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How the Relational Process Shapes Rural Preceptorship

by

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I dedicate this thesis to all the teachers who have left a lasting impression on me throughout my lifetime, most especially those who have mentored and inspired me on this doctoral journey. I dedicate this work to my family, for without them I am not the person I strive to be. My husband Kevin, children Daniel, Ben, Eva and my parents Edmund and Madeline

Abstract

How the Relational Process Shapes Rural Preceptorship

In the rural setting preceptorship is purported to be an important approach to preparing safe and competent nurses. Preceptorship is the one-to-one pairing of a nursing student with a professional nurse who assumes the role of support, teacher, role model, facilitator and guide for the student in a designated practice setting, in this case the rural setting. To date limited research exists in the literature regarding the exploration of preceptorship specific to the rural setting. By understanding the social, psychological process that occurs in rural preceptorship and how that process is unique to rural nursing, the requisite preceptorship approach for the rural setting can be more effectively fostered. The purpose of this study then was to examine how preceptorship prepares nursing students specifically for the rural setting. Because preceptorship is concerned with the process of relationship development among preceptors, nursing students and faculty members, grounded theory was used. The sample was rural preceptors and nursing students placed in rural settings. Faculty facilitated their teaching/learning and were based in a large university in western Canada. While in their preceptorship placements nursing students also interacted significantly with other rural nurses therefore these team members were added as participants to the study.

Findings from this study revealed that the relational process was the intrinsic connection related to all aspects of the formal teaching/learning process. This process also comprised unique personal characteristics that created a welcoming, supportive and collegial atmosphere. The formal and personal relationship existed, first and foremost, between the preceptor and nursing student but included other team members. It was found that nursing students perceived their learning to be enhanced and advanced because of their preceptor and team members' support,

which was essential in the dynamic and complex rural environment. Preceptors and other health care professionals considered the relational aspects of preceptorship to be paramount to ensuring positive and successful completion. They considered this nurturing to be an extension of the rural community ethos, namely being there for each other. Faculty members considered their role as supporting and enhancing the preceptor/student relationship and found this to be achievable because of the attitude of key members of the preceptorship, including preceptors, students and rural nurses and the community spirit they perceived to exist in rural health care settings. Nursing students indicated that the implications of receiving authentic rural preceptorship preparation in terms of strong formal teaching/learning guidance, in addition to genuine support, vis a vis unique personal nurturing, contributed to many of these nursing students staying and working in the rural setting.

The implications from this study are, the implementation of salient nursing education related to rural preceptorship preparation to promote the continued success of preceptorships within this environment. Indeed, relevant education and preparation of faculty members, students, preceptors and rural nurses can serve to promote recruitment and retention of nurses who choose to stay within these setting because of the relational support afforded to them during and following rural preceptorship.

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Summary of the Research Study

Objectives of the Study

The specific objectives of this study were threefold: to, 1) develop an understanding of the social psychological process that occurs in shaping preceptorship in the rural setting; to, 2) examine the unique dynamics of rural preceptorship and how it is manifested in the student/preceptor relationship; and to, 3) generate substantive theory that can be used to understand preceptorship within the contextual reality of the rural setting

Method

The grounded theory method, specifically Glaserian, was used to explore the basic social psychological process occurring in preceptorship to educate undergraduate nursing students for the rural setting.

Data Collection

Data collection was conducted in 2010 within a six month period and comprised the following: 1) semistructured interviews; 2) memos, researcher's journaling, field notes; and 3) secondary data sources included documents deemed appropriate to the study, documents such as literature, curriculum/ course outlines, student reflections and self evaluations.

Sample

The sample comprised five rural preceptors who were currently and/or had in the past been involved with precepting nursing students. Each rural preceptor worked in a different acute care hospital and/or health care centre throughout Alberta. The geographic distance of these facilities from the urban university setting ranged between 50kms and 300 kms. The sample included five undergraduate nursing students from one Faculty of Nursing university in their final senior practicum course. Student participants included those enrolled in both collaborative

and after degree undergraduate nursing program(s). Each student was precepted in a different acute rural hospital or acute health care facility. The sample included three faculty members from one Faculty of Nursing university who were assigned to nursing students placed in rural acute care facilities for their final practicum course. All three faculty members were simutaniously assigned to urban placed students. The sample also comprised two rural nurses who were currently and/or had interacted in the past with precepted nursing students placed in rural facilities and at times considered themselves preceptors to these students. Each study participant was interviewed twice. A total of 30 interviews were conducted.

Data Analysis

Data were analysed using the constant comparison approach. This process requires data to be constantly compared throughout the study at all times and at all stages of analysis. A conceptual process was undertaken using codes and themes derived from the data to formulate a core variable. This core variable emerged as the central concept from which a substantive theory surfaced. An integral component of the analytical process involved the writing of memos by the researcher, a process which in turn provided a record and explanation of the conceptual pathways of the emergent theory. Mechanisms instituted to ensure for the rigor entailed credability, fittingness, auditability, and confirmability.

Underlying Assumptions

The assumptions that informed this study were as follows: a) the rural setting comprises a complex and unique practice and educational context; b) rural preceptors understand the complexity and uniqueness of that setting and its inherent idiosyncrasies; c) a rural preceptorship provides experienced teachers/role models who can promote and enhance the socialization and

critical thinking of nursing students in the rural setting; and d) rural preceptorship can facilitate the development of the competence, confidence and safe practice of nursing students

Limitations

As with any research study, this study entailed limitations which include the following:

1. This study was confined to one undergraduate nursing program therefore findings cannot be considered applicable to all undergraduate nursing programs using rural preceptorship placements.

2. Data were collected using a qualitative method, grounded theory, which was concerned with the process related to particular participants as they engaged in their specific rural preceptorship. *Rural preceptorship* is unique in that it occurs in a specific setting outside of the usual urban setting in which the majority of nursing preceptorships takes place. Rural preceptorship is thus influenced by the rural nursing context which encompasses its own unique clinical environment.

3. The researcher worked within time limitations while being cognizant of allowing adequate time to collect and analyze data to achieve saturation.

4. Researcher bias is always a possibility and thus had to be guarded against by conducting interviews with open ended questions designed to focus on participants' perceptions thereby allowing them to speak freely. Continued field notes and memoing related to the researcher's thoughts, beliefs, assumptions and conceptualizations prior to and throughout the study reminded the researcher to suspend and/or avoid what she may believe, suspect or assume about participants throughout the study and particularly during the interview and data analysis process.

Key concepts

Following are key concepts relevant to this study. These include: the preceptor, the preceptee/nursing student, faculty member, rural nurse, rural practice setting, rural nursing practice, preceptorship, rural preceptorship.

Preceptor

A preceptor is an experienced nurse, who works one-to-one with the nursing student throughout the trajectory of the preceptorship and who assumes the role of teacher, role model, supervisor and evaluator.

Preceptee/Nursing Student

A nursing student is an undergraduate student in her/his final senior practicum course of an undergraduate nursing program prior to becoming a registered nurse (RN).

Faculty Member

A faculty member is an academic educator assigned to a number of students enrolled in the senior practicum course. The faculty member supports both the student and the preceptor during the entire course from orientation to final evaluation and termination.

Rural Nurse

A rural nurse is an experienced registered nurse who practices in a rural setting and has interaction with the nursing student while she/he is in the rural preceptorship.

Rural Practice Setting

Because the rural setting has been described as complex and ambigious no single definition of ‘rural’ currently exists. Rather the literature related to the rural context encompasses an expansive definition of ‘rural’ to incorporate factors such as geographic location, distance and social/cultural factors related to rural health. In terms of health care, rural settings are often

described in terms of accessibility and availability of health care services and health care providers. Rural nurses are perceived as being essential to the provision of health care in rural communities. For the purpose of this study the designated rural practice setting included larger rural hospitals, in addition to acute health care centres throughout Alberta, encompassing a geographic distance of between 50kms and 300 kms from the urban university setting. These rural health care facilities included a diversity of acute health care services, with registered nurses providing the required patient care.

Rural Nursing Practice

Rural nursing practice has been described as unique and diverse. It is an expansive and autonomous practice. Rural nursing practice is a lived, experiential immersion in the rural community.

Preceptorship

Preceptorship is an approach to teaching/learning in undergraduate nursing education in the clinical/contextual setting. It is the one-to-one pairing of an experienced nurse with a nursing student to provide teaching, learning, supervision and evaluation of clinical knowledge and practice. The preceptorship is anchored in a formal relationship among the preceptorship participants, including the preceptor, the student (preceptee), and the faculty member. The preceptor is an experienced nurse, with specific knowledge and clinical/contextual practice expertise. The nursing student is placed in a specific setting in order to learn the role requirements of a nurse in relation to the context/clinical setting. The faculty member has knowledge of the curriculum, undergraduate educational preparation required for nursing students, the preceptorship process and the clinical contextual setting in which the preceptorship is situated.

Rural preceptorship

Rural preceptorship is the one-to-one pairing of a registered nurse (preceptor) and a nursing student in a rural setting. This pairing can facilitate confidence, competence and socialization of the student into his/her professional roles as a rural nurse.

Chapter 1

Introduction

As a rural nurse, nurse educator and administrator it was important to the researcher to explore the process involved in rural preceptorship as it related to preparing undergraduate nursing students specifically for the rural setting. The researcher sought to examine how preceptorship within the rural setting was actually achieving what preceptorship is purported to achieve specifically the formal teaching/learning componants of competence, confidence and socialization. The researcher sought to explore if and what role the rural context played in shaping preceptorship and did this specific preceptorship posses unique rural elements. Answers to particular research questions can then serve to inform undergraduate administration, Faculty, nurse educators and RNs about the role of rural preceptorship and its potential for preparing nursing students specifically for rural practice.

Preceptorship as an educational tool has been used extensively for the purpose of adequately preparing undergraduate nursing students for clinical practice (Myrick, 1988). In the case of rural preceptorship a limited number of studies exist that focus on the unique aspects of the rural practice setting including culture, professional boundaries and professional responsibilities (Sedgwick & Yonge, 2007; Yonge, Ferguson, & Myrick, 2006; Yonge, 2009). To date, however, there is a paucity of literature, specifically examining the social psychological process of rural preceptorship. Yonge (2009) suggests that the social psychological process is embedded in the preceptorship relationship. Research related to particular aspects of rural preceptorship is necessary to ascertain how the role and influence of the rural nurse preceptor contributes to the support and preparation of nursing students for practice in the rural setting.

Examination of the literature indicates that rural preceptorship differs from urban preceptorship. For example Sedgwick and Yonge (2007) note that the culture in rural hospital settings has a strong community environment that presents itself in a team approach to nursing practice that differs from urban hospital settings. Sedgwick and Yonge further state that this particular culture of team nursing influences the dynamics of rural preceptorship. Research indicates that rural practice settings continue to be described as unique (Bushy & Bushy, 2001; MacLeod, Kulig, Stewart, & Pitblado, 2004a). Within these settings rural nursing practice has been described as complex and diverse, where the nurse requires both breadth and depth of knowledge and the ability to practice with greater autonomy than an urban counterpart (Kulig et al. 2006). The rural setting informs nursing practice. Therefore, to ascertain an accurate understanding of the social psychological process involved in rural preceptorship, it was important to the study to address preceptorship within this context, vis a vis the rural setting, in which the preceptorship was shaped.

Context

Historically the term 'rural,' has been used primarily to refer to geographic location and distance (MacLeod, Kulig, Stewart, Pitblado, & Knock, 2004b; Pitblado, 2005). With regard to health care services, distance came to represent kilometres away from or travel to a health centre, with health care centres being depicted as hospitals or acute facilities. Research indicates, however, that the focus on the geographic interpretation fails to fully encapsulate the actual definition of the rural setting and what that term truly represents (Kulig, 2005; Malpas, 1998). In a 2008 Canadian study by Kulig et al. in which they surveyed registered nurses practicing in rural and remote settings, they found four dominant themes. These include community characteristics, geographic location, human health and technological resources, and nursing

practice characteristics. The authors suggest that these themes can contribute to a further understanding of rural settings and nursing practice.

Sorenson and DePeuter (2002) indicate that the concept of rurality has become more expansive in definition and interpretation to include social attributes such as income and education that impact the health of rural populations. The perception of rural in simple geographic terms does not account for the complexity of the rural setting and practice implications (Andrews, 2003; Racher, Vollman, & Annis, 2004). Rural research, including nursing research, has expanded to encompass further understanding of rural health care and professional practice (MacLeod et al. 2004a, b; Pitblado, 2005; Stewart, et al. 2005). Research related to educational preparation for rural nursing practice, however, has not been at the forefront of these studies.

Rural populations have complex health care needs but continually face challenges related to accessibility and availability. Currently rural communities have less access to health care providers, most especially rural nurses, than their urban counterparts. There remains a shortage of rural nurses (Canadian Institute for Health Information (CIHI), 2002). Thus it becomes important to be able to appropriately prepare nurses for rural practice settings.

In a study by Kenny and Duckett (2003) the authors suggest that rural nurses posses the required knowledge and skills to provide expanded health care services in a rural setting using a holistic approach to health care. Health factors and health care services that relate to community structures, inclusive of social support, employment, education, and environmental influences, are understood by rural nurses in conjunction with recognizing their fit within unique rural settings, (Stewart & Langille, 1995). Thus, rural nurses posses the authentic knowledge and practice requirements necessary in the rural settings. Their experience and expertise can thus provide

relevant teaching and role modeling in preparing nursing students for all aspects of the rural setting, through the preceptorship process.

Today, registered nurses constitute the largest profession providing health care in a variety of rural settings (Kulig et al. 2006). Within rural communities registered nurses are considered unique in their professional and personal roles (Crooks, 2004). There is a role blurring between the professional and personal. This differs from the nursing role of their urban counterparts. Rural nurses engage in what can be described as an intertwined relationship between their personal and professional roles in the rural setting. They are community members who are living and practicing amongst their interprofessional colleagues, family, and neighbours in a closer relational proximity than occurs in the urban setting. Researchers indicate that nurses embody their rural practice. (Kulig et al. 2008). This dual role affords nurses the opportunity to immerse themselves in the context of their practice. Kulig (2005) describes this integration of the professional and the personal role as central to creating an authentic knowledge of rural practice. Rural nurses who practice within the various rural settings are patently aware of the unique needs and health care requirements. Rural nurses as representatives of community life, recognize the needs related to essential health care and appropriate provision of such care. In an ethnographic study by Thomlinson, McDonagh, Crooks, and Lees (2004) rural nurses and community members describe the positive social aspects of rural living. While the authors of this study indicate some of the challenges of rural practice they also highlight the ability of rural nurses and community members to feel a sense of open space within the immediate physical environment. This is a strong theme and relates to a feeling of connection to values, beliefs and sense of community. Literature findings indicate that nurses who feel prepared to practice in the rural

setting will be more likely to stay and practice over the long term (Henry, Edwards, & Crotty, 2009; Manahan, & Lavoie, 2008)

Historically and currently it is rural nurses who have been providing essential care to rural populations (Ross-Kerr, 1998; Bramadat & Saydak, 1993; McPherson, 2006). These essential health care providers have been and continue to be a linchpin in rural health care. Recruitment and retention in rural settings remains a challenge (CIHI, 2002). Thus it becomes imperative to recognize the need to educate undergraduate students who are exposed to rural clinical environments within their nursing programs such as rural preceptorships, to ensure adequate preparation for practice in the rural setting (Bushy & Leipert, 2005). Rural preceptorship may be regarded as an effective model to provide educational and practice preparation. Rural preceptorship provides the necessary teaching/learning process that combines theoretical learning and contextual/clinical learning with the required focus on rural nursing practice. Rural preceptorship shapes the experience for the nursing student to allow competent practice in the rural setting.

Problem and Significance

As researchers and academics it behoves us to understand the nature of rural preceptorship, its uniqueness and more particularly the educational process that contributes to the preparation of competent and confident rural nurses (Yonge, 2007). To that end, we must explore the process involved in preceptorship to prepare nursing students for clinical practice specifically in the rural setting. Research indicates that preceptorship has been used in nursing education and practice to achieve support, role modeling and enhance the benefits of best practice for the preceptee (Myrick, 1988). To date, however, a gap exists in the literature regarding rural preceptorship (Yonge, 2009). Kenny and Duckett (2003) suggest that given the unique

complexity of rural nursing it becomes essential that rural nurses receive specific and appropriate educational preparation within undergraduate nursing programs to be able to practice with confidence and competence in the rural setting. According to Sedgwick and Yonge (2008) this practice preparation of nursing students who are placed in rural settings during their nursing programs and upon graduation requires specific models of education related to knowledge and contextual factors. Thus examining the process involved regarding educational and practice preparation in rural preceptorship may serve to provide the necessary teaching and learning elements required (Crooks, 2004; Myrick & Yonge, 2003).

Preceptorship can provide the benefits of educational preparation but given the additional focus of the rural setting it must do so in an authentic way. It is an experienced rural nurse who has the ability to role model, teach and demonstrate professional knowledge, behaviours and critical thinking relevant to nursing practice in the rural context/setting. Myrick and Barrett (1994) posit that critical thinking is an essential element for a preceptor to posses in order to provide better support of the teaching and learning process. Critical thinking requires the preceptor to be well versed and fluid in her/his knowledge of nursing and specific practice requirements, in this case rural nursing practice. Myrick and Yonge (2005) state that role modeling in direct and indirect ways effectively demonstrates the professional role related to nursing and the practice setting. While the authours do not specify a particular context/setting they propose that it is through preceptorship that clinical preparation is achieved. In rural preceptorship the experienced preceptor can demonstrate the rural nurse role in an authentic and professional way which in turn can serve as a pivotal element to provide socialization and teaching of the nursing student for practice in the rural setting. Rural preceptorship therefore

must be authentically related to the rural setting as a necessary, inclusive and preparatory component to provide rural nursing preparation.

In the literature minimal research has been published examining rural preceptorship. Absence of research is evident regarding the social psychological process involved in shaping rural preceptorship. A preliminary review of the literature confirms the well examined role of preceptorship and its influence on learning and socialization of the novice nurse (Crooks, 2004; Hegney, McCarthy, Rogers-Clark, & Gormann, 2002; Myrick, 1988; 2002; Myrick & Yonge, 2005). A distinct lack of research, however, is available regarding rural preceptorship. Many studies indicate the benefits of preceptorship to educate students in the clinical setting but do not articulate or include the substantive area of rural context. (Altmann, 2006; Barnes, Duldt, & Green, 1994; Diebert, & Goldenberg, 1995; Letizia, & Jennrich, 1998; Myrick, 2002, Myrick & Yonge, 2003; 2005). Currently, the small number of existing studies which have been conducted and related to rural preceptorship suggest particular benefits for clinical preparation of students, including nursing students, in the rural context (Crooks, 2004; Kenny & Duckett, 2003;

Manahan & Lavoie, 2008; Sedgwick & Yonge 2007; Sedgwick & Yonge 2008; Shannon et al. 2006; Yonge, 2009). These studies serve to answer some of the questions related to rural preceptorship and stimulate researchers to ask additional and unique questions. The findings of these studies indicate the unique practice of rural nursing, the unique needs of rural populations and the need to incorporate specific findings such as culture, professional boundaries, conflict management and undergraduate and graduate education as important elements of current and future rural nursing education. Research related to rural preceptorship highlights the influence of preceptorship to accomplish teaching/learning components necessary for rural nursing practice. In this study the author examined research questions related to rural preceptorship and the social

psychological process involved. These findings are necessary in order to prepare future nurses to assume the professional role of the nurse in this distinct particular setting.

Purpose of the Study

The purpose of this study was to explore the social/psychological process involved in shaping preceptorship in the rural setting and in preparing nursing students to assume the role of registered nurse for that setting. To date no new study had been conducted that specifically examines the process used in preceptorship to prepare undergraduate nursing students for rural nursing practice. Sedgwick and Yonge (2008) suggest the importance of additional studies to explore how preceptorship can contribute to the preparation of nurses specifically for the rural setting. The authors conclude that understanding the cultural climate that occurs in rural preceptorship is important but note that further examination of rural preceptorship is also required. Yonge (2009) posits that such research can inform rural nursing preparation and contribute to shaping the experiences of those involved. Rural preceptorship can provide a vehicle for the socialization of nursing students to the rural setting (Myrick, Yonge, & Billay, 2010; Myrick & Yonge, 2005). Additional research, however, is needed to illuminate answers to particular, unique questions. It is the contention of this researcher that rural preceptorship can strengthen the connection between classroom and rural practice settings. This study aimed to provide unique and necessary exploration of rural preceptorship for the purpose of contributing to a salient preceptorship that can be specific to rural contexts and praxis. Substantive theory development is important to elicit understanding related to a specific focus of inquiry (Glaser, 1978). The findings from this study can extend the knowledge regarding rural preceptorship to inform specific rural educational preparation.

Assumptions

The assumptions that informed this study were as follows: a) the rural setting comprises a complex and unique practice and educational context; b) rural preceptors understand the complexity and uniqueness of that setting and its inherent idiosyncrasies; c) a rural preceptorship provides experienced teachers/role models who can promote and enhance the socialization and critical thinking of nursing students in the rural setting; and d) rural preceptorship can facilitate the development of the competence, confidence and safe practice of nursing students

Research Questions

The following questions guided this study:

- What is the social/psychological process involved in shaping preceptorship in the rural setting?
- What are the perceptions of the nursing students regarding the process involved?
- What are the perceptions of preceptors regarding the process involved?
- What are the perceptions of faculty regarding the process involved?
- What are the perceptions of rural nurses regarding the process involved?
- How is preparation for rural nursing practice informed through the preceptorship process?

Chapter 2

State of Knowledge

Research related to rural nursing indicates that it is not designated a 'speciality practice'. Furthermore specific educational components related to rural practice are absent (McKay, 2005; Bushy, 2006). Educational preparation becomes a transplantation of urban programs without inclusion of the unique needs for rural nursing practice preparation. Crooks (2004) suggests that rural nursing education and practice preparation requires specific knowledge and practice skills that are ignored and remain unacknowledged. She calls for recognition of rural nursing practice as a unique domain of practice that requires thoughtful and relevant educational preparation. It is important not to negate the rural context, but to recognize it as central to informing the practice of rural nurses. In relation to the rural setting and nursing practice the literature indicates that historically, western Canada was founded on rural communities (Alberta Association of Registered Nurses (AARN), 1947; Cashman, 1966; Paul, 1994). Rural nurses provided care that encompassed acute care, obstetrical care, health promotion and disease prevention (Benoit, & Carroll, 2005; McPherson, 2006). Their role had both breadth and depth of practice (Ross-Kerr, 1998). Rural nurses were lauded as contributing to the much needed health care of rural populations many of whom would have had nonexistent access to health care and were considered the essential caregiver (Stewart, 1979).

As in the past, rural nursing practice is considered to be expansive in terms of the breadth and depth of knowledge and the skills required to provide the necessary nursing care (MacLeod, Kulig, Stewart, Pitblado, & Knock, 2004a). Nursing practice is located within various rural settings which range from larger rural towns or small cities, where health care centres, and/or hospitals are available, to smaller remote rural settings (Health Canada, 2001; Sorenson &

DePeuter, 2002). Because of the contextual influence on rural nursing practice, the ability to role model and teach nursing students must be provided by practicing rural nurses. The influence of the rural context and the experience of rural nurses are thus central in the preceptorship process in contributing to the legitimate and specific preparation of nursing students entering the rural setting.

Research indicates that preceptorship can be a preparatory vehicle for clinical practice. (Canadian Nurses Association (CNA), 1995, 2004; Myrick, 2002; Patton & Cook, 1994; Patton & Dowd, 1994). In a study by Myrick (2002) the author suggests that preceptorship creates an optimal forum for educational and practice learning. Preceptorship as a model of education has been supported by other scholars (McGregor, 1999; Neumann, Brady-Schlutter, & McKay, 2004; Wright, 2002). In a 2009 study by Yonge the authour asserts that it is important to offer a relevant vehicle to support the educational and practical preparation of the rural nurse as s (he) enters the rural environment. Yonge contends it is important to examine the rural setting as it relates to and influences the experience. The rural context/setting which differs from other practice/clinical settings provides an additional component to preceptorship. The authour suggests that more research is required related to preceptorship and the rural setting to close the research gap and to inform rural educational preparation in undergraduate nursing programs. Yonge further suggests that rural preceptorship can combine the tenets of preceptorship with the tenets of rural nursing to elucidate an experience that speaks to both practice preparation and context. To date research related to rural preceptorship has been limited, and specifically lacking is the examination of the social psychological process involved in shaping rural preceptorship for the preparation of undergraduate nursing students.

The Evolution of Preceptorship

Researchers claim that preceptorship within the realm of nursing education and the profession of nursing has evolved and benefitted the clinical preparation of undergraduate nursing students. Some of the underlying principles of preceptorship date back to the teachings and writings of Florence Nightingale (Myrick & Yonge, 2005). Nightingale posited that it was necessary for experienced nurses to teach students how to provide nursing care, through guidance and facilitation of learning. Supportive role modeling and facilitation of educational preparation were perceived to be limited in the apprenticeship models of nursing prevalent in the 1960s, 1970s and 1980s, during which the primary focus was the provision of service, sometimes at the expense of educational learning (Paul, 2005; Ross-Kerr, 1998). In the 1960s, in the United States of America, the preceptorship model emerged to facilitate the preparation of nurse practitioners in the clinical setting. Historically, medicine had successfully used preceptorship to contribute to the education and clinical preparation of its own medical students. Myrick (2002) indicates that nurse educators recognized that as a professional discipline nursing knowledge was embodied in its application to practice. Preceptorship became an important approach to the socialization of novice nurses. In addition Patton and Cook (1994) suggest that clinical experience is the cornerstone of socialization of novice nurses into the profession. Thus in keeping with the history of preceptorship, the model emerged as central to this teaching/learning approach (Myrick & Yonge, 2003).

The Preceptorship Triad

Integral to preceptorship is the triad relationship between the preceptor, preceptee and faculty member. Each member of the triad assumes specific roles and responsibilities. In a study by Myrick and Barrett (1994) it was found that the individual role and responsibilities of

preceptor participants impacts directly on the educational preparation of the nursing student. The authors suggest that if each member of the preceptorship triad assumes specific roles and responsibilities in a knowledgeable way, successful outcomes related to nursing students' preparation can be achieved. Preceptorship is designed to provide teaching and role modeling within a predetermined time frame. In North America, the endeavour to provide formal nursing education within academic institutions shifted the focus from the apprenticeship model to allow theory and practice to converge in the classroom and in the clinical settings alike. This emphasis on educational and practical preparation thus opened the door to preceptorship (McGregor, 1999). Preceptorship became utilized as a primary approach in undergraduate nursing programs to promote knowledge through application (Myrick & Yonge, 2003). The participants in the preceptorship triad all contribute to provide essential elements for theoretical and clinical learning with each participant assuming particular roles and responsibilities.

The Preceptor

The key role of the preceptor is that of teacher and role model. This knowing, showing, and doing are what nurture the nursing student in the clinical context. In a study by Mills, Francis and Bonner (2005) the authors suggest that preceptorship is an important key to preparing undergraduate nursing students who are placed in rural settings. Preceptorship in this setting draws on the rural clinical/contextual expertise of the nurse preceptor to role model, teach, supervise and evaluate to ensure preparation of the preceptee (nursing student) for the specific rural context. According to O'Malley, Cunliffe, Hunter, and Reid (2000) nurturing the student to become a competent and confident practitioner in a specific setting allows a strong sense of connection to the environment and illuminates the required expectations of the nursing care for the particular populations being served. It is the preceptor who possesses the clinical

experience, knowledge and skills to be able to provide strong role modeling and teaching. Preceptorship requires the establishment of a formal relationship between the preceptor and the preceptee, in this case, the nursing student. This relationship takes place over a predetermined time frame of weeks or months (CNA, 2004). In a study by Myrick (1988) the author notes that the emphasis is focused on supporting the student to become successful in learning and practicing in the chosen context setting. The relationship inheres a nurturing aspect to foster supportive learning. The preceptor can contribute to the socialization of the nursing student into nursing practice, with contextual congruence. This social contribution is founded on the preceptorship relationship and the preceptor's practice experiences and the ability to teach and role model how this professional socialization is achieved. Myrick (2002) further suggests that a preceptor may also be able to stimulate critical thinking related to dynamic practice settings. The rural practice setting is considered dynamic where diversity and complexity are encountered regularly. Owing to the dynamic and complex nature of the rural setting, socialization for rural nursing practice and the ability as a practitioner to be able to consistently think critically related to this expansive healthcare context are essential.

Situated in the relational experience are particular teaching components, one being supervision, used to create acceptable and competent practice standards. According to Mills, Francis and Bonner (2005) this supervision entails ongoing evaluation of the student's learning process and successful completion of outcome goals. In the case of rural preceptorship learning requires a combination of nursing knowledge and practice that are both universal in some aspects, and unique in other learning aspects to rural practice preparation. It is important to select a preceptor who has the required knowledge and practice to provide the necessary

expertise for the required role. Thus careful attention to preceptor selection is an important requirement.

Preceptor Selection

Preceptors are required to be competent teachers and role models, setting the stage to prepare novice nurses well for their future nursing roles. Research indicates that it is important to consider more than availability alone as a criterion to provide preceptorship. In a study by Myrick and Barrett (1994) the authors state the importance of considering the type of educational and clinical background of the preceptor as necessary components to provide the essential elements of teaching and role modeling. Availability alone will not create the optimum preceptorship experience. Selection of a preceptor needs to encompass a nurse who has significant experience in the clinical, context area (Altmann, 2006). Yonge, Krahn, Trojan, and Reid (2002) state that the preceptor needs to possess good communication skills that address the relational aspects of the role. Communication skills support the relationship between the preceptor and preceptee and can enhance learning. Communication provides a means to impart expert knowledge and meaning behind a particular practice. In a study by Yonge, Ferguson, and Myrick (2006) they note that a preceptor needs to display leadership skills to be able to take initiative and stimulate critical thinking in the nursing student. Such leadership, nurturing and communication skills can enhance the preceptorship experience. In the case of rural preceptorship the prefix of rural is a necessary antecedent of preceptorship. According to Watson (2003) rural preceptorship needs to reflect a direct rural focus. Because rural nursing is unique, it is essential to prepare rural nurses educationally and formally with a rural as opposed to an urban focus. An authentic rural preceptorship can foster rural socialization and the critical thinking germane to such a context. In order to achieve this authenticity within preceptorship it is

necessary to select preceptors who not only possess communication attributes but also commitment, experience and leadership within rural nursing. These attributes will ensure the merging of the rural aspects of nursing within preceptorship. Patton and Dowd (1994) posit that experiential learning without a connection to educational preparation can leave a novice nurse without confidence and a feeling of being overwhelmed. Thus educational preparation by the educational institution Faculty in the form of initial orientation and continued educational support is important. According to the research literature it is important to select a preceptor who can contribute significantly to the preceptorship experience in all aspects of knowledge, skills, practice, and clinical/context embodiment (Myrick & Yonge, 2005). In the case of rural preceptorship Altmann (2006) and Letizia and Jennrich (1998) note that the preceptor should be selected on criterion including clinical/contextual expertise in rural nursing practice and an ability to communicate well to provide teaching, leadership, skills and role modeling necessary in this complex and unique practice setting. In addition, a preceptor will be required to evaluate the preceptee's clinical competence and performance during and at the end of the preceptorship. This evaluation role is a key element of preceptorship.

The Preceptor as Evaluator

Studies indicate that evaluation of the student's learning by the preceptor is a central element in preceptorship. Throughout the preceptorship both formative assessment of the student's progress and summative evaluation of the student's performance are required. (CNA, 1995; 2004). Formative evaluation is derived from ongoing assessment of the student's performance, combined with support, ongoing feedback and teaching to enhance that performance. In summative evaluation grading is required to denote if the student has successfully achieved the necessary components to pass. In the evaluation process Seldomridge

and Walsh (2006) indicate that if a preceptor is a novice to the preceptorship role, anxiety may occur. A number of studies suggest that anxiety can be experienced as the preceptor balances being supportive and fair in assessing a student's performance (Letizia & Jennrich, 1998; Yonge, Myrick, Ferguson, & Luhanga, 2005).

In addition to the evaluation role of the preceptor the roles of the faculty member and the student are central to the evaluative triad. These roles are key to successful student learning, goals that ensure safe and competent practice in the clinical setting. Myrick and Yonge (2005) contend that successful preceptorship relationships can be brought about by effective communication, written and verbal evaluation guidelines and timely feedback at all stages of preceptorship. In rural preceptorship it is incumbent upon all members of the preceptorship triad, which includes the preceptor, the nursing student being precepted and the faculty member, to recognize the uniqueness of rural practice and how to best evaluate the student's performance to ensure that the student has attained the necessary level of learning, knowledge and skill to be competent and safe. These learning evaluations and outcome goals should require setting standards of rural nursing performance at a reasonable level for a novice rural nurse practitioner. According to Usher, Nolan, Reser, Owens, and Tollesfon, (1999) although preceptorship necessitates assuming roles and responsibilities that require time and effort, preceptors also experience benefits in participating in preceptorship.

Preceptor Benefits

The literature contains evidence to suggest that support for the preceptor assists in creating a positive experience including a number of benefits (Yonge, Krahn, Reid, & Hasse, 2002). The preceptor experiences satisfaction related to witnessing the nursing student gain confidence. Diebert and Goldenberg (1995) suggest this satisfaction derives from being able to

contribute to the development of the student's knowledge and skills which are necessary for practice. It is rewarding to be able to empower the student to be confident in the clinical setting. This feeling of satisfaction in turn contributes to the preceptor's own sense of self esteem. Being able to support nursing students on their journey of learning affords the preceptor a sense of well being. This well-being enhances their self-esteem through a sense of engaging in something important and worthwhile for another as it relates to teaching and supporting nursing care and practice. It can increase their own awareness of the importance of nursing practice and what it means to the people they serve and to their own professional and personal growth.

In a study on rural preceptorship by Shannon et al. (2006), inclusive of a number of health science professionals, it was nurse preceptors who indicated the most positive beliefs (95%) that the preceptorship experience can strengthen professional growth, related to knowledge and practice, for both the preceptor and the precepted nursing student. Being positive about sharing their knowledge, skills and experiences create an internal environment that is less susceptible to burnout. These practicing nurses gained a sense of accomplishment when engaged with the student in preceptorship that tended to offset the everyday reality of workload and practice issues that often contribute to feeling burdened and overwhelmed in their practice settings. Wright (2002) further suggests that preceptors become aware of their ability to be perceived as positive role models and what that can mean to the student in terms of learning and socialization to nursing. It is in the clinical/context area in which knowledge, application and attitude converge. The student learns from the preceptor and the preceptor benefits from the teaching, and role modeling experience (Myrick & Yonge, 2005). For the rural nurse being able to share her/his rural nursing experience with a novice can enhance her/his own practice. Rural nurses are required to provide a disproportionate level of care to the populations they serve, so

preventing burnout is essential (Canadian Institute for Health Information, 2002). This environment will affect the experience in terms of the relationship with the preceptor, but also with other staff. The ability of the preceptor to experience benefits is important in contributing to the preceptorship relationship and to the practice and care given by the preceptor and precepted student. Within the preceptorship relationship the nursing student also assumes an important role.

Preceptee/Nursing Student

Research related to the nursing student within the preceptorship process indicates a number of key items. The student is required, within her/his educational nursing program, to combine theoretical and clinical learning throughout the curriculum. Toward completion of the program the student enters a preceptorship course situated in a specific clinical/context setting where learning is directly and formally supported by an experienced preceptor. In a study by Myrick and Yonge (2003) they indicate that the student is prepared for the experience by receiving an orientation, outlining what the role of the student is within the precepted timeframe. The student, together with the faculty member and preceptor, develops learning goals that will determine and guide the learning required to be successful in completing and passing the course in order to graduate and enter practice. In addition authors note that the student develops awareness of the role of the preceptor who nurtures the student's learning. The student becomes a key member of the triad partnership with the preceptor and assigned faculty member. The student is also required to communicate with both the preceptor and faculty member regarding their own learning needs and the support they require. This open communication among all three members of the preceptorship triad ensures consistency in the evaluation process required by the student, the preceptor and the faculty member. According to Yonge, Ferguson and Myrick, (2006) the student is required to adhere to her/his responsibilities such as ethical practice and

standards of care. It is necessary for the student to provide sound judgement in clinical decision making to ensure safe and competent care to patients. The nursing student must provide respectful interactions with patients and their families. In addition, Yonge (2007) states that the student needs to be aware of her/his strengths and areas that need improvement. The student should be able to receive constructive feedback. Adhering diligently to these responsibilities can contribute to successful preceptorship.

In the case of rural preceptorship a student's orientation may be limited without particular attention being paid to rural components necessary for the student to be prepared to enter the practice setting. The rural setting should be considered an acknowledged element (Kenny & Duckett, 2003). Authentic preparation may be attained by focusing on rural aspects within the preceptorship process. In a study conducted by Yonge, Ferguson and Myrick (2006) it is contended that students within preceptorship in the rural context need to receive adequate orientation not only to the requirements and expectations of preceptorship but to the practice expectation requirements specific to the rural context. Absence of optimum orientation preparation prior to and during placement in the rural context can lead to a student's lack of confidence related to specific knowledge and practice. Choosing experienced rural preceptors and faculty members, who have solid background knowledge in rural practice can provide specific aspects of orientation necessary prior to the beginning of preceptorship. The precepted experience should allow the student to feel supported, with their learning facilitated to allow entry to practice (Altmann, 2006). Support of the nursing student's learning can allow the student to experience the benefits of preceptorship.

Preceptee/ Nursing Student Benefits

The literature regarding preceptorship has suggested that there are benefits for the preceptee/student which can be significant. The student who experiences a positive preceptorship is supported to facilitate successful entry to practice. Myrick (1988) posits that successful entry to practice is the culmination of linking the theoretical classroom learning along with the clinical learning to be able to provide safe and effective nursing practice and care as a registered nurse graduate. The ability to enter practice involves criteria such as skills and judgement (Myrick, 2002). Preceptorship can enhance these skills and judgement developments. Role modeling, teaching and support by the preceptor can hone the student's critical thinking skills which are related to developing judgements (Myrick & Yonge, 2005). Good judgement needs a level of critical thinking that requires higher cognitive levels of analysis and synthesize for practice application. The student benefits from sound knowledge and practice skills. This gives the student a sense of confidence to be able to provide nursing care in the clinical/context environment. Myrick and Yonge (2003) contend that this competence and confidence decreases the timeframe it takes to function independently. Being independent benefits the student after graduation but also has benefits for the patients and health professional colleagues, as the student is able to practice to her/his full scope of practice. According to Manahan and Lavioe (2008) a student entering a practice environment competently and safely creates a feeling of belonging to the profession and of being a capable practitioner. This sense of belonging can contribute to recruitment and retention where a practitioner wants to apply for employment and stay over the long term. For rural practice environments, recruitment and retention are significant issues where nurse to patient ratios are greater than urban comparisions and rural nurse shortages are even greater in number than urban nurse shortages. Thus recruitment and retension issues have a

significant impact as it relates to patient care for rural communities (CIHI, 2002; Hegney, McCarthy, Rogers-Clark, & Gormann, 2002). Creating an environment in which the student feels competent and ready to enter the professional practice setting as a nurse with the knowledge, skills, judgement and critical thinking necessary are crucial. In a study by Sedgwick, Yonge and Myrick (2009) the authors contend that a positive environment in a rural setting has unique challenges because of the dynamics of practice. They suggest that support and learning can be fostered when a nursing student receives support from the assigned preceptor in addition to other members of the multidisciplinary team.

Rural nursing has been described as complex and ambiguous where practice needs change in an instant from mundane routine care to acute critical events (MacLeod, Kulig, Stewart, & Pitblado, & Knock, 2004a). Therefore gaining rural clinical competence is a must for students to successfully transition into rural nursing practice. The factors required to achieve these goals must be addressed in a rural preceptorship. In preceptorship it is important to recognize the relational and supportive role played not only by the preceptor and preceptee but also by the faculty member. Students gain competence and confidence by understanding and experiencing the nature of rural nursing practice (Bushy & Leipert, 2005). Specific understanding can be promoted by preceptors and faculty members who are supportive and knolwdedgeable as it relates to the rural context. The students learning benefits from this exposure and learning experience while in their rural preceptorship and facilitates their ability to practice rurally upon graduation.

The Faculty Member

Myrick and Yonge (2005) state that faculty members in the preceptorship experience are a key connection and can contribute to the preceptorship experience. It is the faculty member

who can bridge the gap between the educational institution, curriculum objectives and the clinical practice settings. The faculty member brings knowledge in the substantive area and teaching expertise. This facilitates both support of the student and support of the preceptor. The faculty member, with excellent communication skills and knowledge of the learning objectives of the course, will assist in the entire process from orientation to evaluation. With clinical on-site visits when possible and frequent contact the faculty member can discuss, observe and suggest how to achieve learning progress consistently and over the time frame allocated. The faculty member is an integral part of the evaluation process during and in the final grading of the student. The final evaluation is a thoughtful combination of feedback from the preceptor, the student and the faculty member to determine an assigned grade related to the student's progress and completed outcomes. The faculty member should be available consistently for the student and the preceptor to answer questions and clarify expectations to ensure congruency between clinical learning and educational requirements. They are knowledgeable and experienced in the evaluation process. According to Neumann, Brady-Schlutter and McKay (2004) faculty members who feel prepared have a researched knowledge of preceptorship. They have a solid understanding of preceptorship orientation, required of them; in addition they are aware of the preparation and roles of students and preceptors. In a study by Barnes, Duldt and Green (1994) the authors suggest that those faculty members who have experience both in the clinical environment as practitioners as well as experience as teachers are in an optimal position to assume faculty member roles in the preceptorship experience. This assists in meeting all of the preceptorship requirements as it relates to their specific role as faculty members and facilitaters, and in the understanding and in the supporting of the other roles/members in the preceptor triad.

Without an understanding and experience of these components faculty members can feel unprepared for the role.

The Rural Nurse

Rural nurse(s), other than the preceptor, are present in the rural setting during a nursing student's preceptorship. Although their relationship is not a formal one such as exists between the members of the preceptorship triad they will have interactions with the nursing student throughout the preceptorship experience. Sedgwick and Yonge (2007) contend that the rural setting creates a team or community approach to rural preceptorship that includes significant interactions with other nurses in addition to the formal relationship between the preceptor, student, and faculty member. Thus, including rural nurses as research particpants within the realm of rural preceptorship was important to provide a more complete understanding of the social psychological process that occurred in shaping the preceptorship.

Rural Preceptorship

Since the 1980s, preceptorship has been successfully used by nursing programs to educate and prepare students to transition into practice (Myrick, 2002). A cornerstone of the preceptorship model is the emphasis on clinical/contextual preparation. It is the ability of the experienced preceptor and the experienced faculty member to provide guidence for the student to be successful. The literature on the benefits of preceptorship to allow a student to feel competent, confident and socialized as s (he) enters the practice areas is well documented (Myrick, Yonge, & Billay, 2010; O' Malley, Cunliffe, Hunter, & Breeze, 2000; Seldomridge, & Walsh, 2006; Usher, Nolan, Reser, Owens, & Tollesfon, 1999). However the unique aspects of rural preceptorship are not well documented. There is a void related to how the role of rurality impacts the preceptorship experience and a gap exists in the literature specific to rural preceptorship. The

small number of conducted studies that focus on rural preceptorship predominantly relate to medical student preparation for practice in the rural context. These studies were specific to physician skill preparation in relation to family medicine and obstetrical practice (Bass & Paulman, 1983; Dobie, Carline, & Laskowski, 1997; Goertzen, Stewart, & Weston, 1995; Lacy, Geske, Goodman, Hartman, & Paulman, 2007). The literature related to nursing and 'rural preceptorship' and more specifically to 'rural nursing preceptorship' in preparing undergraduate nursing students is limited. A study by Yonge, Myrick and Ferguson (2006) examines preceptors and students' perceptions of the rural preceptorship experience. The focus of this study is to understand rural preceptorship in relation to factors that can cause challenges for the preceptor and preceptee such as geographic distance from the educational institute, maintaining interactions and communication with faculty members assigned to the student, intergrating students into rural practice, severe weather conditions, relocation of students to rural communities, finding accommodation and a lack of resources. Study findings by Leipert et al (2008) concur that weather conditions, direct comunication and access to care in rural communites pose unique health care challenges. In another study conducted by Sedgwick and Yonge (2008) the cultural climate of the rural context and its influence on the preceptorship experience is explored. The focus of this ethnographic study is to examine the cultural climate as it relates to the rural preceptor experiences. This study does not examine the social psychological process but rather the cultural aspects of rural preceptorship. Rural preceptorship studies have focused on certain aspects of preceptorship in the rural setting including the roles of the preceptor and the student (Letizia & Jennrich, 1998; McGregor, 1999; Yonge, Krahn, Trojan, & Reid, 2002). Researchers have examined issues such as conflict in the preceptorship relationship (Yonge, Ferguson, & Myrick, 2006). While these studies examine aspects of rural preceptorship,

presently there is an absence of studies that examine the social psychological process occurring in preceptorship and how that process shapes the preparation of the nursing student in the rural setting.

Uniqueness in the Rural Setting

Historically, rural context was conceptualized as geographic location (Pitblado, 2005). Geographic location was defined in terms of distance, using cartographic terminology. In terms of health care services, distance came to represent kilometres away from or travel to a health centre. However research indicates that geographic concepts failed to fully encapsulate the definition of 'rural' (Kulig, 2005). Expressing rural context in simple geographic terms negated the complexity of 'rural' where distance itself did not fully describe the term (Andrews, 2003; Racher, Vollman, & Annis, 2004). Therefore quantitative measures and statistics were included in distance measures (Sorenson & DePeuter, 2002). This type of expansive questioning led to conceptualization regarding accessibility, availability and descriptors of what constitutes rural populations versus urban populations (CIHI, 2002).

Epp (2009) indicates that rural communities are intertwined with their history and their unique requirements including economic and contextual aspects. Rurality descriptors have attempted to allow social issues to be included with geographic issues to portray a more complete image of this environment thereby painting a picture of what community life is like, what the challenges of living in these communities mean and what the needs and rights of these populations entail, thus promoting access to essential services and recognizing those health professionals who can provide these services (Manahan & Lavoie, 2008).

Rural nurses, together with their community members can identify specific health care and other requirements, including how these needs should be met (Stewart et al, 2005) thus

creating political and personal advocacy for the unique needs of rural communities. Rural populations have commonality but also have diversity (Kulig, 2005). Rural nurses who practice within these various settings are patently aware of some of the unique needs and health care required.

To date researchers have conducted a number of studies examining the multiple facets and definitions of "rural" (Andrews, 2003; Boshma, 2005; Crooks, 2004; MacLeod, Kulig, Stewart, & Pitblado, & Knock 2004a; Pitblado, 2005; Racher, Vollman, & Annis, 2004). This rural research serves to facilitate understanding of the rural setting and the nursing practice required. Rural oriented researchers indicate the continued need to provide well prepared nurses for rural practice settings but do not articulate or address how to provide this preparatory education. A gap therefore exists in the literature specifically related to undergraduate nursing education for rural practice. In a study by Kenny and Duckett (2003) the authors note that the literature highlights the importance of educational preparation for rural nurses. However it is suggested that this preparation is best situated within post graduate education. These authors contend that educational preparation is a must but should begin in undergraduate nursing programs and continued in graduate education. Undergraduate preparation should consist of rural theory and relevant practice knowledge. Kenny and Duckett suggest it is this education for specific rural practice that supports the retention of rural nurses who are competent and confident. Because of the connection of rural nurses to their professional practice and rural communities their ability to articulate and role model rural nursing to nursing students is strong and considered essential to rural preceptorship. It is the rural nurses who provide the expert practitioner role in the preceptorship relationship for students who are seeking to practice in the rural setting.

Many students who have an interest in rural nursing and would like to practice in a rural community have been educated in urban nursing programs, using urban clinical settings. Their curriculum does not address or include any aspects of what may be unique to rural nursing (Morgan & Reel, 2003; Sedgwick & Yonge, 2008). Therefore they might then be expected to practice with competence upon graduation in the rural context but their exposure and education is from an urban undergraduate nursing program where rural experience and educational support is absent. According to Charnley (1999) it is only after graduation that these novice practitioners become immersed in rural context and have to begin to learn to navigate a complex and daunting practice setting. Their learning is obtained while they are practicing. This vicarious exposure, experience and support for novice rural nurses create an element of anxiety and stress. Concomitant, they are required to become competent and confident as they practice (Sorenson & DePeuter, 2002). Thomlinson, McDonagh, Crooks, and Lees (2004) indicate that this lack of preparation within undergraduate nursing programs leads many to feeling overwhelmed, choosing to move away from the rural areas or out of nursing. In order to allow nurses who wish to practice in rural areas to feel educationally supported for the rural context, preceptorship can offer a sound vehicle to accomplish preparation for clinical, contextual, socialization and competent practice. If positive and pertinent rural preceptorships can be achieved to support practicing in a rural environment, the ability to provide rural nurses, who will stay because they feel connected and safe to practice, can be a reality. In order to reduce the gap in the literature and provide evidence of what constitutes a rural preceptorship and create specific preceptorship education, studies need to be conducted to examine the experiences of those involved in the rural preceptorship process. It is by exploring these experiences of students as they navigate through a rural preceptorship and the social psychological relational aspects they encounter with their

preceptor that we gain an understanding of what transpires and/or needs to transpire to contribute to the essential preparation of nursing students for rural contexts.

The focus of this research study then was to examine the process involved in preceptorship to prepare nursing students for their role as professional nurses in the rural setting. The rural setting was interpreted and defined using the most expansive terms to include distance, health care needs, accessability, availability, extended autonomus rural nursing practice and social/cultural uniqueness. Examination of rural preceptorship allowed the researcher to ascertain what exactly shapes preceptorship in the rural setting.

Chapter 3

Method

Grounded Theory Method

In 1967 Glaser and Stauss developed a theory that examined the 'social processes' of people as they move through a specific concern or problem. According to Glaser and Strauss (1967) and Glaser (1978) the goal of grounded theory is to create an inductive method of theory that is grounded in the participants' perspectives and communicated through verbalization and observable actions. Grounded theory is founded on the theory of symbolic interactionism which is derived from the premise that individuals come to understand their own and interactive meaning through social processes (Blumer, 1986; Schreiber & Stern, 2001). Symbolic interactionism suggests that individuals have been socialized to develop meaning and understanding of their world based on certain, socially acquired ways to interpret that world (Strauss, 1987). This interpretation derives from a number of sources including social roles, language, individual and social behaviours and the interaction and interpretation of those socially constructed meanings. Grounded theory builds on the theoretical assumptions of symbolic interactionism and further explores the common social patterns people enact (Glaser, 1978). This examination generates a picture of the process involved, in this instance in rural preceptorship. It is the picture of common social patterning that creates theory to explain various social processes. Through grounded theory the researcher is able to explore how individuals deal with concerns in a socially construed way.

Rationale for Selecting the Grounded Theory Method

There is an absence of studies on rural preceptorship that specifically examine the social psychological process that occurs in preparing nursing students for practice in the rural setting. It

is for this reason that a qualitative method of inquiry was used. Qualitative methods of inquiry are used when there is an area of interest in which questions exist or remain without answers. The most suitable method to explore unanswered questions related to the process involved in shaping the rural preceptorship experience is grounded theory (Cresswell, 1998; Morse, 1992).

Grounded theory, specifically the Glaserian approach, was used to explore the process involved in shaping the preceptorship experience as it unfolded in the rural context. Grounded theory had been selected as the preferred method because of its focus on processes (Glaser & Strauss, 1967). This method allowed the researcher to deal directly with *what is actually going on* in the preceptorship experience with regard to rural preceptorship rather than *what ought to be going on*. In other words, "the grounded theory method tells it like it is" (Glaser, 1978, p. 14). A number of authours suggest that grounded theory is well suited to studying areas in which little is known about the phenomenon or social process, or used when a different perspective is being sought to gain new knowledge and understanding (Charmez, 2000; Dey, 1999; Glaser, 1978; Glaser & Strauss, 1967; Tutty, Rotherry, & Grinnel, 1996).

Procedures

A series of semistructured interviews were carried out with all of the participants. As the data were collected, transcribed and themes emerged, supplemental data were sought using relevant sources which included the literature, course outlines, curriculum documents, written evaluations and additional interviews (Glaser, 2005). The researcher kept a journal that recorded personal reflections before and during data collection and analysis. In this journal the researcher articulated her thoughts and reflections as the data emerged. The researcher also kept detailed field notes that reflected any observations or thoughts that occurred during interviews. Field

notes served to contribute additional data that may not be apparent or inclusive in the audiotaped data.

Data collection

In order to begin to explore some of these questions regarding process, semistructured interviews were used (Robrecht, 1995). Semistructured interviews allowed the researcher to ask questions of the participants about their experiences. The participants were able to share their thoughts, feelings and concerns related to preceptorship. The researcher was able to ask further questions and seek clarification to provide further depth. As the participant interviews evolved, the content evolved. It is this evolvement of individual/collective interviews and data analysis that contribute to saturation (Glaser, 1978). It is this endeavour to obtain saturation of the data that requires individual interviews. Although semistructured interviews are labour intensive because of the amount of data generated and the need to meet with all of the participants, it is understood that the data collected and generated may be richer than other methods of data collection. When structured methods of questioning are used such as survey questionnaires the ability to request further clarification and questioning is absent. In semistructured interviews, however, each interview may vary in how it evolves therefore interviews will lack standardization or the ability to directly compare to other interviews. Because of the latitude in structure, researcher bias in the interview process had to be addressed. The researcher strove to ensure the ability of the participant to give voice to a specific process and explore that process. For this reason open ended questions were used by the researcher to begin the interview to explore the experience but caution was taken not to dictate or produce premature focus.

Interviews were conducted at a mutually agreed upon time, date and location. Each interview was tape recorded and lasted 50 to 60 minutes. Prior to the taped interviews the

researcher requested demographic data (Appendix C, D, E, F) from participants. All participants were female. The age of rural preceptors ranged from 35 years to 50 year old, with nine years to 25 years experience in the rural setting and four to ten years experience with precepting nursing students. Age of faculty members ranged from 42 years to 58 years old and all members had five years experience of facilitating students in their final practicum course in rural settings. Nursing students were from both collaborative and after degree nursing programs from one university setting. Their ages ranged between 24 years and 37 years old. All students were near completion of their rural preceptorship at the time of the first interview and a number of students had completed their preceptorhip at the time of the second interview. The age of the rural nurses ranged between 33 and 42 years old. Their rural nursing experience ranged beween three years and 20 years of practice. These rural nurses had encountered and interacted with students during in rural preceptorships. The interviewer used open ended questions (Appendix G, H, I, J) to begin and guide the interview process as the interviewee narrated her perspectives. An example of an open-ended question is “describe your role as a rural preceptor”. To fully understand and explore the participant’s narrative, anticipatory listening was central to the researcher’s asking sub questions that sought clarification and understanding of what was being said by the interviewee. This interview process is in keeping with the chosen method of inquiry.

Questions used as interview guides were formulated based on the literature and checked for suitability and validity by the researcher’s supervisor who has expertise in qualitative inquiry and conducting grounded theory research. To ensure the researcher’s interview skills were adequate the supervisor reviewed the initial taped interview transcripts to access the researcher’s ability to question and probe as necessary. This review assisted in ascertaining the interviews that were uncovered the process in question.

Interview data were recorded, transcribed and read upon completion of each interview. Reading included memos and field notes of the researcher (Glaser, 1992). This process allowed analysis to be conducted as the data were being collected. By organizing the data as it were being collected and reading it as it transpired assisted the analysis process of constant comparison used centrally in grounded theory inquiry.

Sample

The sample comprised five rural preceptors practicing in a variety of acute hospitals and health care centres throughout Alberta who were currently and/or had in the past precepted nursing students. The sample included five undergraduate preceptee/nursing students from one university setting who were placed in a variety of acute rural hospitals and acute health care centres throughout Alberta. In addition, the sample comprised three faculty members from one university setting who were currently and/or had in the past facilitated rural students in their final preceptorship course, in addition to simutaniously facilitating urban students placed in urban clinical settings. Lastly, the sample included two practicing rural nurses who had interactions with nursing students during their rural preceptorship and at times considered themselves preceptors to the students. All research particpants were female. Particpants were sought using a variety of contact avenues which included study information posters placed in acute rural hospitals and healthcare centres. Preceptorship workshops additionally provided a venue for the researcher to provide a brief overview and invite potential rural preceptor and rural nurse participants to partake in the study. Posters were locted in the undergraduate nursing program(s) university setting where students had easy access to the posted study information. A series of semi structured interviews were conducted by the researcher with the individual participants, with permission granted by the participants to allow these interviews to be recorded. Purposive

and snowball sampling was used as the study commenced. Purposive sampling uses specific members of a desired population as study participants, in this case key rural preceptorship members. Snowball sampling is based on the assumption that those with an interest or experience in the same thing will know each other and can provide the researcher with referrals to other potential participants (Brink, 1998). In keeping with grounded theory tenets, the initial data dictated where the data moved in relation to the developing theory (Glaser, 1978). Theoretical sampling was conducted which influenced decisions on data collection and emergent categories. As data emerged and was categorized the researcher examined the literature on existing theories in relation to the emerging themes, codes and categories. This theoretical examination influenced where the data needed further exploration in relation to an emerging theory. Such sampling dictated sample size, including additional participation and interviews. Data collection continued until saturation was achieved (Glaser, 1992). In grounded theory theoretical saturation is purported to be accomplished when no new data emerges, related to categories or sub categories. Saturation of the data is considered only when there is repetition of major recurring themes with no new or further data contributing to the emerging theory. Glaser (1978) contends that saturation is achieved when all data can be explained within the existing categories including variation and achieves conceptual density.

Inclusion criteria for research participants were as follows. All participants were fluent in English. Rural preceptors chosen for this study were those who had been or were currently assigned to working with a student in a rural preceptorship. Students chosen to participate in this study were those who were, during data collection, assigned to a rural setting for their preceptorship. Faculty members who were included in this study included those who in the past or present had been assigned to nursing students placed in a rural setting. Rural nurses consisted

of practicing registered nurses who had interacted with nursing students during their preceptorship placement in the rural setting. All participants were assigned a code number to ensure confidentiality and anonymity. Confidentiality and anonymity must be maintained by the researcher who is conducting the research study (Brink & Wood, 2001). Participants were assured confidentiality and were informed that no one but the researcher and her supervisor had access to the raw data. Anonymity was assured by removing names, addresses and personal characteristics from the data. Adhering to these research requirements provided a means to maintain ethical considerations and also assisted in organizing the data with identifiable codes.

Setting and Population

This study was conducted in a number of rural settings including small acute health care centres and larger rural hospitals, located in Alberta, within 50 kms to 300 kms from the urban university centre. One to one interviews were conducted with research participants. Administrative approval was sought through the Faculty of Nursing to locate posters and engage in interviews with faculty and student participants. In addition rural healthcare administration approval was sought to locate posters requesting participation in the study from rural preceptors and rural nurses. Interviews took place at mutually agreed upon times, dates and locations. The population for this study included key members of the preceptorship triad and other rural nurses, namely the preceptor, the nursing student, the faculty member and rural nurses. The preceptor population included rural nurses who had experience being preceptors. The nursing students were those who had been assigned to a rural placement for their preceptorship. Faculty members included educators who had been specifically assigned to students in rural settings. Rural nurses were registered nurses who practiced in the rural setting and interacted with students during the rural preceptorship.

Data Analysis

Grounded theory as described by Glaser has ‘constant comparison as its linchpin for analyzing data. Reading and comparing data as it is being collected requires a simultaneous process to be implemented. Reading, questioning and analyzing the data in unison is necessary. The intension is to allow data to emerge (Babchuk, 1997; Miles & Hubberman, 1994). Through Constant comparison allowed a core variable to emerge. It is this core variable that linked all of the data including variations in the data. The core variable was the central component from which connections and patterns were explained. The core variable was the essence from which theory was generated (Glaser, 2003).

Throughout the data analysis in this study, coding was used as a means of processing data and arriving at theory development. There are a number of levels of coding used to achieve data analysis (Melia, 1996). Coding of the data and how it is conceptualized and used has variation depending on the data, the concepts evolving and stages of the study. A variety of codes were used to obtain inductive analysis. These included substantive codes, and theoretical codes.

Substantive Coding

Substantive means a sense of belonging and firm connection to the entity in question, in this case rural preceptorship. For analytical purposes, substantive coding was divided into two types, *open coding* and *selective coding*. In open coding, otherwise known as level one codes, each piece of data was examined and compared with other data. Often this process entails examining the data line by line and/ or phrase by phrase to conceptualize the data and patterns that were emerging. This attention allowed single units or clusters of meaning to be identified and labelled as codes and thus began the process of deconstructing and constructing the data into separate parts to identify emerging categories based on the participants’ own experiences and

descriptions (Glaser, 1978; Glaser, 2003). These emerging categories were then linked with the meanings found in the literature. In substantive coding two classifications are used, that of 'in vivo coding' and 'implied coding'. In vivo coding used the participant's own words, cementing the inductive process. Implied coding used the researcher's construction of conceptualizing the meaning, arising from the data (Padgett, 1998). Substantive coding allows clusters of data to be included for analysis and compared to other categories. An endeavour was made to discover as many categories as possible to uncover meaning, and emerging concepts. As the data progressed the codes were reviewed to ensure their relationship to the data. Unrelated codes were discarded and new codes developed and added to move towards theoretical formulation. Questions that the researcher asked in this study related to open coding were: what is going on here in this data? What category does this data belong to or indicate? What are the basic social psychological processes going on in this rural preceptorship?

In selective coding the researcher moved from open coding which is inclusive of all data, to delineating or enacting a process of reduction (Stern, 1994). In selective coding the researcher moved towards amalgamating and/or creating categories, which provided further, more in depth conceptualization of the data, in order to construct a central theme or core variable. The process of reduction and comparison allowed the core variable to emerge. It was this core variable that allowed the data to be inextricably connected with named categories which emerged from the participants' descriptions. The core variable connected data relevant to the social processes that existed in rural preceptorship. By reducing the data and creating categories that fit with the core variable the researcher hoped to move towards a significant social psychological process that was of concern to the participants and how they addressed, coped and moved through this concern and the process involved. The researcher was guided by questions that helped focus the

study and best described what was going on in the data. Questions that guided the coding process at this level included the following: what is the basic social psychological process going on in the rural preceptorship? What are the foci of this study and their relationship to the data?

The researcher used data to conceptualize and construct meaning, situated in the participants' descriptions (Glaser & Strauss, 1967; Schreiber & Stern, 2001). To explore meaning and theoretical development the researcher was sensitive during selective coding to theoretical meaning derived from the literature. The literature was read as a data source to compare meaning to the extant data. This process is referred to as theoretical sensitivity (Glaser, 1978). Theoretical sensitivity connected and informed existing meanings arrived at in the data. It served as a guide to the researcher in a push forward, towards theory development.

Theoretical Coding

Theoretical coding is sometimes referred to as second level coding. This level indicates that initial coding is continued and refined further to allow categories to become more complete and interconnected. During theoretical coding categories were examined in detail, reviewed, and refined to ascertain the dominant emergent categories' and how each of these categories related to each other. Each category was saturated with data that fit with the particular but had an interrelation aspect to other saturated categories', and to the emerging theory. To ensure the categories that remained linked or connected to each other in a way that fit with the emerging theory, the initial categories', the revised categories' and new data were constantly compared as the process progresses (Glaser & Strauss, 1967; Glaser, 1978). The old and new data were clustered into categories that were relevant to the emerging theory. This higher level of categorized data had a justifiable fit as the theoretical process shifted towards a central theory. In theoretical coding open codes were collapsed into higher level coding and higher level concepts.

It was these emerging concepts that reformed and/or refined categories at a higher conceptual level to allow a central theory to emerge.

Memoing

One of the important aspects of analyzing data using the grounded theory method is the process of memoing (Glaser, 1998). Memoing begins even before the research study begins. It continues throughout the data collection and analysis process. By writing down ideas and thoughts throughout the study, memoing contributes to how the data are conceptualized, analyzed and how theoretical evolvement occurs. In the initial stage of memoing and before data collection, the researcher wrote down her thoughts, ideas, reflections or pre-existing assumptions based on the researchers own values, beliefs and experiences. This process allowed reflections to be made in the pre stages of the study as the researcher began to think about the focus of study, the participants and settings involved. This reflection created awareness of what influenced the researcher as she began and awareness of those reflections throughout the study. During the constant comparison of data as it were being collected and analyzed the use of memoing allowed the researcher to write down thoughts specific to what the data were saying, thoughts around concepts emerging and theoretical analysis to provide a core variable and central theory.

Memoing required the researcher to ask certain important questions as the emerging data were being coded and subsequently categorized (Glaser, 2002). Questions that assisted in analysis are as follows: What is going on within the codes? What is the relationship between one code and another? Are individual codes entities in their own right or are they inclusive of a phase or property of a category to explain data and codes? What events and conditions influence the relationship within and between codes?

Memoing captured ideas and reflective analysis as it occurred. It served to allow re-reading and reflection of those analytical and theoretical ideas as they emerged. Memoing was carried out throughout the study to move concepts to thoughtful and relevant abstraction. It ensured that ideas and analysis were not forgotten as the data emerged in large quantity and rich texture. Ideas and reflection were referred to in the memos. They were used as a tool to ensure thoughts were not lost in translation of categories. It allowed an analytical fund to be produced and to be drawn from to produce theoretical ideas. Glaser contends that if a researcher fails to memo and moves directly from coding to categorizing to writing in a linear sequence grounded theory is not occurring. Memoing allowed continued submergence in the data while allowing abstraction from the data to occur for the purpose of theory development (Glaser, 2002; Glaser, 2003).

Rigor in Qualitative Research

In qualitative research validity refers to the gaining of knowledge and understanding related to the essence and meaning of a particular phenomenon under study. To ensure that the research reflected a faithful representation of what was happening and was considered reliable, certain steps were taken to ensure rigor before and throughout the study (Munhall, 1998). The researcher was cognizant and diligent in taking steps to ensure rigor in order to produce credible results. The researcher acknowledged and consciously put aside connections and biases related to personal values and believe that may have had the potential to interfere with what was truly going on in the words of the participants. Steps taken in relation to rigor in qualitative research served to guard against predetermined assumptions from personal values and existing literature.

To ensure rigor or trustworthiness in qualitative research, evidential criteria for assessment is required (Lincoln & Guba, 1985). Credibility is a criterion that reflects the value or

confirmation of the findings of the study with the participants. Fittingness reflects the applicability of the study; auditability reflects consistency with the written evidence provided. Confirmability reflects neutrality. This neutrality was sought to ensure results from the study were derived from the participants. Confirmability is the culmination of all the applicable criteria of credibility, fittingness and auditability to produce a study that resonated with the participants and with a wider audience and had the written evidence to show how the analysis and conclusions were achieved. Confirmability affirmed that the study arose from the data and the participants' experiences.

Credibility

Credibility occurs when the participants recognize and relate to the study's findings and emergent theory. It relates and connects to their individual experiences (Charmaz, 2000; Schreiber & Stern, 2001) where they see themselves in the explicated theory. Credibility unfolded throughout the study as the researcher engaged the participants during the data collection and analytical process. The researcher ensured the participants corroborated the data through member checks and member validation. Participants were asked to reiterate, clarify and confirm concepts as they emerged and were clustered into categories thus creating a process to keep the data inductive even as it is moved to higher level conceptualization and theoretical development.

Fittingness/Transferability

Fittingness or transferability refers to the probability or likelihood that particular substantive research findings are transferred or applied to other contexts in a meaningful way (Morse, 1992). The researcher accessed independent experts, not involved with the study, to

review the findings and to provide commentary on the fit of the findings in the substantive area and how this may fit with other findings.

Auditability

Auditability provides external readers and other researchers with written evidence to allow a concrete trail to be clearly demonstrated. This trail included written materials, code development/ selection notes, field notes of interviews and other data collection venues, and memos. The entirety of this written material was kept in a secured setting. The audit trail reflected the researchre's decisions as she moved through theoretical conceptualization (Glaser, 1998). The audit trail allowes another researcher to comprehend each stage of the data analysis and may be useful in future use by others. In this study having the researcher's supervisor review the coding and categorization, and independently categorize, checked against bias and ensured sound auditability that was dependable.

Confirmability

A study may be said to demonstrate confirmability if it consists of the criteria of fittingness and auditability (Dey, 1999; Stern, 1994). Understanding the criteria and how they must be applied, used and demonstrated throughout the study maintained an order to the study and assured provision of rigor and scholarship required in qualitative research.

Ethical considerations

Permission to conduct this study was received from the office of the Dean of the specific university nursing program. Ethical approval was obtained from the university research ethics board (see Appendix L). A number of important measures were implemented to ensure participant confidentiality.

With permission, the researcher provided the letter of information (see Appendix A) and consent form directly and/or electronically to students eligible to participate in the study. The researcher did not have teaching interactions with any of the students who wished to participate in the research study, to ensure no contact influence and reduce bias. The researcher requested a response from potential student participants through the letter of information contact details. The phone number and e-mail of the researcher appeared on the letter. This process afforded students the ability to choose to participate and indicated such by leaving directions for phone or e-mail contact. The researcher then requested a follow up meeting with student participants to further detail the research study to students. The students were required to sign a written consent form (see Appendix B). Students kept a copy of the consent form and a written description of the study for their own records. The original consent form was kept in a locked file. Once written consent and understanding of the study had been confirmed individual students were asked to meet for an interview with the researcher at a date, time and location convenient to the participant. In the initial interview written demographic data was requested.

Rural preceptors were recruited by the researcher through use of posters and through the student and/or program coordinator to participate in the study. The letter of information (see Appendix A) with phone and e-mail details was provided to the preceptors electronically. If preceptors wished to participate in the study they contacted the researcher via e-mail or phone connection. The researcher then arranged at a convenient time, date and location a meeting, to provide further details of the research study and request written consent and demographic information. The original consent remained in a locked file with the researcher and the preceptor participants retained a copy of the consent and written research study description for their own records.

Faculty members eligible to participate in the study were sent the letter of information (see Appendix A) with contact details directly and/or electronically. If potential faculty wished to participate they contacted the researcher by phone or e-mail. The researcher arranged to meet these faculty members directly at a convenient time, date and location to obtain written consent and demographic data. A written consent copy was held by the faculty member with a written description of the study and the original consent was kept in a locked file with the researcher.

Prior to commencement of the study the researcher met directly with all participants to provide explanation regarding the purpose of the study, the potential benefits of this study, and that participation is voluntary. Participants were requested to sign a consent form (see Appendix B) prior to the initiation of tape recorded interviews. To maintain confidentiality all tape recorded interviews were coded to exclude the name of the participant. A random assignment of coded numbers was given to the recordings, written transcripts and field notes and memos in place of any names. All transcriptions and important data will be kept in a locked cabinet for seven years. Consent forms were locked in a separate storage area. In this study ethical considerations included ethical principles such as beneficence, nonmaleficience, autonomy and justice. Consent and confidentiality of participants were necessary ethical considerations (Brink & Wood, 2001). This is in keeping with research and professional ethical principles.

Limitations

As with any research study, this study entailed limitations which include the following:

1. This study was confined to one undergraduate nursing program therefore findings cannot be considered applicable to all undergraduate nursing programs using rural preceptorship placements.

2. Data were collected using a qualitative method which was concerned with process related to particular participants as they engaged in preceptorship. *Rural preceptorship* is unique in that it occurs in a specific setting outside of the usual urban setting in which the majority of nursing preceptorships takes place. Rural preceptorship is thus influenced by the rural nursing context which encompasses its own unique clinical environment.

3. The researcher worked within time limitations while being cognizant of allowing adequate time to collect and analyze data to achieve saturation.

4. Researcher bias is always a possibility and thus had to be guarded against by conducting interviews with open ended questions designed to focus on participants' perceptions thereby allowing them to speak freely. Continued field notes and memoing related to the researcher's thoughts, beliefs, assumptions and conceptualizations prior to and throughout the study reminded the researcher to suspend and/or avoid what she believed, suspected or assumed about participants throughout the study and particularly during the interview and data analysis process.

Dissemination Strategies

The researcher commenced dissemination of preliminary aspects vis a vis intent to conduct the study, and the state of knowledge in the area of rural preceptorship in a variety of provincial, national and international conferences, focusing on nursing education, qualitative inquiry and nursing practice. Upon completion of the study it was the goal of the researcher to disseminate the research findings to as wide an audience as possible to include researchers and peers. To date the researcher has submitted the research findings to a variety of provincial, national and international conferences. Dissemination of the research findings included the participants who shared in the study's construction and journey. The researcher hopes to share the findings with clinical practice nurses providing direct care in rural settings; a process which

may be achieved through a series of direct or web based presentations, seminars and workshops. In addition the researcher will submit the written findings to a series of publication venues, such as professional organization newsletters and relevant peer reviewed journals, particularly those with a focus on nursing education and rural practice.

Potential Implications

The findings from this research study have the potential to contribute to present and future benefits and implications in undergraduate nursing programs and curriculum development, specifically in relation to how rural preceptorship can best prepare nursing students for rural nursing practice. This study sought to understand how rural preceptorship shaped the practice preparation of nursing students in the complex and ambiguous context of rural settings. Findings included acknowledging that preceptorship is important in authentically preparing nursing students for rural practice. In addition findings from the study served to further understand the roles of each member of the rural preceptorship, including the role of the rural preceptor as an expert practitioner and teacher, the role of the faculty member in supporting the preceptor and preceptee, the teaching/learning achieved by the nursing student during the preceptorship process and the role of the rural nurse in relation to student learning. It is hoped that the overall findings from this study serve to inform research relevant to rural nursing education, specifically to provide preceptorship development for the rural setting.

Chapter 4

Findings and Discussion

How the Relational Process Shapes Rural Preceptorship

The researcher, using constant comparative analysis, identified the emergent social psychological process in this study as a relational process that shaped the rural preceptorship. This relationship became apparent primarily between the preceptor and the student, but it also encompassed other key players, namely, rural staff and faculty. Study findings indicate four key characteristics as being integral to this particular relational process. These included (a) working side by side: being omnipresent (the supportive presence of the preceptor); (b) reciprocating confidence (the shared preceptor/student confidence that contributes to the promotion of the student's learning); (c) fostering team membership (becoming a member of the staff community); and (d) advancing practice through critical reflection (connecting knowledge to practice).

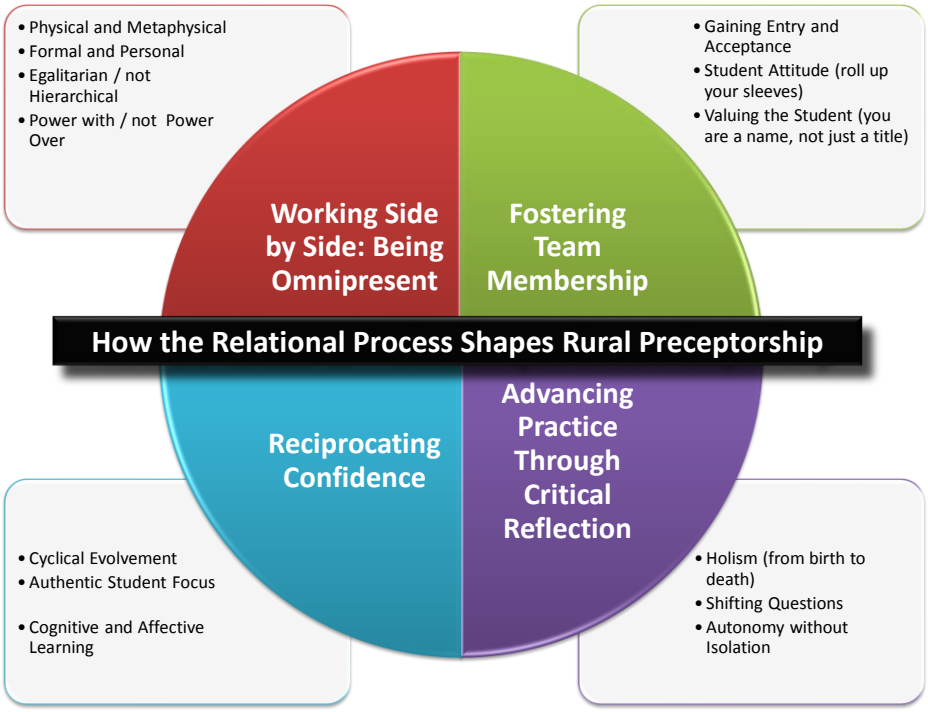
The grounded theory method allowed the researcher to examine what was actually going on between key members in the preceptorship and not what ought to have been going on (Glaser, 1978). It illuminated how the relationship unfolded during the time the student spent in the rural environment. The data provide a rich description derived from the participants' own perspectives of the social psychological process, articulating the key influences and connections essential to the relational process. For the purpose of confidentiality and anonymity when using participants' spoken words each participant was given a pseudonym and number to protect their identity.

Findings from this study indicate that the relational process is the vital, connecting component that emerged to shape the students' learning in the rural context. Learning occurred for the student simultaneously when the preceptor and staff members responded to them in a

respectful manner that reflected and valued their contribution. This relational process provided the support system from the initiation of the preceptorship while the student was adjusting to the rural nursing environment to the termination of the rotation. Support was experienced by the student in two ways: 1) the formal teaching components related to student learning in the clinical practice; and 2) the personal characteristics that allowed the student to feel welcomed into the extant interpersonal relationships in the rural context.

In preceptorship teaching/learning is focused on the ability of the preceptor to support the nursing student's practice thus ensuring that the student becomes proficient and competent in her/his nursing practice. This teaching/learning process is impacted by the relational interactions of the preceptor as the teacher and the student as the learner (Cohen, 2008; Dracup, & Bryon-Brown, 2004; Myrick & Yonge, 2005). In this rural preceptorship study the researcher found that 'the relational process' involved the preceptor and student interacting in a collegial and dynamic manner. This relational process evolved in a uniquely personalized way that evoked the rural context and community ethos. Findings suggested that the preceptor and the student both contributed to how the relationship unfolded and both were actively engaged in the process. Thus the relationship was formal and personal in nature thus promoting a positive preceptorship experience. Ultimately it was the preceptor/student relationship that promoted the interactive connections with other health care team members and enveloped all aspects of the rural preceptorship.

Figure 1: **How the Relational Process Shapes Rural Preceptorship**



Relational Process: Formal and Personal

In this study the researcher found that the relationship that existed between the preceptor and student within the rural context was perceived by them to contain formal elements necessary for preceptorship but additionally included relational elements that positively affected and contributed to the preceptorship process. Preceptorship has been acknowledged by expert scholars as a formal teaching/learning model which requires supervision and evaluation in order to provide the student with contextual/clinical competence (Canadian Nurses Association, 2004; Letizia & Jennrich, 1998; Myrick, 1988; Myrick & Yonge, 2001). Myrick and Yonge (2005) and Neumann, Brady-Schlutter, and McKay (2004) indicate that one of the key factors required to shape and achieve a successful preceptorship is establishing and maintaining a connection at all levels and between all participants, most essentially between the preceptor and the student but

including other health care team members. Teaching and learning are considered formal in nature, but are situated within a relational process that influences the students' perceptions of their learning (Barrett & Myrick, 1998; Yonge, Myrick, & Ferguson, 2011). The researcher in this rural preceptorship study found that the formal aspects of preceptorship existed and were considered necessary by the participants in order to achieve a successful preceptorship. Furthermore study finding indicated that teaching was enacted primarily by the preceptor but also by the faculty member, and health care staff. This was evidenced in the reflections of study participants. Faculty member Leah reflected on her role within the formal learning process:

> I know some of the challenges they [students] might have. I'm prepared for that. I prepare them to share with their preceptor. My role is to make sure they get their assignments done, they understand what is expected of them, what my expectations are. My role is a liaison role. My role is to first of all to smooth the way. Because of the rural setting they [students] get a little bit of everything so that is how rural offers a steep learning curve. But the staff is more experienced, more welcoming... it feels more welcoming to the student, to provide support for the learning curves. The student says I had no idea of the mix of skills [required in rural nursing practice] (Faculty Member, Leah, Interview # 2, Lines 30-57, 227-248, p. 1-7).

Kayley, a nursing student acknowledged the formal teaching role of the preceptor and how this impacted her learning. This student suggested that she was able to engage in the teaching/learning process with the preceptor in terms of the preceptor observing and evaluating the student's progress of knowledge and skills. The student felt supported and achieved progression while transitioning from student to new graduate. Kayley was learning the role of the nurse within the specific contextual environment as indicated in the following words:

> She's [preceptor] been really good, especially after situations to debrief and go through what I can do next time or explaining what is going on. Just giving me feedback has been really good, explaining different aspects and why certain things are important. Just getting used to the differences [urban versus rural practice]. It's been really interesting. I've got a lot more exposure to [skills, practice]. [Rural nursing] is a lot more fast paced, that's a challenge for me and kind of scary (Nursing Student, Kayley, Interview # 5, Lines 39-43, 99-105, p. 2- 3).

In the following reflection Donna acknowledged the formal aspects of her role as preceptor within the rural context:

> My experience with preceptorship has been positive. Students are very keen about learning about rural… [Rural] preceptors have been nursing for years so have the knowledge and skills, it just comes naturally [rural nursing practice]. She [student] knows what my expectations are and I get to learn where her expectations are, where she has areas to grow and where she is very independent. The first couple of weeks there is a certain learning curve. I want them to meet a certain standard. There is a little bit more watching and curving her up to your standards but then her standards in her education are coming along, so it's good. (Rural Preceptor, Donna, Interview # 7, Lines 10-18, 46-55, p. 1-2).

Students who experience a negative relationship with their preceptor have increased levels of stress during the preceptorship. This impedes their ability to learn and engage in the clinical environment. Negative relationships are perceived by the student as creating a sense of disillusionment related to the role of being a nurse and a feeling of disheartenment with the preceptorship experience (Yonge, Myrick, & Hasse, 2002). Students who experience negative

relational interactions are directly affected in their learning process and outcomes. A key factor that contributes to the student experiencing a negative preceptorship is the effect of conflict as the preceptor and student interact relationally. Conflict in the preceptor/student relationship is experienced as a lack of open communication between the preceptor and student. This negative interaction impedes the student's ability to engage well and feel valued in the clinical environment (Myrick et al., 2006).

In this rural preceptorship study findings indicated that the preceptor/student relationship emerged as the key factor in creating a distinctly supportive environment where optimal learning took place and where the student felt accepted and integrated into the clinical setting. The positive 'relational process' between the preceptor and student was found to provide a connection to all elements of teaching and learning, including role modeling, knowledge expertise and socialization of the student into the profession of nursing. Furthermore the 'relational process' incorporated formal and personal characteristics that provided the necessary components for a successful preceptorship. The formal characteristics included a focus on teaching, including supervision and evaluation of the student's learning. The personal characteristics included the nurturing, supporting, and caring for the student to provide a mutual engaging and rewarding relationship. Cohen (2008) indicates that when the preceptor, as the teacher, assumes the position of role model s(he) is able to enhance the student's learning and progress. The preceptor's clinical expertise influences and shapes the student's knowledge and skills within the preceptorship (Dracup, & Bryon-Brown, 2004). However in addition to role modeling and the knowledge expertise of the preceptor/teacher, the most important contribution to a positive preceptorship experience is the relational interactions between the preceptor and student. If the preceptor demonstrates qualities such as compassion, care and empathy this

contributes to nurturing the student's learning (Zilembo & Monterosso, 2008). These relational characteristics are deemed to be exemplary qualities where the preceptor demonstrates that the role of the teacher extends beyond knowledge transference to include and foster relational interactions. It is found that when the student is invited to participate in a collegial relationship it promotes student's learning within a safe environment. It is the preceptor's relationship with the student that provides safety for the student in terms of the challenges experienced in the clinical setting (Barrett & Myrick, 1998). When a strong relationship exists between the preceptor and the student, the student is able seek out the preceptor in terms of her/his learning needs in addition to the social and emotional needs.

In this rural preceptorship study the relational process served as the catalyst in relation to how teaching and learning unfolded and shaped the rural preceptorship. This process was captured in the following words of preceptor Jay where she situated her relationship with the student and explained her motivation for engagement. Jay indicated how this interaction shaped the student's experience and social psychological process involved in the student's learning:

> It was nice to be able to mold them [students] so that they would know what we expected. To be able to speak to her one to one and teach her what I know in the hopes that she would embrace it. I hope I play the role of mentor. I wanted her to be molded into rural nursing. I wanted to encourage her that this is also a wonderful place to work. Molding may not be the right choice of words but it is a different type of nursing (rural) here as opposed to an urban setting (Rural Preceptor Jay, Interview # 1, Lines 32-54, pp. 1-2).

This rural preceptor acknowledged the importance of providing and being involved in the relational process regarding the formal aspects of teaching and role modeling. She used the term molding to indicate her relationship with the student and discussed the outcomes she hoped the

student would achieve. She acknowledged that the experience was unique, specifically as it related to the rural environment. She reflected on how she could best showcase and teach the knowledge and skills necessary for this distinct setting. In addition she captured the importance of her relationship with the student as being essential to the student's learning. She assumed the role of mentor (in terms of a supportive relationship) for the student, providing encouragement and engagement, so the student had a positive learning experience and embraced rural nursing as a rewarding and unique entity. In another interview a nursing student, Rona, indicated that she felt her learning was supported in terms of the teaching process but also in terms of a very strong relationship that impacted her overall experience:

> Like any relationship it does have to be built up but it has been a positive experience from the beginning. She [preceptor] was very helpful and very informative. It's just gotten better. It's been definitely a positive experience and it has been positive for my learning. I would feel really awful and it would be going very poorly if there wasn't that relationship. Definitely within the [rural] facility there is a lot of good, everyone is supportive of each other and they are doing great care of the patient. Everyone likes to get the job done. That's inherent [of rural nursing] (Nursing Student, Rona, Interview # 4, Lines 274-276, 290-303, p. 8-9)

To achieve the teaching learning advancement necessary in preceptorship both the preceptor and the student are influenced by a number of educational theories in order to successfully enact and accomplish learning outcomes for the student. In this rural preceptorship study the researcher found that these educational theories informed the formal teaching/learning and the relational process.

Educational Theories Inform the Relational Rrocess

Preceptorship models have been founded on the principles of a number of educational theories (Billay & Yonge, 2004). These have included cognitive, behavioral, humanistic and transformative theories. In this rural preceptorship study the researcher examined educational theories in connection with the relational process that existed between the preceptor/teacher and the student. Historically a number of theories have focused on cognition and how it is enacted through behavior (Piaget, 1969; Skinner, 1954). Other educational theories have situated relationship between the teacher and the student as a key condition to successful learning (Knowles, 1984; Maslow, 1970; Rogers, 1983). Therefore because this study has followed grounded theory principles which emphasize the social psychological process the researcher examined the scope of educational theories as a necessary and relevant sampling to situate the findings within the formal and relational conditions that existed in this study.

Cognitive learning theories have been based and focused on the principle of forming/processing knowledge. Cognitive theories have been influenced by *gestalt theories,* by theorists such as Koffka (1955), whose intention was to examine how the mind finds patterns to explain the perceived world. Unlike reflexive theories of predictable responsive behavior/actions (Pavlov, 1927) cognitive theorists examine how the mind processes knowledge; knowledge from the external environment to the internal world (mind). Cognitive theorists focus on the process of knowledge formation, namely what processes are going on in the mind, in contrast to examining observed behaviors, vis a vis external behavioral processes. Piaget's *developmental theory*, inclusive of the components of accommodation and assimilation, are focused on the external environment and how external stimuli are accommodated with the pre-existing knowledge/data of the mind (1969). In the adult learner what already exists as knowledge is easily or not so

easily accommodated and assimilated/fitted into what had been developmentally formed since childhood and further expanded within adulthood. Thus the dual process of accommodation and assimilation in the adult is built upon and fitted within an existing knowledge base. Findings from this rural preceptorship study indicated that participants engaged in a teaching/learning process whereby the student experienced cognitive learning and was able to translate that knowledge into behavioral actions in terms of nursing skills. The preceptor as the teacher was able to use her own knowledge to inform the role of teacher in relation to providing cognitive knowledge and role modeling the behaviors of a skilled rural nurse. The faculty member, with nursing and teaching knowledge, was able to facilitate and augment the teaching/learning process where needed to benefit the student's learning process and outcomes. This finding was reflected in the words of the student Sarah, who, through the learning process accommodated existing and additional knowledge into her practice and reflected on how this revised practice fit into the skilled role of a nurse. In addition Sarah commented on how this learning might need to continue to change to accommodate her existing knowledge and behaviors and incorporate new cognitive and behavioral elements to steer the learning process forward:

> I'm going to try to think about the next day, how I reflect on my practice and try to come up with a better way for the next day (Nursing Student, Interview # 14, Sarah, Lines 305-307, p. 9).

The preceptors were responsive to the existing knowledge the students brought to their final preceptorship practicum. They recognized this pre-existing knowledge and skills as relevant and important. They reiterated and augmented the students' previous learning achievements. In addition the preceptors facilitated the students' acquisition of new knowledge and skills. This process was reflected in preceptor Jay's perceptions of the student's learning to date:

> The student was very good, very knowledgeable. The student was very well prepared. She already had some experience. I was teaching her things that I know and giving her experiences of what I do. (Rural Preceptor, Jay, Interview # 1, 22-33, p. 1).

Faculty members were able to discern how the students' learning was progressing. By reading the students' written reflections and interacting verbally with the students the faculty members recognized the knowledge and skills that the students had acquired and continued to acquire and how learning progressed to a higher level of cognitive understanding and enactment of skills and how this related to the rural context. This finding was observed by faculty member Wanda:

> I think their [student] reflections talked about how they started to know and ask questions. To discover what was going on. [Student's words to faculty member]….."When I first started I didn't trust my knowledge, now I trust my knowledge". Students need reviews to access what they need [knowledge, practice] of what they might experience working and being better prepared [for the rural community]. Students need to think about going to an agricultural community, they are going to see farm safety or not, issues of electrical power [lines], bicycle safety, these can be huge issues (Faculty Member, Wanda, Interview # 10, Lines 47-50,119-150, p. 2-4).

In addition to cognitive and behavioral theories a number of theorists explore the relationship between the teacher and the student related to the learning process and outcomes achieved by the student. These theorists seek to examine what already exists in the form of theoretical assumptions and expand or explore other theoretical concepts. For example Skinner's *operational theory* is based on a system of rewards and punishments, instigated by the teacher, to enhance or deter specific learning for the student (1954). Furthermore Skinner questions whether

one theory, either cognitive or behavioural theories can be considered exclusive to the process of learning. He suggests that theory development should not always derive from deductive or pre-existing theories/assumptions but can be explored from an inductive research perspective of what is actually going on in the teaching/learning environments. This has been linked and further developed by Bandura in what is termed the *social learning theory* (1971). Bandura states that cognitive learning and subsequent behaviours are influenced by social and environmental factors and are brought to fruition as a result of role modeling observed behaviours. Brookfield (1995) also cautions against considering extant theories on adult learning as being the panacea of adult education. He challenges and provokes us to think about the major areas of research related to adult learning. Brookfield suggests that self-directed learning, critical thinking, historical and social influences need to be considered. He views the influence of culture as an emerging and necessary factor and relationship between teacher and student as vital in the teaching learning process. Maslow (1970) and Rogers (1983), with backgrounds in psychology, consider relationships and interactions with others as necessary components of a humanistic model of being in the world. They explore how persons learn to be in the world. Maslow contends that if a person has the basics of life then s (he) can move towards the pinnacle of self actualization. Self actualization is understood as the culmination of achieving the desired and complete aspirations of whom and what a person can be, in relation to themselves and others. Roger's humanistic approach concurs with the premise of the human/subjective experience and the vital role personal experience plays in one's life.

In this rural preceptorship study while the formal aspects of the teaching/learning process existed it was the relational process in particular that distinguished it from other preceptorships. Based on the participants' perceptions of what makes this rural preceptorship

distinct was the strong personal connection that permeated the relational process. This connection was first and foremost between the preceptor and the student but involved others in the preceptorship including other health professionals. Shannon, a rural preceptor captured the duality of her formal and relational role that developed with the student within the preceptorship experience:

> I'm a teacher. I'm a mother hen. I'm someone they [students] can come to if something bad has happened, they've been in a trauma or someone has died. Someone they can come to safely talk about it. That's kind of how I am to them. I'm a teacher and a guider and a mentor. A lot of these students when they come first [to the rural community] do not know anybody in the community, so they are alone, they don't know very much so they need somebody to talk to. They can contact me and feel safe to talk. (Rural Preceptor, Shannon, Interview # 8, Lines 72-78, pp. 2-3).

Faculty member Wanda reflected on her perceptions as they related to the rural hospital community and how it affected the preceptorship experience in terms of a relational process for the student:

> I got an overwhelming sense it was like family. The student was included. In a rural small hospital it is that way. They [preceptor and staff] are very supportive. They're very much wanting the student to learn and including them in social events. I think much more intense (relationship) than for instance at a major hospital. (Faculty Member, Wanda, Interview # 10, Lines 222-234, p. 6).

Alexis, a student, demonstrated how she experienced a more personal, in depth relationship within the rural preceptorship process:

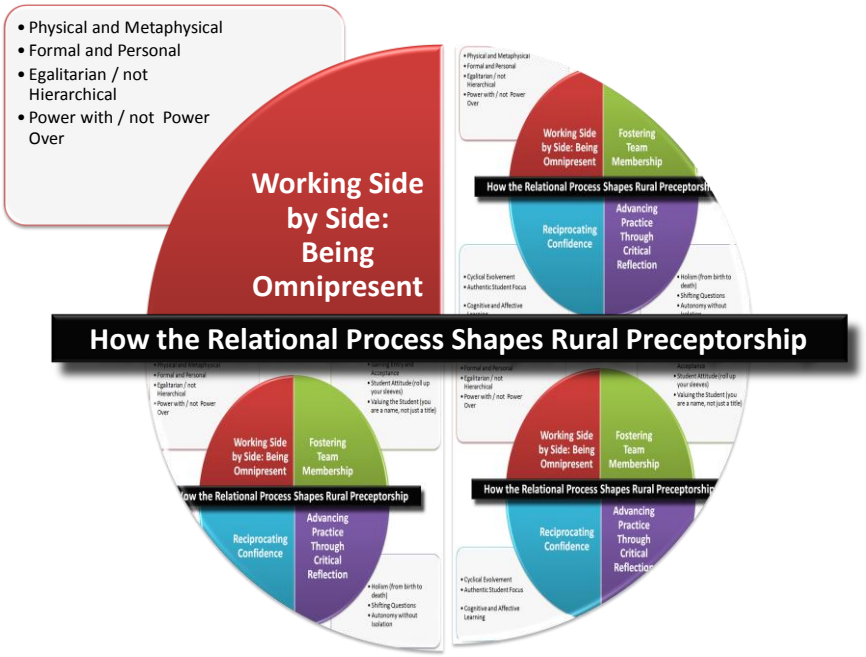
> You are going into a completely new setting, it's not a speciality [rural nursing practice definition] but you are going to be doing everything [diversity of rural nursing practice] so it was very intimidating but I learned so much. It was very welcoming. I chose a small town for the small town feeling. You are very much welcomed there. I definitely found there was more support in the rural preceptorship. I felt like we [preceptor, student] became colleagues rather than segregated as student teacher because I think of the open communication. We became more comfortable with each other. She [preceptor] was very respectful. She also outside of there showed me different aspects to different things. She was developing me within the clinical experience. She was also developing me in my career. She went up to that extra level for me. She was willing to do that for me. (Nursing Student, Alexis, Interview # 11, Lines 145-169, pp. 4-5).

Thus relationship was experienced as uniquely personalized, one that unfolded and was coalesced to the rural context within which it was situated. This relational process connected and affected all aspects of the teaching/learning process, most especially socialization, vis a vis support through relationship to become a new graduate and become welcomed as a rural nurse. The researcher found that this rural preceptorship was distinct in its relational process, not because relationships do not exist in other preceptorships but because it went beyond a formal pedagogical relationship to encompass a personal relationship. This relational connectivity is the gestalt of the rural preceptorship, distinguishing it from other preceptorships. This type of personal relationship within the rural context is seminal in the literature describing these nursing environments. Mills, Francis and Bonner (2008), for example, suggest that experienced rural nurses cultivate novices through supportive relationships. The impetus for such relationships derives from their own history of living and working in the community. Kulig (2005) uses the

term ‘embodiment’ to reflect the interwoven nature of living and working within a community where everyone knows you, simultaneously as a nurse and as a community member where the personal and the professional elements coexist thus relationships are uniquely experienced because of the rural context. Rural communities have their own culture where long term relationships between community members and health professionals evolve in a personal way (Kulig, Stewart, Penz, Forbes, Morgan, & Emerson, 2004; Morgan & Reel, 2003). It is the rural context that influences the distinct relational process experienced by those participating in the preceptorship. It is the rural context and culture that creates a sense of family where the student feels welcomed by the preceptor and other staff and becomes what is termed a ‘family/team member’ (Sedgwick &Yonge, 2007).

Findings reflected that it was the forged relationship between the preceptor and the student that fostered entry for the student to become a welcomed and legitimate rural team member. This process is the natural coalition of the formal and personal connections that evolved in the preceptorship relationship. Thus the key characteristics intrinsic to the core variable of ‘how the relational process shapes rural preceptorship’ included: (a) working side by side: being omnipresent (the supportive presence of the preceptor); (b) reciprocating confidence (the shared preceptor/student confidence that contributes to the promotion of the student’s learning); (c) fostering team membership (becoming a member of the staff community); and (d) advancing practice through critical reflection (connecting knowledge to practice)

Figure 2: Working Side by Side: Being Omnipresent



Working Side By Side: Being Omnipresent

The one-to-one relationship between a preceptor and a student has been considered a central component of teaching/learning in preceptorship (Goldenberg, 1987; Ouellet, 1993; Myrick & Yonge, 2005). This process has relied on the one-to-one pairing of an experienced nurse with a student as an essential element to enhance successful transition of the student to assume her/his professional role (Letizia & Jennrich, (1998). Furthermore Daigle (2001) indicates that the goal of having one teacher assigned to an individual student is intended to provide a more exclusive teaching/learning model where the teacher is able to dedicate her/his attention to the student to allow optimal learning to occur. The student is situated in an environment where attention to her/hislearning needs is prominent. In the case of this rural preceptorship study the term side by side as opposed to the term one-to-one was deliberately used to illustrate the importance of a collegial relationship and how it shaped the preceptorship.

Further the term side by side illuminated the teacher/student interactions, drawing attention to how a supportive relationship was uniquely nurtured in the rural environment. The preceptor did not have to be in a one to one teaching position at all times where physical presence was continuous; rather it was found that the student experienced the physical presence of the teacher most especially during the initial phase of the preceptorship but as the student's relationship and learning progressed she continued to feel the presence of the preceptor in a metaphysical sense, providing the necessary support. This process was perceived by the student as a continuous *sense of presence* of the preceptor throughout the preceptorship. This created the emotive feelings of support and of the preceptor being omnipresent. Rather than creating a sense of abandonment or lack of direction the experience of omnipresence sustained the relationship and the learning, thereby creating a relational connection for both the student and the preceptor. This experience of working side by side; being omnipresent in rural preceptorship consisted of a number of elements. These included (1) physical and metaphysical; (2) collegial, not hierarchical; and (3) power with, not power over.

Physical and Metaphysical

Preceptorship models are based on the premise of consciously assigning one preceptor to each student thus creating a supportive teaching learning environment (Luhanga, Billay, Grundy, Myrick & Yonge, 2010). This relationship is found to be essential in order to promote student competence, provide consistency and develop a positive network for the student (Callaghan et al 2009). According to Zilembo and Monterosso (2008) if a one-to-one relationship does not exist or is inconsistent, with the student being passed from nurse to nurse might cause confusion, leading students' to feel less nurtured and unsupported. Luhanga, et al (2010) indicate that it is essential to continue to preserve this relationship especially in a complex workplace

environment. The rural setting consists of a complex practice environment where the student may be exposed to multiple practice specialties (MacLeod et al., 2004 a). Many times in order for the student to embrace and participate in these expansive areas of practice they may move around the facility and interact with other health care team members other than their preceptor, depending on the acute event happening at a given time. The researcher found that when the teaching time was optimal the students were able to engage in nursing practice that did not always have the preceptor's direct presence. However because of the extant relationship, during the times the preceptor was elsewhere, the student did not have a sense of absence, chaos or confusion, she did not feel abandoned or passed around to others, rather she continued to feel the sustained presence of the preceptor metaphysically. The inclusiveness of other health care members in the learning process is a distinct occurrence in the rural setting. The preceptor/student relationship is first and foremost in preceptorship and is established prior to the student engaging with other members of the health care team (Sedgwick & Yonge, 2009). In the case of this rural preceptorship study it was found that the students never relationally disengaged from their preceptors even when they were working alongside other staff members at various times in the preceptorship. Students perceived that they had a supportive preceptor, where a relationship was established at a very early stage and was consistently nurtured and fostered throughout the preceptorship. It was the relational process that allowed the student to continuously feel the support of the preceptor directly and indirectly during each learning situation. The words of the following students Daisy and Rona demonstrated the relational role of the preceptor and her influence on fostering the student's learning within a cocoon of support:

> Anytime there is a new skill that I have not practiced she is right there with me and if she is not, she makes sure someone else is right there. A lot of times it's really reassurance.

> You can be nervous going into a new practice situation but she is really reassuring and has been really positive. I spent a lot of time thinking what I wanted from my preceptorship and rural [nursing practice] interests me so I chose this [rural] site (Nursing Student Daisy, Interview # 9, Lines 247-256, p. 5).
>
> It needs to be a support system. That kind of side by side [relationship] is needed for it [preceptorship] to be effective. In rural preceptorship there is a huge bonus to allow you to develop team skills and learn how to operate within a team. I didn't see that in other clinical settings (Nursing Student Rona, Interview # 18, Lines 198-200, p. 6).

Rural nurse Barbara who perceived herself to be both a rural nurse and a preceptor indicated how she valued and fostered the relationship with the student in a number of different ways:

> I usually showed them [students] how to work with people, with respect, with other employees, how to be a nurse and to make their decision and to be able to follow through on it, take them under my wing. I show them by example and I support them doing the same for themselves. [Rural preceptorship] relationships are very important because students know they have a safe place to come to in the rural setting. [As a rural nurse and preceptor] they can come to me and discuss things in private (Rural nurse and preceptor, Barbara, Interview # 13, 36-41, pp. 1-2).

The relational engagement of the preceptor and the student was influenced in a distinct manner because of the rural context whereby the student perceived support from the preceptor as a continuous presence in a physical and metaphysical sense as each learning situation warranted. A second element that contributed and set the tone for the preceptor to work side by side with the student included a sense of collegiality rather than a hierarchical relationship.

Collegial, not Hierarchical

The rural environment is a distinct entity in terms of the relationships that a rural nurse encounters (Yonge, 2007, 2009). In the close knit community that defines rurality a nurse's practice consists of professional and personal characteristics. Within this setting Yonge examined whether the preceptor/ student relationship was impeded by the rural setting in terms of overstepping professional boundaries and thus negatively impacting the ability of the preceptor/teacher to supervise and evaluate the student's learning. She further examined the perspectives of the students, exploring if the relationship the students experienced with the preceptors impeded their ability to be a learner and engage in the formal teaching/learning components necessary in preceptorship. Yonge indicated that both the preceptor and the student were aware of and adhered to their professional boundaries in order to enact the formal components of the teaching learning process. These findings were supported in this rural preceptorship study in which the researcher found that the friendliness and personal support of the preceptor and the other team members did not encroach on the formal aspects of the preceptorship; rather it augmented the experience in terms of the student's learning and socialization. Both the preceptors and the students intuitively knew how to seamlessly blend the formal and personal elements to create a relationship that was expansive but did not extend beyond their professional boundary requirements. According to Dalton, Butwell, Carlson, Husband, Schmidt, and Hillier, (2002) students placed in a rural setting can maintain their professional responsibilities as they interact with their preceptors, health care team members and patients. They do not become enmeshed or overly engaged with patients and coworkers. The personal relationships that the students formed enhanced their learning and gave them a sense of being a respected and valued team member. The relationship between the preceptor and the

student progressed in a collegial manner which supported the student's learning in addition to fostering her becoming a nurse within the culture of the rural setting. It emerged that the *personal* characteristics intrinsic to the relational process cemented the preceptorship. Students respected the authority of the preceptor as the teacher, with knowledge and practice expertise but appreciated how the preceptor treated them as a person, perceiving them as more than just a student. Thus the preceptor/student relationship while not equal in terms of knowledge and skills was equally important in terms of respect and engagement. The student Daisy captured the sense of relational collegiality she experienced in the rural setting:

> A friendly relationship is nice because I feel like I'm around peers more than people I'm really separated from. In other clinicals I felt a lot of nurses were really distant and it was hard to get that feeling like you're really contributing. In this [rural] preceptorship I feel like the work that I'm doing is valued, that I do belong. I contribute to the team. (Nursing Student, Daisy, Interview # 9,170-176, p. 5).

Preceptor Shannon identified how her relationship with the student was personal while she and the student were still able to maintain professional boundaries, even within the closeknit rural context:

> Nursing is about relationships. In [rural] nursing we are on a one to one basis with family, friends, patients. You have to develop relationships. You have to develop rappour. We have to keep it [relationship with the student] personal but at the same time at a professional level. Nursing is about being involved with the whole person. (Rural Preceptor, Shannon, Interview # 8, 99-110, p. 3).

Thus the ability of the preceptor and other team members to be collegial with the student set the tone for learning to occur while maintaining professional boundaries. Furthermore the

preceptor and staff demonstrated the role of the rural nurse with regard to being respectful to each other. Respect is witnessed as a necessary factor in the working relationships of health care professionals in the rural environment, a value which was transferred into the relational process that the students encountered.

Findings from this rural preceptorship study also indicated that another element that was integral to the student experiencing the preceptor being consistently by their side in a supportive manner was the student's perception that the preceptor/student relationship was underpinned by a 'power with' and not a 'power over' the student's learning and emotional needs.

Power with, not Power Over

Findings from this rural preceptorship study indicated that the preceptor as the teacher acted as a facilitator where the learner's needs were central. The preceptor nurtured the student who was viewed as an individual with her own experiences and values. The tenor of humanistic theories situates the importance of the individual learner's needs, values and experiences as relevant aspects of an educational process (Knowles, 1984). In this study the researcher found that the student was actively engaged in teaching /learning interactions and articulated what her learning needs were in consultation with the preceptor. This finding was reflected in student Daisy's perceptions of her role in the teaching learning continuum and the influence of the rural setting:

> This rural site serves an extremely large area. So I am getting to experience all of nursing [diversity of rural nursing practice]. That's been the best thing about a rural preceptorship. In the rural setting you are not sure what you are going to have to care for each time you go on duty. We [preceptor, student] talked a lot at the beginning of the preceptorship of what the expectations would be. I needed to set some goals, what type of

> things would be well facilitated. She [preceptor] was really supportive and making herself available. (Nursing Student, Daisy, Interview # 9, Lines 213-220, p. 6).

As an adult learner the previous experiences that the student brings to the preceptorship are considered prominent and influential thus building on her/his learning on a continuous basis. In this study the students were motivated and excited to learn the role of the rural nurse. They were open and purposeful in becoming informed and proficient in their skills related to practice. Knowles (1984) suggests that adults learn best when they are motivated to learn. Their readiness to engage in their education depends on their beliefs and their perceptions of the projected value and relevance of the content. It is found that education is located in a shared power between the teacher and the student. According to Dewey (1916) the aim of learning is to be attentive to how this interactive process unfolds in order to achieve the goal of gaining knowledge and practice expertise. The subject matter/content and the teaching methods are not separate or experienced in duality rather they form a holistic experience. This perspective is congruent with findings in this rural preceptorship study where the content provided by the preceptor was perceived by the student as essential nursing content and the preceptor and other health care team members were privy to, possessed and readily shared this expert knowledge. Findings further suggested that the teaching methods instigated by the preceptor were founded on facilitation rather than instillation or knowledge edification alone thus fostering a relational process in which the student felt empowered to learn. The students were encouraged and praised for their achievements. The preceptor enhanced the student's ability to experience her learning, where the preceptor sought and promoted clinical opportunities to support the student's learning. For a student to become concretely knowledgeable s (he) must have practical experience to solidify the content (Dewey, 1916). This study's findings indicated that students felt supported and respected thus open

interactions were engendered with their preceptors, ensuring that both preceptor and student were invested in the progression of the student's learning. One preceptor Dawn stated what she perceived her role of teacher and facilitator and how this approval contributed to a form of student transformation from dependence to independence, a challenge in the diverse requirements of rural nursing practice:

> At first they're [students] quite dependant. My role as a preceptor is just keep pushing them into independence but they need to know that you're not going to squash them. These students didn't know what to expect as they did a lot of their clinical practice in the cities and rural is different (Rural Preceptor, Dawn, Interview # 15, Lines 53-56, p. 2).

Transformative learning is achieved in a twofold manner, namely instrumental and relational (Mezirow, 1991). Both have to be present to ensure meaning is constructed for the student as it relates to her/his learning. The student must be able to experience learning through practical encounters in order to fulfill instrumental learning. In addition the type of communication instigated between the teacher and student is paramount in solidifying and encompassing a more complete holistic approach to knowledge, practice and meaning. These findings were supported in this rural preceptorship study in which the researcher found that the preceptor/student relationship supported instrumental achievements and open communication. The beliefs and experiences of the preceptor and most especially the learner were acknowledged. Findings suggested that an ebb and flow existed as it related to the teaching/learning interactions throughout the rural preceptorship. It was found that these were experienced by both the preceptor and the student as an ability to share power. The relational process provided the connection thus encouraging and fostering a shared fluidity in the teaching learning achievements. At times the preceptor was perceived to be the expert in clinical content and

practice; however the student was encouraged and felt empowered where relevant to share previously acquired knowledge and experienced skills with the preceptor and other health care team members. The student felt valued and able to contribute, in terms of both teaching and learning, within the rural practice setting. This finding was indicated in the following preceptor reflections of the teaching/learning relationship between preceptor and student:

> She [student] brought experiences to me that I didn't have so there were things that she [student] was able to teach me as well that I thought was a really good exchange of information (Rural Preceptor, Jay, Interview #1, Lines 175-177, p. 5).

Another student Sarah perceived how she felt valued and able to share her experiential knowledge and learnt skills:

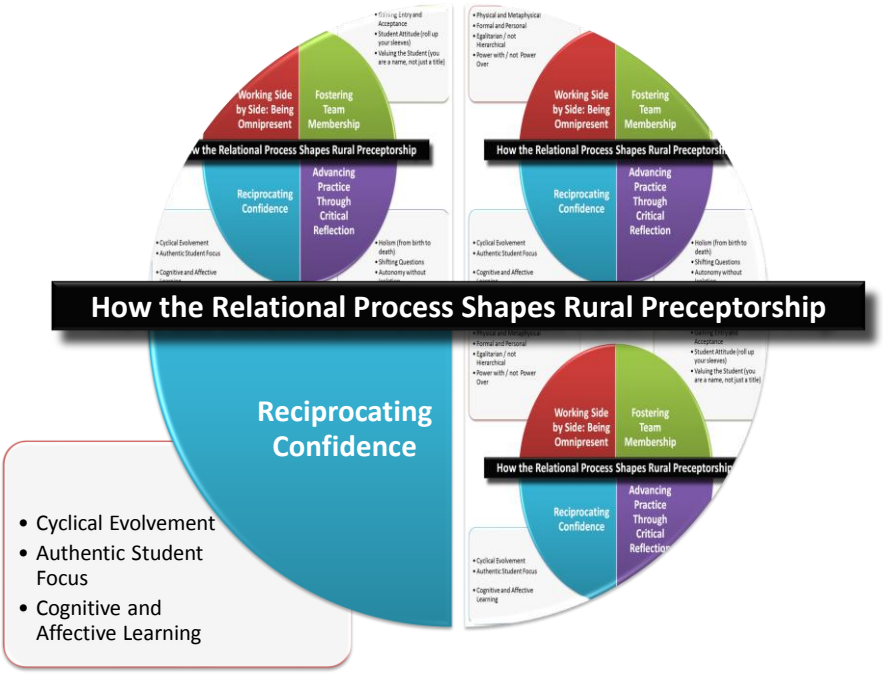
> [Rural setting/preceptorship] helped my learning and my investment into becoming a nurse. I felt I had more control in the rural setting. I had a chance to speak to the interdisiplinary team. I am in a much bigger charge role position [contributions being valued] than in [urban settings]. They [staff] were very interested in learning the new evidence or the different way (Nursing Student, Sarah, Interview #14, Lines 350-352, p. 10).

The researcher thus found that the term side by side better described the preceptor/student relationship in which support for the student was manifested in a *physical* and *metaphysical* presence and included having a *collegial, not hierarchical* interaction that translated into the student experiencing a *power with* the preceptor and not the preceptor instigating a *power over* the student thereby inhibiting the relational or learning process.

Reciprocating confidence was found to be a second key characteristic intrinsic of the core variable in 'how the relational process shapes rural preceptorship'. The term reciprocating

confidence denotes a confidence that was shared between the student and the preceptor to foster the student's learning.

Figure 3: Reciprocating Confidence



Recipricating Confidence

In this study student confidence was found to be seminal to the preceptor/student relationship. When students perceived that they were consistently supported in a non threatening manner they steadily gained confidence in the required knowledge and skills as they proceeded through the rural preceptorship. Students who are the recipients of acceptance, support and trust from their preceptors as they assume clinical responsibilities, feel safe, valued and gain confidence (Happell, 2009). Preceptors who protect and encourage their students foster student confidence and competence (Koontz, Mallory, Burns, & Chapman, 2010). Students' individual ability to acquire self assurance in their clinical performance, in coalition with the preceptor's belief in the student's ability to perform was identified by the researcher as reciprocal confidence which comprised three ambient elements 1) cyclical evolvement; 2) authentic student focus; 3) and cognitive and affective learning.

Cyclical Evolvement

Confidence may be defined as a belief that one will act in the proper, right or effective way. The importance of confidence in health care providers cannot be overestimated because of its relationship to greater patient outcomes (Hecimovich & Volet, 2009). Furthermore confidence is influenced by the close professional relationship between the preceptor and the student thereby creating an environment that encourages student participation. One of the goals of preceptorship is to promote a student's confidence to achieve competency. If the relationship is nurtured and supported by the preceptor then the ability of students to feel self assured in their practice is a positive outcome of this process (Myrick & Yonge, 2001). These findings are congruent with this rural preceptorship study in which the researcher found that as students advanced in their confidence as it related to their knowledge and skills of specific content, it was interwoven with the preceptor's relationship with the student. The relationship impacted student confidence as to how timely this confidence surfaced, progressed and was strengthened. Reciprocity denoted a dynamic, mutual interaction; in this case between the preceptor and the student, whereby confidence was not achieved in isolation by the student, rather it was influenced by the preceptor's ability to actively support the student. Furthermore preceptors demonstrated to the students, through word and action, their belief in the students' continued progress regarding knowledge and skills. This finding was indicated in the preceptor's demonstration and acknowledgement of the student's progress and how the student was able to gain confidence as the relationship progressed as reflected in preceptor Karri's words:

> At the start she [student] buddied with me then when I saw her perform a skill I let the reins go accordingly. If it was something more complicated I stayed with her longer until

> I felt and she felt comfortable (Rural Preceptor, Karri, Interview # 6, Lines 76-83, pp. 2-3).

When a preceptor demonstrates trust in a student's ability it alleviates a student's 'imposter' fears and fosters the student's self belief and autonomy development (Hayes, 2000). Furthermore preceptors who have a personal interest in the students' learning recognize the vulnerability of the students in their role transition from being a student to becoming a graduate nurse. In this study the preceptor's ability to develop a conscious support and trust of the students' learning was found to be integral to nurturing confidence and alleviating potential stress, anxiety and fear. This was found to be paramount in the ever changing rural practice setting. This cyclical transference of confidence was reflected in the words of the following two rural preceptors Jay and Donna:

> I think it's [rural preceptorship] such a nice way of introduction into the profession. It's very intimidating for these students to come out [to the rural setting] and be expected to function as a senior nurse. I just feel by coupling them with somebody else, a more senior person you can story, talk about things, show them, and teach them. You're [preceptor] going to just simply build confidence that they experience it [preceptorship] with the help of someone. Then when they are ready to take off on their own they can do it [rural nursing practice] on their own (Rural Preceptor, Jay, Interview # 21, Lines 179-193, p. 5).
>
> It becomes a confidence in each other where they both grow, as a preceptor and as a student (Rural Preceptor, Donna, Interview # 22, Lines 52-53, p. 2).

Ferguson (1996) indicates that the relationship between the preceptor and the student is an important and necessary connection to enhance students' self confidence. However a student's confidence is built not in isolation of the preceptor/student relationship rather it is

enhanced and nurtured by the relational interactions. In the case of this study it was found that students associated the ability of their preceptor to instil and augment their confidence as being essential, particularly in the rural context where practice challenges were a regular occurrence as was reflected in the words of Daisy, a student:

> There was a lot [diversity of rural nursing practice skills] that I had not done before but my clinical [rural preceptorship] came together. I felt a little shaky but you get an opportunity to do those things [rural nursing practice] while you're still a student, you're protected; there is always someone there who can help you. I feel I don't have to jump in as a practicing nurse. I feel I had a lot of solid clinical skills coming in and now I get the opportunity to practice, refine and learn how I do things based on the needs of the people in the rural setting (Nursing Student, Daisy, Interview # 9, Lines 64-74, p. 2.).

Students denoted their ability to gain confidence as they interacted with their preceptors while applying their knowledge and skills to patient needs as stated by students Alexis and Daisy:

> I definitely think that it helps to build confidence when you have somebody [preceptor] to go to whether it's just for clarification or you just need to talk to someone. Maybe you don't understand fully or you're not sure how to cope. It's huge, your colleagues [preceptors] are a big part of it [confidence building] (Nursing Student, Alexis, Interview #11, Lines 259-267, p. 7).
>
> At the end of it I was a lot more confident and competent in those areas I really worried about starting off in the preceptorship. Most of that was directly because my preceptor really instilled a sense of confidence in myself and I also felt confident in myself by the

> end of the preceptorship, I could be independent (Nursing Student, Daisy, Interview # 23, Lines 131-136, p.4).

In this rural preceptorship study the cyclical nature of confidence building for the student was based on the preceptor's attitude of observing, facilitating and verbalizing a trust in the student's learning and practice achievements thus promoting the students' confidence. In addition to cyclical evolvement findings from this study indicated that reciprocal confidence was best promoted when it had an authentic student focus whereby the preceptors were motivated to concentrate their attention on the student.

Authentic Student Focus

Reciprocity experienced between the student and the preceptor in this study related to the engendering and building of confidence in the student. It was this attention to the student's needs that created an environment where from the relational support experienced by the student elicited a fostering of the student's confidence as a process and cemented the end product of competency. Because of the preceptor's confidence in her role as rural nurse, teacher and preceptor she was thus able to be student focused as reflected in the following words of Jay, a rural preceptor:

> I was teaching her [student] things that I knew and giving her experiences of what I do that were within our scope of practice for when she graduates. It was nice to be able to speak to her one to one and teach her what I knew in hope's that she would embrace that and use it (Rural Preceptor, Jay, Interview # 1, Lines 28-36, pp. 1-2).

Myrick and Yonge (2005) indicate that the ability of the preceptor to assume the position of teacher and role model is essential for the student's learning. Preceptors'unfamiliarity with their role in the preceptorship this impacts the student's learning. To enhance preceptors'

confidence in their role, integral to the teaching learning process, providing sufficient preceptor orientation and support nurtures this confidence. According to Young and Patterson (2007) ensuring adequate support for the preceptor contributes to the preceptor benefitting in her/his position as teacher and the student benefiting as the learner. Thus the role of the educational institute's faculty member within preceptorship is to contribute a support mechanism for the preceptor such that the support contributes to promoting a teaching learning environment that is not impeded by an anxious or resistant preceptor (Myrick, & Yonge, 2003; Yonge, Ferguson, & Myrick, 2006). In this rural preceptorship study faculty members assumed a liaison position, facilitating communication and links to the educational institute and contributing to the ongoing support of both the preceptor and the student where needed as reflected in the following faculty member Leah's words:

> I always share with them [preceptor or student] at the beginning if you feel you need me to come and liaise or help you communicate with this person [preceptor or student] let me know. I think we [faculty members]can go in and try to create a]positive] environment for them [preceptor or student], to set them up for success (Faculty Member, Leah, Interview # 2, Lines 40-45, p. 2).

Another faculty member Dora observed how she was able to contribute to supporting the preceptor in her role as teacher thus allowing a positive relationship to develop between the student and preceptor without undue stress related to a lack of confidence by the preceptor in her role requirements:

> That's why we have workshops as they [preceptors] need to develop professional relationships and Number 1 is the preceptor/student relationship. So my role is to oversee

> that and support each, mostly the preceptor in terms of teaching and the student in terms of learning, my role is for both (Faculty Member, Dora, Interview # 3, Lines 77-81, p. 3).

High levels of preceptor confidence facilitate a positive relationship developing between the preceptor and the student (Young & Patterson, 2007). Faculty support allowed the preceptor to focus on the student as the learner and foster student confidence without the potential hindrance of a lack of confidence in her own role in the preceptorship relationship. Preceptors found support from faculty members, and in addition were experienced in their role as preceptors, therefore their confidence was apparent, as was their ability to foster the student's confidence rather than focus on self. This faculty support and preceptor confidence was reflected by preceptor Karri in the following words:

> She [faculty member] was very faculty oriented. I think she was very good at her job. She was positive and supportive. She was really happy and grateful to us [rural preceptor and staff] for taking a student and for the student being able to have rural nursing [experience] (Rural Preceptor, Karri, Interview # 6, Lines 318-325, p. 9).

Students were aware of the role of faculty members and appreciated their support and communication with the student and the preceptor as indicated by the following two students Rona and Kayley:

> I think that the faculty member is a support, an extra support to both the preceptor and the student and to be available to discuss [preceptor, student needs] and everything else [preceptorship course requirements] (Nursing Student, Rona, Interview # 4, Lines 200-205, p. 6).

> It's nice knowing that there is someone else if you have a problem or something that you can't work out (Nursing Student, Kayley, Interview # 5, Lines 221-223, p. 6).

The preceptors' confidence in their roles as teachers and rural clinicians solidified their ability to engage in an authentic student focus thus promoting confidence and competence. In addition to there being a student focus, reciprocal confidence inhered both cognitive and affective learning. Both of these learning conditions were influenced by the relational interactions between the student and her/his preceptor.

Cognitive and Affective Learning

The notion of knowledge as a coupled concept, vis a vis cognitive and affective learning, is articulated by educational and philosophical scholars and informs a number of educational theories. Bloom (1956) indicates that learning for the student occurs within the realms of the cognitive and the affective domains, where both have a complimentary duality in order to achieve learning. Learning may not be achieved if only one or the other exists. Receiving information does not translate into retaining knowledge or applying one's learning without the tenets of affect to cement the obtained knowledge. Furthermore Nussbaum (2001) contends that emotions should be considered more than feelings, rather she envisioned emotions as thoughts that are evaluative in nature thus are not separate from cognition. Emotions are thoughts, in other words, they are cognition. Emotions and cognition are inextricably linked and cannot be divided. The heart and the head cannot be separated and are required in human learning (Hargraves, 1997). In this study learning was apparent and observable by both the preceptor and the student whereby increased confidence in the student culminated in a progression along the learning continuum. The researcher found that the relationship nurtured by the preceptor was key to fostering the student's emotional well being which in turn garnered a positive learning evolution. The students reflected that the more nurtured they felt in the relationship the more knowledge and skills they readily achieved thus learning achievements translated into increased confidence

and vice versa. In one case where the student Kayley experienced an extended period of relationship building with the preceptor it took her time to feel and act with confidence. Initially she felt an anxiety to perform for the preceptor. However when she and her preceptor settled into a mutually rewarding relationship her learning excelled, her anxiety diminished, and her confidence grew:

> I definitely think my confidence grew and everything in the preceptorship. I found it [diverse rural nursing practice] difficult at first. I think she [preceptor] expected me to be quite confident from the beginning. You're told to be more confident but it's hard when you don't have the experience (Nursing Student, Kayley, Interview # 29, Lines 83-88, p. 3).

The preceptor as the teacher had a significant impact on the student's cognitive and emotional learning. Emotions are more than non reasoning, non thinking movements. Rather "emotions shape the landscape of our mental and social lives" (Nussbaum, 2001, p.1). Therefore our learning is located within the social realm thus the influence of society and others to one's learning is salient (Bandura, 1971). Learning is experienced and affected by relational interactions. The effect of the relational process on the student's learning and emotional well being was apparent in this study. Preceptors Mary and Barbara reflected on their role as teachers and the emotional supports for students during rural preceptorship:

> It's the role for introducing and for support, kindness and patience (Rural Preceptor, Barbara, Interview # 13, Lines 132, p. 4).
>
> You [as the student] always experience it [learning] moving along a continuum and so it is our gift to be able to notice where it [learning] is and try to encourage the student where we can (Rural Preceptor, Mary, Interview #19, Lines193-195, p.5).

> I was there to teach them [students], not to discipline them, not to bring them down but to teach them so we [preceptor, student] did very well [in the preceptor/student relationship](Rural Preceptor, Barbara, Interview # 13, Lines 350-352, p. 10).

According to Brookfield (2009) to be a skilful teacher, the organization and dissemination of content is not enough, rather the ability of the teacher to relate to the student is essential. If the teacher is aware of how s (he) is being perceived and how the student's learning is actually progressing it is necessary to develop an awareness of the emotive aspects related to the student's learning. If the emotional attitudes of the student are considered important then the relationship that is forged between the teacher, in this case the preceptor, and the student is vital. It is within this relationship that trust is fostered. Therefore trust for the student entails the teacher having specific knowledge in addition to possessing and sharing the relational self. Thus the student must trust the preceptor to feel safe in articulating and reflecting truthfully not only on the content but also on the process. Trust is achieved within the realms of a safe relationship. Students, who have a good relationship with their preceptor, experience the sense of having a *safety net* for their learning (Barrett & Myrick, 1998). This perceived safety net is constructed from both the support of their preceptor in terms of knowledge acquisition and their emotional wellbeing. The preceptors in this study were intent on creating a supportive and safe learning environment. Students trusted the preceptors' knowledge and the portrayal of their relational selves which culminated in their feeling safe and their learning protected. This finding is observed by a student Sarah:

> What I learnt from this preceptorship is what nurse I want to be. I had the needed elements [within the preceptor/student relationship to learn and be] (Nursing Student Sarah, Interview # 14, Lines 394-397, p. 11).

Another preceptor Donna observed:

> You definitely have to work together [as a team] because your work [in the rural setting] can go from the bottom to the top [mundane to acute/critical]. Working together you feed off each other's knowledge fields and experiences. You worry for the student [in the role of becoming a rural nurse] therefore it is the preceptor that sets the value [of including and supporting the student]. You are giving positive feedback [related to the student] to all your team members and trying to make sure the student fits in, as that is what works [being welcomed and included]. So it is the preceptor that gives to the student and can make or break it for the student (Rural Preceptor, Donna, Interview # 22, Lines 134-143, p. 4).

Faculty member Wanda reflected on the preceptor/student relationship and how the cognitive and affective learning domains were present and necessary for effective teaching:

> I think it is paramount that the preceptor and student get along. If they [preceptor/student] have a good relationship everything else just falls into place. Then they feel freer to voice their anxieties, they feel freer to say "wait a minute, I don't know this". That's the key [relationship]. That relationship is the most important thing; we cannot separate our emotions, or our affective domain from everything else. They [preceptors] play a key role in reducing anxiety. Without anxiety learning occurs more naturally, the mind isn't cluttered with stress (Faculty Member, Wanda, Interview # 16, Lines 36-48, pp. 1-2).

The teacher is only able to connect with students as learners when they are able to imagine and reflect on what it is like to be learner; where there is a sense of anxiety with not knowing, being uncomfortable with new knowledge, feelings of inadequacy, all contributing to a sense of unease (Brookfield, 2009). Reflections for the teacher necessitate remembering what it

is like to be a learner, in order to obtain and retain new knowledge, skills and the experience of being a novice. The teacher/preceptor requires a portrayal of empathy for the novice learner and a reflexivity of being in a similar situation as observed by the student Daisy:

> With my preceptor she still remembers what it is like to be a student so she really validates things I feel needs to be validated but she lets me have my independence. I think she recognized the whole point of preceptorship. I think we really have a good partnership together (Nursing Student, Daisy, Interview # 9, Lines 178-188, p. 5).

According to Rogers (1969) the ability to validate the student as the learner is not achieved without valuing the person in a relational way. This valuing of the student is not encountered as a predictable linear process; rather it is an intuitive interaction that requires empathy, acceptance and trust. When these values are present in the relationship then the freedom to learn is nurtured and not diminished. Preceptors in this study were found to be empathetic and cared for the student thus learning occurred in the presence of a positive relationship. This finding was reflected by rural nurse Barbara, who also considered herself a preceptor, in connection with a student's perceptions, after graduation, of the preceptor/student relationship:

> Initially I did not get feedback as a preceptor but as they [students] have gone on to graduate they say how easy it was to talk to you [as the preceptor] about anything and be treated like a graduated nurse even when they [students] were still involved in the preceptorship. How they found challenges [for their learning] and accomplished this [the learning with the preceptor's help]. I don't think they had time to think about the relationship [when it was happening] that's something they thought about later on (Rural Preceptor, Barbara, Interview # 13, Lines 324-331, p. 9).

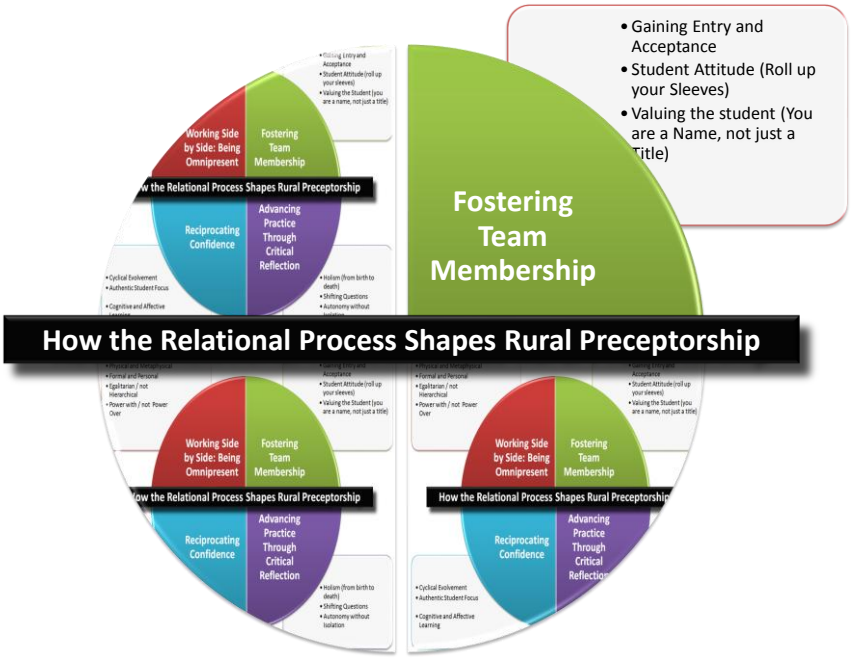
Another preceptor Dawn reflected on her role as a preceptor and teacher:

> I think my role is like a mentor, that would be the best word, like a mentor, supporter and then it's just like anything you kind of kick them out of the nest [towards independent practice] but let them know you are still there [if they need you] (Rural Preceptor, Dawn, Interview # 15, Lines 81-84,p.3).

In this rural preceptorship study *reciprocating confidence* was a salient characteristic that promoted student learning through a process of relational interactions. *Cyclical evolvement, authentic student focus* and awareness of the *cognitive and affective learning* conditions fostered student confidence thereby reducing anxiety while simultaneously nurturing both the student's learning and the preceptor/student relationship.

A third key characteristic inherent to the relational process and how it shaped rural preceptorship was the fostering of team membership. It was found that the relational process between the preceptor and student connected and extended beyond the preceptor/student relationship to include an acceptance and welcoming of the student by other staff members, thus becoming a legitimate member of the rural team/community.

Figure 4: Fostering Team Membership



Fostering Team Membership

In the rural context the preceptors' relational interactions with the students and how they role model and communicate team membership is important to facilitating student entry for becoming a new member, including interacting with the interdisciplinary team (Sedgwick, Yonge, & Myrick, 2009). In this rural preceptorship study the researcher found that the preceptor/student relationship held a pivotal connection to allowing the student to feel welcomed, supported and valued as a team member. The preceptor set the stage and paved the way for the student to becoming a legitimate member of the team community. This team membership contained a number of elements that fostered admission for 1) gaining entry and acceptance; 2) student attitude (roll up your sleeves); and 3) valuing the student (you are a name and not just a title).

Gaining Entry and Acceptance

A distinct nursing practice exists in the rural context (Kulig et al, 2008). This practice is often referred to as 'team nursing'. However in this study the term *team* differed conceptually from a number of studies in which 'team nursing' refers to a specific model of care. This model of care denotes a particular way of practice whereby a group of registered nurses and other allied health care workers are designated to care for a group of patients as opposed to one registered nurse caring for the complete needs of fewer patients, in the model of care known as case management (Cioffi & Ferguson, 2009). The researcher in this rural preceptorship study found that the term '*team*' was synonymous with a philosophical and cultural way of being rather than a particular model of nursing practice. In the rural context physicians are not on site 24 hours a day. Therefore nurses must rely on each other to provide best care for the patient, drawing on the experience and expertise of the nursing staff, who remain on site around the clock, thus pooling their knowledge and skills (Bushy & Bushy, 2001; Krebs, Madigan, & Tullai-McGuiness, 2008). This conceptualization and mentality of team is in keeping with the larger rural community attitude of working and supporting each other, including family, friends and neighbours. In the rural culture supporting other members of the community is perceived as an obligation in order for all in the community to benefit (Vollman, Anderson, & McFarlane, 2007). The researcher found that the rural culture of what it means to be a community member extended into the health care facilities and into the everyday practice of the nursing and other health care staff. There was solidarity of togetherness that permeated the rural health care environment as indicated by the preceptors and other nursing staff. This solidarity was reflected in the following words of the rural nurse Mary:

Rural nurses working together is something that happens as a community experience (Rural Nurse, Mary, Interview # 12, Lines 180-190, p.1).

Preceptor Karri commented on her experience of the uniqueness of the rural setting including its required knowledge and practice implications:

> I had an experience of working in [urban]. I'll never go there again because you're on your own. Here [rural facility] you're never alone. It doesn't matter if it's an RN or LPN we all work together, we are a team. Everyone works so well here and that is why the patients like it here (Rural Preceptor, Karri, Interview # 6, Lines 190-197, pp. 4-5).

Given the cultural influence of the rural context findings from this rural preceptorship study indicated that the preceptors were supportive of their colleagues and vice versa. This supportive ethos automatically extended to the student as she arrived for her preceptorship. A supportive relationship was instigated from the beginning of the preceptorship between the preceptor and the student thus setting the tone for the student entering into the rural environment. Because the preceptor had a close collegiality with her team members the preceptor was a respected member of the staff community. Thus when the preceptor vouched for the student as a potential member of the close knit community this in turn facilitated the student gaining entry and acceptance into the team as reflected in preceptor Donna's words:

> In the first two weeks she was my [preceptor's] student then she became everyone's student, going to any of the nurses, LPNs, physicians, discussing issues and learning from them. Working in a small and a very open community really helped, she felt very confident (Rural Preceptor, Donna, Interview # 7, Lines 128-134, p. 4).

In rural preceptorship, although the initial relationship is formed between the preceptor and the student, relational interactions are further expanded to include the team (Sedgwick & Yonge, 2008). Thus student membership into the team is culturally significant in terms of the student experiencing a positive, supportive preceptorship. Team membership is likened to entering into a family unit. These findings are corroborated in this rural preceptorship study where it was found that the team support experienced by the student served to contribute to the student's learning and her perceptions of an augmentation of the relational process, thus becoming a bone fida member of the health care community enhanced the preceptorship experience. This finding was reflected in student Daisy's perceptions of gaining entry and acceptance into the team:

> That's one of the things I really noticed about the hospital, they seem like a pretty tight staff to begin with. Everyone enjoys working together which again is different to other clinical settings where I felt shut out. Everyone really tries to band together. It's been encouraging and really what has made the preceptorship [positive] for me. You feel like you're welcome (Nursing Student, Daisy, Interview # 9, Lines 278-292, p. 8).

Faculty members perceived the rural environment to be unique. This distinct setting translated into a culture of nursing practice that was inclusive of the preceptor and other team members as indicated in the words of faculty members Dora and Wanda:

> I can't say enough positive things about rural nurses. They have this sense of community. I guess it's about the size of the staff where there may be nine [registered nurses] in the hospital as opposed to nine hundred in the bigger centre, that is important [for community

> spirit]. They embrace other nurses, colleagues and students (Faculty Member, Dora, Interview # 3, Lines 190-192, p. 5-6).
>
> I got an overwhelming sense it was like family [rural clinical setting] so the student was included as a team [member]. Everyone [staff] had a much more intense involvement. They are very much wanting the student to learn and including them. It was just like open arms. They valued her input. (Faculty Member, Wanda, Interview # 10, Lines 222-238, p. 6).

Dalton et al. (2002) indicate that students from an urban program, prior to going rural, contemplated whether they would feel welcome by staff or whether they would become more scrutinized because of the smallness of the community and health care facility. Upon completion of the preceptorship, in the Dalton study, the students found that they are welcomed and valued as contributing members of the team and are able to perform and implement their knowledge and skills in a positive way. Contrary to the rural context creating challenges it is the tenets of the rural nursing culture which serves to facilitate a positive and rewarding experience whereby becoming a member of the team and community serves to enhance their experience and promote their practice. The findings from the Dalton study are supported in this rural preceptorship study where the researcher found that the students felt nurtured. They were valued and respected thus allowing them to feel that they were accepted as peers and colleagues. This further facilitated their transitioning from student to graduate nurse. They experienced a sense of what it was like to be a registered nurse and team member. Students Rona and Sarah reflected on their entry into the team community:

> I found it did develop into more of a peer kind of relationship with both the preceptor and the rest of the staff. It was kind of developing a relationship for [future] practice (Nursing Student, Rona, Interview # 18, Lines 39-46, pp. 1-2).
>
> It was definitely nurturing, from everyone that I encountered within the [rural] community of my preceptorship. I hadn't really gotten a lot of that [support] in the past (Nursing Student, Sarah, Interview # 22, Lines 49-52, p. 2).

Team membership is important in the rural setting and the student's ability to gain entry into the team is vital and is facilitated by the team's openness and acceptance of the student as an inclusive member. In this rural preceptorship study the second element that fostered team membership was the students' attitude which resulted in the students' readiness to actively 'roll up their sleeves' as contributing staff members.

Student Attitude (Roll up Your Sleeves)

Rural nursing is a dynamic practice which requires nurses to have a broad and diverse knowledge base and skill requirement to meet the multiple and extensive needs of the populations served (Crooks, 2004; Thomlinson et al., 2004; Macleod et al, 2004 b). Oftentimes this rural contextual practice stipulates the requirement of a number of specialty areas within a single health care facility. Thus rural nurses and staff have multiple practice requirements and must be flexible in their delivery of care. In the rural setting a working day may go from the mundane to the most acute or emergent care (Crosby et al., 2000). Given this work environment rural nurses have an attitude and work ethic that demands 'all hands on deck' where stipulated, to ensure that patients receive the best and timeliest of care possible (Thomlinson et al., 2004). This rural work ethic extends to all members of the staff team and by default this includes the student as a team member. The preceptor demonstrated, by role modeling, a strong work ethic, as

did all members of the rural team, for the student to follow. This attitude was reflected in the following words of Jay, a rural preceptor:

> When you are nursing in an urban centre you have your doctors, other nurses and other disciplines at your beck and call whereas in the situation of rural nursing you might be the only one and there may not be anyone to call so you want them [student] to feel they can face as many crises as possible but also they can handle the mundane everyday patient care. You want them to feel that they can handle as many situations as possible (Rural Preceptor, Jay, Interview # 1, Lines 84-89, p. 3).

Rural nurse Mary indicated why the rural context is challenging and how important it is for a new team member to be able to fit into the practice context:

> I believe in the rural setting it's a particularly stressful setting in which people really need to work together to practice properly. Rural nurses are unique in terms of practice comforts. Many units will have a special dynamic and each newcomer will need to understand and be able to communicate. This is very important in terms of trust and credibility and it affects the dynamics. One of the most important parts is willingness and a caring that have to be shared so people can relax and do their jobs (Rural Nurse, Mary, Interview # 12, Lines 31-42, pp. 1-2).

Because of their ethical work beliefs rural nurses do not need external motivation or control to provide best health care for patients. Because the patients they nurse are family, friends and neighbours their willingness to provide expansive care is discernable. They are self motivated in their practice provision, being flexible to the required demands (Kulig, 2000; Thomlinson et al. 2004). The researcher in this rural preceptorship study found that team members valued the rural work ethos and ensured that they, as individuals, and as a collective

team, contributed to patient care. In addition to the preceptors' abilities to act as role models to the students they facilitated setting the students up for successful team membership by illuminating why and how the student needed to "*roll up your sleeves*" in order to contribute to the team as reflected by rural preceptor Karri:

> As a team [member] I laid out the ground rules and said this is how we [staff] work here [in the rural clinical setting] and I wanted her [student] to be aware so she would fit in with the team and she did. I reminded her a few times to ask the team if they needed help. By the end of it she was working well. I received positive feedback about her willingness to help. She was willing to do any job and she was always eager to help (Rural Preceptor, Karri, Interview # 6, Lines 200-207, p. 6).

According to Lee and Winters (2004) the distinctness of rural nursing is underscored by the ability to provide extensive and holistic practice. Rural nursing calls on each nurse individually and collectively, as part of the community, to conscientiously partake in wide ranging nursing practice. In this rural preceptorship study the students work ethos and contribution served to further enhance their membership into the staff community and translated into caring for the patients using best rural nursing practice. The students were able to observe the importance of the work ethic in the rural environment. They embraced this practice as something to emulate and wanted to be a part of this nursing context. The students' attitude to work and their enthusiasm to fit into the team and provide the patients with holistic care further demonstrated to them, their preceptors and staff that the students did indeed roll up their sleeves and were contributing to any and all care that was required of them during a day's work. This attitude and it's translation into a strong and flexible work ethic ensured their legitimacy into rural nursing thus allowing them to transition to becoming a rural nurse, inclusive of its distinct

practice, required upon graduation. This finding was indicated in the following students' Alexis and Rona's reflections:

> You're welcomed there [rural setting] as long as you're willing to work. If you have the proper attitude, if you come in with the attitude that you're willing to work, to ask questions, to help everybody, to work as a team. That's the core of nursing. It's a team. I was very much respected (Nursing Student, Alexis, Interview # 11, Lines 18-23, p. 1).
>
> It's really been beneficial to see everything. I feel like a jack of all trades but I definitely like the rural setting. There have been days when it is a bit slow and even too hectic. Rural nurses have been constant [in their practice] and this [observed consistency] can assist [me as the student] as a forerunner to graduation (Nursing Student, Rona, Interview # 4, Lines 338-346, pp.10-11).

The ability of the students to actively connect, communicate and participate with the rural health care team is essential to them becoming welcomed, valued and legitimate team members. They learn from the preceptor's role modeling and facilitation, in unison with their own attitude, to negotiate the entry requirements of membership (Sedgwick, Yonge, & Myrick, 2009).

The third element that solidified the students becoming a welcomed and respected team member was the ability of the team to value the student, whereby the student perceived from the staff a sense of personal engagement rather than being viewed as 'only the student'. The student experienced being a name (personal) and not just a title (student).

Valuing the Student (You are a Name and Not Just a Title)

A variety of factors contribute to the student experiencing a positive preceptorship. One of these contributing factors is the influence of the workplace environment and personnel in relation to the student's ability to learn thus gaining confidence, competence and autonomy

(Ockerby, Newton, Cross, & Jolly, 2009). The influence of a positive, supportive environment cannot be overestimated (Charleston & Happell, 2006). Much of the responsibility for learning and providing a positive experience for the student falls primarily to clinical practitioners thus fostering this teaching learning process. These practitioners facilitate this obligation by working alongside the student to provide teaching opportunities and socialization of the student into the role of the registered nurse. Preceptors serve as clinical experts who foster learning and create an optimal environment to promote this learning. Preceptors who successfully achieve this teaching role demonstrate characteristics such as motivation, approachability and strong interpersonal skills (Zilembo & Monterosso, 2008). In this study the researcher found that preceptors were able to nurture the students' learning. They demonstrated exemplary interpersonal interactions with the student thus promoting learning, socialization and approachability that exuded support. However it is also incumbent on the preceptor to negotiate entry and integration of the student into the nursing team so they too can share their knowledge and skills (Diebert & Goldenberg, 1995). The researcher found that facilitation of entry into the team for the student was actively negotiated by the preceptors and was consistently overseen by them throughout the preceptorship thus contributing to the student's integration into the staff community. Thus the students consistently felt protected and connected to the preceptor throughout their preceptorship as illustrated in the student Sarah's reflections:

> If you had a problem you could go to her [preceptor] and discuss that with her. She was on my side. If she was not happy with the way another was treating me she would give them [staff member] a talking to and say to support the student (Nursing Student, Sarah, Interview # 14, Lines 212-214, p. 6).

In another reflection, preceptor Shannon indicated that her role in facilitating integration of the student into the team consisted of ensuring a protection and support for the student:

> There are some staff who forget what it is like to be in a vulnerable situation so I sometimes have to advocate for the student. They [students] are human in their learning and I say when they [student] get to your [staff] age they will know as much as you do (Rural Preceptor, Shannon, Interview # 8, Lines146-151, p. 4).

The sense of belongingness for the student is influenced by factors such as the individual characteristics of the student and the staff, interpersonal relationships among the student and other health professionals, patients and their families and the clinical environment. Furthermore attention to understanding these factors is required as the clinical environment has the ability to positively or negatively affect a student's sense of belonging (Sedgwick & Rougeau, 2010). In this study the researcher found that the students experienced a strong sense of being valued and being positively responded to by other members of the team. This valuing of the student was encouraged by preceptors but it was further supported by team members as part of a culture of 'family' as indicated in preceptor Karri's words:

> It was more of a personal involvement with the student. It's a closer knit group [rural team members] and that person comes into the group, kind of like one of our family members, an extended family member (Rural Preceptor, Karri, Interview # 27, Lines 49-51, p. 2).

The students felt this sense of value and collegiality as expressed in the following reflection by the student Daisy:

> I felt during my preceptorship I was accepted as a team member more so than just being a student. I think essentially their focus is on working as a team so it's much easier to join a

> group of nurses where everyone is focused on taking care of the patient. Everyone has their role but everyone plays a part and when there's a new member they just make room (Nursing Student, Daisy, Interview # 23, Lines 44-51, p. 2).

Rural nurse Mary illustrated how the team should and must contribute to the preceptorship experience of the student:

> It's the responsibility of the community of support, to be there, to try and assist those new experiences so they can be gotten in a human, healthy way. That's another part the team can play which is a great opportunity because the preceptor never acts alone. The preceptor always needs a community of support. The preceptor/student experience happens within a community and for that to be a positive experience the entire community needs to be responsive to the experience and willing to grow so that's how it can be a healthy relationship (Rural Nurse, Mary, Interview # 19, Lines 99-109, p. 3).

According to Ockerby et al. (2009) the ability of the preceptor and other practitioners to be empathetic nurtures the student and diminishes the perceptions of a stressful environment. Furthermore students respond to practitioners who recognize the student's individualism and support their personal knowledge and skills. Preceptors who portray a team spirit contribute to an environment where team effort is focused on the good of the patient and the facility functions at an optimal level of care (Kewley, 1995). Everyone has a clear idea of their role and contribution in relation to self and other colleagues. These findings are supported in this rural preceptorship study where the relational process occurring among the preceptor, the team and the student nurtured the student's feelings of being personally supported, encouraged and being provided greater autonomy of practice. Relationships were formed with team members and an atmosphere of collegiality was instigated. It was this nurturing of the students, where their prior experiences

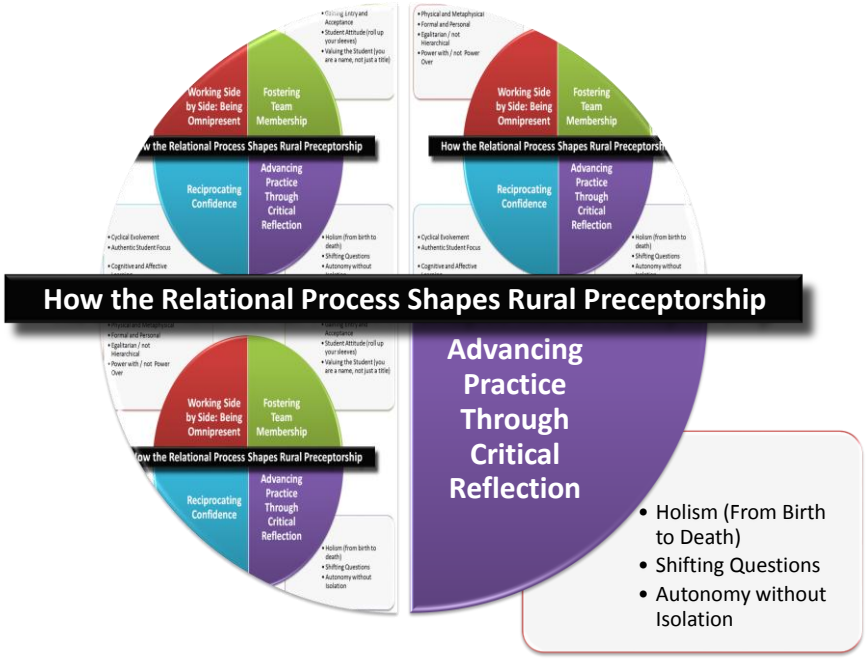
and personal attributes were vaulted that created a sense of friendliness and a sense of belonging as experienced by the students Sarah and Alexis:

> I found that everyone was there trying to help me in my practice, all the different levels of nurses, RNs, LPNs, they were there as team members. It was a community and I was part of that so they wanted to make sure that I succeeded (Nursing Student, Sarah, Interview # 24, Lines 163-168, p. 5).
>
> The relationship was a huge part. It just helps with that positive relationship. It [preceptorship relationship] just helps you consolidate everything you have learnt not just within the preceptorship. It just helps you to bring everything together that you've learnt over four years (Nursing Student, Alexis, Interview # 25, Lines 81-185, p. 5).

The rural clinical setting is dependent on a team mentality whereby all members interact and support each other thus contributing to best care for their patients. *Fostering team membership* for the student in rural preceptorship is critical. Facilitation of legitimate team inclusion entails *gaining entry and acceptance* whereby the *students' attitude* of physically and metaphorically rolling up their sleeves is rewarded by the team and demonstrated by welcoming and *valuing the student* as more than the impersonal title of student. Thus they become *a name and not just a title.*

A fourth characteristic related to the relational process was the advancing of student practice through critical reflection. Rural nursing practice requires expansive knowledge and skills in which the theoretical/knowledge connections were formulated by the students through the process of critical reflection.

Figure 5: Advancing Practice through Critical Reflection



Advancing Practice through Critical Reflection

The rural context is often described as 'low tech' due to the decreased accessibility by rural health care practitioners of advanced technological equipment frequently utilized in urban/tertiary care centres. In the rural setting, given the limitations or absence of such resources, the literature indicates that rural clinicians therefore require an expanded knowledge and skills in order to provide the patient with expedited, timely and expert care in the absence of such technology, equipment and/or specialty consultations (Bushy & Bushy, 2001). Practitioners recognize their role in patient care and facilitate patient requirements in the multiple requirements of onsite care, transference and return care of the patients they encounter. Thus the knowledge and skills required by rural nurses is diverse and imbued with a depth and breadth of practice (Hegney, McCarthy, Rogers-Clark, & Gormann, 1997; MacLeod, et al, 2004 a). Rural

nursing requires a level of practice that is consistently gaining and pursuing advancement of knowledge and skills. This advancement of practice is gained through critical reflections thus facilitating a seamless connection of knowledge to practice. In this study, students' perceived that their practice was advancing throughout the rural preceptorship and was influenced by the three elements: 1) holism (from birth to death); 2) shifting questions; and 3) autonomy without isolation.

Holism (from Birth to Death)

Within the realms of nursing practice holism has been described as the ability of the nurse to care for patients as complete beings, inclusive of their physical, psychological, social, spiritual and cultural needs. Studies have indicated that holism, where the patients are seen as more than a sum of their parts, is essential to providing all encompassing care (Fenton & Morris, 2003). Nurses who are adept at practicing in this manner do so by drawing on all aspects of their knowledge and skills and applying it to individual care. This care requires an ability by nurses to be critically reflective in the moment and for the longevity of their practice. Nurses posses a depth of knowledge, expertise, critical thinking capacities and skills which assist others in achieving and maintaining health and wellness (Dossey, Keegan, & Guzzeta, 2005). The more holistic nurses are the more completely they can apply the principles of knowledge, critical reflection and skills in the interactions with patients and their environments. Holistic nursing embraces a goal enhancement which focuses on healing the whole person, from birth to death (The American Holistic Nurses' Association & American Nurse Association, 2007). Health care for the rural community is a lifelong process in which the continuum of care is not experienced or provided in a dichotomous or separated form; rather it is an integrated model of nursing practice necessary to meet the needs of the community in its entirety (Kulig et al., 2008). Care

begins at birth where labor and delivery services are essential in addition to the provision by nurses to end of life care. In between birth and death, nursing practice simultaneously focuses on persons in acute, chronic or wellness states of being. In this rural preceptorship study the researcher found that students perceived that they were able to genuinely engage in holistic nursing, often attaining a more complete practice experience. They indicated that this experience of 'getting the whole picture' was influenced by the rural context. The students were afforded the opportunity to experience caring for a labouring mother, attending to newborns, assisting in the care of palliative patients and partaking in acute critical episodes such as cardiac and injury events all within the scope of a day's, week's or month's practice. Thus being exposed to the diversity and expansiveness of a person's health/illness needs served to illuminate to the students what was required in their relational interactions with the patients. This diversity of care attended to the bio, psycho, social, spiritual and cultural influences that impacted the rural nurse's practice thereby providing individualized care. This holistic approach was reflected in the words of the following student Daisy:

> I was nervous to begin with. I wasn't sure how things [rural nursing practice] were going to be done. But we had a quick exposure to a couple of things. In my first shift we had a delivery in the first 20 minutes and I had to figure out what is going on. Since then I have had the opportunity to see more deliveries from start to finish. If you're there to see the whole thing you really get the gist of what is going on and what needs to be done. You can relax about it and not stress as much. I've also had patients who have come in with chest pain and we go through the chest treatment protocol. We have sent patients off [to tertiary centres]. I feel my assessment skills and my ability to determine my own

> confidence has increased, I've really started to get comfortable with and really be able to say I'm competent (Nursing Student, Daisy, Interview # 9, Lines 118-135, p. 4).

Another student Alexis indicated how she was able to cope with the variety of learning exposures she faced during her preceptorship and how she found rewards in the learning and nursing practice achievements gained as the preceptorship progressed:

> There's always going to be learning challenges but you have to look at the rewards that you are going to get from it. I'm still scared some of the time at work because you are constantly learning. You're thrown into situations that are not necessarily always challenging but can be emotionally challenging so you have to learn how to cope with different things. Working with palliative patients for example, when I was starting in this rural preceptorship, we had a couple of patients pass away on our shift so that was definitely challenging to overcome but the reward was dealing with the family and being there and knowing you made a difference in their grief and maybe a difference in that patient's life near the end, you know the help to bring closure (Nursing Student, Alexis, Interview # 11, Lines 54-68, p. 2).

The following words indicated how Leah as the faculty member was able to discern how the student's learning was advancing and how the student was able to reflect on the whole picture of care related to what was happening to patients within the rural environment:

> Their reflections are really indicative of what they talk about and reflect about. The moments when the student goes "oh ok it all makes sense", when the student steps back and goes "ok it's the bigger picture. It's not about the dressing changes, it's about my whole day, and it's about how I am going to manage my environment" (Faculty Member, Leah, Interview # 2, Lines, 159-162, p. 5).

The following words from the student Sarah illustrated the concept of holism within the rural environment and how it was connected to the individual patient, to the health care staff and to the community at large:

> The homecare nurse is also in charge of the discharge planning so she knows all these people in the community, she knows them when they've been in the hospital and she's known them before they have and after they have been in the hospital. It's a tie, from birth to death, this transition period and connection to the community. I was pretty impressed with that overall connection to the people [in the rural setting] (Nursing Student, Sarah, Interview # 29, Lines 26-37, p. 1).

The heterogeneous nature of the required knowledge and skills related to the distinct rural environment in this study served to situate the students' experience of nursing practice which incorporated their prior and additional learning into holistic care. For the students it was this opportunity to nurse patients from birth to death that provided a salient connection of knowledge to clinical practice.

Advancing of practice through critical reflection contained a second element, that of shifting questions, whereby the students experienced a progression of their questioning, in terms of open questioning, advancing to additional questioning and finally to enhanced and deeper levels of questioning.

Shifting Questions

Rural nursing practice requires the possession of generalist knowledge and skills rather than a particular focus on one form of specialty knowledge. Crooks (2004) indicates that rural nursing practice entails a diversity of knowledge and skills to provide an all encompassing care for the communities rural nurses serve. This focus on the individual as a whole and the community as a whole in turn directs and situates the practice of rural nurses. Thus nurses must be able to understand the requirements of the rural communities and be able to navigate their knowledge and skills thus providing diverse care as a matter of course (MacLeod, Misner, Banks, Morton, Vogt, & Bentham. 2008). In this rural preceptorship study findings support practice as expansive and diverse and required critical reflection to promote expert practice. This was especially so when resources and personnel were limited and where the nurse often had to draw on all elements of knowledge and skills to ensure it was relevant to the patient care and distinct context. Students experienced questioning as an antecedent of the learning process. Thus the more they learned, the more questions they formulated. Furthermore students perceived that the questions they initially formulated were related to the *what* and *how.* Students found it necessary to ask about policies, procedures and what they should be doing and knowing. A student Alexis reflected on her experience of learning within the first couple of weeks:

> The first couple of weeks are always the most challenging for your work and your learning. You're learning what and how to work within the setting, the people, and the environment. Learning what the routines were, how they worked as a team and finding opportunities to ask questions and not be afraid to ask those questions. (Nursing Student, Alexis, Interview # 11, Lines 75-82, pp. 2-3).

As the preceptorship progressed students perceived an advancement of their knowledge and skills but rather than decreasing the need to ask questions it stimulated them to ask more questions, in addition to different, more depthful questions. This shift of questioning transcended from the *what* and *how*, into the *why* thus promoting their knowledge/skills and advancing their practice toward competency and independence as reflected in student Alexis's words:

> I was able to show independence and take a lead and be the team leader. She [preceptor] was happy that I was showing independence where there was a huge shift, where you have learned the basics; you have learned routines and completed skills you had not done before. Then it really encompassed the bigger picture, you took that step from student, now you're the nurse, you are now acting and working as the nurse. You are able to be in charge [advancing practice] (Nursing Student, Alexis, Interview # 11, Lines 185-198, pp. 4-5).

The students' own perceptions of their shifting questions were reflected in the following words of the student Rona:

> I think it is [critical reflections and practice] gone from more of what do I do, to why am I doing it. I think that is a good thing for learning at this level and degree (Nursing Student, Rona, Interview # 4, Lines 157-159, p. 5).

Furthermore preceptors and faculty members perceived this ability by the students to be more critically reflective and observed how students were able to attain higher level questioning as the preceptorship continued which facilitated their learning and practice. Faculty member Wanda indicated how rural nursing necessitated a holistic and advanced approach to practice which required a high level of critical reflection to attain answers and competency in rural

practice which was beneficial to the student's experience and learning as indicated in the following words:

> Rural is low tech but the students and rural nurses in general have to rely more on their assessment skills and their actual nursing skills and not on the equipment to get answers as the CT scan and other equipment is not readily available. In rural hospitals they use their nursing senses, their skills, their knowledge rather than relying on technology to give them the answers. I think that it is positive (Faculty Member, Wanda, Interview # 16, Lines 107-116, p. 3).

Nurses who practice in a holistic manner, with an emphasis on the whole person and environment, must incorporate a number of elements into their practice. These elements include nursing knowledge, theories, expertise, intuition and creativity. Furthermore nurses must be able to function across three domains; cognitive (knowledge/theory), experiential (expertise), and affective (intuition/creativity). A holistic nurse values and utilizes all of these elements (Frisch, 2001). Rural nursing expertise may be derived from rural theory and practice perspectives and the exposure of students to rural clinicians, patients and environments, thereby providing in depth clinical experiences (Bushy & Leipert, 2005). Thus in order to practice and remain in the rural environment nurses need to be highly skilled and creative to confidently and competently practice rurally. This requires rural nurses to advance their practice to its fullest potential in a critically reflective way.

Critical reflection is essential to the demands of increasingly complex health care environments (Fowler & Chevaness, 1998). Critical reflection is a reasoning process that provides nurses with the capacity to defend their actions and provide sound clinical judgment. Nurses who use critical reflection skills investigate and reflect on all aspects of a practice

situation thus ensuring appropriate actions. These skills require a broad outlook, creative solutions and multiple pathways to achieve the quality of care expected (Ulsenheimer, Bailey, McCullough, Thornton, & Warden, 1997). Thus critical reflection is more than a set of cognitive skills rather it is a composite of skills, knowledge and attitudes. It comprises understanding the nature of making inferences and generalizations and the aquanaut to carefully consider the logic and evidence provided (Watson & Glaser, 1980). The role of attitude in critical reflection is the ability to question assumptions and complex issues. Brookfield (1987) identifies four components of critical reflection. First, identifying and challenging assumptions, being mindful of how assimilated assumptions shape a person's perceptions and understanding, second, promoting the importance of context, third, having the capacity to imagine and explore alternatives thus being lateral in thought, and fourth, reflective scepticism. Learning to think critically involves expanding a person's thought processes. In the case of this rural preceptorship study critical reflection was integral to the advancing of practice thus incorporating the expansive and distinct knowledge connected to rural practice. This finding was indicated in preceptor Donna's words:

> She asked questions the whole time she was here; she was able to balance those questions. She was able to answer questions and feel confident in asking and getting them answered. She would ask questions on what is the best way and research that [best practice] (Rural Preceptor, Donna, Interview # 7, Lines 155-160, p. 5).

Another preceptor Shannon reflected on the clinical advancement of the students and the shifting of questions connected to learning throughout the preceptorship as indicated in the following words:

> Definitely the questions [from the students] change. Initially the questions [from the students] are very related to how do you do this, how do you put up this IV line on the pump but later on in the process they are now looking at why am I using this IV solution for this particular condition and why are we using this rate so their critical thinking skills are becoming more advanced as they are learning. They learn a lot in the 10 weeks [of the preceptorship]. (Rural Preceptor, Shannon, Interview # 8, Lines 45-51, p. 2)

The ability by the student to ask shifting questions was situated in a relational environment whereby the student was encouraged and expected to ask questions as indicated by student Alexis's words:

> I took from this preceptorship never to be afraid to ask questions. They [staff] feel better if you ask questions even if it is just for clarification. Even as a graduate its [questioning] appreciated (Nursing Student, Alexis, Interview #11, Lines 75-82, pp. 2-3).

Critical reflexivity by the students as they advanced in their preceptorship practice was captured in faculty member Leah's observations related to the students' learning:

> Because of the rural setting the students get a bit of everything so they don't feel extremely proficient at the beginning because they might be in labor and delivery, and then they might be in the recovery room the next day, and then they might be in outpatients and then in the surgical area. Students certainly get a bigger variety [of practice experience] that they need to get their heads around [connecting knowledge to practice] but at the end of it [preceptorship] they are far more comfortable and able to manage the pace and able to priorize their work based on what they have seen and done. By the end they really have the bigger picture [holistic practice] under wraps (Faculty Member, Leah, Interview # 2 Lines 227-239, p. 7).

Students' motivation to ask questions and seek answers thus linking knowledge to practice was essential in the dynamic practice of the rural environment and was fostered under the auspice of a relational process that encouraged and did not stifle student questioning.

The third element necessary to promote critical reflection and contribute to advancing practice was the ability of the students to move towards autonomy of practice in the clinical context without feeling they were alone or unsupported in their practice. Students perceived that they had practice autonomy without the feelings of isolation.

Autonomy without Isolation

It was found that students were capable of advancing their practice because of the support of their preceptor and other health care team members. The preceptor and staff facilitated learning opportunities throughout the preceptorship, creating higher levels of learning exposure and experiences as the student progressed in their knowledge and skill attainment. The students were able to embrace and respond to these learning /practice experiences, advance and excel because they perceived being supported at all stages and never felt the fear or experienced the reality of being left alone inappropriately. This type of teaching/learning environment is seminal in the rural context where prior to preceptorship students can feel an anxiety related to the diversity of clinical knowledge and skills expected, and how they will perform and advance given these perceived learning challenges. Rural nurses reflect a heritage of resilience, resourcefulness, adaptability and creativity. They must be flexible and adept at interfacing and interacting in a collegial manner with other health care professionals. These attributes contribute to their autonomy, inherent in practicing in the rural environment. Rural nurses report enjoying this independence and diversity but note that it may be overwhelming to manage multiple responsibilities without peer support and access to other professionals (Bushy, 1999). Support for

the students in this study was paramount to foster learning that, owing to the rural setting, was dynamic and expansive. It was essential for the preceptor or other team members to be present for the students as they encountered new and advanced learning. This presence of the preceptor or others contributed to the success of the students in acquiring knowledge and skills under welcomed guidance while simultaneously promoting student autonomy by discerning the readiness and timing for independent practice activities. This support of the student was reflected in student Rona's words:

> They [preceptor and team] are there to provide guidance and help in the transition from being a student, to you [as the student] being a nurse. I think that has been going on [in this rural preceptorship]. She [preceptor] has been helping me a lot with the transitioning and going from guide for my skills and nursing care to allowing me more independence (Nursing Student, Rona, Interview # 4, Lines 146-150, p. 5).

Paradoxically what is viewed as limitations of fewer resources, fewer staff, less technology and the smallness of community is what positively contributes to the students' learning. Thus the challenges for rural health in general serve as a catalyst for the students to promote independent nursing practice as identified by both students and rural nurses (Van Hofwegan, Kirkham, & Hardwood, 2005). Thus when students are able to observe and partake in the role of the rural nurse they are facilitated in the development and advancement of their practice in this distinct clinical setting. Although the students felt intimidated at the commencement of their preceptorship, related to the expectations of the role of the nurse, what was challenging, vis a vis rural practice, became the impetus for advancement of skills and experiential rewards. This finding is indicated in student Rona's words:

> It's just how rural nursing is, all these different areas, all these different skills. I think you had to sink or swim at some points [in the preceptorship]. Just being able to go into something you weren't comfortable with before and at least attempt it with supervision. I found that it was very fulfilling. What was most challenging at the beginning became the most rewarding at the end of the course (Nursing Student, Rona, Interview # 18, Lines 110-119, pp. 3-4).

Rural nurses prefer the variability of practice that requires autonomy but they recognize how support is necessary for both incoming and experienced nurses (Molinari & Monserud, 2008). In this case the preceptor and other staff members were able, through a relational process, to support the student in becoming socialized into the role of the rural nurse inclusive of the advancement of the knowledge and skills required. This was reflected in the following words of preceptor Donna and rural nurse and preceptor Barbara:

> As time goes on you see the benefits, you see the student learning and feeling more confident and comfortable and she is one of the team members. By the time they are leaving they are very independent and I think they are almost ready to practice rurally (Rural Preceptor, Donna, Interview # 7, Lines 267-271, p. 8).

> These students do very well with that extra bit or relationship and kindness…. That's how I always practiced, just encourage them, give them support and the confidence [to practice] and in return they do very well…. I saw it all the time, every day there was progress (Rural Preceptor, Barbara, Interview # 26, Lines 42-71, p. 2).

Student Kayley reflected on her progression of knowledge and skills throughout the rural preceptorship with the support of others. This experiential practice and nurturing navigated her towards competence and independence:

> With [having the support of] the preceptors and team members, just having someone there to teach you. You [student] can learn some things from the textbooks when you read about it but the hand on practice is always different. Things never look like the plastic models so just having the real life experience [of rural nursing practice], but I have someone here to help me if I need help, I can get help and that puts you [student] at ease, to experience doing it hands on but you know you can do it right because of the support (Nursing Student, Kayley, Interview # 5, Lines 143-152, p. 4).

Support and experience by preceptors and staff members can contribute to the student recognizing the attributes of the rural setting and choosing to remain in that environment. Recruitment and retention issues are influenced by the type of nursing care delivered and the professional interactions experienced by nurses (Stratton, Dunkin, Szigeti, & Muus, 1998). Furthermore students who are nurtured in an environment in which practice proficiency and learning opportunities are promoted contribute to the student contemplating a career in rural nursing. According to Neill and Taylor (2002) recruitment is best promoted when the nurse is exposed to positive rural practice experiences. A positive workplace environment is integral to students who are contemplating career and employment opportunities as new graduates (Boychuk-Duchescher & Myrick, 2008). In this rural preceptorship study the researcher found that the staff was aware of the value of positive relational interactions in the context of recruitment and retention possibilities related to the student and promoted support as a two pronged approach to setting the tone for possible career choices by the student within the rural context. Firstly, preceptors and staff advanced the students' learning to incorporate the expansive nature and necessities of rural practice. Secondly, they demonstrated the interactionary support with each other and the student which is germane to the rural setting. This focus on relationship

served to create an environment of autonomy without the sense or actuality of feeling or being isolated. This in turn fostered the possibility of a career in rural nursing for the students where they perceived that support for them as students extended into support of the newly graduated nurse in the rural environment. This finding was reflected in students Sarah's and Alexis's words:

> I always felt like it would be really interesting. I thought I would like to get a rural experience in case I wanted to live out there. I thought I would like to live in the rural setting. In a rural hospital my husband's life was saved because when he was at the tertiary hospital they [urban health care professionals] basically sent him home but the rural hospital took him in and they [rural health care professionals]did not let him go anywhere until it was safe enough [to send him home]. It definitely influenced my decision to choose a rural preceptorship and to stay on at this rural hospital because of my experiences (Nursing Student, Interview # 14, Sarah, Lines 92-109, p. 3).
>
> [During my program] when I [student] got more of an education and I understood a little more about what rural nursing was in comparison [to urban nursing]. It [rural nursing] was a lot more encompassing. I found it intriguing and thought it was a very good experience to get labour and delivery, medicine, OR and emergency nursing. I got all of those specialties rolled into one. I got a better experience and decided I was moving to rural after graduation (Nursing Student, Alexis, Interview # 11, Lines 32-43, pp. 1-2).

In this rural preceptorship study the researcher found that because of the complexity of the rural practice experience the students were able to advance in their knowledge and skills. Critical reflection was enacted though a progression of *shifting questions* to facilitate this learning process. The *holistic approach* (*from birth to death)* witnessed in the rural context

enabled practice advancement. However it remained seminal that preceptors followed by other health care team members were available and willing to be present for students thus providing direct guidance where necessitated and continuously accessible for indirect guidance to ensure students received *autonomy of practice without isolation.*

Chapter 5

Summary and Conclusions, Implications, Recommendations and Limitations

Summary and Conclusions

Grounded theory is founded on the principles of a social psychological process that occurs between two or more people. It draws from the underpinnings of 'symbolic interactions' in which persons come to understand themselves and the world around them in a socially constructed manner. Meaning is drawn from encounters with others through the social norms of language and behaviours (Glaser, 1978). Preceptorship is concerned with a teaching/learning process situated within a relationship thus it is important to locate what is going on through the perceptions of each of the participants involved in the preceptorship. Preceptorship is a triad relationship between the preceptor, the student and the faculty member. In the case of this study, however, the rural context served to influence that relationship in terms of being inclusive of those others in the rural environment who were also engaged with the student and the preceptor, namely the other rural staff members. Therefore, it was essential to further expand the study to include an exploration of the perceptions of the preceptors, the students, the faculty members and the other rural nurses thus providing a more complete understanding of rural preceptorship. The researcher was curious to ascertain: 1) what was actually going on in the rural preceptorship experience; 2) did the rural context contribute to a unique and distinct preceptorship experience for the student; 3) did the rural preceptorship enhance the ability of rural nurses to prepare students for the rural setting; and 4) were students able to successfully transition into the role of a rural nurse upon graduating. What the researcher uncovered through the process of inquiry and

analysis was that a distinct relational process occurred in rural preceptorship. This relational process served as the intrinsic connection to the successful progression of the formal teaching/ learning components within the preceptorship, additionally extending beyond the formal elements to include a distinct personal/ interactive relationship. Thus the relational process comprised four key characteristics intrinsic to 'how the relational process shaped rural preceptorship.

The first characteristic was the supportive presence of the preceptor throughout the preceptorship experience. This support was perceived by the students as promoting a *working side by side: being omnipresent* relationship whereby the students sensed the relational and teaching support of the preceptor in a physical sense in the beginning of the preceptorship, progressing at times to a metaphysical presence in which support was within reach as required or requested by the student. This cemented the formal and personal aspects of the preceptor/student relationship and allowed the preceptors' physical and metaphysical presence to foster learning. Essential to this nurtured teaching/learning progression was the ability of the preceptor to be engaged in an egalitarian relationship in which the student did not fear a power exerted over the student in the preceptored relationship rather they perceived being valued and respected thus allowing them to retain their own power of person. There was an acknowledgment of the students' own knowledge and skills, guided and enhanced by the preceptor.

The second characteristic integral to 'how the relational process shaped rural preceptorship' was the *reciprocating confidence* that was manifested between the preceptor and the student. Confidence building and enhancement were promoted as a *cyclical evolvement*. Reciprocity denoted the students' ability to gain self assurance as it related to their knowledge and skills. However it was apparent that this sense of competence was not in isolation of the

preceptor/student relationship. Rather the preceptor was seminal in engendering and nurturing the students' confidence. Relational support and encouragement from the preceptor facilitated attainment of the students' confidence and competence. When preceptors perceived the students' increased clinical proficiency it prompted them to advance the students' learning with regards to practice autonomy and independence. Furthermore the ability of the preceptor to be *student focused* was essential. When the preceptors possessed a pre-existing confidence in their own roles as preceptors/teachers, the focus of the teaching/learning process was related to the student, without the hindrance or need to focus on preceptor confidence. Thus the preceptors' relational and teaching efforts were allocated to advancing the students' learning and role transition. In the preceptor/student relationship the preceptors were able to recognize that their teaching strategies and the promotion of student learning related not only to the formal aspects of knowledge and skills but required a focus also on the emotive needs of the student. *Cognitive and affective learning* elements were included. The students noted that their ability to learn was enhanced by the relationship with the preceptor where support and guidance was interwoven throughout the teaching components. Both knowledge and affect were necessary parts of the teaching relationship and therefore were given due attention by the preceptor and the student.

The third characteristic related to the relational process was the *fostering of team membership* within the rural preceptorship. In preceptorship, the primary interactions occurred between the preceptor and the student. In this rural preceptorship study it was found that the relationship was first and most importantly established between the preceptor and the student. The rural context, however, incorporates a team community mentality where inclusion is paramount. Given that the preceptor was an existing team member the student *gained entry and acceptance* into the team when the preceptor vouched for the student. The preceptors were

trusted staff members so when they sought inclusion for the students this was granted by the other healthcare members, in addition criteria for team membership consisted of the student attitude whereby they were willing to *roll up their sleeves* and work in a collegial and shared way. In the rural setting team members are required to be available for each other and for the patient to ensure expedient and excellent patient care. Students recognized this work ethic as a positive asset and willingly complied with this ethos. The students felt welcomed and supported by team members thereby further enhancing the relational process and advanced their learning and role transitioning. Staff *valued the students* and thus they became legitimate team members. Furthermore students perceived that staff members viewed them *as more than just a title, they were a name.* They felt accepted not just as the label of students but as persons, as team members, in their own right and with their own expertise and talents. This community atmosphere symbolized to the students that they were not outside of the team relationships but were wanted and included members.

The fourth characteristic that was inextricably connected to the relational process in this rural preceptorship study was the *advancement of practice through critical reflection*. The rural context, with its diversity, complexity and lack of resources, calls on rural nurses to be more autonomous, to work to their fullest scope of practice and to incorporate and to continuously connect knowledge to practice through the process of critical reflection. In this preceptorship study students perceived that their knowledge was directly connected to practice because they were able to experience caring for patients *holistically, from birth to death*. For students, this opportunity to implement the continuum of health care to patients cemented the nursing principle, namely that patients are more than the sum of their parts. Students perceived that they were moving to the full potentiality of their previous and newly acquired theoretical and clinical

learning. This advancing of their practice was related to their ability to continuously ask *shifting questions.* There was a distinct shifting of their questioning whereby they initially inquired about the 'what' and the 'how'. As learning progressed they moved their reflections to the 'why' and how the context influenced the questions and application of skills. Students perceived that they were permitted and encouraged to ask questions. This lack of fear of appearing unknowledgeable was attributed to the relationships they encountered with their preceptors and team members. In the rural context it is expected, given the diversity of care, that questioning is a part of clinical practice and due diligence, and is expected. Furthermore students noted how rural nurses had to be innovative, resourceful, and flexible, all attributes of critical reflexivity. It was found that this role modeling by preceptors and staff, in which they consistently assessed, analyzed and synthesized practice knowledge and skills facilitated the progressive clinical independence for the students. Preceptors and staff facilitated students' autonomy which did not stifle the transitioning of the student into the role of rural nurse, but rather provided a teaching and supportive presence whenever requested or required by the students. *Autonomy without isolation* promoted learning and advanced competence. Students perceived that rural nurses were there consistently for each other as supports. This assistance was extended to the students so that advancement towards the goal of becoming an experienced rural nurse was a realistic journey. Additionally, students perceived that collegial support was not terminated when students graduated. Rather peer support continued and contributed to the students contemplating moving to and staying within the rural settings. They indicated that clinical autonomy was rewarding but perceived that the protection emanating from their experienced colleagues prevented isolation and assisted them in overcoming the challenges of a complex practice environment.

The researcher found that the four ambient characteristics intrinsic to the relational process in rural preceptorship did not exist in a linear or predetermined manner. Rather each characteristic was inextricably woven throughout the preceptorship experience. Findings indicated that the relational process could not be enacted without the preceptor and student being engaged in a collegial manner that was supported and valued by both. Faculty members further supported this relationship, providing contributions required of them as well. They perceived their role to be that of liaisons, to communicate with and compliment the preceptor/student relationship. In the rural context the cultural phenomenon of 'team' and the importance of the relationship with other healthcare professionals' existed. In team membership, establishing the relational process to further incorporate the new student member provided extended teaching/learning, practice advancement and additional support for the student. Rural nurses indicated that new members to the staff community should be welcomed like 'family members'. These four characteristics served then to provide students with positive teaching/learning and socialization components required in preceptorship. In addition the unique elements related to strong and extended personal interactions fostered the rural preceptorship.

Implications for Nursing Education

In light of these study findings there are several nursing educational implications.

1) The core variable intrinsic to this rural preceptorship experience was the 'relational process' that provided the linchpin for the teaching/learning process. In preceptored rotations, the process of learning and the outcome of knowledge and clinical proficiency are expected. To this end the pedagogical influence of educational theories to guide the preparatory process for the students is essential. Thus educational theories that incorporate relationship as a preferred teaching/learning method should be incorporated into preceptorship courses and curriculum development.

2) Within the realm of nursing education it is necessary to recognize the rural context as unique, in which there are other partners in the preceptorship relationship, in addition to the faculty member, preceptor and student, who participate in demonstrating the role of the rural nurse. Preceptorship workshops and educational resources related to this distinct clinical setting should incorporate communication that translates into access and inclusion of the other healthcare team members, vis a vis including them in workshops, and permitting them to access a multiplicity of teaching/learning resources. Rural preceptorship education should extend from the triad relationship to incorporate the other rural team members. In preceptorship the ability of the student to become socialized into the role of the registered nurse is desired. In this rural preceptorship study the relationship between the preceptors and the students was central as it related to role modeling and socialization but the ability of the faculty member and other rural healthcare team members to support this relationship was important.

3) In this study students were transitioning to the role of the rural nurse that encompassed expanded and dynamic practice. This exposure to a complex clinical environment can provide both rewards and challenges for students. The educational preparation of nursing students placed in rural practice settings requires some understanding and upfront preparatory learning related to theoretical, laboratory and simulated learning as a necessity, prior to going to the rural context. This preparation should be completed by nurse educators who have a strong background in theory/knowledge and rural practice that can begin 'an upstream' exposure for the students to the type of knowledge and practice linkages they will encounter when they begin and throughout their rural preceptorship. Nurse educators need to develop curriculum content that reflects the breath and depth of knowledge and skills utilized in the rural setting. Case scenarios, skills labs and simulated experiences should enact the reality of diverse rural practice requirements. Learning modalities should incorporate specific nursing care requirements related to patient needs in the rural context.

4) In nursing education the importance of recognizing learning as a process is critical. The development of clinical nurses as preceptors requires primary and ongoing education related to preceptor orientation. There is a need to promote a weighted focus on the teaching/learning process, and not on outcome measurements alone. The evidence indicates that fostering learning as a process positively contributes to attaining the desired outcomes of knowledge and skills. Dissemination of research findings related to the scholarship of teaching and learning can serve to encourage preceptors to implement educational theories to guide their practice and use teaching scholarship to influence their expected roles. In this study preceptors set the tone for the relational interactions with the

students by valuing each of them and providing a welcomed and sustained support for the students. This nurturing of the student's learning had direct contributions to the success of confidence and competence attained by the students. The preceptors indicated that the process of learning, situated within a strong personal relationship, allowed the outcomes of knowledge and skills to be achieved.

5) The relational process served to provide a positive preceptorship for the students in the rural setting. Relationship is important in all preceptorship experiences. In nursing education providing the evidence of studies and educational theories that promote personal interactions as an expectation can influence how relationship is essential to all preceptorship experiences. Providing theoretical and practical components within curriculum development facilitates and acknowledges the importance of cognitive and affective learning. The acknowledgement of relationship as a teaching/learning endeavour and required strategy permits the preceptor, student and others to not only want but need to partake in a supportive relational process.

Implications for Future Research

In light of these study findings there are several implication for nursing research:

1. This research opens up a new area of study that addresses the ‘relational process” as intrinsic to student learning within preceptorship.
2. Study findings suggest that the teaching/learning process can be fostered when there is a focus on relational learning. These findings suggest that nursing research should continue to engage in research projects that focus on educational theories, inclusive of cognitive and affective learning that serve to promote scholarship of and within the realms of clinical teaching. These may include exploration of the following questions:
    a. How do educational theories, with a focus on relational interactions, serve to support the teaching/learning process for students and for teachers?
    b. Does a focus on the cognitive and affective aspects of learning serve to provide students with a positive learning experience?
    c. How do positive experiences within the teaching learning process impact knowledge and skill outcomes?
    d. What role does culture and environment play on the teaching learning process?
    e. What nurtures the development of relationship in connection to the teaching /learning process?
    f. Do studies related to the relational process serve to promote the scholarship of nursing education?

In conclusion, the data generated from this study are important for the development of a sound theoretical base for the promotion of best clinical teaching and learning within the preceptorship experience. This research provides empirical findings that reflect the social

psychological process engaged in by students, preceptors, faculty members and other nurses within rural preceptorships. It has generated data that contribute to understanding the contextual reality of the preceptorship relationship and its influences on the learning process and the outcomes of competency and socialization as students' transition from student to the new role of rural nurse.

Recommendations

Based on the findings of this study the following recommendations are suggested:

1. Prior to rural nurses assuming the role of preceptors, specific orientation courses/workshops should be available to provide salient preparation and confidence in the role required of them:

    1.1 Preceptors should have access to orientation programs through a multiplicity of accessible recourses, including on site orientations, distance delivery through web based learning modules, and video conferencing. These teaching/learning modalities facilitate accessibility to initial and advanced preceptorship preparation.

    1.2 Initiate ‘train the trainer programs’ in which experienced preceptors, who have previously partipated in preceptorship workshops and who engage in ongoing preceptorship with students, can assume the role of educator for novice preceptors for on-site support.

    1.3 As part of continuing education policies utilize regional rural nursing educators to provide teaching/ learning modules for rural staff who directly engage with students during their preceptorship.

2. Continue to introduce and augment specific rural content into preceptorship learning modules derived from research findings and evidence, especially in the final theoretical course immediately prior to preceptorship placement in a rural setting. Further incorporate rural concepts/content into preceptorship preparation, inclusive of distinct rural practice expectations related to knowledge and skills, rural community expectations, professional boundary guidelines, peer and interprofessional working initiatives.

2.1 Address the importance of relationship within the rural context and how the preceptors' role facilitates the relationship with the student. Use theoretical and scenario development tools to situate how relationship is maintained and nurtured by all members of the preceptorship.

3. From the beginning of their program(s) introduce students to the role of the rural nurse to generate understanding of the distinct role involved:

3.1 Provide rural scenarios as a learning mechanism for students within context based nursing programs to promote an understanding of the role of the rural nurse. This exposure to rurality can provide consideration and knowledge of that role whether as urban nurses interacting and connecting with their rural peers as it relates to patient care, or for future consideration as a career choice

3.2 Provide students who have chosen a rural clinical placement for their preceptorship simulated and context related revision of the knowledge and skills they will incorporate within that setting. The enactment of skills required and situated learning serves to decrease anxiety and begin to build confidence related to the understanding of what they may experience and be exposed to in the rural setting

4. Ensure faculty members who are facilitating rural preceptorships have access to workshops that have a rural focus:

4.1 Access to rural preceptorship workshops serves to provide faculty members with an understanding of their roles in rural preceptorship, and the challenges related to distance support of the student and the preceptor.

4.2 Promote and be diligent about providing alternate ways of being engaged in the preceptorship process such as e mail, phone, video conferencing and web based

technology that allows visual, audio and written connection with the preceptors and students.

Limitations

As with any research study, this study entailed limitations which include the following:

1. This study was confined to one undergraduate nursing program therefore findings cannot be considered applicable to all undergraduate nursing programs using rural preceptorship placements.

2. Data were collected using a qualitative method which was concerned with process related to particular participants as they engaged in preceptorship and cannot be considered genreralizable to other rural preceptorships. *Rural preceptorship* is unique in that it occurs in a specific setting outside of the usual urban setting in which the majority of nursing preceptorships takes place. Rural preceptorship is thus influenced by the rural nursing context which encompasses its own unique clinical environment.

3. The researcher worked within time limitations while being cognizant of allowing adequate time to collect and analyze data to achieve saturation.

4. Researcher bias is always a potential and thus had to be guarded against by conducting interviews with open ended questions designed to focus on participant perceptions thereby allowing them to speak freely. Continued field notes and memoing related to the researcher's thoughts, beliefs, assumptions and conceptualizations prior to and throughout the study reminded the researcher to suspend and/or avoid what she believed, suspected or assumed about participants throughout the study and particularly during the interview and data analysis process.

In this study data were collected over a period of 19 weeks. This timeframe was utilized so as to capture students' perceptions of their experience during the final completion stage and immediate completion of their rural preceptorship. It may be considered that the ability of students to reflect for a longer period of time on their experience was lacking and which may

have provided a further richness of the data. However the preceptors' perceptions of rural preceptorship allowed for current and past reflections. The preceptors also referenced some of the students' later reflections and included self reflections of when they were a student in a preceptorship experience.

A further limitation may be related to gender uniformity, in which all preceptors, students, faculty members and other rural nurses were female. The experiences of male students and other members of the preceptorship relationship may reflect alternate perceptions. Given the percentage of female to male nurses that currently exist in nursing programs provincially, nationally and internationally, having mixed gender participation without purposive sampling is challenging. Students, however, in this study were exposed to interdisciplinary teams, which incorporated both male and female healthcare professionals; these teams consisted of physicians and other allied health care providers. Students' were able to reflect on these mixed interactions as experienced during their preceptorships.

During the research process personal bias can pose a potential risk. Choosing the Glaserian method of analysis promotes a postponement of immersing oneself in the literature prior to the commencement of the study and allowing the data findings to emerge as perceived by the participants (Glaser, 1978). It was important for the researcher to contemplate her pre-study assumptions, thereby guarding against formulating presumptive ideas of what may exist in the preceptorship experience prior to initiation of the study. The conscious activity of written memoing was paramount for the researcher who had experience as a rural nurse. The researcher used open questioning as an interview technique to allow participants to indicate in their own words and from their personal perspectives what was going on in the settings. She refrained from acknowledging her experience as a rural nurse and took a neutral role in the interview process;

not verbalizing or using body language that may indicate agreement or disagreement. As interviews were the primary data source initially, being neutral and using open questioning reduced the potentiality of participants providing information that they perceived the interviewer wanted to hear (Morse & Field, 1995).

Finally, another safeguard against personal bias was to implement theoretical sensitivity and sampling of the literature to locate what is actually going on in the data with what other research findings indicate (Glaser, 1978). This analytical technique served to locate the substantive findings of the study. However analytical creativity is a learned activity so member checking with participants and using an experienced researcher in qualitative data analysis was essential. The researcher used additional interviews with participants to check data analysis and refine the findings as necessary. She also reviewed her data findings with her supervisor, an advanced grounded theory researcher, early on in the process and throughout the data collection and final analysis proceedings.

Reflections on the Process

This study proved to be an exciting endeavour for the purpose of exploring 'how the relational process shaped rural preceptorship'. During the interview process, I as the researcher was able to experience in an active and interactive way how all participants in rural preceptorship perceive their roles in promoting students learning and moreover demonstrating the fostering nature of support experienced in the rural contact. It was a privilege to hear their reflections on what the rural context espouses to be and how it is genuinely enacted by those within this setting.

In this study I was afforded the opportunity to hear from preceptors who situated the formal and the personal aspects of preceptorship as one. They conceived their roles as being personalized, in addition to being formalized. They priorized the personal aspects of teaching and learning and indicated a belief that the formal would stem from the relationship. From student interviews I observed that students felt their emotional needs were attended to and learning became a due process. They perceived an inclusion in rural nurse membership and as such began the transitional journey early on in the preceptorship. Faculty members recognized the uniqueness of the rural environments, in which the culture of familial provided enhanced support. They perceived their role as facilitating the preceptor/student/rural relationship and found this easy to accomplish despite geographic distance and lack of face to face encounters. They attributed the absence of crisis or problematic events to the relational characteristics of rural preceptorship and were thoughtful with regard to relationship building and incorporating it into other preceptorship experiences and settings.

As a rural nurse it was affirming to witness how positive relationships developed and how this process nurtured the students. The study findings illuminated the culture of nursing care

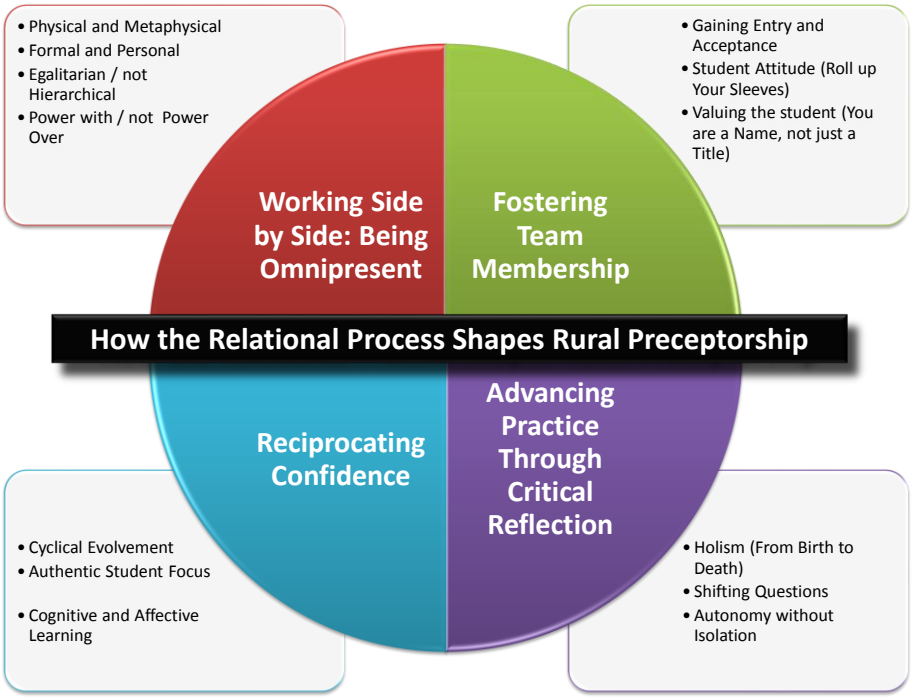
and highlighted the advanced practice requirements. As a nurse educator the findings solidified for me the premise that educational theories must incorporate not only the cognitive but also the affective teaching components to inform scholarly teaching and learning.

In conclusion this study will contribute to a further understanding of the social psychological process of rural preceptorship. The knowledge generated by this study regarding the relational process and its role in shaping and preparing students for the rural context opens up new ways of recognizing the role of relationship and its connection to nursing education thereby developing new and innovative ways of incorporating teaching/learning strategies for students in rural and other preceptorships.

Nursing knowledge may be at its most powerful when it is shared for the benefit of others.

Deirdre Jackman, Registered Nurse

How the Relational Process Shapes Rural Preceptorship



This model is a visual representation of the findings of the research study. Highlighted in black is the core variable entitled *How the Relational Process Shapes Rural Preceptorship* which is situated centrally indicating its connection to all four key characteristics of the social psychological process that emerged in this study. Characteristics are differentiated by colour. The essential elements of each characteristic, namely *Working Side by Side: Being Omnipresent; Recipricating Confidence; Fostering Team Membership; Advancing Practice through Critical Reflection* are represented in smaller headings alongside each characteristic. All four characteristics are flush with each other and intersect with the core variable to demonstrate the interconnectedness between each other and the core variable. The circle represents a non linear process. All four characteristics are important in their own right but there is no precedence in direction, rather as one characteristic finding occurs the others occur. All four characteristics serve to influence and support each other and connect directly to the core variable as a requirement of grounded theory development.

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Appendix A: Information Sheet

FACULTY OF NURSING
UNIVERSITY OF ALBERTA

Research Study: Shaping Preceptorship in the Rural Setting.

Information Sheet

Principal Investigator:

Deirdre Jackman, RN, MN, PhD student
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Co-Investigator:

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Phone: (780) 492-0251

Purpose of the Study

As an undergraduate nursing student, preceptor, faculty member or practicing rural registered nurse you are being invited to participate in a research study to examine your experience of preceptorship which occurs specifically in a rural setting. The goal is to develop an understanding as to how rural preceptorship shapes the educational learning and practice preparation of nursing students placed within rural settings.

Background

Preceptorship is an important teaching/learning approach used in preparing safe and competent registered nurses for clinical practice. Preceptorship is the one-to-one pairing of a nursing student with a professional nurse who assumes the role of support, teacher, and role model to facilitate the student's learning in a designated contextual/clinical setting, in this case the rural setting. Rural nursing is considered to be unique and important to the profession and to health care generally. Thus rural preceptorship is considered a key preparatory vehicle to promote competence, confidence and socialization for nursing students. Data gathered from this study can provide greater understanding of the social psychological process required in a rural preceptorship that provides the appropriate support, socialization and contextual competence required for rural nursing practice.

Voluntary Participation

Participation in this study is entirely voluntary. You may decide not to participate or may withdraw from the study at any time without fear of reprisal. Should you choose to withdraw your consent to participate any information you have provided to the researchers will be deleted and not used in the data analysis.

Participating in the Study

If you consent to be in this study you will be asked to participate in two to three interviews with the principal investigator. During the interview you will be asked to reflect on, explore, and describe how you participated in preceptorship. The interviews will be audio-taped and later transcribed into research data. The initial interview will likely last 45-60 minutes while the second interview may be shorter lasting 20-30 minutes. The interviews will take place at a time and place that are mutually convenient for you and the researcher. Also I would like to observe you both (student and preceptor) in the practice setting for a few hours as you work together.

Confidentiality

Any information obtained from you or about you during this study will be kept confidential by the researchers. The digital interview files and electronic copies of interview transcripts will be stored on the principal investigator's laptop computer and will be password protected. Hard copies of the interview transcripts containing coding notes will be locked in a filing cabinet in the researcher's office. Upon completion of the study and dissemination of the findings, all research data will be deleted and destroyed.

Benefits and Risks

It is not known whether this study will benefit you. However, it is possible that through sharing of your personal perspective you may come to greater understanding as to how preceptorship is shaped in the rural setting. There are no identifiable risks to this study however; it is possible that reflecting on challenging personal experiences can lead to some emotional discomfort.

Questions

If you have any questions about taking part in this study, please feel free to contact either of the two researchers listed on page one. Thank you for taking the time to read the information presented here and for considering participating in this research study.

Sincerely,

Deirdre Jackman.

Appendix B: Consent Form

FACULTY OF NURSING
UNIVERSITY OF ALBERTA

Research Study: Shaping Preceptorship in the Rural Setting.

Consent Form

Principal Investigator:
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Phone: (780) 492-0251

To be filled out and signed by the participant	**Please check**	
Do you understand that you have been asked to be in a research study?	Yes	No
Have you received a copy of the information sheet?	Yes	No
Have you had the opportunity to ask questions and discuss the study?	Yes	No
Do you understand that you are free to refuse to participate or withdraw at any time without giving a reason?	Yes	No
Has the issue of confidentiality been explained to you?	Yes	No
Do you consent to being interviewed?	Yes	No
Do you consent to having the interview audio-taped?	Yes	No
Do you consent to have your data reviewed at a later data?	Yes	No
Do you understand who will have access to your information and comments made during the interviews?	Yes	No
This study was explained to me by: Date:		

I agree to participate in this study.

Signature of participant	Printed name	Date

I believe that the person signing this form understand what is involved in the study and has freely chosen to participate.

Signature of investigator	Printed name	Date

*** A copy of this consent form must be given to participants.**

Appendix C: Demographic Data

FACULTY OF NURSING
UNIVERSITY OF ALBERTA

Research Study: Shaping Preceptorship in the Rural Setting.

Demographic Data – Nursing Student

1. Code: _____
2. Age: _____
3. Previous Clinical Experience: _____
4. Gender: _____

Appendix D: Demographic Data

FACULTY OF NURSING
UNIVERSITY OF ALBERTA

Research Study: Shaping Preceptorship in the Rural Setting.

Demographic Data – Preceptor

1. Code: _____
2. Age: _____
3. Gender: _____
4. Years of professional experience in the rural setting
5. Brief description of previous experience precepting students:

_____

_____

_____

_____

Appendix E: Demographic Data

FACULTY OF NURSING
UNIVERSITY OF ALBERTA

Research Study: Shaping Preceptorship in the Rural Setting.

Demographic Data – Faculty Member

1. Code: _____
2. Age: _____
3. Gender: _____
4. Years of professional experience in the rural setting
5. Brief description of previous experience precepting students:

_____

_____

_____

_____

Appendix F: Demographic Data

FACULTY OF NURSING
UNIVERSITY OF ALBERTA

Research Study: Shaping Preceptorship in the Rural Setting.

Demographic Data – Practicing Rural Registered Nurse

1. Code: _____
2. Age: _____
3. Gender: _____
4. Years of professional experience in the rural setting _____
5. Brief description of previous interactions with students during their preceptorship:

_____

_____

_____

_____

Appendix G: Interview Guides

FACULTY OF NURSING
UNIVERSITY OF ALBERTA

Research Study: Shaping Preceptorship in the Rural Setting.

Interview Guide (Preceptor)

1. As a preceptor, talk about your experience with preceptorship?
2. What is your understanding of the role of the preceptor?
3. What is your understanding of the role of the preceptee (nursing student)?
4. What role does the faculty member play in preceptorship?
5. Describe what a typical day is like for you as a preceptor in the rural setting.
6. How do you engage with your student as you work together in the rural setting?
7. Tell me how you facilitate the student's preceptorship experience.
8. Can you describe some specific strategies that you use?

Appendix H: Interview Guides

FACULTY OF NURSING
UNIVERSITY OF ALBERTA

Research Study: Shaping Preceptorship in the Rural Setting.

Interview Guide (Preceptee/Nursing Student)

1. As a preceptee, talk about your experience with preceptorship?
2. What is your understanding of the role of the preceptee?
3. What is your understanding of the role of the preceptor?
4. What role does the faculty member play in preceptorship?
5. Describe what a typical day is like for you as a preceptee in the rural setting.
6. How do you engage with your preceptor as you work together in the rural setting?
7. Tell me how the preceptor facilitates your preceptorship experience?
8. Can you describe some specific strategies used by the preceptor to facilitate the preceptorship experience?
9. What are some strategies you use to facilitate the preceptorship experience?

Appendix I: Interview Guides

FACULTY OF NURSING
UNIVERSITY OF ALBERTA

Research Study: Shaping Preceptorship in the Rural Setting.

Interview Guide (Faculty Member)

1. As a faculty member, talk about your experience with preceptorship?
2. What is your understanding of the role of the faculty member?
3. What is your understanding of the role of the preceptee (nursing student)?
4. What is your understanding of the role of the preceptor?
5. As a faculty member describe how you engage with the nursing student and preceptor during the rural preceptorship.
6. Tell me how you facilitate the student's preceptorship experience.
7. Can you describe some specific strategies that you use?
8. Describe how you facilitate the preceptor's experience?
9. What are some of the strategies that your preceptor uses to facilitate your learning?

Appendix J: Interview Guides

FACULTY OF NURSING
UNIVERSITY OF ALBERTA

Research Study: Shaping Preceptorship in the Rural Setting.

Interview Guide (Practicing Rural Registered Nurse)

1. As a rural nurse, talk about your experience in the practice setting?
2. What is your understanding of preceptorship?
3. What is your understanding of the role of the rural nurse, other than the preceptor, in relation to a nursing student during her/his preceptorship?
4. What is your understanding of the role of nursing student?
5. What role does the preceptor and faculty member play in preceptorship?
6. Describe what a typical day is like for you as a registered nurse in the rural setting.
7. Do you interact or engage with the student as you work together in the rural setting?
8. Do you facilitate the student's preceptorship experience in any way?
9. If so, can you describe some specific strategies that you use?

Appendix K: Research Budget

FACULTY OF NURSING
UNIVERSITY OF ALBERTA

Research Study: Shaping Preceptorship in the Rural Setting.

Research Budget

Item	Rationale	Cost
Computer (lap top)	Portable to enter data when travelling to location	$1200.00
Digital transcriber	Record interviews	$130.00
Transcriber for interviews	Interview transcribing rate of $17.00 per hour	$ 1147.00
Paper for hard copies of all transcriptions, participant handouts and filing data needed	Audit trail, simultaneous access of multiple hard copy	$80.00
Black printer cartridges	Hard copy printing	$135.00
Travel mileage for within 150 kms radius	Travel to rural locations for observations and interviews	$5000.00
	TOTAL	$7692.00

Appendix L: Ethics Approval

Ethics Application has been Approved

ID:	Pro00013904
Title:	Rural Preceptorship
Study Investigator:	A Myrick
Description:	This is to inform you that the above study has been approved. Click on the link(s) above to navigate to the HERO workspace. Please do not reply to this message. This is a system-generated email that cannot receive replies.

University of Alberta
Edmonton Alberta
Canada T6G 2E1