

THE BENEFITS AND CHALLENGES OF ONE
NEW ZEALAND NURSING UNDERGRADUATE CLINICAL
EDUCATION MODEL: A CASE STUDY

by

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ABSTRACT

This research project has utilised a case study approach to give ward managers a voice in the literature, by exploring and describing from their perspective the benefits and challenges of one particular nursing undergraduate clinical education model. The Tertiary Education Provider contracts the Health Provider to provide Clinical Nurse Educators (CNEs) to support second and third year undergraduate nursing students during their clinical experiences. The CNEs are seconded from their respective wards to meet the organisation's contractual obligations.

Data were gathered from two ward manager's using semi-structured interviews. A thematic analysis using the 'colour coding' method as described by Roberts and Taylor (1999) was used to analyse the interview data. The findings elucidate the role of the undergraduate CNE, highlighting benefits such as the CNE being supernumerary to ward rosters and having time to teach, not only supervise students. CNEs are student-focused and easily accessible as they are based on site. The CNE was the one person who was 'there' for a student as a student's preceptor can change shift-by-shift and day-by-day. One significant challenge which emerged was the replacement of ward staff, not only of senior nurses who can leave their wards for up to 12 weeks to undertake the CNE role but also that of the student's preceptor if the student's preceptor was on annual, sick or study leave. Other challenges such as the inability of ward managers to pre-book casual staff; preceptor work-loads; skill-mix issues and fluctuating full-time equivalents (FTEs) are also discussed.

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I would also like to acknowledge the work of previous writers who have undertaken work at masters level and have written from different perspectives on the collaborative model in this case study.

The author intends that this work will contribute to the body of knowledge surrounding nursing education in the practice setting. In particular, it will build on previous work already carried out on one New Zealand nursing undergraduate collaborative partnership model as it evolves and grows and looks towards meeting the needs of future generation of nurses.

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GLOSSARY OF TERMS

Buddy	Registered Nurse who has not completed a formal preceptor/clinical teaching course and who provides support to a student.
Casual staff	Registered Nurses, Enrolled Nurses and Health Care Assistants who are available to work on an as required basis at short notice. Casual staff are managed internally by a Registered Nurse.
Clinical Education	Knowledge acquired by learning and instruction in clinical practice settings.
Clinical Educator (CE) (hospital wide position)	Registered Nurse employed by the Health Provider to promote quality and evidence based nursing practice through education and professional development of staff within the clinical setting at a post graduate level.
Clinical Nurse Educator - CNE (undergraduate nursing education)	Registered Nurse who is seconded from a ward/area/department to provide clinical education to undergraduate students of the Tertiary Education Provider whilst students are on clinical placement.
Clinical Nurse Educator (post-graduate, specialty focus)	Registered Nurse who has specialist knowledge in a particular area of practice eg ICU/CCU/Cardiology who develops and maintains orientation and education programmes specific to the specialty.
Clinical Teaching	Use of instruction, supervision, recognised teaching strategies including assessment and feedback and the application of the principles of adult teaching in the clinical practice setting versus classroom or

laboratory (simulated clinical practice lab).	
Competent (Level three)	A Registered Nurse who provides holistic care using up to date knowledge and relevant evidence based practice, demonstrates competence in the clinical skills relevant to the area, competently manages emergency care and accepts additional responsibility.
Registered Nurse on Clinical Career Pathway (CCP)	
Faculty Lecturer	Employee of a Tertiary Education Provider who does not do ‘hands on teaching’ in the clinical practice setting.
Formative evaluation	Formative evaluation refers to structured evaluation while the students are on placement to monitor student learning.
Full-time equivalent (FTE).	Registered Nurse working full-time, i.e. 40 hours per week (1.0 FTE).
Joint appointment	Formalised agreement between two institutions where an individual holds a position in each institution and carries out specific and defined responsibilities.
Lecturer-Practitioner	Registered Nurse who has responsibility for both practice and education within a defined clinical area. This role has two broad aims; 1) to identify and maintain the standards of practice and policies within a defined clinical area, 2) to prepare and contribute to the education programme of students in relation to the theory and practice of nursing in a ward/unit.
Mentor	Experienced professional, nurturing and guiding, inspiring and supporting novices, colleagues and peers.
New Graduate	Registered Nurse who is in his or her first

Preceptor	year of clinical practice post registration. Identified experienced practitioner who has attended a formal teaching course, has responsibilities for a client group and who enhances student learning by assisting a student in the attainment of skills and knowledge in a clinical setting.
Preceptorship	Individualised teaching/learning method in which each student is assigned to a particular preceptor/nurse so she/he can experience day-to-day practice with a role model and resource person immediately available within the clinical setting.
Reflective Practice -Johns' model of reflection (1994)	The following cues are offered to help practitioners to access, make sense of, and learn through experience.

Description

Write a description of the experience

What are the key issues within this description that I need to pay attention to?

Reflection

What was I trying to achieve?

Why did I act as I did?

What are the consequences of my actions?

For the patient and family

For myself

For people I work with

How did I feel about this experience when it was happening?

How did the patient feel about it?

How do I know how the patient felt about it?

Influencing factors

What internal factors influenced my decision-making and actions?

What external factors influenced my decision-making and actions?

What sources of knowledge did or should have influenced my decision making and actions?

Alternative strategies

Could I have dealt better with the situation?

What other choices did I have?

What would be the consequences of these other choices?

Learning

How can I make sense of this experience in light of past experience and future practice?

How do I now feel about this experience?

Have I taken effective action to support myself and others as a result of this experience?

How has this experience changed my way of knowing in practice?

Secondment

The practice of one institution making the services of an employee available to another entity for short period of time while continuing to remunerate the employee.

Senior Nurse

A Registered Nurse (RN) who is deemed competent (Level three or above) on the Health Providers Clinical Career Pathway.

Summative evaluation

Summative evaluation refers to structured evaluation provided at the end of a course to measure student learning and

Tertiary Educator Provider	satisfaction. Institution that provides undergraduate and post-graduate nursing education. Includes, Polytechnics, Institutes of Technology and Universities.
Tihei Mauri Ora (the Breath of Life)	Tihei Mauri Ora is a parallel stream within the Nursing, Midwifery, or Foundation Certificate curriculum at Waikato Institute of Technology for students who identify as Maori and/or Pacific Island, and provides students with specific knowledge and understanding of Kaupapa Maori, and has Maori and Pacific students consider their own cultural practices and partnerships with Whanau, Hapu, and Iwi.
The whare tapa wha model	Maori health model comparing health to the four walls of a house. All four walls are necessary to ensure strength and symmetry, though, each represents a different dimension; taha wairua (the spiritual side), taha hinengaro (thoughts and feelings), taha tinana (the physical side), taha whanau (family).
Trendcare	Clinical and information software programme. Managing & reporting on: Patient acuity/clinical pathways/discharge analysis/bed management/diet ordering/human resource management.
Ward manager	Registered Nurse who is in charge of a ward/department/unit within an acute care hospital and who manages both financial and human resources.

VIGNETTE

I think from my perspective even though it's quite tricky to manage sometimes with the educators, there is that underlying sense that there is back up if things fall apart. You don't want to think that you have got a nursing student who is in a frightening or unsafe situation because of stuff that is happening, for example, staffing problems on the ward. It's quite comforting to know, that there's always the CNE back up, there's always somebody there who can offer the support that's maybe needed on the day. (Mary)

CHAPTER 1

1.1 Introduction - Positioning myself in the world of clinical education

I begin by placing myself in the world of nursing, and will then describe how my interest in clinical education has developed over my 30 year career. I conclude by describing how my personal experiences have led me to my research question.

My interest in the field of undergraduate education, in particular clinical education, began in the early 1990s when I was employed part-time by a Tertiary Education Provider as a Clinical Educator teaching second and third year Diploma of Nursing students. Throughout my writing I refer to the terms Clinical Education and Clinical Teaching. To assist the reader to understand the differences between these two terms, I have included a definition of both in my glossary (refer p. vii). Clinical Education is often used as a broad term to describe knowledge acquired by learning and instruction in clinical practice settings. Clinical Teaching implies performing the act of teaching in practice. Clinical Teachers use instruction, supervision, recognised teaching strategies including assessment and feedback and the application of the principles of adult teaching in the clinical practice setting versus classroom or laboratory (simulated clinical practice lab.) In this case study, a Clinical Nurse Educator (CNE) will not only provide clinical education but will also advocate for students while they are in the clinical practice setting. The CNE is familiar with the Tertiary Education Provider's curriculum and students' learning outcomes, and by using recognised teaching strategies assists students to link the theoretical component of the paper to clinical practice. The role of a Registered Nurse who has attended a recognised preceptorship course includes enhancing a student's learning by assisting a student in the attainment of skills and knowledge (*knowing how*) to deliver

nursing care in a clinical practice setting. To assist the reader to understand the differences between classroom teaching and clinical teaching I will discuss these two concepts in more detail in Chapter 2.

During the 1990s my passion for teaching began to evolve. I had always enjoyed teaching students and colleagues and as a charge nurse I actively encouraged staff education. I became aware of the importance of role-modelling. Morton-Cooper and Palmer (1993) believe role-modelling to be an important 'helper' function of a mentor. I agree with their description of the role model function, of providing "an observable image for imitation, demonstrating skills and qualities for the mentoree to emulate" (p. 63).

It was during this time that it became apparent to me that Registered Nurses had begun to disassociate themselves from their role as educators of students. Nurses in clinical practice were teaching patients but believed the role of student education sat with 'polytechnics'. Nurses would make comments such as "it's not my job to teach the student - that's yours". This was an interesting comment considering students were at that time also buddied. Buddying is when a student, or perhaps a new employee, is allocated to work alongside a person who shows them 'the ropes', rather than using recognised teaching methods to meet set learning outcomes. At the time of my Clinical Educator role, students were working in a number of wards and across two shifts and were therefore not under my direct supervision at all times. I observed at that time Registered Nurses were unaware of how important they were as role models, especially in role-modelling professional behaviours.

I completed a Graduate Certificate in Clinical Teaching and during this process I became aware of the principles of adult teaching, the importance of assessment and moderation, of giving feedback, of documenting student progress and the importance of developing life long self-directed learners. Following my time as a Clinical Educator my career diversified into the areas of staff development, human resources, operational management and lecturing. As a nursing lecturer I currently teach both as a faculty lecturer and as a clinical practice with year one Bachelor of Nursing undergraduate students.

As an operational manager in an acute care organisation I became exposed to clinical teaching again some seven years later. However, this time it was as a manager, with direct line accountabilities (ward managers directly reported to the position) and with one particular model of undergraduate clinical nursing education. This I believe has given me the ability to view the role of clinical education from more than one perspective. On one hand I can see the value of having nurses from clinical practice providing clinical education, but on the other hand whilst I was in an operational management role, I could also see the demands that this placed onto already pressured ward managers. My personal experiences of having to deal with staffing shortages and a changing skill-mix on a daily basis led me to my research topic.

The international and national shortage of nurses, especially experienced nurses, is beginning to impact on the ability of ward managers to release staff from already understaffed wards. At times, nurses from clinical areas in this case study, can be taken off ward rosters for up to twelve weeks a year to undertake clinical teaching roles in other wards within the hospital.

In May 2001, KPMG Consulting released their report to the Nursing Council of New Zealand on the strategic review of undergraduate nursing education. A key recommendation from the report was for education and service providers to be encouraged to demonstrate commitment to shared responsibility for undergraduate education. KPMG Consulting state:

“Partnership is an essential tenet of nursing education and this should be exploited in as many different opportunities as possible between education and service providers to ensure that clinical teaching is effective in producing competent Registered Nurse for the future” (p. 4).

The report acknowledged that there is a growing awareness in New Zealand that the quality of student clinical placements and teaching is in jeopardy. The KPMG Consulting report made recommendations that quality clinical placements needed to be included early in the undergraduate programme. The report recommended “any time after the first eight weeks” (p. 85). The report also highlighted the need for education and service providers to work more collaboratively to ensure that the clinical learning opportunities for students are within the competencies required for initial registration (p. 9).

My experience in management and clinical education has given me the benefit of viewing the collaborative model in the case study from both perspectives. There is an increasing pressure on the health sector to provide clinical education at undergraduate and post graduate level (Health Workforce Advisory Committee, 2003). In the undergraduate clinical education model in this case study this is in the form of Clinical Nurse Educators (CNEs) and preceptors. But there are also increased pressures on faculty lecturers within the Tertiary Education sector to undertake further study and produce research outputs. Perry

(1999, as cited in KPMG Consulting, 2001, p. 94) supports this view and describes “workload, lack of time, management and administration activities, and the demands of working outside areas of expertise” along with expectations to “obtain Masters Qualifications” have all contributed to the increase in workload and expectations.

Here in New Zealand, it is now widely accepted within the health industry and by the Ministry of Health, (Health Workforce Advisory Committee, 2003) that there are increasing difficulties in recruiting and retaining nurses, particularly experienced nurses. Difficulties recruiting and retaining nurses is having an effect on the health sector to provide quality clinical placements, and is illustrated by the fact that while over 40,000 nurses hold Annual Practising Certificates only 29,000 are actively practising as nurses (Report to the Ministerial Taskforce on Nursing, 1998). Jane O’Malley, President of New Zealand Nurses’ Organisation, reported that her organisation had estimated two years ago that there was a 10% vacancy rate in Auckland, Tauranga and Rotorua, and a 5% rate in the rest of the country (Welch, 2002).

In my role as an operational manager I was in a position to access data, which confirmed my intuitive knowledge, that there had been a change in skill mix within the hospital over two-to-three years. The data identify that in the general inpatient wards, which provide general medical, surgical and orthopaedic services, the number of level three nurses (defined as competent nurse on the organisation’s clinical career pathway) had changed from approximately 40% of the nurses in 1999-2000 to 25% in July 2002. The number of new graduates had risen over that period from approximately 9% in 1999 to approximately 18% in

July 2002. (NB these data do not make a comparison between skill-mix and turn over rates.).

Such a trend has impacted on the organisation's ability to release staff from ward rosters, for anything from four to twelve week periods during an academic year to undertake clinical education roles.

The demand for competent Registered Nurses (Clinical Career Pathway, level three) to perform preceptoring and mentoring roles has increased. Not only are they expected to preceptor undergraduate nursing students but also new graduates and post-graduate nursing students. The current care delivery model of team nursing also requires competent nurses to undertake team leader roles which have led to an increased workload for nurses in clinical practice. These pressures are a few of many placed on Registered Nurses in today's nursing environment.

The implementation of the Health Practitioners Competency Assurance Bill (2004) and subsequent Nursing Council Annual Practice Certificate (APC) requirements will also add to the demands already placed on nurses working in acute care environments. The requirement to undertake post-graduate education will place further pressures on nurses from a workload and financial perspective. It may also increase the time a nurse is away from their ward, and this has the potential to have an impact on staff that are left on wards. These staff are expected to deliver quality patient care as well as supervise students, new graduates and unqualified staff and are already working under the pressure of staff shortages, casualisation of the workforce and changing skill mix.

My desire to give ward managers a voice in the literature has led to the area of study for my research project. On reviewing the literature surrounding clinical teaching and clinical education it became apparent that most of the research

undertaken to date has been centred on Clinical Educators, preceptors and students perspectives. Little has been written from a ward manager's/charge nurse's perspective. This led me to my original question; What impact has one collaborative model of undergraduate clinical teaching had on several ward rosters over a two-year period, in an acute care hospital? My goal was to gather information, using a mixed method approach, to assist both the Acute Care Organisation and Tertiary Education Provider in the case study to further develop their existing collaborative model and to inform future clinical education possibilities. This is consistent with Patton's (1997) work as he believes "programme evaluation is the systematic collection of information about the programme, improves programme effectiveness, and/ or informs decisions about future programmes" (p. 23). Due to course commitments and a desire to manage this project within the boundaries of a two paper dissertation, the project has been narrowed and a qualitative case study approach taken.

For the purpose of this project, the boundaries of my case refer to one particular acute care hospital and one Tertiary Education Provider in New Zealand and their particular collaborative undergraduate clinical education model. This model will be described in detail in Chapter 2. Stake (1995) referred to a case study as the "study of the particularity and complexity of a single case, coming to understand its activity within important circumstances" (p xi). I believe that by using a case study approach, a particular collaborative undergraduate clinical education model can be defined as a "case".

For this study when I refer to 'home ward', I mean the ward where a ward manager has released (for a period of secondment) staff from their ward roster to perform clinical teaching roles outside of their usual place of work

(ward/department). The CNEs have attended a two-week preparatory course delivered by the Tertiary Education Provider. In this case study the Tertiary Education Provider contracts the Health Provider to provide clinical teachers for second and third year students during their clinical placements. The Health Provider then seconds Registered Nurses from within the hospital to educate/teach students while they are on clinical placement. For the purposes of this case study these nurses will be referred to as Clinical Nurse Educators (CNEs). A ward manager is a term used to describe a Registered Nurse who is 'in-charge of a ward' (department/unit) and who has both financial (holds a ward/department/unit budget) and human resource responsibilities.

This study seeks to investigate the following: (1) what do ward managers see as benefits and challenges of the current model of undergraduate clinical education? (2) what are the barriers to releasing staff to undertake the CNE role? (3) what are the benefits and challenges of the current model on the ward manager's ability to recruit and retain Registered Nurses? (4) what do ward managers see as future possibilities for the collaborative model? The study design was focused on exploration and description. Emphasis was placed on the purpose and aims of the study and not on the formulation of propositions.

The phenomenon under investigation arises when Registered Nurses from one New Zealand acute care hospital are seconded from the clinical practice setting to undertake clinical education roles for second and third year undergraduate nursing students while the students are on clinical placement. The CNEs remain the employees of the Health Provider. Stake (1995) describes three types of case study: intrinsic case study, instrumental case study, and collective case study. I believe my research project fits in what Stake describes as an

instrumental case study. Issues are raised to “force attention to complexity and contextuality” (1995, p. 16). This will be discussed in more detail in sub-section 4.2.2.

In this chapter I have positioned myself in the world of clinical education and nursing research. I have alluded to some of the staffing difficulties I faced on a day-to-day basis as an operational manager, to maintain safe staffing levels in an acute care hospital. I have discussed the growing concern amongst the health and education sectors that the provision of clinical education is not currently well resourced. I have defined the case and relevant terminology. In the following section, I will use the work of Karuhije (1997) who following her literature review presents a list of fifteen specific and significant differences that exist between classroom teaching and clinical teaching.

1.2 Classroom Teaching versus Clinical Teaching

“To visit the temple of memory is not merely to journey back to the past; it is rather to awaken and integrate everything that happens to you. It is part of the process of reflection which gives depth to experience”

(John O’Donohue, 1997, p. 222)

In this section to assist the reader gain a greater understanding of the different teaching skills required for clinical teaching and classroom teaching I will refer to the work of Karuhije (1997). Karuhije identified fifteen factors or aspects of classroom and clinical instruction taken from the nursing literature, then made comparisons between teaching in a classroom versus teaching in a clinical practice setting.

Teaching in the classroom requires different teaching strategies from teaching in the ‘real world’ of clinical practice. Clinical practice for the purposes of this study refers to teaching in an acute care hospital in New Zealand, specifically during a three year period of undergraduate education (2000-2003). Karuhije (1997) reviewed the nursing literature surrounding the differences between classroom and clinical teaching, and based on the work of Dickoff, James and Weidenbach (1986), identifies fifteen factors or aspects of classroom and clinical instruction. Karuhije acknowledged the fifteen factors were “by no means inclusive or exhaustive” but “allows sufficient comparisons to illustrate instruction that requires very different teaching skills for success in both settings” (p. 7). The list outlined in Table 1, does however begin to identify differences in the roles and responsibilities for each setting. Karuhije then analysed the list and using Benner’s (1984, p 7) definition of a domain [which is a “cluster of competencies that have similar intents, function, and meanings”], found three teaching domains emerged; instructional, evaluative and interpersonal (p. 8).

Table 1: Comparison of five basic instructional components.

Classroom Teacher	Clinical Teacher
Instructional	
Full authority over classroom environment	Authority may be limited in clinical environment
Learning experiences planned for a full term or a at least semester	Experiences planned for a day can be changed by others
Utilises lecture primarily; application of knowledge delayed	Mainly utilises demonstrations and return demonstrations; immediate application of knowledge can occur
More often transmits new knowledge and reinforces previous knowledge; infrequently correlated to clinical experience	Intended to facilitate use of knowledge from the classroom to transform/translate theory for use in practice
Teaching hours variable and presented to fragmented sections of a single class by different teachers	Teaching usually occurs for entire class in a 3-5 time frame per week by the same teacher
Evaluative	
Evaluation of cognitive learning prevails	Evaluation of psychomotor skill dominates
Achievement test; for the most part written	Achievement evaluated mostly by observational methods
Evaluation of learning experiences based on course specific objective	Evaluation problematical; clinical objective often unknown to student; many time unknown to instructor
Evaluation of student classroom performance may generate low to moderate anxiety	Evaluation of student clinical performance often generates high anxiety

Classroom Teacher	Clinical Teacher
Academic credit (points, letter grades), given for student performance	Student performance seldom associated with letter grades or credits. Hours spent in clinical often out of proportion to accepted academic credits ratios
Interpersonal	
Interpersonal relationships are essentially related to the student nurse and academic faculty only	Interpersonal relationships include many students, patient/client, head nurse, doctors, administrators, dietary, team members, housekeeping, maintenance, etc
Objective and learning experience determination may be independent of interpersonal interaction	Objective and learning experience dependent upon interaction with agency and health team
Typically teacher to large group; close contact with individual student unusual	Instruction group rarely exceeds 10-15 students; likelihood exists to know individual student
Classroom consider "home" resulting in feelings of comfort; effectiveness enhanced	Frequently perceived as a " guest" in the clinical setting resulting in feelings of discomfort and reduced effectiveness
May spend more time with departmental secretary than with students; can maintain a high degree of isolation	Considerable amount of time spent in close interaction with student; facilitates interpersonal processes

Differences between the three domains range from the amount of authority a teacher has over the learning environment, utilisation and mastery of lecture presentations versus demonstration abilities, evaluation of cognitive as well as psychomotor skills, formal evaluative strategies versus observational methods,

and lastly one of the most significant differences, that of interpersonal relationships. A classroom teacher must be able to form an interpersonal relationship with the student whereas the clinical educator must be able to develop an interpersonal relationship with the student and preceptor. In clinical practice the teacher must develop working relationships with students, patients, family members, preceptors, doctors, charge nurses, a number of allied health professionals, and administration staff just to name a few. My anecdotal experiences as a Clinical Educator confirm Karuhije's assumptions, and I agree with one other difference Karuhije identifies; the teacher being seen as a "guest" in clinical practice. This difference, I believe, is a significant challenge for the Clinical Educator who may not be familiar with a particular clinical setting. The CNE, in this case study, has the advantage of being employed by the Health Provider, is therefore already familiar with the learning environment and has already well established working relationships.

I believe clinical teaching involves instruction not only role modelling, supervising or mentoring. The term 'supervision' is sometimes loosely used as an 'umbrella' term to describe different models of clinical '*teaching*'. Peutz (1985, as cited in Fowler, 1996) proposed that supervision is a "continuum from *role model*' through '*preceptor*' to '*mentor*'. A role model is fairly passive; a preceptor is more active teaching and supervising, whilst a mentor is willing to invest time and energy over many years" (p. 475).

In this case study the CNE is not directly responsible for a group of patients, but instead provides support to students through a preceptorship model of undergraduate clinical nursing education. The preceptor's position description requires nurse preceptors to teach, complete formal assessments, and give

feedback, all of which are competencies for teachers rather than role models or mentors. The CNEs roles and responsibilities are outlined in a formal contract between the two organisations. The CNE is expected to;

prepare and provide clinical education programmes that are linked to the theoretical component of the paper and tutorials to meet student learning needs; to assist students to deliver care that meets the client needs for nursing input and that meets professional and legislative standards and requirements (p 15).

In theory, students in the case study are supported by one-on-one teaching from a preceptor and CNE who provide, formal educational programmes, tutorials, clinical supervision, formal assessments, informal feedback, direct observation, one-on-one assistance with patient care, role modelling and serve as advocates for students within a practice setting.

The differences between classroom and clinical teaching using the work of Karuhije (1997) and my own experiences have been discussed. The following chapter discusses what is meant by a collaborative partnership approach to undergraduate nursing education. I will also describe the implementation of the particular collaborative model in the case study and present a more in-depth overview of the role of the CNE.

CHAPTER 2

2.1 Overview of Collaborative Partnership Model

As previously discussed it is important to place the case study described in context. Particularisation is key when using case study as a qualitative research method (Stake, 1995). This chapter places the collaborative model in the case study into its particular context. I begin by discussing what a collaborative model means in the world of nursing today in New Zealand then describe in more detail the model used in the case study.

Cooney, Dignam and Honeyfield (2001) in their booklet “The Potential of Joint Appointment and Clinical Chairs to Promote Nursing Education, Practice and Research”, attempt to clarify the differences between ‘clinical chair’ and other ‘joint appointments’. They describe one collaborative model of joint appointment within the New Zealand context today as ‘shared appointments’.

They explain;

skilled nurses employed by service delivery organisations provide clinical lectureship to nursing students. That is, the skilled nurses are released from their direct patient/client care roles to work with students in either the practice setting or the educational setting (p. 2).

I believe this description best fits the model in this case study. However, I believe one significant detail Cooney, Dignam and Honeyfield do not address is how this ‘shared appointment’ relates to and interacts within a preceptorship model. The particular model I refer to in this case study describes nurses who provide clinical lectureship as CNEs.

The programme being described was first developed in the late 1990s between one Tertiary Educational Provider’s Nursing School and a Crown Health

Enterprise and was subsequently introduced into the Acute Care Hospital in this case study in 2000. There is some evidence that the Acute Care Hospital programme was reviewed internally in June 2000 and sometime in 2001. I have obtained minutes of meetings held during this time; however no date is recorded on the 2001 minutes. The minutes do refer to ward managers being consulted but there does not appear to be any evidence of how they were consulted. The Student Placement Co-ordinator writes, "I have received excellent feedback from students, preceptors and ward managers about the quality and appropriateness of clinical supervision during each placement period". I acknowledge at this point that information presented here is from an acute care organisational perspective and the Tertiary Education Provider will have their own formative evaluation documentation. There appears to be no formal programme document which specifically refers to the Acute Care Hospital's partnership programme (in the case study) with the Tertiary Education Provider.

On inquiring, I was given a copy of the previous Crown Health Enterprise's programme booklet dated 1999. The programme goals outlined in this programme booklet include providing a "positive nurturing clinical experience" and "enabling students to achieve mastery of clinical competencies". Goal three refers to providing "feedback from the educational provider to the Crown Health Enterprise on the effectiveness of their clinical practicum environment for students". Goal four relates to building "partnership relationships" and goal five relates to providing a "new clinical pathway for experienced staff within the organisation" (p. 3). The students in the programme are year two and three students and are supported by either a trained preceptor or a buddy. Students are also allocated a CNE who attends a two-week preparatory programme run by the

Tertiary Education Provider. This course is held at the Tertiary Education Providers campus over two, one-week blocks, (December/January). The CNE gains knowledge about the curriculum, student learning objectives and assessment processes in this time at the Tertiary Education Providers campus. CNEs provide a 1:5 teacher to student ratio for year two students and a 1:6 teacher to student ratio for year three students. Both students and CNEs are deemed to be supernumerary to the ward roster but preceptors and buddies are not.

The Training and Development department of the DHB currently offers preceptors a New Zealand Qualification Authority (NZQA) approved programme. The local College of Education recognises the programme within NZQA approved Graduate Certificate of Clinical Teaching (Level 7) offered nationally by the College. The Crown Health Enterprise booklet has evidence of summative evaluation undertaken in 1998 between the Education Provider and Crown Health Enterprise. This evaluation focuses on student appraisals and the role of the CNE. The programme does not appear to refer to a pre-determined formative or summative evaluation process.

The Tertiary Education Provider contracts the Acute Care Hospital (organisation) to release Registered Nurses to provide clinical education for undergraduate second and third year students. Elective students are also included in the contract but they are not supported by CNEs under the contract. Also in the contract, the Acute Care Hospital agrees to provide a designated Student Placement Co-ordinator. The Student Placement Co-ordinator liaises with the Tertiary Education Provider and the clinical areas within the District Health Board, to co-ordinate student placements not only for the Tertiary Education Provider in the case study, but also other education providers. This position is

funded by the Health Provider and, at the time of writing is a dedicated 0.2 full-time equivalent (FTE) position reporting to the Training and Development Manager. This is a formal process and the contract is signed by the Head of the Nursing School and Director of Nursing as delegated representatives of their respective organisations. However, the Acute Care Hospital's Training and Development department 'operationalises' the contract. The Training and Development department manages the budget, manages the recruitment and selection process of the CNEs and Student Placement Co-ordinator, and liaises with the Tertiary Education Provider through the Student Placement Co-ordinator. The Training and Development Manager is operationally responsible for the CNEs and Student Placement Co-ordinator but the CNEs are held professionally accountable to the Director of Nursing.

The roles and responsibilities of the CNEs as outlined in the contract are to:

- (1) prepare and provide clinical education programmes that are linked to the theoretical component of the paper and tutorials to meet student learning needs;
- (2) assist students to deliver care that meets the client needs for nursing input and that meets professional and legislative standards and requirements;
- (3) facilitate student learning by assisting students to reconcile problems in a supportive manner, acting as a student advocate, assisting students to recognise their learning needs and develop their learning objectives;
- (4) ensure the clinical area provides a safe environment for student learning: to maintain clinical and theoretical expertise in area of practice;
- (5) provide students with clear outlines as to learning outcomes and assessment expectations;
- (6) participate in student evaluations and promotion of discussions;
- (7) act as a role model for the student in standards of

dress and professional behaviours; (8) and develop clear communication between the students, student coordinator and health provider.

In this chapter I have provided an overview of how the undergraduate nursing clinical education model in the case study was initially established with one Health Provider and then offered to another. The role of the CNE has been explained and how collaboration between education and health providers can occur has been illustrated. It is important to place the 'case study' in this project into context both nationally and internationally, thus acknowledging the ongoing evolution of undergraduate nursing clinical education, since the move from the traditional 'apprenticeship style' training in the hospital setting to education in the tertiary education sector in the mid 1970s. The following chapter gives an overview of New Zealand's journey followed by a 'snap-shot look' from a global perspective. I have used the words 'snap-shot' here to reflect the timeframes that are associated with undertaking a two-paper dissertation. The literature review was performed over an academic year and therefore I acknowledge the limitations that this has on the quantity of the information which was accessed. I will now move on to discuss the published research commentary surrounding the topic of undergraduate clinical education. The following chapter examines clinical nursing education within the New Zealand context, and then explores the international literature.

CHAPTER 3

3.1 Review of the Literature

3.1.1 The New Zealand context

Chapter three begins with describing the New Zealand context followed by discussion of the overseas literature and its relevance to the collaborative model in the case study. The aim is that the reader is given a sense of the diversity of models used to support undergraduate clinical education.

In New Zealand the move from hospital-based nursing education to comprehensive nursing education occurred during the years 1973 to 1992. During this period nursing programmes combined general, obstetric, community, psychiatric and psychopaedic components into one course leading to a Diploma in Nursing and registration as a New Zealand Comprehensive Nurse. The introduction of the Education Amendment Act in 1990 enabled educational institutions other than universities to award degrees. A ten year transition period has now seen all programmes in New Zealand leading to registration as a nurse offered at undergraduate degree level (KPMG Consulting, 2001).

In New Zealand, within undergraduate nursing programmes, there is some variation in the approach to clinical experience particularly in the students' first year. One of the key recommendations of the review, commissioned for the Nursing Council of New Zealand by KPMG Consulting in 2001 was that "Nursing education providers include quality clinical experience earlier in the first year of the undergraduate programme"(p. 9). At present, within the organisation discussed in this case study; students' clinical placements are in the second and third year of the programme. If the KPMG Consulting report recommendations transform into reality and student placements are sought earlier in acute care areas

to deal with an increase in student numbers, then further pressures on staff within acute care facilities are a very real possibility.

In preparation for this study I made a number of informal enquires by email, to a number of Tertiary Education Providers throughout the country to determine how clinical education is delivered. From fifteen email requests for information I received five responses. This information assisted me to narrow my research topic and it was acknowledged at the time to each organisation contacted, that it was not my intention to use the information as part of my final research project. However, the responses do suggest that there appear to be a variety of models used throughout the country. In some institutions faculty nursing lecturers supervise students in the clinical practice setting at all times, particularly in their first year of the programme. In years two and three of undergraduate Bachelor of Nursing programmes, nursing faculty lecturers can provide supervision for a number of students across a number of placements. They do not remain with a group of students for the entire shift and tend to 'visit' the students. In some tertiary education providers, clinical supervision is provided by part-time clinical educators. The part-time educators are employed directly by the education provider. Preceptors and buddies are also used widely to provide clinical teaching and/or supervision. However, at present, there is no national requirement for Clinical Educators or preceptors to undertake formal adult teaching courses.

Dyson (2000) carried out exploratory/descriptive qualitative research which looked at the role of the lecturer in the preceptor model of clinical teaching in one New Zealand school of nursing. The study findings support research carried out by other studies, (for example Carlisle, Kirk & Luker, 1997; Clifford, 1993; Crotty, 1993; Forrest, Brown & Pollock, 1996; and Lee, 1996) which identified

liaison and support roles for lecturers. In Dyson's study, lecturers provided a link between the education and clinical areas and endeavoured to support preceptors in their role. The participants described what they saw as the difference between faculty lecturer and preceptor. The faculty lecturer believed that the preceptors focused on teaching the practical skills of nursing and day-to-day nursing routines, where the faculty lecturers focused on "teaching the thinking of nursing" (Dyson, p. 19). Dyson's research identified the need for preceptors to be given more support, particularly making sure preceptors and students have clear descriptive learning outcomes. Preceptor workshops are encouraged and feedback strategies are taught.

A model beginning to appear in New Zealand is that of the joint appointment. Joint appointments are described by Lantz et al (cited by Cooney, Dignam & Honeyfield, 2001, p. 2) as a "formalised agreement between two institutions where an individual holds a position in each institution and carries out specific and defined responsibilities". In April 2001, the Nurse Executives of New Zealand and Nurse Educators in the Tertiary Sector (NETS) published a booklet written by Cooney, Dignam and Honeyfield titled "The Potential of Joint Appointments and Clinical Chairs to Promote Nursing Education, Practice and Research". This booklet was developed as a result of the 1998 report of the Ministerial Taskforce on Nursing. In this booklet the authors aim to separate the 'clinical chair' role from that of other 'joint appointments'. Cooney, Dignam & Honeyfield (p.1) make the following differentiation;

while a clinical chair role is a type of joint appointment with the primary intention of fostering nursing research, other joint appointment models are introduced for a range of other reasons. For example, joint appointments may

assist with nursing staff development and student supervision (Lachat, Zerb & Scott, 1992); they may help to increase nurse lecturer clinical credibility (Murray & Thomas, 1998); and they can aid in improving relationships between service and educational institutions (Tamlyn & Marrick, 1995).

It is important to understand the difference between a clinical chair and a joint appointment when discussing collaborative practice models. Following discussions with several CNEs at the hospital in the case study, I have been able to establish that CNEs are not currently involved in research, nor does the Teritary Education Provider have a joint research study in progress with the acute care hospital. The CNEs are employees of the District Health Board. They are not employed by both organisations and are therefore not joint appointments.

McKenna and Roberts (1999) in their article 'Case study of a joint appointment' describe how for the past four years they shared lecturing, clinical supervision and client care responsibilities for second year students in a forensic unit in New Zealand. In this model each "Monday and Tuesday the appointees literally swap positions" (p. 15). On the Monday and Tuesday the Registered Nurse teachers in the classroom at the faculty and the faculty lecturer works "pre-negotiated shifts" in the unit at the hospital. Student evaluations indicate that there is a positive advantage to clinical educators having knowledge of the area and "being known within it" and "classroom teaching was also considered to be relevant and more interesting due to the ability of the educator to draw on current clinical involvement" (p. 18). An overall comment made by the authors was the success of the joint appointment model which required "personal commitment" by both the health professionals involved in teaching and the "open door" management styles of the middle and senior managers in the health service (p.16).

Another innovative programme which aimed to enhance student learning and facilitate meaningful links between theory and practice was a clinical practice education exchange programme at Christchurch Polytechnic Institute of Technology. In this programme a nurse educator and a clinician exchanged their respective positions for one year (Brasell-Brian & Vallance, 2002). The outcome of the clinical practice/education exchange (CPEE) described by Brasell-Brian and Vallance was that both educator and clinician became “revitalised and refreshed” about their nursing practice and felt that by bringing recent clinical expertise to the classroom they were able to make their teaching more relevant in both the classroom and clinical practice setting. In their recommendations the authors recommended that formal evaluation occurs of CPEEs to assist both the education and health sectors to determine the future possibilities of this model.

3.1.2 Implications for Maori nursing students

In the summary report on ‘Consultation Hui with Maori’, the KPMG Consulting 2001 report refers to the concept of Maori having the “ability to undertake clinical placements in their own community” (p. 145). Maori nurses consulted believe Maori students should have more exposure to Maori communities during their clinical placements in preparation for dealing and interacting with Maori clients. Nursing students may come from a variety of different Maori iwi. As part of the evaluation process by the Tertiary Education Provider in the case study, continuing iwi consultation needs to occur with a number of communities. A twelve-month pre-nursing course has been set up for local Maori who wish to become Registered Nurses. These students, if successful, will enrol into nursing programmes. Another model exists at the Waikato Institute of Technology for students who are enrolled in the Tihei Mauri Ora option of the

Batchelor of Nursing programme. Students in this programme have clinical placements with Maori preceptors and CNEs. If the KPMG Consulting report recommendation is to be followed then the aim in future will be to offer local clinical placements supported by Maori clinical educators.

3.2 Review of International Literature

3.2.1 Australia

In Australia the transfer of nursing education from the hospital setting to universities began in 1984. In 1994 funding responsibilities for Australian nursing education were transferred from different state governments to the Federal government. During this time, supervision and preceptorship became the two established models of teaching in the clinical setting (Grealish & Carroll, 1998). In the clinical supervision model, academic staff also known as supervisors, worked directly with undergraduate students in clinical practice. Often the supervisor was on site with the students 2-3 days each week during the semester and provided direct supervision and instruction for a small group of students. Supervisors in the University of Canberra, until 1996, worked with ratios of one supervisor to six students. However financial pressures have resulted in an increase in 1 to 8. Grealish and Carroll (1998) surveyed seven clinical supervisors and thirty-four preceptors at the University to find out about their perceptions of their respective roles. Their findings included the following statement: “if the health care funding crisis continues and staffing levels continue to fall, the work demands on Registered Nurses will increase” (p. 5). The major disadvantages their participants identified were: “situation stresses such as busy wards made it frustrating to stand back and not take over from the student, and difficult to monitor the progress of one student in isolation from the others” (p. 7).

Dedicated Education Units (DEUs) are another approach to clinical education that have developed in South Australia, between Flinders University and health providers. In this model DEUs are “existing health care units that are further developed through strategic collaboration between nurse-clinicians and academics” (Gonda, Wotton, Edgecombe & Mason, 1999, p. 172). Key features of the DEU clinical learning environment are: reflective practice, peer teaching and guidance by a mix of academic facilitators, clinical educators, and visiting academics. When DEUs were first introduced into three acute care settings, third year students were placed in each unit for three days per week for fifteen weeks from week one of the semester. Second year students were placed in week six and attached to the third year students and first year students were placed in week ten and attached with either a second or third year student. This was the only model of this kind that I found in the literature where students were ‘attached’ to other students. This model introduced the concept of peer teaching, which refers to students teaching other students. Students who participated in Gonda et al’s (1999) evaluation research project of the DEUs, indicated an overwhelmingly positive response to this concept and believed “teaching other students reinforced their own learning” thus supporting the assertions of Goldenberg and Iwasin (1992, p. 175), “that they actually learnt together”. Registered Nurse supervisors were responsible for the overall planning, implementation and evaluation of patient care. The role of the clinicians was that of mentor.

A mentor is described by Fowler (as cited in Gonda et al, 1999) as an “experienced professional, nurturing and guiding, inspiring and supporting the novice” (p. 173). The academic facilitators from the University ensured the:

provision of relevant clinical experience so that students could achieve expected learning outcomes and evaluate these achievements. These academics worked directly with students for eight to ten hours each week; discussed teaching strategies with clinical staff, and collaborated when evaluating students' achievements (1999, p. 173).

Formal fortnightly meetings between ward staff and an academic facilitator were held on each DEU. This enabled monitoring of the DEUs and student progress. Multi-disciplinary tutorials were offered in each DEU by a visiting academic at three - four weekly intervals and were attended by students from all year groups. During these tutorials students were encouraged to analyse recent patient care incidents focusing on required learning objectives, eg., sociological, ethical and legal perspectives, thereby contextualising theoretical aspects of their programme. Gonda et al. (1999) took an evaluative research approach in judging the success of the programme. Samples of ninety-one nursing students from three DEUs were invited to participate and 54% responded. Sixty clinicians were invited to participate with twenty-one responding. Data were collected by two anonymous self administered questionnaires. A thematic analysis as described by Talbot (1995) was used to interpret the findings. Overall the research identified six dominant themes: "preferred placement model; student/clinician learning; peer teaching/learning; clinical facilitation; workload and relationships" (p. 173). The finding that nurses working in areas where they received nursing students from more than one university, indicated that it is difficult for Registered Nurses to focus on students from more than one course as there was a range of different learning methods and goals (Grant, Ives, Raybould & O'Shea, cited in Gonda, et al, 2002 p. 175).

3.2.2 *United Kingdom*

In the United Kingdom with the introduction of Project 2000 in the 1980s, A New Preparation for Practice Report (UKCC, 1986) recommended a three-year, university-based diploma programme, and nursing moved from hospital-based training programmes to universities. In Scotland and Northern Ireland the transfer has continued into the late 1990s. A minority of Project 2000 three-year courses have been developed at the bachelor's degree level, and in parallel with the establishment of four-year degree programmes. However, at present, students graduate with a diploma after three years full-time study, which leads to registration in one of four branches: Adult, Child, Mental Health, or Learning Disabilities (Lusk, Russell, Rogers, & Wilson-Barnett, 2001).

In the United Kingdom, The Royal College of Nursing issued a pamphlet advocating three-year degrees for all entrants to nursing education (RCN, 1997). There is no externally set examination following completion of the degree or diploma programme and universities set their own assessments tailored to the curriculum. A statutory body, the English National Board (ENB), reviews assessment processes.

A variety of models have evolved in the United Kingdom. Examples have been the development of a link tutor role (Humphreys, Gidman, & Andrews, 2002). In this model lecturers are assigned to specified practice areas. Another model is what Humphreys et al. call the personal tutor model. In the latter model, 'personal tutorial' arrangements are established in the university and a tutor is assigned students. This arrangement may last throughout the programme.

Crotty (1993) undertook a Delphi Survey of twenty-five colleges of nursing that had implemented Project 2000 between September 1989 and April 1991. The

survey was followed by in-depth interviews with a sample of respondents (nurse teachers). The findings indicated teachers did not perceive their role to be that of teaching students through 'hands on care'. The study participants felt this was the role of qualified staff in the clinical areas.

Murphy (2000) supported Crotty's research that found nurse lecturers had difficulty meeting role expectations, with the move to higher education. The faculty lecturers in both Murphy and Crotty's studies cited that lack of time and research requirements had impacted on their ability to provide clinical teaching.

Rolfe (cited in Murphy, 2000) undertook research and concluded "the nurse lecturer's area of expertise is now teaching and research not clinical practice" (p. 705). If there is already a gap between theory and practice then there is now a potential for a gap to develop between lecturers whose main function is to generate and undertake research and those who teach inside tertiary institutions. This raises concerns that nursing lecturers have the potential to become further removed from clinical practice.

A recent role has evolved in the United Kingdom which has been given the overarching name of Lecturer Practitioner. A Lecturer Practitioner is a nurse employed in a joint appointment between the University and the clinical area. Jones (1996) carried out an exploratory study funded by the West Midlands Regional Health Authority Department of Nursing. The one year study looked at the implementation aspects of the Lecturer Practitioner role in Oxford and twelve others in the United Kingdom. Jones concluded from his study "no particular Lecturer Practitioner model was more frequently identified than any other" (p. 34). Jones commented further "this would tend to reinforce the idea that the role and function of the Lecturer-practitioner must be flexible and responsive to

service and/or educational need” (p. 34). Participants in the study described the role of the Lecturer Practitioner as having common responsibility in both the services area and in curriculum planning and delivery. Another key role identified for the Lecturer Practitioner in the study was to provide a close communication link between service and education providers. One of Jones’s key recommendations was that managers have a responsibility to consider where/ how the role fits into the career structure in nursing.

As I reflect on this I begin to question where does the CNE role fit into the organisation’s nursing structure in the case study? This role is not currently formally acknowledged within the organisation’s nursing organisational structure. However, as far as I am aware, at the time of writing, there is no formalised nursing and midwifery structure in the District Health Board.

Vaughan (cited by Jones, 1996) describes the Lecturer Practitioner as someone who has:

responsibility for both practice and education within a defined clinical area, with two broad aims; 1) to identify and maintain the standards of practice and policies within a defined clinical area, 2) to prepare and contribute to the education programme of students in relation to the theory and practice of nursing in that unit (p. 338).

If I compare Vaughan’s perspective to the model in the case study then the CNE would be ward/unit based. But in the model in this case the opposite occurs; the CNEs (ward/department/unit) nurses are taken out of their ward, leaving gaps in ward rosters for the duration of their secondment to the CNE role.

Murphy (2000) described her action research project in Wales, which aimed to improve the educational experience of pre-registration nursing students through

the implementation of a teaching programme taught by both lecturer and the practitioner. This was a formal teaching programme and was developed on a gynaecological ward over a period of twenty-one months. Weekly one-hour tutorials were held jointly by practitioner and lecturer. A reflective practice framework was utilised based on John's 1994 model, (refer to glossary) where the students were asked to bring a 'critical incident' pertinent to the chosen themes to be analysed. Practitioners in this research were unanimous that teaching in more formal sessions was part of their role as Registered Nurses. The teaching session helped students to think about, and review their practice. Discussing various strategies with students and the lecturer facilitated this process. This concept of both lecturer and practitioner working closely together supports what Rolfe (as cited in Murphy, 2000, p. 712) suggested as "an example of an encounter between equals, between the experienced practitioner and the experienced educationalist".

Elliott (1993) described an initiative taken in one United Kingdom health unit to overcome travelling difficulties caused by a wide geographical area that the school of nursing covered. Elliott called the model Locality Based Teaching (LBT). In this model the lecturer based themselves in the ward and held formalised tutorials twice a week. Staff and student seminars were held monthly on clinical matters. Lesson preparation and marking was done on the ward and the lecturer was accessible for one-on-one teaching with students. The research was of a qualitative design and data were collected by the use of questionnaires and participant observation. The findings indicated that there was a benefit to having lecturers on site at all times. Elliott comments that the key to the success of the project was having "the freedom and opportunity to teach, and the learners given the freedom to learn. This concept is compatible with the principle of androgogy

which underpins the current philosophy of nurse education” (Elliott, 1993, p. 38). This research was small scale and in one specific area, which has limitations, but it reinforces that no one organisation has found the perfect clinical education model. Elliott’s study did however demonstrate a number of positive benefits to students when lecturers are based on site. This can ensure safe practice through both direct and indirect supervision, and teaching can be more realistic as both students and lecturers are part of the team. Learning opportunities are increased and lecturers are seen as “clinically credible” (Elliott, 1993, p 37).

Baillie (1994) conducted an exploratory study utilising focused interviews with ten nurse teachers, which explored their participation in clinical practice and their feelings about this. Baillie concluded that:

the nurse teachers in the small study could identify many benefits of such clinical practice experience, yet for most this was not actually achievable. Teacher participation in clinical practice will need to be valued and given organisational support for it to become a reality (p. 158).

In the UK there are sixteen pilot sites for a new-look nursing diploma course (O’Dowd, 2000). The new look diploma course has a common foundation programme of twelve months and nursing students will have some early training with other professions such as medicine and social work students. O’Dowd (2000) reported that clinical placements would start as early as eight weeks. However, in her article “On the wards in eight weeks” (after the programme commences), O’Dowd did not explain what model of clinical education will be utilised in the programme.

3.2.3 *Canada*

During the 1990s undergraduate nursing education in Canada moved to a baccalaureate degree course within the university setting (Myrick & Barrett, 1992). Preceptorship has been the dominant strategy which has evolved in Canada to provide clinical teaching for students. Preceptorship is defined by Chickerella and Lutz (cited in Myrick & Barrett, 1992) as an “individualised teaching/learning method in which each student is assigned to a particular preceptor so she can experience day to day practice with a role model and resource person immediately available within the clinical setting,” (p. 107). Myrick and Barrett (1992) cite several studies that support the view that the role of the preceptor is crucial (Chickerella & Lutz, 1981; Crancer, Fournier & Mary-Hess, 1975; Huber, 1981; Liman, Bargagliotti & Spencer, 1982; Scheetz, 1989). Whilst some of these studies were carried out in the 1970s and 1980s and are therefore relatively dated, I believe it is important to acknowledge their influence on the development of preceptorship as an accepted clinical education model.

Shamian and Lemieux (1984) evaluated two teaching methods: the preceptorship-teaching model, and the formal teaching model. Results from this study revealed that preceptorship models, when compared to the formal or traditional model, produced superior results in the areas of knowledge attainment and assessment skills. Shamian and Lemieux defined a preceptor as a Registered Nurse who acts as resource person and role model as well as teacher, counsellor and evaluator to the preceptee or student nurse. In this small study what did emerge was that nurses in the preceptor units “retained knowledge longer and more completely over a three-month period, whereas the recall of the formal teaching group member slipped dramatically” (p. 88).

Myrick and Barnett's (1992) study focused on determining the presence of selection criteria for clinical preceptors in Canadian baccalaureate Schools of Nursing. They used a self-administered questionnaire and employed an exploratory descriptive design. Of the twenty Canadian baccalaureate Schools of Nursing, and the thirty-one University Schools of Nursing which participated in the study, 70% indicated that they employed clinical preceptors to teach their students in practice settings. Myrick and Barnett concluded that 45% actually had defined specific criteria for the selection of their preceptors and only 30% of those schools that use preceptorship completed a performance evaluation of their clinical preceptors, despite the fact that 65% did not require their preceptors to have any previous clinical teaching experience.

This study highlights the need for programme evaluation. Whether a programme chooses formative or summative evaluation methods, evaluation is an essential part of programme development and maintenance.

3.2.4 The United States of America

During the 1920s and 1930s, university baccalaureate degree programmes for nurses were developed throughout the United States (US) but they did not expand as rapidly as nurse leaders had hoped. Following World War II, nursing education expanded into less-expensive community colleges (Lusk, Russell, Rodgers & Wilson-Barnett, 2001). Community colleges offered two-year associate degrees. These were designed to facilitate post-high school education for the middle and lower classes (Fagin & Lynaugh, as cited in Lusk et al., 2001). Three distinct educational programmes developed: a three-year hospital diploma, a two-year associate degree and a four-year baccalaureate degree. All programmes prepared

applicants to sit for the same licensing examination necessary for nurse registration.

In response to this anomalous situation, in 1965 nurses at the American Nurses Association convention recommended that the baccalaureate degree should be entry level standard for “professional nurses”. Associate and diploma school graduates were to be called “technical nurses” (Lusk, et al., 2001). This historic emphasis on individuality means nursing education remains divided. The majority of nurses in the US graduate from two-year diploma programmes. However, nursing education in the US is primarily college-based and the American Nurses Association continues to give its significant support to one entry level, a baccalaureate degree, for pre-registration nursing education.

There are a range of different teaching models described in the US literature. (Hermann 1997; Melander & Roberts, 1994; Schoener & Garrett, 1996; Oermann, 1996; Baird, Bopp, Kruckenberg, Langenberg, & Mathis-Kraft, 1994; Chamings & Payne, 1994; Weber, 1993). However preceptorship (refer to glossary) appears to be the most common model discussed in the literature.

I will now discuss one model of clinical teaching found in the US literature which differs from those described in the previous subsections. In California, Close, Koshar and DelCarlo (2000) have given the clinician (Registered Nurse) the title of Assistant Clinical Instructor (ACI). The university pays an ACI for hours of clinical instruction and supervision outside of his or her regular job hours in the acute care setting. Each full time faculty member responsible for clinical instruction is required to give student supervision for only a portion of the clinical day, thereby effectively releasing them to engage in other teaching activities.

The ACI teaches and supervises students during the entire clinical session and the faculty member is present during the last hour that the student is providing direct patient care. The faculty lecturer facilitates the post conference at the end of the shift (a debriefing /reflective practice session). The ACI provides role modelling for direct patient care and the faculty member assists the student to look 'beyond the bedrails' to further develop their clinical thinking and judgment skills. During the clinical session the Assistant Clinical Instructor's time is paid for by, and is accountable to the university rather than the acute care agency. Therefore, the Assistant Clinical Instructor's primary focus during the students' clinical session is education of students, and not providing direct patient care.

The article is unclear regarding this and does not elaborate on teacher to student ratios. The ACI provides input on students' clinical competence (including specific examples). The faculty member is responsible for evaluation and written assignments, including nursing care plans, journals and student identified clinical objectives. The faculty member retains formal grading responsibilities.

The Acute Care Hospital's programme in this study has similarities to this US model but a significant difference is that the CNEs perform clinical assessments and complete practicum assessments. Faculty members then moderate the Clinical Nurse Educators' assessment processes.

3.2.5 Summary

It appears that when nursing education moved from hospital-based training to higher education in polytechnics, universities and colleges, clinical teaching seems to have fallen through the gap. Nurses in service organisations are expected to teach students, and faculty lecturers are expected to obtain higher qualifications

and undertake research. This has led to localised models of clinical teaching developing in order to meet student needs and regulatory requirements.

Throughout the published research reviewed to date, it is clear that the preceptorship model is the most commonly used model of clinical teaching in undergraduate nursing education. The amount and type of support that both the education and service providers give students and preceptors is what differs. A mixture of models has evolved which are due to specific organisational needs. Either practitioners employed in clinical practice are employed to provide clinical teaching, or faculty lecturers work in both schools of nursing and clinical areas. Both these models still require the student to have a preceptor or buddy from practice.

One of the key requirements of a preceptor is to teach and it is in this area that the model has limitations in today's acute care environment. Registered Nurses were not initially given the skills and knowledge to teach and service providers have not appreciated that to teach in clinical practice requires manageable patient workloads. In New Zealand it appears when nursing education moved from hospital-based training programmes to higher education, no one strategy across the country was introduced to manage the clinical teaching component required in the undergraduate nursing programmes. This has led to a variety of models evolving which attempt to meet individual organisational needs. In the current healthcare environment, with a national and international shortage of nurses, and with fiscal constraints and high patient acuity, the ability of preceptors to teach undergraduate students as well as provide direct patient care is becoming an increasingly difficult task.

Presently, the Nursing Council of New Zealand degree programme requirement is for a student to have a minimum of 3000 hours in their programme, divided on a 50:50 basis between theory and clinical practice. Ten percent of clinical time may be used for laboratory simulation experience. The 2001 KMPG Consulting report recommends that the “clinical component needs to be emphasised” (p. 111). Nursing is a practice discipline, and as such collaborative partnerships between education and clinical practice are critical. It is apparent from the plethora of articles that since the move from the apprentice-style hospital-based training to the higher education institutions, and the move from comprehensive diplomas to undergraduate degrees, no one country has developed ‘thee’ clinical education model.

The changing health care environment allows the nursing profession the opportunity to be innovative and encourages both the education and health sectors to evaluate programmes, disseminating knowledge gained and therefore contributing towards decisions about what model works best in the acute care setting and for educational providers. Changes in nursing structures within the acute care environment will need to address whether nurses are to be released from direct patient care to perform clinical teaching. Both education and service providers need to understand that undergraduate students are only part of a ‘bigger picture’. There are currently demands on the ward staff in the case study to precept not only undergraduate students from one specific educational provider but students from other educational institutes. There are also postgraduate students seeking clinical placements. For example; nurses undertaking Graduate Certificate and Graduate Diploma studies in specialty papers. Not only are nurses in clinical practice expected to preceptor undergraduate and post-graduate

students but also new graduates, health care assistant clinical placements, back-to-nursing students and overseas nurses gaining New Zealand registration. More recently (2003) in some areas in New Zealand enrolled nurse students (second-level nurse/nursing assistants) are now in the workplace and also require clinical supervision. Nurses are also required to orientate new staff. These demands on ward staff cannot be sustained without the commitment of both education and service providers to seek innovative solutions and provide both financial and human resources at ward level.

In concluding this chapter, the increasing nursing shortage, changes in skill mix and increasing patient acuity appear to be having an effect on Registered Nurses' ability to teach in the clinical practice setting. Students are supernumerary, but preceptors are not. Preceptors are expected to teach at the same time as being responsible for direct patient care, as well as providing supervision for inexperienced and unqualified staff. As the health industry moves into a decade of more understaffing, the pressure on preceptors and students is set to rise. Students are the future nursing workforce. If Education and Health Providers ensure quality clinical placements right from the beginning and have support structures in place for students, then the health and education industries will reap the rewards: that is, recruit new graduates, and retain competent nurses, who in turn can preceptor future generations of nurses.

My experiences in operational management and education along with my passion for nursing have led to my desire to explore these issues. The following chapter describes the purpose and aims of my research project, my chosen methodology and my research journey.

CHAPTER 4

4.1 The Project

I begin this chapter by outlining the project aims which assisted me to choose my research methodology. A brief description of two well known authors on case study methodology Robert Stake and Robert Yin are given, followed by reference to the use of case-study methodology in New Zealand and overseas nursing literature. The challenges of obtaining ethics approval for my project are discussed and the chapter concludes with an overview of how my case study deals with the issues of congruence and rigour, both of which are required to give qualitative research projects credibility.

The purpose of the study was to investigate the benefits and challenges of one New Zealand nursing undergraduate clinical education model from a ward manager's perspective. This study sought to investigate: (1) what do ward managers see as benefits and challenges of the current collaborative partnership model? (2) what are the barriers to releasing staff to undertake the role of CNE? (3) what are the benefits and challenges of the current collaborative partnership model on the ward manager's ability to recruit and retain Registered Nurses? (4) what do ward managers see as future possibilities for teaching undergraduate students in practice?

4.2 Method - Case study

A case study method has been utilised for my research project. Robert Stake's (1995) work has informed this project. Stake initially developed the approach in 1975 and became an evaluation theorist who advocated the use of case study methodology in evaluation and qualitative research. Before I discuss

how my research project fits with Stake's view of case-study methodology I begin with a brief historical overview.

4.2.1 Historical overview

Case studies have been used to take an in-depth look into a particular case and historically evolved from the social sciences of psychology, social work and sociology. The use of case study has been widely used in the fields of medicine and law (Tellis, 1997).

In the United States of America (USA) during the 1900s until 1935 the University of Chicago Department of Sociology was "pre-eminent in the field and the sources of a great deal of literature" (Tellis, 1997, p. 2). In the USA during this period of time, growth in immigration was experienced and issues of poverty and unemployment were studied using case study methodology. However following 1935, the use of quantitative methodologies and the scientific paradigm began to strengthen and case study methodology took a back seat. It was not until the 1960s when Strauss and Glaser (1967) became disillusioned with quantitative research and its limitations, and developed the concept of 'grounded theory' that case study methodology was rediscovered. Case study methodology has also been used in evaluative research. Yin (1994) described a number of well known case studies, in his 1994 book *Case Study Research, Design and Methods*. *Case studies such as Street Corner Society* (1943/1955) by William F. Whyte, is a classic example of a descriptive case study where a single-case study was used to identify; "generalisability to issues on individual performance, group structure, and the social structure of neighbourhoods" (p.4). Later investigators repeatedly found similar issues to those of Whyte.

Another well known single explanatory case study, which Yin (1994) referred to was the “*Essence of Decision: Explaining the Cuban Missile Crisis*” by Graham (1971). In this case study three competing theories or models were used to explain the course of events. By comparing each theory with the actual course of events, Graham developed the best explanation of this type of crisis. Yin himself described three different case study strategies; descriptive, exploratory and explanatory. ‘What’ and ‘how many’ or ‘how much’ questions focus descriptive and exploratory case studies while ‘how’ and ‘why’ questions focus explanatory case studies. If I used Yin’s theory of case studies then I believe my research project would be described as an exploratory case study. However Robert Stake (1995) refers to intrinsic, instrumental and collective case studies.

4.2.2 Instrumental case study

The case in this research project concerns one particular collaborative nursing undergraduate clinical education model. If I had chosen to investigate the case in its entirety then Stake, (1995) would refer to this as an intrinsic case study. “We seek greater understanding of the case. We want to appreciate the uniqueness and complexity of the case, its embeddedness and interaction with its contexts” (p 16). But, because I have chosen to focus on ward managers’ perspectives in an attempt to ‘give them a voice’ within the literature I have consciously made the decision not to interview students, faculty lecturers, the organisation (s) senior management and preceptors. Instead I believe my case study fits with Stake’s description of an instrumental case study. Issues are raised to “force attention to complexity and contextuality” (p. 16). Stake (as cited in Denzin and Lincoln, 2000, p. 437), explains instrumental case study further;

I call it instrumental case study if a particular case is examined mainly to provide insight into an issue or to redraw a generalisation. The case is of secondary interest, it plays a supportive role, and it facilitates our understanding of something else. The case still is looked at in depth, its contexts scrutinised, its ordinary activities detailed, but all because this helps the researcher to pursue the external interest.

In this case study, issues such as staff replacement, skill mix, recruitment and retention are the everyday world of a ward manager and it was these issues which originally led me to my research question (s). I wish to reiterate at this point, that it is my understanding that some formative evaluation has taken place by the Tertiary Education Provider in the form of preceptor and student evaluations, but to my knowledge only minimal evaluation has taken place which focuses on how ward managers are dealing with the day-to-day operational and professional issues as a result of this particular model. Stake (cited in Denzin and Lincoln, 2000), refers to a number of instrumental case studies, two of which he refers the reader to are “*Campus Response to a Student Gunman*” (Asmussen & Cresell, 1995/1997) and “*On the Border of Opportunity; Education, Community, and Language at the U.S.-Mexico Line*” (Pugach, 1998). Stake (1995) goes onto say that “a researcher may jointly study a number of cases in order to investigate a phenomenon, population, or general condition”. Stake describes this as a collective case study, that is, “It is instrumental study extended to several cases” (p. 437).

The purpose of the case study is to describe the case in sufficient detail that the reader has a sense of ‘being there’. This is what Stake calls *thick description*. The narration is strong enough for the reader to have that “ah ha” feeling. Stake

(1995) calls this phenomenon '*vicarious experiences*' (p. 63). He believes that a single case is not about making generalisations but instead it can build on previous experience. Stake calls this '*naturalistic generalisation*'. "Naturalistic generalisations are conclusions arrived at through personal engagement in life's affairs or by vicarious experience so well constructed that the person feels as if it happened to themselves" (p. 85). Stake (1995) makes recommendations to the researcher of how to organise the final research report. He suggests the use of vignettes, (briefly described episodes to illustrate an aspect of a case) one at the beginning and one to conclude. The purpose of the study should be identified and extensive narrative descriptions given to define the case and its context, ideas developed, and assertions made. This differs from Yin who believes five essential components of a research design are important; a study's questions, its propositions, if any, units(s) of analysis, its logic linking the data to the propositions, and the criteria for interpreting the findings. I have chosen to use Stake's framework to inform my final report and have included three vignettes in my final document, one at the beginning and two to conclude this research study.

4.2.3 Case study - Examples from New Zealand

Both Yin and Stake refer to case study research both overseas and outside of the field of healthcare. The following two sections describe some examples of case studies applicable to the work of nursing, midwifery and healthcare. Here in New Zealand case study methodology has been used to investigate the New Zealand College of Midwives Standards Review Process by Joan Skinner, (1998). Skinner's research findings are presented in her thesis. Case study methodology was used by Skinner to describe midwifery's review processes in detail and placed midwifery in New Zealand within an historical and political

context. Her research has laid the groundwork for future research projects such as whether midwives using the process find it useful, in particular how it has assisted them in their professional development. Further research may also increase the body of knowledge on the nature of reflective practice and how it is best facilitated.

McKenna and Roberts (1999) who come from a mental health background and are previously discussed in the New Zealand section of my literature review, have demonstrated the positive use of case study methodology. Their published research adds to the growing body of clinical teaching research, in their case, the use of joint appointments to facilitate undergraduate nursing education.

Case study research has also been used to look at the effect of the Employment Relations Act (ERA) by the New Zealand Department of Labour (2003). In this case study, twenty-one healthcare organisations were involved over a three-year period, to investigate the short term impacts of the ERA which was introduced in New Zealand in October 2000. The evaluation investigated the extent to which parties to employment relations are aware of, and were conducting their relationships in accordance with the objectives of the ERA. The evaluation used case studies, survey data, and in-depth interviews to obtain data (Anderson, Waldegrave & Wong, 2003).

4.2.4 Case study - Examples from USA and Canada

In the USA Zucker (2001) describes how the use of case study methodology can be used to uncover the experience and meaning of living with Chronic Heart Disease (CHD) across time in an era of high technology (after 1985). Zucker found that “physiological processes, while central to experience, were only a portion of that experience. This level of analysis assisted in bringing together the

notions of experience and meaning as seen within the context of life” (p. 10). Zucker believes that case study methodology can be used to emphasise the patient’s perceptive which is central to delivering nursing care.

In 2004 Carolyn Pepler a Canadian nurse researcher and Associate Professor, School of Nursing, McGill University, Quebec, presented to a group of nurse educators, the use of multi-site case study research. The research team, led by Pepler, used a case study approach to examine factors related to research utilisation in staff inpatient and outpatient oncology and neurology acute care units. Each ‘case’ was one of a purposeful sample of eight clinical units across four merged acute care hospitals. The research design included interviews, questionnaire and direct observations. The study findings concluded; that where a unit (a case) had the following; (a) strong culture of harmony amongst staff; (b) high motivation to learn; (c) supportive administrators; (d) goal orientated, for example, there was a shared vision and staff were patient focussed; (e) high level of creativity within a unit; (f) staff demonstrated critical inquiry; (g) mutual respect and staff used available resources, understood and used research utilisation in their practice compared to units which ranked low in the above.

I was impressed at the ability of the case study to give me that ‘*ah- ha*’ feeling. As the researcher presented the research findings I felt myself nodding my head in agreement. I got a real sense of what Stake refers to as vicarious experiences. I have been *there*; I have worked in both ward cultures during my nursing career.

This section has highlighted how case study methodology can be used to investigate a wide range of phenomena. Case studies can be used to directly improve patient outcomes, for example in Zucker’s work on men’s experiences of CHD or indirectly by investigating processes and systems which impact on the

delivery of quality patient care as in Pepler's work determining the use of evidence-based practice in the day-to-day work of nurses in the practice setting.

4.3 Project - My process

Case study methodology can use either quantitative or qualitative methods or a combination of both to gather data (mixed-method approach). For my case study I chose to take a qualitative approach by undertaking semi-structured interviews to gather data from my participants. I also used a variety of data sources in an attempt to assist me to establish what Yin (1994) refers to as "construct validity and reliability of a case study" (p. 90). Whereas Stake (2000) refers to a variety of data sources as triangulation, he believes "triangulation has been generally considered a process of using multiple perceptions to clarify meaning, verifying the repeatability of an observation or interpretation" (p. 443). Data have been gathered from within the organisation, for example, position descriptions, programme booklets, skill-mix data, and minutes from meetings to establish the reliability of the case study. The following sections of this chapter outline the research process in more detail.

4.3.1 Design

Two ward managers were selected for the research study. Stake (1995, p. 4) clarifies that a case study is not "sampling research" as the purpose of a case study is to understand a particular case. However for the purposes of this project the final sample was dependent on availability of participants for interview, receiving their written consent, and having evidence that a minimum of two Registered Nurses had been released from their ward roster to undertake undergraduate clinical education roles for the Tertiary Education Provider in the case study. The participants were approached in a confidential manner. Initially participants were

approached individually by phone, by the researcher. Once verbal agreement was obtained, a letter inviting them to participate was sent to their home address in a sealed envelope. The letter inviting them to participate included a consent form, an information sheet, and a return addressed envelope. Once ethics approval (Appendix A) was granted consent was obtained and interviews were held in a place chosen by the participant.

Using an interview guide semi-structured interviews of approximately one to two hours were held. The interview guide reflected the aims of the project and included the following questions; (a) can you tell me from your perspective what are the positive effects of the current model? (b) can you tell me what are the negative effects of the current model? Has having CNEs on your ward helped you to recruit and retain Registered Nurses? (c) what has been the negative aspects for your ward from having senior staff leaving to undertake the CNE role? (d) what are the barriers to releasing staff to undertake the role? The interviews were audio-taped and the tapes transcribed by a Dictaphone typist, (who had previously signed a confidentiality agreement) and myself. The transcribed tapes were given back to the participants within four weeks to review. The reviewing of the transcriptions by participants for confirmation and further illumination are what Stake (1995, p. 115) refers to as “member checking”. This helps to “triangulate the researcher’s observations and interpretations”. A second interview was required with one participant to seek clarification of some data prior to transcribing. No amendments to the transcriptions were required following this process by the participants. The participants also indicated at this point that there were no data which could not be used in the final report.

4.3.2 Data analysis

A thematic analysis of the transcriptions using what Roberts and Taylor (1999) refer to as 'colour coding' followed. Each transcription was 'taken apart' (analysed) initially using different coloured marker pens and focusing on the project aims to guide the analysis. I divided the themes (words/ideas/sections that appeared to be connected) under the following project aims; benefits and challenges; barriers to releasing staff; recruitment and retention; and future possibilities. The issues of recruitment and retention emerged under both benefits and challenges. Once identified in the typed transcripts I cut up all the same coloured pieces of text and pasted them onto five separate large pieces of cardboard. From this point I re-read and re-read through the data and began to make my interpretations of the data. I found it was important to have breaks from the data between each reading, during which I took time to 'reflect' on what the ward managers were saying and not my interpretation of events. This I believe assisted me to address the issue of bias within my project. I had been very 'close' to the issues and ward managers in my previous employment; however at the time of undertaking interviews for this research project I was no longer an employee of the organisation. Finally I merged similar ideas into four main themes, benefits and challenges (recruitment and retention were merged into either of these themes), barriers to releasing staff and future possibilities. I summarised the data from each cardboard onto A4 sized writing paper. The paper and cardboard will be stored for ten years along with all project data before being destroyed

4.3.3 Interpretation of data

Interpretation of the data has been performed following reading and reflecting on the data obtained. Interpretation differs from that of data analysis and involves

working with the data to construct knowledge. The project aims assisted me to focus my research. I have drawn on my experiences in nursing practice, nursing management and clinical education, as well as the literature review, archival records, programme documents and interview data, to draw conclusions and determine my findings. Member checking and discussions with my supervisor have been used to validate data.

The aims of the project have been used to focus the research. They have been used to guide the interview and highlight the key themes that emerged from the data. The study focused on exploration and description, and emphasis was placed on the purpose and aims of the study and not on the formulation of propositions.

4.3.4 Method of recruitment

Permission to undertake my research project within one particular acute care organisation was gained in 2002 from the Chief Executive Officer (CEO). I arranged a meeting with the CEO then followed this up with a confirmation letter. Consultation with the Head of School in the Department of Nursing of the Tertiary Education Provider, and the Director of Nursing, Acute Care Hospital, occurred during 2002 and 2003. A list of CNEs and their respective wards was obtained from the Training and Development Manager of the Acute Care organisation. Ward managers who met the criteria were initially approached by phone. Criteria for choosing the final sample as previously stated in sub-section 4.4.1, were dependent on the availability of a participant for interview, receiving their written consent, and validating evidence that a minimum of two Registered Nurses from their ward/area had attended the compulsory clinical education preparatory programme provided by the Education Provider.

4.3.5 Informed consent

Potential participants were provided with a verbal explanation of the research, its purpose and potential risks. During this time, I explained that they would receive a detailed letter by mail to their home address. This letter outlined the research project, and was accompanied by an information sheet and written consent form. The letter requested them to sign the consent form and return it in an enclosed pre-paid envelope. Participants were given the opportunity to ask questions about the research by phone at any time during the research project by using a 0800 number.

Participants were also informed that they had the right to withdraw from the research at any point. Written consent from the participants and approval given by the local ethics committee was gained prior to commencing the interviews. Approval was sought for the following: (1) collection of data; (2) confidentiality of participants; (3) release of data to the transcriber and thesis supervisor; (4) use of the data for the completion of a thesis in partial completion of a Masters of Arts (Applied degree), Graduate School of Nursing and Midwifery, Victoria University of Wellington; (5) to use the data to inform the development of future clinical education models; (6) to use the data to inform possible future nursing structures, for example the inclusion of clinical nurse educators; (7) to use the data for publication and conference purposes; (8) to use the data to form reports at the conclusion of the research to my funding sponsors, current and past employees. No data are to be released, which relate to the participant's personal and professional identify.

4.3.6 Interviews

Once I received the signed consent forms, I then conducted semi-structured interview(s) with each ward manager. The interviews took place outside their normal place of work. An interview guideline was developed. (Appendix B). The purpose of this was to ensure that the same information was gathered, this approach helps make interviewing different people more “systematic and comprehensive” (Patton, 1987, p. 111). However Patton goes on to identify that a weakness of the interview guide is the potential for important and salient topics to be inadvertently missed. This was overcome by the researcher listening to the audio-tapes after the first interview and clarified during a second interview with the first participant.

No information relating to participants’ geographical locations or professional employment details have been included in my final written documents. Pseudonyms have been used in any written text. Only I hold any references to the participants and the pseudonyms and this information is kept secure at all times. The Dictaphone typist was required to sign a ‘non-disclosure of information statement’.

No person, other than me, and the thesis supervisor, who is bound by both confidentiality obligations by Victoria University of Wellington and their professional code of ethics, was given access to the audio-tapes and /or written data. The data have been stored in a secure filing cabinet in my private home. All data are stored for ten years following completion of the project in a locked filing cabinet. Copies of the transcribed audio-tapes were delivered to participants in sealed envelopes marked ‘confidential and private’. Participants were requested to review the transcriptions.

4.3.7 Ethical considerations

In the course of my research project, attempts have been made to safeguard individual and organisational rights. Privacy, confidentiality and protection of identity have been addressed throughout the research. As I have chosen a case study methodology, I acknowledge that there is a risk of identification of the two organisations involved in the project to the wider nursing community, once my thesis is published. This is due to the size of the New Zealand nursing community and fellow colleagues may identify the location in which my research has been undertaken. To minimise this risk to individuals however, I have used pseudonyms and individuals have been given the opportunity to discuss any concerns with me and my supervisor. The Tertiary Education Provider and Acute Care Hospital have not been mentioned by name nor have any references been made to geographical location.

4.3.8 Ethics approval - perseverance the key

Ethical approval has been a learning experience and is expected and planned for as part of the *Master's* journey, but it has also been a very frustrating, and at times, a demoralising experience. This project was submitted three times to the local ethics committee before ethical approval was eventually granted, despite being approved and supervised through a well respected University based School of Nursing and Midwifery. The committee appeared to take on the role of supervisor and there appeared to be a lack of understanding surrounding qualitative research, in particular the uses of case study as a method. This was demonstrated when feedback was received from the committee in one letter which stated “ the committee seeks clarification as to how an analysis of the results are to be presented as there does not appear to be a control group for comparison”

(July 2003). The process of sending ethics applications, waiting for the committee to convene and await feedback three times, has meant what was initially a manageable project within the academic year, turned out to be a drawn out, costly and demoralising process. Eventually ethics approval was given along with ethics approval from my current employer's ethics committee.

Qualitative research must address issues of congruence and rigour (Roberts & Taylor, 1998). The following section describes to the reader how I have managed these two important facets of qualitative research within a case study method.

4.4 Congruence & Rigour

Congruence is defined by Roberts and Taylor (1998, p. 398) as the “correspondence, agreement, or fit, between foundational ideas and the activity phases of the research”. By choosing to focus on ward managers' perspectives then I believe my case study ‘fits’ well with Stake's description of an instrumental case study. I have demonstrated in my literature review that both nationally and internally there is no ‘one’ undergraduate clinical education model used within nursing therefore *particularisation* must guide the choice of methodology and design. Case study fits well with the design of my research.

Rigour on the other hand as described by Burns and Grove (cited in Roberts and Taylor, p. 173) is “associated with openness, scrupulous adherence to a philosophical perspective, thoroughness in collecting data and consideration of all the data in the subjective theory development phase”. According to Roberts and Taylor (1998), to determine if a research project has addressed the issue of rigour, it must demonstrate credibility, fittingness, auditability, and confirmability.

4.4.1 Credibility

Credibility has been addressed by using the research technique of ‘member checking’ throughout my research project. I have had participants check the interview data for accuracy and to ensure the final document reflects their own experiences as ward managers. Also this research project is part of a formal qualification and therefore there is the requirement for supervision. My supervisor and a ‘second reader’ have critiqued my work. This has assisted me in developing my ideas and has supported me throughout this research journey. This is similar to what Robson (1993) calls ‘peer debriefing’. He suggests that “exposing one’s analysis and conclusions to a colleague or other peer on a continuous basis can assist in the development of both the design and the analysis” (p. 404). Position descriptions and expression of interest flyers have also been verified. This has been carried out mainly by email or telephone. Emails have been placed on file.

4.4.2 Fittingness

Fittingness (Roberts & Taylor, 1998) refers to the extent to which a “project’s findings fit into other contexts outside the study setting” (p. 174). I believe I have described my case study in enough detail, along with narratives from my participants (*thick description*) so that naturalistic generalisations can be made from my study. The aim is that my fellow nursing colleagues, particularly ward managers/charge nurses will have ‘vicarious experiences’ that is, feel a sense of ‘being there’ (Stake, 1995).

4.4.3 Auditability

Auditability is the production of a decision trail, which can be scrutinised by other researchers. My report clearly outlines my methods and the processes that I have used throughout my research journey. For example in Chapter 4 I have

outlined the study design. This chapter and subsequent sections describes not only the study design but also demonstrates the study's ethics approval process.

4.4.4 Confirmability

Confirmability of a project is achieved when credibility, audibility and fittingness can be demonstrated. In order for me to demonstrate confirmability I intend that all the following information is held secure for ten years following the end of the project: raw data, transcriptions; process data, letters, consent forms; data reconstructions and synthesis; process notes, working diagrams, schedules; materials relating to intentions and disposition, original proposals, ethics approval instruments, development information, interview schedule, and draft thesis. The final product in the form of a thesis will be made public.

4.4.5 Summary

Case study as a qualitative research method has been discussed which I believe 'fits' well with my research project. *Particularisation* is the key to case study research. My research process has addressed issues of informed consent, and confidentiality both of which are essential tenets of research. My journey obtaining ethical approval has also been described. This journey highlights some of the pitfalls a novice researcher needs to deal with when seeking ethics approval. By outlining how I have addressed the issues of credibility, fittingness, auditability and confirmability throughout my research I have demonstrated congruence and rigour within my research.

The following chapters present the findings from my research. I begin with discussing the challenges and offering possible solutions, followed by the benefits and future possibilities.

CHAPTER 5

5.1 Study Findings

In presenting and discussing the study findings I have chosen to begin with describing the challenges ward managers deal with on a day-to-day basis. In making the decision to begin with the challenges faced by ward managers rather than the benefits of the model, it was my intention to give nurses, preceptors and ward managers a feeling of 'being there'. Staff replacement, inappropriate skill mix, workload pressures all emerged as the key themes. I believe nurses in practice will be able to identify with these issues given the acute care environment in New Zealand at this time. I conclude the chapter by discussing briefly recruitment and selection processes for CNEs and then discuss the retention of nurses following their time as a CNE. Throughout the chapter I will explore future possibilities, possibilities identified by the participants and myself. I begin with vignettes from each participant describing what they believe clinical teaching within the nursing profession is followed by looking at the replacement of 'senior' staff that are seconded to undertake a CNE role and the effect this has on the wards.

5.1.1 Clinical teaching, participant's perspectives

At the commencement of data collection I asked the participants what they believed clinical teaching to be. The following describes their responses.

Mary described her thoughts as follows:

from my perspective it is the opportunity for the tutor to work with the student, in this case we are talking about students you know side by side if you like, question them on the job look at their rationale for doing things. I guess have discussion with them first hand, with the preceptor get any

feedback that is going on that the preceptor, is seeing things or that student has a problem with, really just supervise them and test their knowledge too I suppose, as they go along in the actual work place so they are looking at the whole, applying theory to practice, and making those links actually on site you know, with where they are actually putting hands on patients.

Anna explained;

It means teaching in the clinical area, it means showing to me, its simply one person showing another person how to carry out clinical care and that person can be someone who is trained or it can be someone who just has the knowledge and who has worked in the area and is mentoring or preceptoring somebody in an area to an area that they are not familiar with so yeah, its teaching in the clinical area.

The participants' opinions differed with one ward manager focusing on the demonstration of skills, mentoring or preceptoring, whilst the other believed clinical teaching to involve assessing student's knowledge, giving feedback and assisting student to integrate theory to practice. For a quality learning environment to occur for undergraduate students, I believe it is critical ward managers are familiar with what the philosophy of the Tertiary Education Provider and their expectations of students, preceptors and CNEs in the clinical learning environment. In the collaborative model in the study a CNE will spend two weeks prior to commencing in their role as CNE being inducted into the culture, curriculum, philosophy and assessment processes of the Tertiary Education Provider but ward managers who are responsible for providing the learning environment are not given to the same level of information.

5.2. Challenges of the current model, the participants perspectives

5.2.1 CNE and preceptor replacement

During the interviews ward managers described how 'senior' staff may be seconded from their 'home' ward for anything from six weeks to fourteen weeks (inclusive of the two week preparatory course) to teach in the undergraduate programme. This excludes any annual leave, study leave or sick leave taken by the CNE over a twelve month period. As previously discussed this means, in 'real' terms the Registered Nurses are off ward rosters for even greater periods of time.

The preparatory course is held annually in two separate week blocks, one week in December and followed by another week in January. Depending on skill mix and ward full-time equivalents (FTEs) these dates may impact on a ward manager's ability to release staff who wish to take annual leave during December and January. Historically within the health industry, this is when staff is encouraged to take annual leave. Ward managers who have staff that have been successful in their application for a Clinical Nurse Educator position, will be aware of these dates and can take the necessary steps to ensure their wards are safely covered during the times. However potentially ward managers may have to deal with competing service and education needs which add to their workload pressures. On one hand they may have to release a nurse (s) who wishes to undertake a CNE role and on the other hand they will have staff who have pre-booked annual leave over the Christmas-New Year period. An example when this conflict may occur is if a ward manager receives a staff member's resignation during December and January. Registered Nurses are required to only give two weeks notice under the current Collective Employment Agreement (CEA). Ward

managers are then put into the situation of having to decide one of the following;

a) ask another staff member to cover, b) request replacement from casual pool knowing that the likelihood of obtaining the same skill-mix is low, c) overturn staff member's approval for annual leave, d) overturn approval for staff member's attendance at the preparatory course.

The lead in time for the four week placements does not appear to be an issue. Ward managers liaise directly with the Student Placement Coordinator and have the ability to negotiate with the Student Placement Coordinator when their staff are seconded to undertake a four week block. This allows the ward manager to manage the amount of annual leave approved in advance. The Student Placement Coordinator is based on site and is easily accessible to ward managers either in person, by telephone and email.

In 2003, due to insufficient numbers of CNEs, it appears that an additional two week preparatory course was held mid year, over the winter months (July/August). This appears to have resulted in pressure being placed on ward managers to release staff at very short notice at the busiest time of the year. Staff who had already had their shifts allocated, and confirmed on ward rosters had to be released in order for the organisation to meet its contractual obligation with the Tertiary Education Provider. Under the organisation's Collective Employment Agreement (CEA), ward managers are obliged to display new rosters two weeks prior to the commencement of the following roster. One participant [Mary] had the additional pressure of replacing a nurse who regularly works night shift.

challenging to have to try and replace those people with only two weeks notice that kinda thing is the worst bit.

Participants demonstrated their commitment to nursing by spending hours ensuring CNEs and preceptors are released to support students therefore providing a quality learning environment for students. Re-working rosters on a week by week, day-to-day, hour-by-hour basis appears to be a very time consuming part of their role. CNEs, students, and preceptors are only one part of the incredible time consuming job of roster ‘juggling’. Ward managers spend hours negotiating with staff. This supports what Sullivan, Bretschneider and McCausland (2003) found during their qualitative research project in the US when they looked at designing and developing a leadership programme for nurse managers. Getting staff to work was one of the most challenging aspects of the nurse manager’s role. The participants in their study described making a ‘phone call begging...’ and discussed being ‘mired in staffing’ (p. 546).

Mary commented;

I never roster people onto night shift, at too short of notice. I mean, I think, I can jiggle around mornings and afternoons if you ask them nicely but most people get a bit towy if you have to put them onto night duty at short notice. I just, you know, you redo, rehash the roster.

At times when a preceptor rings in sick ward managers again have to ‘juggle’ the roster. Mary described this situation as shifts that just ‘go to custard’.

the other thing is that too, all the best laid plans can fall apart at the last minute.

On these occasions the only person who can preceptor a student maybe the senior nurse of the shift. To assist the reader identity with what is considered to be the role of a senior Registered Nurse within the acute care’s organisation, the following is taken from documents used in the recruitment of CNEs and from the

organisations Clinical Career Pathway documentation (CCP). The expression of interest flyer sent out by Training and Development, went out to staff and states “minimum of Level 3 CCP and this senior nurse enjoys teaching and supporting staff and ideally has some adult teaching experience or qualification” (2003).

Under the CCP in 2003, a Level 3 Registered Nurse was considered competent when he/she can demonstrate the following;

A nurse/midwife who consistently provides holistic care using up to date knowledge and relevant evidence based practice;

Demonstrates competence in the clinical skills relevant to that area and competently manages routine and emergency care;

Accepting additional responsibility and leadership within the team;

Independently provides care for clients with increasingly complex needs;

Able to prioritise workload and client needs appropriately;

Develops specialist knowledge and demonstrates the relationships between therapeutic actions and client responses;

Demonstrates flexibility and adaptability in responses to unpredictable situations;

Shares knowledge with colleagues and acts as a role model/preceptor.

(Clinical Career Pathway Resource Book, 2003, Version 2, p. 17)

What contributes to a senior nurse’s workload while preceptoring is that the care delivery model currently used in the hospital is team nursing. Senior nurses are often the team leader and are allocated the most acute patients in the ward because they have the skills, knowledge and experience to care for high acuity patients. This puts additional stress on both the student and the preceptor. Mary

made the following comments regarding the pressures her few senior staff are under;

they are senior nurses, we generally allocate extra responsibilities to them, things like being the team leader, coordination of the incoming admissions for the ward and those kind of duties on top of their five or six patient group.

Mary went on to comment on one particular shift, which highlights the additional pressures senior staff are under when preceptoring undergraduate students;

the poor girl she was absolutely worn out running backwards and forward to the phone and trying to work with the student.

The impact on the ward manager's ability to release staff is greater if the 'senior' nurse works 0.8-1.0 FTE. Staff can be left feeling unsupported when the CNE is off the ward. The other participant Anna, described her observations of the phenomenon;

taking them (senior nurses) out of the clinical area it leaves their colleagues who are less experienced to struggle on without them, and creates a difficult environment for them to go back to.

Another challenge identified by ward managers was ensuring there are sufficient numbers of preceptors on the ward. Not only are ward managers trying to find replacements for CNEs, but they also need to ensure the ward has a number of trained preceptors, not only for undergraduate students but also new graduates. Their ability to safely cover the ward while both CNEs and preceptors are off the ward adds yet more work onto an already pressured ward manager's workload. There are no guarantees about who will replace either the CNE or preceptor.

Mary explained;

it would be who's available on the day and could be an EN (Enrolled Nurse).

Having to find replacements, especially when they may be rostered to do their 'stint' on night shift, can be a very time consuming job. At present ward managers can pre-book their part-time staff in advance but not casual staff. Asking staff who have chosen to work part-time to always 'pick up' extra shifts in itself can have a flow on effect such as staff taking sick leave on their normal rostered shift. Not being able to 'book' preceptor and CNE replacements in advance, contributes significantly to the week-by-week, day-by-day, shift-by-shift constant juggling of ward rosters. Both ward managers described their frustration regarding the inability to pre-book casual staff especially staff with a similar skill set to fill the void when their senior nurse (s) were off ward rosters undertaking the CNE role. Mary stated;

we are not allowed to pre book from the casual pool.

while Anna comments;

I don't think the staff really understood that the impact of this person being away, it was me who felt it and me who felt the stress and me who worried about having a really inexperienced person there who was replacing someone whom I know had experience.

The data clearly demonstrate a ward manager's frustration in not being able to pre-book staff to cover both CNEs and preceptors when they are off their ward either preparing for their roles, or when CNEs are off their 'home' wards undertaking the CNE role. One strategy the organisation could consider to minimise the additional workload on ward managers is to allow the pre-booking of staff from casual pool in advance, especially senior staff to cover CNEs. This

practice is discouraged under employment law although pre-booking of casual staff in advance in today's health care environment is custom and practice.

Mary viewed the ability to pre-book as;

that would be really positive, really great and it would be a benefit because I would know who as going to come and know that they were the right skill mix.....I didn't have to beg, borrow or steal staff from somewhere else if things got a bit tight.

Pre-booking of staff from a casual pool of staff would assist ward managers to decrease the hours spent looking for staff on a week-by-week, day-to-day, shift-by-shift basis and reduce the amount of 'crisis' management thus reducing their workload and stress. It would give ward managers the ability to ensure appropriate skill-mix and staff and students are supported. The ability to pre-book casual staff for the planned study leave associated with the model and when the CNE is off their 'home' ward when seconded to the CNE role would be a significant benefit.

Limiting the number of Registered Nurses seconded at any one time from an area for each four week block is another future possibility proposed by one participant. This would reduce the pressure on ward managers to find replacement staff, in particular competent (Level 3) nurses. The fact that a senior Registered Nurse is off a ward roster for four weeks is only part of the issue. Participants explained that CNEs still accumulate annual leave during the secondment and for one ward manager this became significant when her Registered Nurse undertook a CNE role. This time away from their 'home' ward includes time away to attend the two week preparatory course.

Anna explained;

because the nurse worked shift-work they were entitled to considerable annual leave so in a sense I didn't have the nurse available for my roster for in excess of three months of the year and that had a big impact.

Staff replacement also becomes an issue when wards are understaffed: under their budgeted FTEs. At the time of the interviews both ward managers were near their maximum budgeted FTEs. However both participants had experienced the impact that reduced FTEs and inadequate skill mix levels can have on their ability as ward managers to support the current undergraduate clinical teaching model. Mary shared her previous experiences during times of reduced FTEs and inadequate skill mix;

I mean if you're five FTE's down and you just haven't got those people, well its a disaster.

Staff replacement is a significant issue for ward managers, and what FTE a preceptor works also appears to have an effect on the number of preceptors a student may have during their clinical placement. When a preceptor works less FTEs than a student, for example a preceptor may work 0.6 FTE while the student may work 0.8-1.0 FTE, then this also contributes to the 'rostering nightmares' that ward managers have to deal with on a day-to-day basis.

Mary explained;

so you have got problems rotating through nights, having leave, having study days, having low FTE's, so you end up with (the student) ends up with sometimes multiple preceptors.

Anna confirmed this;

I have just had one, (a student) she,(the student) has had three people.

Traditionally nurses in hospitals work rostered and rotating shifts, therefore a student's preceptor may not only work part-time but may also be required to be rostered onto night shift for two to three nights during a student's clinical placement. Ward managers then have the dilemma of deciding whether to roster a student onto night shift with their preceptor for two or three nights and roster the student to remain on night shift with another preceptor or buddy, or bring them back on to mornings or afternoons with another preceptor or buddy. What this study begins to highlight is that in practice the ideal world of a student having the same preceptor or even buddy during their clinical placement is not a reality. This may compromise the quality of the clinical experience for students.

Recommendation 7.19 of the KPMG Consulting (2001) report states "Nursing Council standards be revised to promote quality rather than variety of placements (p 83). However I recommend consideration be given to include 'consistency of clinical educators/preceptors' as one of the performance indicators, to measure if an organisation provides quality clinical placements.

Due to fluctuating FTEs and skill mix in the nursing workforce today, the ward managers are only too aware of the potential risk to patient safety and the health and safety of their inexperienced staff when 'senior' nurses are taken off ward rosters without the ability to replace them with staff that has similar skill sets. The nurses when providing preceptorship for students, including elective students, are required to take a full patient workload despite the added responsibility of students and undertaking team leader roles. However despite there being no formal FTE budget for supernumerary time or reduced patient workload, ward managers appear to informally manage these issues the best way they can within their budgeted FTE.

Mary commented;

I am really careful not to load them up (preceptors) because it actually takes longer to have a student everything takes longer when you are working with a student everything is slower.

The findings in my case study begin to reflect the findings of the 2004 New Graduate First Year of Clinical Practice Nursing Programme Evaluation Report by the Clinical Training Agency to the Ministry of Health (Ministry of Health 2004). While the report refers to New Graduates, it does evaluate preceptorship as a model of delivering clinical teaching. A key finding of the report states “over a quarter of preceptor respondents stated that their clinical workload had not allowed any time for preceptorship” (p. 4). The sample study group consisted of 162 preceptors, however the response rate from the preceptors at the beginning of the programme was 48% compared to only 30% at the end of the programme. The preceptors commented that the main factor affecting the delivery of preceptorship was the underlying tension between the needs of the service and the support needs of the new graduates. I suggest that similar findings would emerge if undergraduate students, preceptors and CNEs were asked the same questions. The report goes on to say about the tension and the preceptor’s inability to perform their role;

new graduates and preceptors were often not rostered together, even if they were working the same shift, workload pressure might limit the amount of support the preceptors could provide, there was little opportunity for off-ward teaching and reflection sessions (2004, p. x).

Preceptors talked about “support and guidance” (p. x) and 49% of participants believed it was important for new graduates to have one designated preceptor: a

preceptor who was available and who they trusted and who they felt they could approach for support when required. I believe there are the same issues for undergraduate students, too, although students learning within the model presented in this case study have an added advantage of having not only the support of a preceptor, but also an on site, easily accessible, educationally focused qualified, clinically competent practitioner who can be accessed within minutes to support students, preceptors and ward managers.

Despite the pressures on preceptors, some nurses go on and apply for CNEs positions. The following section discusses issues raised by ward managers and looks at the different experiences both ward managers have had regarding the retention of their senior nurses once the CNEs return to the ward following their secondment.

5.2.2 CNE recruitment and selection

Ward managers raised some concerns surrounding the selection process for CNEs. There is the potential for one area to have a number of CNEs and the employment process is managed by the Training and Development department. On the 'Expression of Interest' flyer, potential CNEs are encouraged to check with their managers if they are "prepared to release you for the training and the time throughout the year" (June, 2003). However, this discussion appears to be just that, an initial discussion around what the Registered Nurse would like to do and whether a ward manager would be prepared to release the nurse from their ward roster. This support, as the study participants highlighted, can never be given with any degree of certainty due to the changing nature of the ward and hospital environment. However ward managers are not involved in the recruitment and selection process. A ward manager may support a staff member in

principle to apply for a CNE position but it is the Registered Nurse who makes the initial approach to the ward manager. Purely from a ward manager's perspective, if ward managers were involved in the selection process, for example if there was a requirement that Registered Nurses applying for CNE positions had to provide their ward manager as one of their verbal referees, then this may give managers the opportunity to minimise the risk of potential staffing issues arising at a later stage. It appears that to meet the organisation's contractual obligations there is an expectation from the Training and Development Department that ward managers have to release their staff member should they be successful in their application as a CNE. From my perspective working in the model there appeared to be a culture of 'fait-accompli' - an expectation that they would just be released. Ward managers by the mere fact of their position are aware of the work history of their staff, and privy to information that other staff may or may not be aware of.

Mary explained;

They assume that because they get to the interview stage that I support their application. I don't know if referee checking is part of the process.

Anna highlighted the issue of not being consulted despite the possible implications of taking a senior nurse off *her* ward;

Staff self-select, however they do come to me and tell me when they have been successful. They have the dates in the year that they are going to be required to be away from the ward and off the roster and I have been quite lucky but I must say I sort of wiped my brow and hoped that there weren't four people who wanted to go off to be CNEs.

A CNE is expected to deliver the Tertiary Educational Provider's course but it is the Health Provider who conducts the selection process. Ward managers are

expected to operationalise the current model of undergraduate clinical education but they are not involved in the selection process.

5.2.3 CNE retention following secondment - Mary's experiences

The interview data demonstrate different perspectives on retention of nurses who have been CNEs. Mary described her staff who put their hand up to become CNEs as keen learners and teachers, and nurses who participated actively in professional development activities for both themselves and others;

they are already interested in teaching and learning and being involved they are probably already one of your preceptors, they are already a senior person who has made the effort to get on the progression of the CCP, the ones always enthusiastic nurses, want to further develop themselves, wanting to do things well, set high standards of themselves.

The CNEs who work in Mary's ward/unit have undertaken a variety of roles. For the purposes of maintaining confidentiality, and as the research project uses a case-study methodology, the nature of the roles and responsibilities of staff are not able to be clearly identified. As there is currently no educationally-focused position, or part of a position for example associate charge nurse or clinical nurse specialist, within the wards. In Mary's ward when CNEs returned following their secondment, the majority of CNEs have sought other employment opportunities outside of the ward. Mary felt that these nurses were the nurses who were self motivated and self directed and believed that despite the risk that she may lose them from the ward, she believed in supporting them in their professional career as this also supported the nursing profession.

Despite no formal ward-based-education focused role within the ward, both ward managers attempt to utilise their staff's CNE's skills and knowledge in other

ways. Examples Mary described were such things as assisting with the development and introduction of new policies and procedures, assisting in the development of clinical caremaps and clinical protocols, giving presentations to New Graduates as part of the organisation's New Graduate programme, and participating in quality and risk management programmes. But as Mary pointed out;

this is over and above their normal shifts...study etc. There is only so much time in the day so much you can ask of them when they already carry high patient workloads and they are often the most senior on shift.

A nurse who has a passion for teaching which may have been demonstrated by their commitment to a preceptorship and CNE role, does not under the current nursing structure, have a formal clinical education career pathway. In the original agreement with the first Health Provider prior to 2000 the issue of developing a clear clinical education career pathway was clearly intended. Goal five states “ a new clinical pathway for experienced staff within the organisation” (p. 3).

Participants believed the introduction of a ward-based position which supported professional education could be beneficial. They saw this position being responsible for both undergraduate and post-graduate clinical teaching. This would give ward managers more certainty around leave and skill mix, help drive best practice and raise professional standards within the ward. It would also give nurses a career pathway which acknowledged and valued clinical education.

Mary's experiences regarding retention were different from Anna's.

5.2.4 CNE retention following secondment - Anna's experiences

Anna's experiences differed from Mary's and she described how one of her CNEs decided, after performing in undergraduate clinical teaching role, that this

was not where they wanted to be. From discussions with the nurse, Anna's observations were that the nurse struggled with the students' "lack of understanding of what was actually going on" and their "lack of putting themselves forward to learn". At times the frustration was that "students actually had no idea" and therefore "had no idea what to really ask....you had to drag everything out of them and had to inspire them". Anna believed the nurse found this quite frustrating.

Anna commented;

I think we retained the nurse because they tried it (CNE role) and didn't like it.

However this nurse who was enthusiastic and committed to ongoing education has continued to teach undergraduate and postgraduate students and post-registration nurses in the preceptor role.

The current lack of recognition of the importance of day-to-day ward-based education has the potential to impact on the retention of nurses at ward level. Nurses, despite the requirements of the organisation's CCP, do not have the capacity within the current nursing model to be allocated supernumerary time or a reduced workload to teach either undergraduates or post-graduate students. The exception is in some of the speciality areas such as theatre, ICU/CCU. Registered Nurses in these roles focus on developing and maintaining postgraduate nursing orientation programmes to their respective speciality areas and may teach in clinically focused post-graduate certificate and graduate diploma courses which are run in conjunction with educational providers other than the educational provider presented in this case study.

When ward managers were asked if any undergraduate students applied for positions following graduation the answer was 'yes'. Students, who had spent

time in their electives (clinical placements in their final year) just prior to registration, had applied for positions post-registration. The data gathered from this small case study have demonstrated that having students can be a successful recruitment strategy, but case study methodology clearly articulates that the research can not be generalisable or replicated. Ward managers reading this project may have experienced similar success stories and therefore make what Stake (1995, p. 85) refers to as “naturalistic generalisation”.

Undergraduate nursing clinical education may have a direct link to recruitment but the challenge is then to keep the graduate in the workforce. I acknowledge that ongoing education is not the only factor which may enhance retention. Remuneration and working conditions also play a major part in both the recruitment and retention of nurses.

Nurses who have experienced what a supernumerary role can achieve when teaching undergraduates may become disillusioned when they return to the ward situation where teaching is not formally recognised or valued as part of the Registered Nurse’s role. Registered Nurses are required to support new graduates, develop post graduate nurses in speciality practice, orientate new staff, supervise unqualified staff , preceptor undergraduate students as well as provide quality nursing care to a group of five-six patients. They then can also be asked to undertake ward co-ordination and team leader roles. Anecdotal evidence suggests Registered Nurses can be put under extreme pressure. Nurses, like all health professionals, are not only accountable to their legislative body (Nursing Council of New Zealand) but also to the legislative requirements such as Health and Disability Commissioner Act, 1994 and the Health Practitioner Competency Act, 2003.

In today's ever changing acute care environment, this type of supernumerary role (CNE) is extremely valuable and any changes to this role and its relationship with the preceptorship model would need to be carefully considered. This position is a critical component of the collaborative model in this case study. If one part of the model was to change, then it would have a domino effect and the flow on effects would need to be taken into consideration and alternatives carefully considered.

The data have highlighted that the current model does place significant pressures on ward managers. Pressures such as; the ability to maintain safe staffing levels, a healthy workforce, and therefore provision of a quality clinical learning environment for students within their wards/departments. The current acute care environment means students can be exposed to multiple preceptors. Giving ward managers the ability to pre-book staff from casual pool to cover some of the CNEs' study time and secondment period, along with preceptors' study time, has been suggested as one way to reduce the day-to-day 'crisis' management that appears to occur. The data alludes to the difficulty some ward managers have in retaining staff that have a passion for clinical education and clinical teaching. Both participants believed an educationally-focused ward-based position would be of benefit to themselves, students, preceptors and their staff. However what the current model does have is the ability to provide one person (CNE) who offers students, preceptors and ward manager's consistent support and who is not directly responsible for patient care, but who is responsible for and focused on student learning.

CHAPTER 6

6.1 Benefits of the current model, the participants perspectives

While the current model provides a number of challenges for both ward managers and students it also has a number of benefits. I have named the collaborative model in my case study as the '*three-pronged approach*'. Clinical nursing education consists of the student, the preceptor and a CNE. Indirectly the student is also supported by the Student Placement Co-ordinator and the Tertiary Education's Course Coordinator. From a ward manager's perspective the most significant impact of this model is the immediate support the CNE can provide to students in times of uncertainty, such times include when a student's allocated preceptor maybe away from the ward due to sick leave, bereavement leave, study leave, or because of staff shortages. For nurses working with the model or a similar model, I hope this chapter continues to give them a sense of 'being there', and for students and nurses who are working under different models, I believe they will recognise the benefits of this model.

6.1.1 CNE provides consistent support to student

Participants acknowledged that their only experience with undergraduate nursing clinical education had been their own personal experiences as students and from working with the current model in this case study. An unexpected theme to emerge from the interviews was that the CNE is the one 'constant' support person who provides support not only to students amongst the day-to-day chaos of a busy acute ward/area, but also to ward managers. As discussed in sub-section 5.2.3 ward managers do not have a second-in-charge position to support them in the day-to-day running of the ward, nor do they have an educator position or nurse specialist position either within their ward or attached to a specialty area with the

exception of theatre and ICU/CCU. This lack of clinically focused support has been addressed to some extent over the past two years with the introduction of a Clinical Educator (CE) role. This position's direct line manager is the hospital's operational manager, but is expected to collaborate with the organisation's professional nursing team and training and development department. This position covers all of the hospital excluding ICU/CCU and Theatre. The position facilitates and coordinates clinically focused in-house, nursing education programmes, for example, CPR updates for ward/area based CPR instructors, introduction of new protocols and equipment, intravenous therapy updates, venesection, and cannulation workshops.

CNEs on the other hand take on a trouble-shooting role and provide support on a shift-by-shift basis both directly and indirectly to students and staff.

Mary explained how the CNE role provided support to her on a day-to-day basis;

for instance if I am having a day off and I delegate someone else to, you know oversee the ward and this happened recently, the student had been allocated to a nurse and I think the nurse was off sick so the preceptor was off- the student felt she wanted to have continuity of looking after the same group of patients so she stayed with that group of patients but she was given , the nurse who was then looking after those patients, who was supposed to be preceptoring her, was completely, really inappropriate, really just not the best person.

In these situations Mary has the following expectation;

I would hope that the CNE would come in, assess the situation and do something about that, and be able, you know, have a look, weigh it up and think this isn't going to work very well and make decisions to change it.

CNEs will also work one-on-one with students teaching specific skills and assisting students to meet their set learning outcomes. CNEs also facilitate reflective practice sessions and undertake student assessments. A key area which is perhaps not recognised by either the Tertiary Education Provider or the Health Provider is the support the CNEs give to preceptors and ward managers. The CNE can alleviate some of the pressure on preceptors, especially during times when the workload is high due to a high turnover of patients or during times of inadequate staffing, inappropriate skill mix, and reduced FTEs.

One ward manager highlighted this when she commented;

their (preceptor) primary responsibility is those five patients and the student is kinda shouldn't be but is sort of kinda accessory to that really.

In situations where the preceptor is focused on direct patient care then the CNE can move in and utilise a 'teachable moment' as well as provide the student and preceptor with support. CNEs provide stability to students and preceptors in the acute care environment and in doing so are able to provide a more accurate assessment of a student.

6.1.2 CNE is focused on student learning

CNEs are consistently in the hospital environment and are aware of occupancy rates, staffing issues, especially skill mix issues, and patient acuity levels on a day-by-day, shift-by-shift basis. Subsequently they are aware of workload pressures the preceptors maybe under. As CNEs are supernumerary and cover a number of wards, they have the ability to assess and prioritise their own workload and can spend more time with one or more students if required. If the ward environment is not conducive to learning, and the CNE feels it is necessary to remove a student(s) from an area for a short period of time then the CNE has

the skills and knowledge of the undergraduate programme to utilise this time to facilitate course work by holding a tutorial or reflective practice session.

Alternatively CNEs can move into a ward and work one-on-one with students.

Situations where this maybe necessary are when a student's preceptor is not on shift and there is no one suitable to fulfil the preceptor role, or when a ward is short staffed and the preceptor is the most senior nurse on the shift and is unable to support the student.

Mary described a situation where she would contact the CNE;

the one person who is consistent who can offer student backup you know I might ring the CNE and say "look today can you come to the ward this afternoon her preceptor has gone off sick" and "the level 3 nurse is a casual nurse you're going to need to be here to back up the student and back up the person who's supposed to be preceptoring who's from the casual pool and who doesn't know her.

However during 'stressful' times preceptors can be role models for the students. They role model and demonstrate time management and prioritising skills. The CNE role in the case study is responsible for student learning therefore it is their responsibility to assess a ward environment and then make a professional judgement about whether a situation is conducive to learning or exposes a student to risk. When a CNE makes a professional judgement that a ward environment on a particular shift is not conducive to learning, then their priority is to the student, and this is one of the most significant benefits of this model.

The preceptor is not given a reduced workload whilst preceptoring a student, but at ward level, ward managers are aware that preceptoring a student, just like a new graduate or new staff member, does put extra time pressures on staff. Despite

no supernumerary time built into ward budgets, ward managers try to reduce the workload of preceptors. This is not always possible, especially if a preceptor is the most senior nurse on the shift, or if they are the only permanent ward staff other than the most senior nurse on shift.

Mary was only too aware of the pressures her senior nurses are under;

I did it one day and it was a classic case, one of my poor senior nurses I had her working with a student and being the admissions coordinator and being the team leader and you know she worked really hard all day and then told me at the end of the day that she thought that maybe next time it would be better not to do that.

Under the current model, CNEs are experienced nurses who enjoy teaching and are familiar with students' learning outcomes, are student focused and therefore have the ability due to their supernumerary status to facilitate student learning.

6.1.3. Supernumerary status of CNEs

In the collaborative model having nurses from practice, who are familiar with organisational culture, the organisation's established policies and procedures, who have established working relationships and who are based on site and supernumerary, must be a real 'plus' for the students. Supernumerary status for the CNE is stipulated in the formal agreement between the Tertiary Education and Health Providers. Not only is this role of benefit to the student but also to ward managers, preceptors and subsequently patients and the organisation in general. As discussed in the literature review, in some models faculty lecturers who teach in both classroom and clinical practice settings may only spend two-three days each semester with students as there is an increasing pressure on tertiary education nursing lecturers to undertake further education and research.

Given the current workforce issues will continue for some time yet, the retention of the CNE position or a similar position needs to be given careful consideration. It has been identified that the ability of the organisation to recruit and retain CNEs is not guaranteed and further evaluation of the issues surrounding recruitment and retention of CNEs will require further investigation. The fact that this position is supernumerary to ward rosters is critical to the success of the model. An issue which needs to be raised is that possibly faculty lecturers may not have worked in or taught in the practice setting for a number of years in this acute care hospital. The Tertiary Education Provider's clinical placement purchasing budget (monies) will have been allocated to paying the health provider. If the organisation in the case study was unable to meet its contractual requirements and unable to supply CNEs, then both organisations would need to carefully look at other options. It would be essential to acknowledge the critical role this position plays within the hospital.

6.1.4 Easy accessibility of the CNE to the student and preceptor

This ability, of the CNE to be '*Johnny on the spot*' appears to have a significant benefit to the students, unlike other models where a faculty lecturer may be working between different sites. On the other hand one could say that a CNE could be drawn into role conflict by being primarily employed by the healthcare provider. This role conflict is minimised due to the students clinical experience being held over a four-week block, which allows time for the Registered Nurse to change his/her focus from being patient-focused to student-focused. In some other models students can be placed into clinical areas for one, two and even three days a week over a period of time. This on-again, off-again role between Registered Nurse with a group of patients, and then switching to

CNE with a group of students has the potential to lead to role confusion. During the clinical placement in this case study, CNEs are “seconded” to the Tertiary Education Provider, and are not in a purely employer-employee relationship with the Tertiary Education Provider. Yet in true collaboration if a CNE became aware of an unsafe situation either for patients or staff, whilst in the CNE role, then they would have a professional responsibility to take all practical steps to intervene. The CNE is also familiar with the environment and is able to take the necessary action(s) and can communicate any concerns. The interview data highlight the working relationship that this role has with ward managers.

Mary’s comments about a recent situation;

they (CNEs) will certainly come and express concerns to me. I mean I got I certainly got feedback about that situation and we addressed.....

Ensuring the student is exposed to appropriate learning opportunities and a learning environment conducive to meeting their learning outcomes is a challenge for any clinical educator, especially a novice CNE. On one hand they are an employee of the Health Provider and subject to the organisations policies and procedures, and on the other they are expected to advocate for the student whilst in the role of CNE. This surely must bring about ethical, professional and operational tensions from time to time. CNEs require guidance and support to appropriately deal with issues as they arise. The formal contract between the two organisations clearly states “discipline and control of the students and institute staff is the responsibility of the Institute” (Tertiary Education Provider in the case study) (p 10). From an operational perspective there is no full-time faculty person on site who has an educational focus and is familiar with the curriculum and sector processes. Although CNEs can contact the Tertiary Education Provider’s

year Coordinator for advice and support by telephone or email, the communication channels currently in place mean in reality the CNEs would discuss any issues with the Training and Development Manager and or Student Placement Co-ordinator. This area has the potential for further initiatives, for example the development of a joint appointment model.

6.1.5 Informal and formal feedback from the CNEs

Another indirect support that the CNEs give ward managers is that of feedback. Feedback is not only on how the student and preceptor are managing, but also on how the shift went overall. The majority of feedback is informal, and is not necessarily a visible part of the role.

Mary commented;

It's just all informal really; there isn't a formal process, checking in or feedback with ward managers, no timetabled structured process.

When things aren't going well, the CNE advocates for the student. The ward manager, the student, or the preceptor, can notify the CNE by pager and the CNE is on site and can 'be there' in a matter of minutes. However, Mary believed the practice of preceptors paging CNEs directly was not common practice. Mary gave an example of a situation that was unsatisfactory but was dealt with by an 'astute ward nurse'. Mary explained;

so I mean, it was potentially it was a problem, this other Registered Nurse just moved in and took her under her wing and must have sorted it all out and the CNE input at that point, she must have come in at a later stage on her routine call and found it. She saw what had happened and was satisfied with the solution.

The easy access of the CNE to ward managers and vice versa may create an environment where either the feedback role of the CNE position is not formally recognised or issues surrounding role conflict may not be identified and addressed. The model may benefit from the introduction of a more structured process of feedback which complements informal feedback and provides formal feedback. Novice CNEs may struggle from time to time about who they are advocating for - the student, the preceptor, the organisation, the patient? Formal feedback sessions may assist both organisations to mentor novice CNEs, as well as to provide consistency of solutions across the acute care hospital and greater organisation. Participation in the development of student and preceptor evaluation tools may also be of value to ward managers. Feedback specific to the quality of learning environment that a ward provides, may be useful to ward managers. Information on workload, care delivery model (team nursing), and staff support may provide insights on ways to improve learning environments for students.

Ward managers and CNEs are familiar with the ward environment and staff and will often communicate on an informal basis raising issues and problem solving together to ensure the student has the best possible learning experiences and learning environment. The CNE model in this case study does have an advantage over some other models. The CNE is often well known to ward managers and is familiar with the culture of a particular ward/area/department, hospital and organisation. This relationship assists with feedback between the students, ward staff, CNEs, Ward Managers, Student Placement Coordinator and the Tertiary Education Provider. Ward managers were unable to clearly recall being involved in any formal or informal feedback processes with the Tertiary Education Provider. Personally, I do recall a representative of the Tertiary

Education Provider visiting the hospital and obtaining feedback from ward managers on one occasion. The ward managers do receive feedback from some CNEs following a particular shift if there has been a 'significant issue'. One possibility could be a forum where ward managers and CNEs could come together perhaps at the end of each four-week block. This forum could be currently facilitated by the Student Placement Coordinator. Any issues could be raised and action plans developed in a collaborative manner to ensure issues are addressed proactively. This may ensure all issues are being addressed in a fair and consistent manner throughout the organisation/hospital/wards. The organisation's staff, whilst working in the CNE role, liaises with the Student Placement Coordinator and the Student Placement Coordinator liaises with the Tertiary Education Provider (s). Ward Managers deal mainly with the Student Placement Coordinator. It is the Student Placement Coordinator who liaises directly with the Tertiary Education Provider. This position as it stands does not have an educational focus but purely a coordination role. It would seem the Student Placement Coordinator, who is based in the acute care hospital, is a vital link between the Tertiary Education Provider and the Health Provider in this case study. This position is funded by the Health Provider not the Tertiary Education Provider and may therefore view issues from the health provider perspective rather than an education perspective.

Mary commented;

If I wanted to give any feedback I would do so through the student placement coordinator.

The formal agreement between both organisations requires students to complete evaluation forms at the end of each placement, but ward managers are not

involved in the development of these. Ward managers are given a copy of the evaluations but the data collected may or may not be valuable from a ward manager's perspective. It is essential from a quality feedback perspective that ward managers are given formal feedback on their ward's ability to provide an effective learning environment; and that they have an opportunity to take the necessary steps to ensure students are provided with a safe learning environment; and that preceptors are able to perform their role and responsibilities as both clinician and teacher on a day-to-day basis. Participating in the development of future questionnaires about the students learning environment would benefit both organisations.

At times this invisible but vital part of the CNE role, feedback, is an area from which both organisations may benefit by further developing and refining feedback loops in future programmes. Clear expectations as well as effective communication are also important. Ward managers were also unclear about the roles and responsibility of the CNE position. Linking in ward managers to current and future position descriptions may ensure that there are valuable working relationships between students, preceptors, ward staff and CNEs. Good working relationships will enhance the students' learning environment. An example of the need for ward managers to be aware of the CNE roles and responsibility was when one participant was unsure if a CNE had the mandate to change preceptors during the course of a shift. It was the participant's expectation that CNEs would "step in" and believed "that's what should happen". Ward staff however may not be clear that CNEs have the 'mandate' to change a student's patient allocation and preceptor. Unclear responsibilities can lead to conflict and have the potential to have a negative effect on a student's learning environment.

Another communication issue which was raised by one of the interviewers was their perception that some CNEs lacked the support of an academic lecturer in times when students were struggling. One participant felt some CNEs struggled if they had to deal with students' unsatisfactory performance.

Mary's observed;

I think they do especially when they you know when they are struggling with somebody and worrying about a student's performance or where to go with it, I think they feel quite isolated.

There are a number of possible reasons for this. One reason maybe that CNEs may not have sufficient knowledge, skills, and experience of academic processes to confidently deal with student performance issues. It may also be due to a lack of communication between CNEs and faculty staff. The area of addressing poor student performance may be an area both organisations may wish to investigate further.

Good communication is a challenge in any large organisation. When two organisations from different philosophical stances come together and enter into a collaborative agreement, it is vital that good communication processes are established and maintained. Part of good communication is feedback. Ward managers discussed the use of informal feedback between themselves and CNEs. This is an *ad hoc* arrangement and dependent on the skills of a of a particular CNE and ward manager.

6.2 Summary of the benefits and challenges

The study findings have been described and discussed in the previous two chapters. The data gathered from the participants during the study has highlighted benefits of the current collaborative model such as the CNE being supernumerary to ward rosters, and having time to teach, not only supervise students. CNEs are student-focused and easily accessible to ward managers, preceptors and students as they are based on site. The CNE was the one person who was '*there*' for a student as a student's preceptor can change shift-by-shift and day-by-day. One significant challenge which emerged was the replacement of ward staff, not only of senior nurses who can leave their wards for up to 12 weeks to undertake the CNE role but also that of the student's preceptor if the student's preceptor was on annual, sick or study leave. Other challenges such as the inability of ward managers to pre-book casual staff; preceptor work-loads; skill-mix issues and fluctuating full-time equivalents (FTEs) have also been discussed. The following chapter discusses future possibilities.

CHAPTER 7

7.1 Future possibilities

This chapter discusses future possibilities reflecting data gathered from this study, information gathered during the literature review and my own personal experiences of working with different undergraduate clinical teaching models.

7.1.1. Dedicated Education Units (DEUs).

One model I believe may be worth investigating further, is the Dedicated Education Unit which has been developed in the School of Nursing, at the Flinders University of South Australia, in clinical practice settings. The key features of this model are “reflection, peer teaching and guidance by a mix of academic facilitators, clinician teaching, and visiting academics” (Gonda et al., 1999, p. 172). This model has the potential to build on existing structures such as the CNE and Clinical Placement Coordinator roles and two week preparatory course and the recent development of an ‘off site’ campus. I would go further and suggest that the ‘off site’ campus become ‘on site’ and be based on the Health Providers main campus. In South Australia the DEU’s were “existing health care units that are further developed through strategic collaboration between nurse-clinicians and academics” (1999, p. 172). The possibility of CNEs working in their ‘home’ ward providing clinical education at both the undergraduate and post-graduate level maybe worth investigating. But, for clinical education in the practice setting to occur not only for undergraduate students but also new graduates, competent, proficient and expert practitioners’ supernumerary time and a career pathway needs to be developed for nurses who are interested in teaching. Clinical teaching in practice needs to be acknowledged and valued by both organisations in a collaborative partnership model, as essential tenet of a long

term successful recruitment and retention strategy and a nursing workforce of professional nurses who are able to provide a high quality nursing service.

The CNE position itself does not necessarily provide one-on-one clinical teaching rather the position supports the preceptor and under the current model, it is the preceptor who is responsible for one-on-one teaching. The CNE is the 'link' between the education and health sectors but is employed by the health provider. It appears that with the introduction of the preceptorship model no recognition, either locally or nationally, that teaching takes time has been acknowledged or valued as an integral part of staff development. No reduced workload or supernumerary time is built into ward budgets for preceptors to undertake their role.

7.1.2 Joint appointment

What has become apparent during the course of this case study model is that the CNE has no formal accountability to the Tertiary Education Provider. At present the CNE is employed by the Health Provider but expected to deliver the Educational Provider's programme. The CNE is the link between the educational curriculum and facilitating student learning and undertaking student assessment in clinical practice. The CNE attends an initial two week preparatory programme but is not then held accountable for their performance as an educator/teacher by the Educational Provider. This evolving model lends itself to moving towards establishing a joint appointment to oversee the development and implementation of the clinical education model within the clinical practice setting. There appears to be an uneven balance in the partnership and a joint appointment is one way the Educational Provider could increase its participation within the partnership. This role could in time, support joint research projects. A joint appointment could

provide an education; mentorship (CNEs) and research focus to the Health Provider and, on the other hand, provide updated clinical and service knowledge to the Educational Provider. This role could also be responsible for the CNE recruitment and selection process, ongoing development of clinical assessment tools, moderation of student and preceptor assessments, facilitation of course evaluations and regular evaluation of the learning environment. I see a joint appointment role also developing a nursing research culture within the Health Provider with joint research projects between education and practice been undertaken in the future. The Student Placement Coordinator role would remain coordinating both undergraduate and post graduate student placements. Students who are not only with the Tertiary Education Provider (in the case study), but students who also come from other education providers could remain with this role. Undergraduate and post-graduate students can come from anywhere in New Zealand as well as from overseas to undertake clinical placements. If the nurse appointed into a joint appointment role was to teach also in the Tertiary Education Providers institution then this position would be full-time and a stand alone position. The Student Placement Coordinator role then would remain a part-time position and continue to be funded by the Health Provider.

If the Tertiary Provider's off site campus were to come on site, then the appointment of a joint appointment would be even more logical. Partnership between the two providers would be enhanced by such a position. However one of the key issues surrounding joint appointments is finding a suitable person with a credible profile and skill set to work in the clinical and educational setting (Cooney et al., 2001). The challenge for both organisations is to facilitate the growth and development of a cohort of staff who could meet both the academic

and clinical requirements of a joint appointment position. If a joint appointment position was to be considered, then processes (memorandum of understanding) and structures would be required to be in place and it would need consultation and strategic planning.

7.1.3 Formal recognition for Clinical Nurse Educators

The interview data have also identified the lack of career structure for nurses interested in education. It was a clear expectation when the first partnership model was initiated prior to 2000 that the Health Provider at that time would develop a career pathway for Registered Nurses that would support the model and develop strong links between both organisations. With the transport of the model from one Health Provider to another the commitment to this aspect of the model appears to have been lost. CNEs at present have limited opportunities to utilise their new skills and knowledge, and specialise in their passion of clinical teaching, since the health provider has limited speciality focused nurse educator positions and one hospital wide clinical educator position. The Health Provider needs to look at supporting ward managers by establishing a number of speciality focused nurse educators to not only support undergraduate students but also new graduate nurses and post-registration nurses who require experience, skills and knowledge in speciality areas to become proficient in their chosen speciality. Nurse Educators would also be responsible for teaching in post-graduate nursing education in partnership with education providers. Educational support also needs to be given to other employees such as Health Care Assistants/Caregivers. The challenge for both organisations is to facilitate the growth and development of staff who could meet both the academic and clinical requirements of a joint appointment position. If a joint appointment position was to be considered, then processes and structures

would be required to be in place in both organisations and a collaborative approach (not just a consultative process) would need to occur with strategic planning.

7.1.4 Implications for Maori nursing students

This research project has used a case study methodology to inform the work and data gathered from the participants were specific to their experiences. The issue of providing quality clinical teaching to Maori students was raised during the Nursing Council Strategic Review of Undergraduate Nursing Education in 2000. One key issue that emerged was that of Maori students having the opportunity to undertake clinical placements in their own community (KMPG Consulting Report, 2001). If future clinical teaching models are to embrace the principles of the Treaty of Waitangi (Partnership, Participation and Protection) nurses in the future need to be knowledgeable and aware of not only Maori models of health such as the Whare Tapa Wha (Durie, 1986) but they will also need to have the ability to; communicate in Te Reo (Maori language); and have knowledge of Maori communities and the diversity of those communities, particularly those in the acute care hospital region. Future interactions will need to respect local tikanga (custom) and kawa (etiquette). Innovative partnerships between education providers, iwi (tribe) health providers, primary health organisations, hapu (sub-tribe) and whanau (family) are essential to ensure quality clinical placements. Funding issues and the need for Maori clinical educators and mentors will need to be addressed.

This case study has been within one specific acute care facility. It is hoped this work will be used as a resource and provide material that will lead to discussions and a strengthening of partnerships between the many and varied

health and educational providers both Maori and non-Maori to inform the present and plan for the future to ensure Maori nursing students are supported in clinical practice by both the education and health sectors.

7.1.5 Summary

It appears with the natural evolution of the current collaborative model, a joint appointment model of undergraduate clinical nursing education could fit well, however I have also discussed another alternative Dedicated Education Units. I believe that the establishment of Dedicated Education Units, along with the establishment of speciality focused clinical nurse educators within the acute care hospital could be an evolutionary stepping stone towards the establishment of a joint appointment between the education and health partners in this case study. Whatever the future may bring, it is evident that there is no one 'right' model therefore the way forward can be as creative and as innovative as both organisations want it to be.

CHAPTER 8

8.1 Conclusion

8.1.1. Study purpose and aims

It is important when using case study as a method to remain focused on the purpose and aims of the study. It was not my intention to formulate propositions, rather I sought to explore and describe ward managers' perspectives regarding the benefits and challenges of one New Zealand nursing undergraduate clinical education model. Using the study questions I believe I have outlined what ward managers saw as positive benefits of the model. The interview data revealed positive benefits such as consistent support not only to ward managers but students and preceptors, easy access to CNEs by ward managers, and the student advocacy role of the CNE. The most significantly negative aspect of the model was the pressure of staff replacement, not only for CNEs but also for preceptors. One of the barriers to releasing staff was the inability of ward managers to pre-book staff with the appropriate skill-mix from casual pool. Dedicated Education Units and Joint Appointment models have been offered as future possibilities.

8.1.2 Limitations of the study

The study has limitations in relation to its ability to give the reader a holistic and comprehensive picture of the current model. Due to timeframes, the need to make my research project manageable, and my desire to give ward managers a voice in the literature, I chose to investigate ward managers' perspectives only. The inclusion of preceptor, student, CNE, Student Co-ordinator and Tertiary Provider evaluation data would give a more comprehensive picture. Nevertheless I believe I have utilised case study as a method by clearly defining the goals, aims and boundaries of my case. I have used a qualitative approach to gather data but

the addition of quantitative data for example the number of hours CNEs and preceptors are off ward rosters would have also contributed to the rigour of the case study.

8.1.3 Recommendations for future research

This study has suggested that globally there are many and varied models of undergraduate nursing education and nationally, from my informal enquiries, New Zealand appears to have followed this trend with the proliferation of nursing schools within the education sector, for example polytechnics and universities. One model which does appear consistently in the literature is the preceptorship model. In my experience of working within the health industry for the past 30 years, most hospitals and organisations, while having commonalities, collect, interpret and report data slightly differently. I acknowledge over the past few years there has been a drive to start standardise data with the introduction of Trendcare in fourteen District Health Boards and Private hospitals through out New Zealand. Therefore, I believe the case study method is a useful tool to investigate issues surrounding undergraduate and postgraduate clinical education and its integration with practice. Anderson, Waldegrave, and Wong (2003) have successfully used case study to look at the effects of Employment Relations Act (ERA). Their research acknowledges the differences rather than trying to use a comparative approach. Due to the differences in each District Health Board, and amongst the many and varied Tertiary Educational Providers throughout the country, case study research would be valuable to investigate the quality of undergraduate clinical education throughout New Zealand today, given the increasing acuity within acute care environments and current nursing shortage.

Research into the link between student placement and recruitment of nurses is also an area which needs attention.

8.1.4 Reflections on my research journey

Looking back on my research journey, my final report has been an evolving piece of work. Choosing to use a qualitative methodology and the use of case study method was negotiated between me and my supervisor. As I worked through the issues of ethics approval and study design then immersed myself in the transcriptions I became more and more in 'awe' of the ward managers/charge nurses and their role. The role of nurses in middle management is very complex and at times a very stressful. I have always believed it is one of the most undervalued positions within the health industry. This role and the people who are in it are pivotal to the standard of patient care both from a nursing and interdisciplinary perspective. As I listened to the participants, their passion for nursing and the profession was very apparent, such was their commitment to their staff and patients/clients, and despite not being given any real decision making ability within the collaborative partnership, they gave one hundred percent towards making it work. They demonstrated their commitment to the next generation of nurses by literally spending hours on the phone looking for staff, ensuring students had suitable preceptors to teach and role model professional behaviours.

There appears to be little research published reflecting the variety of undergraduate clinical education models are currently being used in New Zealand today. There now have been a number of pieces of work written about this particular model using different lenses. I hope that my research project will contribute to the body of knowledge surrounding undergraduate clinical

education.

VIGNETTES

The advantage of the CNE model is because they (CNE) come off the floor, they know that things turn to custard at short notice. They know the difficulties, the shif-by-shift problems that can arise and hopefully that will mean they can offer students some reassurance, first hand experience. They will be able to get alongside and say look this is how it is some days it's really hard to manage because we're managing a number of problems. They have first hand experience of it, where somebody that maybe a polytechnic based tutor doesn't have currency of experience in the way of, the hospital environment (Mary)

The students usually become quite close to the nurses they work with closely. I think they (students) really do appreciate what the nurses do for them. They always get cards from the students who are leaving. They leave a card on the desk and say this has been the most amazing experience etc and I think the nurses feel really good when somebody says this, its good because they feel that they have made a bit of difference to up and coming nurses I guess (Anna)

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Note - due to confidentiality requirement, references referred to in the main body of this work, which refer specifically to the education and health providers in the case study, cannot be named. They are held by the researcher

APPENDIX A. ETHICS APPROVAL

Ethics Committee

22 September, 2003

Deborah Sims
 Nursing Lecturer
 C/- Graduate School of Nursing and Midwifery
 Victoria University of Wellington
 PO Box 600
 Wellington

E-mail: simsd@cpit.ac.nz

Re: The benefits and challenges of one New Zealand Nursing undergraduate clinical teaching model – A case study of ward managers' perspective's.

Investigator: Deborah Sims.

Site/Area: (Site specific)

Thank you for your letter and amendments received 22/9/03.

The Ethics Committee is now satisfied that the amendments and matters as detailed in their original approval letter dated the 22nd August have been met, and now grant final ethical approval for the above study under Chairs delegated authority.

Approved Documents

Information Sheet and consent form (Not dated)

Deborah Sims, Nursing Lecturer, Christchurch Polytechnic Institute of Technology.

Certification: Not Applicable

Accreditation

This Committee by the Health Research Council and is constituted and operates in accordance with the Operational Standard for Ethics Committees, March 2002.

Progress Reports

The study is approved for the full duration of the study. The Committee will review the approved application annually. A progress report is required for this study by the 22nd September 2004. You will be sent a form requesting this information. Please note that failure to complete and return this form may result in the withdrawal of ethical approval. A final report is also required at the conclusion of the study.

Requirements for SAE Reporting.

Please advise the Committee as soon as possible of the following:

- any study in another country that has stopped due to serious or unexpected adverse events
- withdrawal of Investigational product from continued development
- withdrawal from the market for any reason
- all serious adverse events which result in the investigator or sponsor breaking the blinding code at the time of the SAE or which result in hospitalisation or death.

Amendments:

All amendments to the study must be advised to the Committee prior to their implementation, except in the case where immediate implementations is required for reasons of safety. In such cases the Committee must be notified as soon as possible of the change.

General

It should be noted that Ethics Committee approval does not imply any resource commitment of administrative facilitation by any healthcare provider within whose facility the research is to be carried out. Where applicable, authority for this must be obtained separately from the appropriate manager within the organisation.

Please quote the ethics committee reference number being in all correspondence.

Yours faithfully,

.....
CHAIRPERSON

APPENDIX B. INTERVIEW GUIDE

Thank you for being willing to take part in this research project. Can I first of all assure you that you will remain anonymous and no records of the interview will be kept with your name on them. The interview will be taped and I have with me today two tape recorders one of which will be used as a back up tape. The tapes will be transcribed by a person who has signed a confidentiality agreement and myself. The transcriptions will be given back to you for you to listen to and validate. If there is any information on the tape (s) that you do not wish me to use, then please document it and send it back to me with the transcription. I will include a self addressed envelope.

In beginning this interview, firstly I wish to tell you the format for today. Please feel free to stop at anytime and help yourself to light refreshments. This interview is semi-structured therefore I have a number of questions to ask today. However there will be room for you to contribute your experiences.

Each of the questions reflects the aims of the research project. This study seeks to investigate the following: (1) what do ward managers see as benefits and challenges of the current model of undergraduate clinical education? (2) what are the barriers to releasing staff to undertake the CNE role? (3) what are the benefits and challenges of the current model on the ward manager's ability to recruit and retain Registered Nurses? (4) what do ward managers see as future possibilities for the collaborative model?

Before we begin to explore your experience, can you tell me what your understanding of clinical teaching is?

Followed by:

Do you see the undergraduate clinical teaching role as an important role?

Can you tell me from your perspective what are the positive effects of the current model ?

Can you tell me what are the negative effects of the current model?

Who do you see as the most appropriate provider of undergraduate clinical teaching? Education provider or health provider?

What have been the positive benefits to the ward from having staff trained as clinical teachers?

Has having CNEs on your ward helped you to recruit and retain Registered Nurses?

What has been the negative aspects for your ward from having senior staff leaving to undertake the CNE role?

What are the barriers to releasing staff to undertake the role?

How can the organisation assist you to support the current clinical teaching model?

What do you see as future possibilities?

Is there anything else that you wish to share today?

Thank you for participation today. I will now stop the tape. Before you go we need to make arrangements for me to send the tape to you and agree timeframes for you to send back. If I choose to use some of your transcriptions in the form of a vignette in the final report I will contact you again to confirm your approval just in case you have changed your mind since signing the consent form.