Main St
Regional Center for Health Professions, Room 211
Kingsport, TN 37660
Phone: (423) 354- 5123 (office)
(423) 646-9830 (cell)

Appendix D

Information Sheet

Perceptions of Nurse Preceptors for Undergraduate Pre-licensure Nursing Students

INTRODUCTION

You are invited to participate in a research study. The purpose of this study is to explore staff nurse experiences as preceptors to undergraduate, pre-licensure nursing students. Emphasis will be placed on exploring registered nurses' (RN) perceptions of the role, specifically the preparation for, support in, and understanding of what the role entails. This study is part of Katherine C. Hall's academic work at the University of Tennessee.

INFORMATION ABOUT PARTICIPANTS' INVOLVEMENT IN THE STUDY

This study will require not more than 2 hours of time, with 60 to 90 minutes of time in a focus group session. A focus group is a group interview in which participants discuss a specific topic, often based on shared experiences. You will attend only one session conducted on the campus of either the University of Tennessee, Knoxville in the College of Nursing or Northeast State Community College in the Regional Center for Health Professions or in the Kingsport Center for Higher Education in Kingsport, Tennessee. You may attend the focus group site of your choice. The focus group session will be audio recorded. The recordings will be heard only by the PI and her Faculty Advisor. All data will be identified only by a code, no names will be attached.

After the group, you may be contacted by e-mail up to eight weeks after the end of the focus group session to ask for feedback of the interpreted results.

RISKS

Anticipated risks to participants are minimal; however, they do exist. There is a risk of loss of confidentiality. Participants may inadvertently communicate about the study or their involvement with others. There is also the potential that you may know others in the focus group from work or other outside activities. There is also potential for bothersome feelings or emotions during or after the focus group discussion. Other discomfort may be related to the physical environment in which the focus group will take place. Every attempt will be made to ensure your comfort and confidentiality during the focus group session. You have the right to leave the focus group session at any time.

BENEFITS

Benefits to any individual are limited, although the opportunity to verbalize within a group of peers may be beneficial to some. Anticipated benefits are primarily related to knowledge generation for the nursing profession, including education and practice regarding the role of preceptor.

CONFIDENTIALITY
Information in the study records will be kept confidential. Data will be stored securely and will be made available only to persons conducting the study unless participants specifically give permission in writing to do otherwise. Your personal identity and participation in this group will be protected by assigning an alphanumeric label to the information in lieu of your name. No reference will be made in oral or written reports which could link you to the study. As a participant, you agree to refrain from communicating about your or others' participation, comments, and conversations that occur once the session has ended.

As professional nurses, you know the concept of confidentiality in practice. Although you will not be asked to sign such a statement, participants will not feel comfortable to be candid unless there is a certain trust within the group. Both the PI and the facilitator have signed confidentiality agreements and received certificates of having completed human subjects' protection courses, but we cannot assure that there will be complete confidentiality kept by members.

COMPENSATION
If you choose to participate in the full focus group session, you will receive a $20.00 gift card at the end of the session. As this is a qualitative study, there are no alternatives for participation or compensation.

CONTACT
If you have questions at any time about the study or the procedures, you may contact the researcher, Katherine C. Hall, at Regional Center for Health Professions, 300 West Main St., Office 211, Kingsport, TN 37660, or (423) 354-5123 or (423) 646-9830. If you have questions about your rights as a participant, contact the Office of Research Compliance Officer at (865) 974-3466.

PARTICIPATION
Your participation is entirely voluntary and you have the opportunity to withdraw from the research study at any time without penalty and without loss of benefits to which you are otherwise entitled. You may decline to participate without penalty. Your participation or lack thereof will not affect your employment status in any way. Employers will have no knowledge of your participation unless you share it. If you withdraw from the study before data collection is completed your data will be returned to you or destroyed.

Appendix E

Form D

Status for Changes and/or Project Termination for Form B Approved Research Involving Human Subjects

Research Compliance Services
Office of Research
The University of Tennessee, Knoxville
1534 White Avenue
Knoxville, TN 37996-1529

1. IRB No.: 9255 B
2. Principal Investigator: Katherine C. Hall, PhD candidate, MSN, RN-BC

   Department: College of Nursing
3. Mailing Address: 7144 Pembroke Circle

   City: Bristol State: VA Zip: 24202
4. Project Title: Exploring staff registered nurse perceptions of the role of preceptor to undergraduate, pre-licensure nursing students

PLEASE CHECK THE APPROPRIATE BOX(S) BELOW (see instructions on next page):

5. ☐ Change of Project Title
6. ☒ Change of Principal or Co-Principal Investigator(s), Other Collaborators, Student Advisor
7. ☒ Change(s) to Project Which Affect Participation of Human Subjects
8. ☐ Change(s) to Informed Consent Forms and/or Assent Form(s)
9. ☐ Additional Locations for Conducting Project
10. ☐ Adverse Events
11. ☐ Project Completed -- Please Close the IRB Files.

12. SIGNATURES

Principal Investigator: Katherine C Hall **Date:** 10/4/13

Student Advisor: Marian H Conan **Date:** 10/5/13

Departmental Review*: _____ **Date:** _____
***(if required)**

Appendix F

Demographic Survey

Code: _____(For research purposes)

Nurse Preceptor Study Questionnaire – Part A

Thank you for your participation in this research study. Please take a moment to complete the following survey. Your responses will be kept *strictly* confidential.

Questions:

Age:
- 50+
- 40-49
- 30-39
- 18-29

Gender:
- Female
- Male

Highest level of ***nursing*** education:
- Diploma
- Associate degree
- Baccalaureate degree
- Master's degree
- Post-Master's Degree
- PhD or DNP

Which of the following academic degrees have you earned? **Select all that apply.**
- Associate degree in nursing
- Associate degree in another field
- Bachelor's degree in nursing
- Bachelor's degree in another field
- Master's degree in nursing
- Additional Master's in nursing
- Master's degree in another field
- Doctorate in nursing
- Doctorate in another field

Years of ***nursing*** experience:
- 0-5
- 6-10
- 11-15
- 16-20
- 20+

Years of ***preceptor*** experience:
- 0-5
- 6-10
- 11-15
- 16-20
- 20+

Highest level of ***general*** education obtained:
- Diploma
- Associate degree
- Baccalaureate degree
- Master's degree
- PhD or other doctorate

In what year were you initially licensed as a registered nurse? **Report as a four digit number** (Ex: 1978)

_____

Current employment unit:

- Medical-surgical
- OB/Labor & Delivery
- Pediatrics
- ER
- Psychiatric/Mental health
- Surgery/PACU/Recovery
- ICU
- Stepdown/Telemetry/Transitional/Progressive Care
- Other (list)

_____

Number of students precepted ***per year***:

- 1-2
- 3-4
- 5+

In the past, which types of nursing students have you precepted? ***Select all that apply.***

- LPN
- Diploma
- Associate Degree
- Baccalaureate degree
- RN-to-BSN

What is the educational level of your ***most current*** nursing student?

- LPN
- Diploma
- Associate degree
- Baccalaureate degree
- RN-to-BSN

Have you ever received any formal preceptor training or preparation?

- Yes
- No

If **"YES",** please describe:

_____
_____
_____
_____
_____
_____
_____

If **"NO",** would you be willing to attend a formal preceptor training program if it was offered?

- Yes
- No

When you precept, ***typically*** how far in advance are you notified that you will have a student?

- Same day
- < 1 week
- 1-2 weeks
- 3-4 weeks
- >4 weeks

When precepting, do you find that faculty are available?

- Yes, faculty are in the facility
- Yes, faculty are not in the facility, but are available by phone, text, or e-mail
- No, faculty are not available

Please return this completed questionnaire to one of the focus group leaders. If there are questions about your responses, a focus group leader will check with you prior to the end of this focus group.

Thank you for your participation!

Appendix G

Semi-structured focus group interview guide

Semi-Structured Focus Group Interview Guide

Opening statement:

- Thank you for coming to talk about your experience as a nurse preceptor.
- Let's begin by introducing ourselves (name, how long you've been a nurse, and why you became a preceptor).
- We want to assure you that everything said in this group is strictly confidential and in no way will your words or statements allow for identification.
- Ground rules – respect and confidentiality within the group

Introductory question:

- What is your experience with precepting undergraduate nursing students?

  ➡ **Prompt:** What are the benefits of precepting? What are the challenges of precepting?

As participants introduce themselves, if they mention that they became preceptors because they, themselves, had negative experiences, such as in nursing school or as a new nurse, we need to have them elaborate on those experiences, both what happened and as motivation for becoming a preceptor.

- "Let's go back and talk just a little bit about your own personal experiences.
    - What was that experience like?"
    - How has it affected your present preceptorship experience?

Transition question:

- How does precepting affect your everyday work?

Key study questions:

- How would you describe your role in being a nurse preceptor?

  ➡ **Prompt:** *if needed: Research tells us that nurses in a preceptor role often experience role conflict, overload, and uncertainty in knowing what the role entails.*

  ➡ **Prompt:** if needed: *Research also tells us that nurse preceptors feel unprepared and unsupported in their roles as preceptors, particularly if you have a student who you think is incompetent or unsafe.*

- *Think about the past or present support you have had, or do not have, as a nurse preceptor.(peer, faculty, administrative)*

  ➡ **Prompt:** *What kinds of support networks do you have as a nurse preceptor? (Peer-to-peer, recognition, faculty feedback)*
    - Where do you find support if any?

- What kinds of support do you think are most important or critical?
- How do you go about finding support?

- *Now, let's think about dealing with a student who is incompetent or unsafe – regardless of whether you have actually dealt with one.*
  - What do you think would be most important to you as a preceptor in that kind of situation?
  - What do you see as your role in this situation?
  - Would you be willing to fail a student? What are your thoughts about that?

    ➡ **Prompt:** *How would you go about it? What would you need? What would you expect?*
- If participants, themselves, have not had the experience of dealing with an incompetent or unsafe student, have they seen it with a co-worker or other?
  - How did this affect their preceptoring role (skills, attitudes, etc.)?
- Finally, what are your thoughts about your confidence as a preceptor – in your abilities to precept, abilities to evaluate student performance, and in your own nursing skills?
  - What provides you with that confidence? What factors influence your confidence?

- Have you ever experienced anything that has diminished your confidence, even for a brief moment in time?

Facilitator synopsis of discussion, followed by: *Does this sound as though I have heard your discussion clearly?*

Closing: *We have talked about your experiences of being a preceptor. So, as we wrap up, I would like to know if your overall perception of being a preceptor has changed.*

➡ **Prompt:** If anyone indicates that their perception has changed: If so, how?

Thank you for your participation in this study. Your thoughts and ideas were very helpful to the purpose of this study.

Appendix H

Informed Consent Form

Perceptions of Nurse Preceptors for Undergraduate Pre-licensure Nursing Students
Focus Group Participant Consent Form

You are invited to participate in a research study. The purpose of this study is to explore staff nurse experiences as preceptors to undergraduate, pre-licensure nursing students. Emphasis will be placed on exploring registered nurses' (RN) perceptions of the role, specifically the preparation for, support in, and understanding of what the role entails. By signing below, you acknowledge the following:

- This focus group is part of a research study.
- This focus group will last between 60 and 90 minutes.
- You will only be participating in one (1) focus group.
- The focus group discussion will be audio recorded to capture essential information.
- Up to 8 weeks after the focus group, you may be contacted by the primary researcher via e-mail to help validate or invalidate study findings.
- Your identity will remain confidential.
- The information in the study records will be kept confidential. No names or organizational affiliations will ever be attached to any findings or publications.
- Data will be stored securely and will be made available only to persons conducting the study unless you specifically give permission in writing to do otherwise.
- No reference will be made in oral or written reports which could link you to the study. Pseudonyms will be used when reporting quotes or comments.
- Anticipated risks include potential for bothersome feelings or emotions during the focus group process or completing the questionnaire. Additionally, there is a risk of loss of confidentiality. Participants may communicate inadvertently about the study or participation therein. Participants may also know others in the group. Every attempt will be taken to maintain your confidentiality, although it cannot be guaranteed.
- You have the option to not answer any part of the research study at any time.

Participant Initials _____ **Page 1 of 2**

UTK EXPEDITED Approval:
AUG 08 2013 - AUG 08 2014

- Your participation in this study is voluntary; you may decline to participate without penalty. If you decide to participate, you may withdraw from the study at any time without penalty and without loss of benefits to which you are otherwise entitled. If you withdraw from the study before data collection is completed your data will be returned to you or destroyed.

- Benefits of this study include adding to the body of nursing knowledge information about understanding the role of a nurse preceptor, although the opportunity to verbalize within a group of peers may be beneficial to some.

- You will receive a gift card valued at $20.00 at the end of the focus group session.

- As this is a qualitative study, there are no alternatives for participation or compensation.

- As a study participant, you realize that within group confidentiality is a shared responsibility and agree not to talk about this study outside of our focus group.

- As professional nurses, you know the concept of confidentiality in practice. Although you will not be asked to sign such a statement, participants will not feel comfortable to be candid unless there is a certain trust within the group. Both the PI and the facilitator have signed confidentiality agreements and received certificates of having completed human subjects' protection courses, but we cannot assure that there will be complete confidentiality kept by members.

If you have questions at any time about the study or procedures, you may contact the primary researcher at:
Katherine C. Hall
300 West Main St., Kingsport, TN, 37660
(423) 354-5123 (day) or (423) 646-9830 (cell)
khall32@utk.edu

If you have questions about your rights as a participant, contact the Office of Research Compliance Officer at
(865) 974-3466.

CONSENT
I have read the above information. I have received a copy of this form. I agree to participate in this study.

Participant's signature _____ Date _____
Investigator's signature _____ Date _____

UTK EXPEDITED Approval:
AUG 0 8 2013 - AUG 0 8 2014

Vita

Katherine C. Hall was born in Bristol, Tennessee in 1974 to Mike and Joyce Arnold. The oldest of four children, she knew she wanted to be a nurse at the age of seven. After graduating high school in Bristol, VA in 1992, she attended a community college to become a registered nurse. She graduated in 1995 from Virginia Highlands Community College in Abingdon, VA with an AAS in Nursing and began working as a bedside nurse. After five years of work, she attended the University of Virginia's College at Wise to obtain a baccalaureate degree in Nursing. Shortly thereafter, she began precepting students at the bedside and served as an adjunct instructor for her alma mater. It was then she realized that her life dream was to become a nurse educator. She attended Old Dominion University in Norfolk, VA and received a Master's of Science degree in Nursing with a concentration in Nursing Education in 2006. In 2009, she started on a life-changing journey at the University of Tennessee, Knoxville when she began her doctoral coursework. Professionally, she has worked in a variety of clinical settings and is certified as a Medical-Surgical nurse by the American Nurses Credentialing Center. She has worked as a full-time nursing educator since 2007 at Northeast State Community College in Blountville, TN teaching Fundamentals of Nursing and Adult Medical-Surgical Nursing I. She is a member of Phi Kappa Phi International Honor Society and the Gamma Chi chapter of Sigma Theta Tau International Nursing Honor Society. She will graduate with a Doctor of Philosophy in Nursing in August 2014.