Using Community-based Participatory Action Research to Optimize Clinical Teaching in Baccalaureate Nursing Education in Ghana

by

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Abstract

Nursing education facilitates the preparation of professional nurses who contribute to population health within a society. The provision of meaningful supervised clinical practice, an important component of nursing education, is a worldwide challenge that needs to be context specific in relation to health needs, nursing roles, and availability of human, fiscal, and clinical resources. A 2010 study of preceptorship as a clinical teaching model in nursing education in Ghana revealed weaknesses, and led to a four-cycled community-based participatory research (CBPR) study, that engaged stakeholders in a process to ascertain the strengths and weaknesses of the current model(s) of clinical education in one undergraduate baccalaureate nursing program in Ghana. Findings offer strategies to enhance clinical teaching effectiveness that would meet or surpass national standards and be feasible within current and potential resources.

Data collection commenced in 2016 and included external and internal stakeholders in a process of identifying issues and needs. Working with a four-member local Collaborative Research Team, Cycle One survey data revealed: stakeholder support for the CBPR initiative, need for effective clinical supervision for patient safety and to build students' competencies, inadequate clinical equipment, meaningless clinical evaluation practices, environments not conducive to teaching and learning, insufficient collaboration between academic and clinical settings, and excessive travel times for clinical practice opportunities. Individual and focus group interviews in Cycle Two provided greater detail about the initial findings and sought suggestions for a way forward. Cycle Two also involved presentations on Cycle One findings, the process of CBPR, and an overview of eight potential clinical teaching models used for clinical education of nurses. A decision to focus on reconceptualization of preceptorship was made and Cycle Three involved creation of a vision and strategies for change. Potential strategic initiatives included: central planning; faculty planning and development; same shift for preceptors and students; focus

on relationships, defined roles, and responsibilities of preceptors, nursing staff, clinical faculty, student peers, and students; clear clinical objectives and evaluation criteria and process; and, preceptor appreciation. Cycle Four, completed in 2018, involved validation of the utility of the recommended strategic initiatives with internal and external stakeholders and discussion of where the implementation of changes could start.

Overall, this dissertation demonstrated the merit of using the collaborative and cyclical processes involved in CBPR to engage stakeholders in identifying issues in clinical education, promote collective decision-making, and partner across different interest groups in developing a vision and subsequent strategies for change. The CBPR initiative also served a capacity-building function. Stakeholders, particularly the Collaborative Research Team members, gained practical experience with CBPR. Knowledge of potential approaches to clinical nursing education expanded across stakeholder groups, leadership skills were further developed and practiced, and my understanding of the application of change theory was enhanced.

Preface

This dissertation is an original work by Mary Asor Asirifi. The research project, of which this thesis and manuscripts are a part, received ethics approval from the University of Alberta Research Ethics Board, Project Name "Using Community-based Participatory Action Research to Optimize Clinical Teaching in Baccalaureate Nursing Education in Ghana," No. Pro00058691 (Renewal), February, 2017 – February, 2019. Furthermore, ethics approval was obtained from Noguchi Memorial Institute for Medical Research, 082/15-16; and Korle-Bu Teaching Hospital, KBTH-STC 00061/2016, both in Accra, Ghana. The four manuscripts contained herein were prepared by Mary Asor Asirifi and at this time, one is published with the supervisory committee and Collaborative Research Team members as co-authors.

Dedication

This dissertation is dedicated to my mother, an African woman who did not have a formal education but totally understands the essence of education for her girl child. I remember her telling me when I was young that "*my daughter, if it takes to sell all my belongings for your education, I am always ready to do that*." She helped tremendously in taking care of my daughters when I was in Canada studying until they joined me. Her motivation has kept me going in my educational endeavor up until this time. I remain very grateful.

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CHAPTER ONE

Setting the Context

Clinical teaching plays an important role in nursing education worldwide as it provides the opportunity for students to acquire professional nursing experience in clinical settings (Billing & Halstead, 2005; Mohammad & Norouzadeh, 2015; Myrick & Yonge, 2005; Niederriter, Eyth, Thomas, 2017). Clinical education connects theory to practice and helps nursing students acquire the intellectual knowledge, affective attitudes, and psychomotor skills necessary for professional practice and is critical in the academic preparation of skilled, safe, and competent graduates (Phillips & Vinten, 2010). Clinical teaching models in nursing education vary and are based on healthcare needs, resources available for effective utilization of the clinical model, and negotiation between nursing faculty members and administrators in clinical agencies (Bourgeois, Drayton & Brown, 2011; Casey, et al., 2008; Maguire, Zambroski, & Cadena, 2018).

As a Ghanaian graduate student in nursing at a Canadian university who has student nurse, staff nurse, and nurse educator experience in Ghana, I was intrigued by the concept of preceptorship as a model for clinical teaching and knew that the preceptorship model for student nurse clinical education had been adopted in some schools of nursing in Ghana. I, therefore, conducted a research study in my Master of Nursing (MN) program entitled "Preceptorship in the Ghanaian Context". The purpose of the study was to explore and gain insight into preceptorship from the perspectives of the key members involved in preceptorship in a diploma nursing school in Ghana. Findings revealed that preceptorship was not well established and that external stakeholders, such as the Ministry of Health (MOH) and the Ghana Nurses' and Midwives' Council (GNMC), are influential stakeholders in relation to nursing education practices and policies. For example, in order to curb the shortage of nurses, there was an MOH

policy to increase the intake of students in nursing schools by more than 200% between 2007 and 2011 (Ghana Human Resource for Health Plan, 2008), with little increase in human and material resources allocated to nursing education. Also, preceptorship was not formally integrated into the national nursing education curriculum; therefore, not all schools used preceptorship in clinical teaching. The clinical teaching approach did not reflect the concept of preceptorship as developed in North America and, while nurse educators, preceptors and nursing students had basic knowledge about the intent of preceptorship, the concept was not well understood. I became interested in exploring possibilities for optimal clinical teaching models that would fit the Ghanaian context. I was particularly interested in baccalaureate programs in nursing as they are likely to produce the next generation of nursing leaders.

Thus, the purpose of my PhD research was to engage stakeholders in a research process that would ascertain the strengths and weaknesses of the current model(s) of clinical education in one undergraduate baccalaureate program in Ghana; and to offer strategies that would meet or surpass national standards and would be feasible within current and potential resources. As my MN research had uncovered issues in the preceptorship approach to clinical nursing education in Ghana, I wanted to: expand my PhD research to encompass other possibilities in the exploration of the merits of the current model(s) of clinical education in one undergraduate baccalaureate nursing program in Ghana; and, make room for the potential to find alternative or supplementary strategies for organizing clinical teaching in nursing education. The specific research questions for the study became:

- What are the challenges, including strengths and weaknesses, of the current clinical teaching models used in the school of nursing in the study institution?
- What are the opportunities for change in clinical teaching effectiveness?

- What would a process for change in clinical teaching strategies look like?
- How could the first step of change be developed and implemented?

The following operational definitions guided the research:

Professional Nursing Education: Nursing education that leads to licensure as a registered nurse (SRN in Ghana).

Clinical Education: Application of the knowledge, skills and relevant attitudes that nursing students learn in the classroom to a real life clinical setting or situation through guidance and supervision by staff nurses, preceptors, nurse managers or clinical instructors.

Nurse Educator: A registered nurse who is qualified to teach and who is teaching nursing students in a university or college educational institution.

Clinical Instructor: A nurse educator who guides, supervises and evaluates practical experience and educational preparation of nursing students in the clinical setting, or who facilitates such activities in collaboration with preceptors or staff nurses who are performing such activities.

Clinical Teaching: The process of teaching students to put theory into practice in a healthcare or community environment (or other places where nursing practice exists).

Clinical Setting/Field/Site: Healthcare agencies, including hospitals, community settings, etc., in which student nurses are assigned to undertake clinical experience.

Faculty: Nurse educators who teach at university or college educational institutions. They may or may not be engaged in clinical teaching but have influence over how student clinical practice is planned, implemented and evaluated.

Nursing Student: For this study, the term refers to an individual pursuing nursing education at the baccalaureate level, in a nursing educational institution in Ghana. There are still some diploma-level nursing programs in Ghana that lead to eligibility for licensure at the SRN level.

Preceptor: A clinical nurse who provides practical experience and educational preparation to nursing students ideally on a one-to-one basis.

Staff Nurse: A nurse in clinical practice in an agency where there are students who, while not an official preceptor, may be asked to guide and supervise one or more student nurses during a shift.

Nurse Manager: A nurse in a clinical agency who has responsibility for the administration of a unit or program.

Stakeholders: Individuals involved in nursing education in Ghana such as clinical faculty, academic faculty, staff nurses, clinical agency preceptors, students, recent graduates (nurse interns), Nursing and Midwifery Council of Ghana, Ghana Nurses' Association, College of Nursing of Ghana, and Ministry of Health for Ghana.

Community-based participatory action research (CBPR) was chosen as the research approach most likely to be successful for attainment of my goal. CBPR is a research approach that includes both the researcher and representatives from the participant group (community) in collaborative, egalitarian, and partnership processes to assess and problem solve an issue that, in ideal circumstances, is chosen by the community (Bomar, 2010). Therefore, CBPR was an appropriate approach to investigate, collaboratively, the possibilities for optimising clinical teaching in baccalaureate nursing in Ghana within the constraints posed by resource limitations and in cognizance of the possibilities that exist.

Nursing Education in Ghana

As this is a manuscript-format thesis, my introduction to nursing education in Ghana will be brief as the first manuscript (Chapter Two) provides more detail. Ghana is in West Africa, was formerly a British colony, is part of the British Commonwealth, and in 1957 was the first sub-Saharan African country to gain independence. It is politically stable and, in recent years, was reclassified from a low-income country to a lower middle-income country.

Nursing education in Ghana, originally modelled on the British nursing education system, has undergone evolutionary change allied with expansion of nurses' roles to keep abreast with international standards (Akiwumi, 1992; Opare, 2000). Both local and international nursing leaders have worked diligently to achieve the high standards mandated by this goal. It was Canadian nurses, in collaboration with nurse leaders in Ghana, who introduced the first university-level nursing education program in the 1960's and later fostered a problem-solving approach to teaching and learning in nursing education (Akiwumi, 1992; Opare, 2000). Canadian nurses continue to contribute to nursing education in Ghana. The first graduate program in nursing in Ghana was a Canadian International Development Agency (CIDA) funded project involving a partnership, still active, between the University of Ghana and the University of Alberta.

In order to enhance the effectiveness of clinical teaching and learning in Ghana, the preceptorship clinical teaching model was introduced in the 1990's by Mary Opare (2002). Dr. Opare looked at preceptorship in clinical teaching in Canada for her MN thesis at the University of Alberta and introduced it into clinical nursing education on her return to Ghana. Preceptorship is a model or approach to teaching and learning that pairs students or novice nurses with experienced practitioners to assist the learners in meeting specific educational and clinical learning objectives (Myrick & Yonge, 2005). The role of a preceptor is to teach, facilitate, guide, and evaluate performance throughout the clinical experience. The nursing student must demonstrate commitment to clinical learning by adhering to ethical standards of practice, interacting with key members involved in the healthcare team, displaying knowledge about the scope of practice, and reflecting prudent judgment in clinical decision-making and nursing assessments and interventions (Yonge & Myrick, 2005). The roles of faculty members in clinical

teaching in the preceptorship model include serving as resources to preceptors and students, meeting with preceptors in person, and paying regular visits to the clinical site throughout the clinical experience (Myrick & Yonge, 2005). The notion underlying the formal preparation of preceptors in Ghana was to create a liaison between hospitals and health educational institutions to facilitate the connection of theory to practice (Asirifi, Mill, Myrick & Richardson, 2013).

Theoretical Perspectives

A goal of this study was to empower participants to work together in understanding issues, identifying problems, addressing conflicts, and visioning the future as they engaged in exploration of clinical teaching/learning possibilities in nursing in Ghana. Participants were invited to have their voices heard in discussions related to clinical teaching in nursing education. Therefore, critical social theory and existentialism/humanism were theoretical underpinnings of this study.

Critical Social Theory

Critical social theory, with its origins from the Frankfurt school in Germany, focuses on justice, equality, and freedom. It holds that knowledge and truth are socially constructed, and facts are relevant only through the lived experiences of persons (Iwasiw et al., 2009). Fulton (1997) explained that the aim of critical social theory is to liberate groups from constraints either consciously or unconsciously. Critical ways of knowing emanated from sources such as liberation movements; for example, feminism and the revolutionary ideas of those working with underprivileged populations such as Paulo Freire in Brazil. Fulton (1997) explained further that since the social condition distorts the individual's perception, it is the insight from critical social science that will allow people to see situations for what they are and find ways of getting rid of constraints and become free. Also, critical social theory acknowledges that language plays a major role in knowledge development. The critical social theorists believe that language is paramount to how people comprehend meaning and create knowledge. Power relations and

historical context are central concepts in critical theory.

In nursing education, critical social theory enables students and faculty to share a re-visioning and re-construction of former potentially oppressive and coercive cultural, political, and social ideologies and practices (Lupam, 2012). Critical social theory gives the nurse the opportunity to use critical self-reflection, as well as dialogue with others, to examine healthcare and other structures (including their own role in oppressive practices); and advocate for changes in the situations that create oppression and influence health (Freire, 1997; Iwasiw, Goldenberg, & Andrusyszyn, 2009).

Critical social theorists believe that all meaning and knowledge are shaped in the context of social history (Lupam, 2012). Boutain (1999) added that some of the key assumptions of critical social theory are that there is no historical, value-neutral, or foundational knowledge that can be known outside of human consciousness. Therefore, understanding patterns of human behaviour involves knowledge of both historical and existing social structures, as well as the communication processes that define them. Another important feature of critical social theory is the notion that power relationships inform knowledge development. In other words, a critical social theory perspective provides means of questioning power in social relationships in terms of whom power includes, and whom it marginalizes or excludes (Sumner, & Danielson, 2007). This statement supports the idea that social oppressions are not natural or fixed because historical and social conditions contributed to their production and maintenance (Boutain, 1999).

Existentialism and Humanism

Existentialists and humanists share a common value regarding the role of education with the aim to assist individuals to become who they can be. Existentialists focus on discovering the personal meaning in a world of impersonal rational thought (Iwasiw, et al, 2009). The function of education from the perspective of the existentialists is to help the individual explore the reason

for existence. Existentialism is characterised by competently intervening for patients or serving as their advocate and values each person as unique with unique needs. Existential knowledge encourages experiential learning and allows the learners to apply theory to practice through critical thinking. It also enhances the learner's understanding of the nature of nursing, becoming a nurse and being a nurse (Billing, & Halstead, 2007; Gerrish, 1990; Iwasiw, Goldenberg, & Andrusyszyn, 2009). The primary concern of humanism as an educational theory is the autonomy and dignity of human beings (Billings & Halstead, 2007). Humanism promotes self-reflection, which helps with the recognition of the meaning and value of clinical teaching and learning experiences and of nursing practice. Additionally, humanism encourages learner and teacher interaction. Through the interaction process there is clarification and an increased ability for students to express themselves, thereby adding to the collective voice in ensuring high standards of clinical teaching and learning outcomes (Billing, & Halstead, 2007; Gerrish, 1990; Iwasiw, Goldenberg, & Andrusyszyn, 2009; Kleiman, 2007). These processes within the humanistic approach encourage life-long learning and active participation of students in the teaching and learning interaction.

Using an existential approach in action research as a guide to my study of clinical teaching in Ghana enabled the stakeholders of clinical teaching and me to reflect on, as well as understand, our ways of being in our professional practice situation. Understanding our way of being in clinical teaching situations enabled us to identify the constraints within practice. Through discourse and deliberation, we took initiative and made decisions that have the potential to overcome the constraints. Going through the aforementioned processes gave us the freedom of choice to identify or develop clinical teaching strategies and model(s) that could enhance the achievement of optimal clinical teaching and learning outcomes in Ghana.

Relevance of Critical Social Theory, Existentialism and Humanism to Research on Clinical Teaching in Baccalaureate Nursing Education in Ghana

An understanding of humanist, existentialist and critical social theory perspectives reveals that these theoretical approaches have similar philosophical underpinnings to those desired in the pursuit of increasing the quality of nursing education in Ghana, such as empowerment, enhancement of power balance, respect, good interpersonal relationships, promotion of critical self- reflection, and dialogical equity. The explications below about the background of nursing education in Ghana, and the power relationships between teacher and student, physician and nurse, and nurse and patient, will increase understanding of the relevance of the recommended theoretical perspectives in nursing education in Ghana.

Nursing education in Ghana started as a vocation where nursing was learned on the job. It progressed to include classroom teaching and creation of a positive learning climate. In other words, nurses in Ghana saw the need to shift from a traditional apprenticeship approach to a deliberative problem-solving approach in order to enhance students' knowledge and skills through self-directed learning, critical thinking, and life-long learning (Akiwumi, 1994; Takahashi et al., 2011). In the traditional teaching approach, the teacher serves as the controlling agent who determines the learning expectations. In other words, students are perceived as passive learners who memorise information and then recall or demonstrate it during an examination process (Candela & Benzel-Lindley, 2006; Ebert, 2014). This teaching approach is also known as teacher-centered learning. In the problem-solving approach or the learner-centred paradigm, the central focus of teaching and learning is the learner or student. In this case, the learners take significant responsibility for discovering and building on their knowledge (Candela

& Benzel- Lindley, 2006; Harrelson & Leaver-Dunn, 2002; Schaefer & Zygmont, 2003), while the teachers offer guidance, resources and assessments to facilitate the educational process.

Although the problem-solving approach was introduced in Ghana in 1992, the teaching strategies mostly used in nursing education reflect passive student participation in teaching and learning. Khalil (2006), in a reflective article on her experiences of teaching nursing in four countries (Ghana, Uganda, South Africa and the United Kingdom), revealed that teaching strategies used in nursing education in Ghana and Uganda are dominated by the traditional teaching strategies (lectures) due to limited text books and other learning materials. The author explained that lecturers were required to prepare detailed teaching notes for distribution, because in most cases it was unrealistic to give project activities requiring extensive literature research.

In the Ghanaian context, a traditional hierarchical relationship exists between the teacher and the student, which is a reflection of the Ghanaian culture where elders are given respect as the authority, and there is minimal questioning of their opinions. This relationship is reflected in teacher/student interactions. The teacher is perceived as the authority regarding knowledge and students are expected to listen and conform without challenge or critical questioning (Bohmig, 2010). These approaches discourage student-centred learning. Effective learning happens in a comfortable and safe environment that promotes comfortable dialogue and questioning between the student and the teacher (Diekelmann & Lampe, 2004; Freire, 2001). Additionally, the traditional hierarchical relationship ripples into the physician-nurse relationships with respect to patient care (Agyeman, 2013; Ofosu-Kwarteng, 2012). Nurses are expected to carry out orders without collaboration or question. These hierarchical relationships are replicated in nurse-patient relationships, whereby nurses are seen as the authority in patient care and patients are expected to obey instructions (Korsah, 2011).

The above explication of the hegemony that exists in teaching and learning, as well as in healthcare practitioners and patient relationships, could be reduced by the introduction of humanism/existentialism and critical social theory in discussions relating to nursing education in Ghana. This would also open a safe space for teachers and students to identify and minimize constraints in nursing education that inhibit student-centered learning. In this project, the possibilities for more student-centred learning emerged particularly strongly in reference to possibilities for student input into designing personal clinical objectives and a need for student clinical performance self-assessment as part of the clinical evaluation process.

Change Theory

Change is an integral part of CBPR. Kotter's eight step theory of organizational change (Kotter, 2012) was used to guide this study. The steps are: a) creating a sense of urgency; b) building a guiding coalition; c) forming a strategic vision; d) communicating the vision; e) enabling action by removing barriers; f) developing or generating short term achievements; g) sustaining 'accelerations'; and, h) instituting change.

Creating a sense of urgency involves seizing or creating a significant opportunity to sensitize people to get involved in change. Building a guiding coalition entails bringing together people with the power and ability to lead and support a collaborative change within an organization. Forming a strategic vision and initiative involves creating and shaping a vision to facilitate the change effort and establishing strategic initiatives to achieve the vision. Communicating the vision means sharing the vision and strategies with the people in the community who are ready and willing to effect the change (Kotter, 2012). Enabling action by removing barriers is achieved by removal of actual or potential obstacles and structures that pose threats to accomplishing the vision. A typical example is empowering people through the provision of training and information needed for the change. The sixth step, the development or

generation of short-term achievements, involves consistent evaluation and tracking of small and large accomplishments. This leads to ensuring that there are early short-term wins and achievements that demonstrate the purpose of the change. Sustaining accelerations is the seventh step and entails putting structures and policies in place to sustain the change. The final step is instituting change. This involves implementation of the change process and establishing the means to ensure ongoing leadership development and succession. It also involves consolidating improvements to produce more change over time (Kotter, 2012; Lachman, Runnacles & Dudley, 2013).

Research Approach

I was interested in looking at clinical teaching in a broader perspective than the preceptorship model and in working collaboratively with interested stakeholders in evaluating possibilities. Therefore, as stated previously, the purpose of this study was to engage stakeholders in a research process that would ascertain the strengths and weaknesses of the current model(s) of clinical education in one undergraduate baccalaureate nursing program in Ghana; and offer strategies to enhance clinical teaching effectiveness that would meet or surpass national standards and are feasible within current and potential resources.

Action research, specifically a four-cycle community-based participatory action research (CBPR) approach, was used to inform and guide this study. The stakeholders of nursing education are referred to as a community because the group involves individuals working together towards a common goal of providing a high standard of nursing education to students (Stringer, 2007). According to Greenwood and Levin (2007), action research is one of the most powerful ways of generating new knowledge. It aims to change the situation of a group, organization or a community and encourages group participation by involving everyone (participants and the researcher) to take some responsibility in the research process. The setting for the research was the School of Nursing at the University of Ghana where I completed my

undergraduate degree and, therefore, know many of the faculty members. My co-supervisors have both visited the School (one of them 13 times and was Canadian Director of the successful CIDA project to implement an MPhil[Nursing] program at the university).

Collaborative Research Team

Of prime importance in this research design was the development of a Collaborative Research Team composed of four faculty members at the School of Nursing. The Collaborative Research Team was consulted and their participation was integrated into all cycles of the research. They received a copy of the proposal before my Candidacy Examination and were asked to make comments about the research questions, sample and research tools in particular. They provided advice regarding the ethical review process at the University of Ghana and offered guidance on sampling/recruitment strategies, reviewed data collection instruments, and facilitated access to documents. They assisted with the Cycle Two presentations and with survey administration in Cycle One. The collaborating team members benefited from being part of a CBPR project as they gained experience of the research approach. They are co-authors of the first publication of the research project (Chapter Two) as they engaged in the review and critiquing of the article and offered suggestions for revisions as needed. They will be offered the same opportunity for the same reasons when the second manuscript (Chapter Three) is submitted for publication.

Research Cycles

Each of the four CBPR cycles moved the research forward. The first research question was addressed in Cycle One, the second research question in Cycles Two and Three, and the third research question in Cycle Four.

Cycle One:

Data were collected from stakeholders through document analysis, questionnaires, and individual interviews. See Appendix A for all data collection instruments. Analysis of clinical

teaching documents (clinical objectives, clinical evaluation forms and logbooks) was followed by stakeholder surveys and interviews. Questionnaires (open ended) were completed by 79 undergraduate students, 21 nurse interns, 18 graduate students, and nine faculty members. Individual interviews were conducted with six external nurse stakeholders associated with the Ministry of Health (MOH), the Ghana Nursing and Midwifery Council (GNMC), and the Ghana Registered Nursing and Midwifery Association (GRNMA). See Appendix B for recruitment flyers. Early preliminary analysis of this initial data answered the first research question. Cycle-One data revealed challenges of clinical teaching in Ghana (Asirifi et al., 2017). The intents of Cycle One were to get a sense of stakeholders' perspectives on strengths and issues related to the clinical practice components of the nursing education program and to raise awareness of external stakeholders, including policy-makers, about the research and garner their interest and support. While the Collaborative Research Team received a summary of the findings for discussion and interpretation, they did not get the raw data as responses could identify specific participants.

Cycle Two:

The analysis of baseline data collected in Cycle One was shared with students and faculty in presentations to honor their participation and solicit feedback and further input. The feedback from the presentation was shared with the Collaborative Research Team for their comments and interpretations and to plan the next steps. Also, presentations on eight clinical teaching models used in nursing education and on CBPR were delivered to faculty members and graduate students. This expanded participants' awareness of potential clinical teaching models and provided an orientation to the research process in which they were engaged.

Individual interviews with seven faculty members and focus group interviews with six graduate students and with eight nurses from a clinical agency where students receive clinical

practice (included selected preceptors, staff nurses with experience supervising student nurses clinically, and nurse administrators) were conducted by the end of Cycle Two (see Appendix A for interview guides). All individual and focus group interviews were audio-recorded and transcribed verbatim and participants signed informed consents. See Appendix C for all information sheets, consent forms, and institutional ethics approval letters. Collaborative Research Team members also signed informed consent forms. Detailed notes were kept of all research team meetings. Field notes were kept of important details about the interviews. Content analysis of clinical teaching documents contributed to understanding of requirements and supports available for clinical practice. Summaries of data obtained from the interviews were developed in an integrated form and shared with the Collaborative Research Team and interested faculty members again to solicit their interpretations and to discuss what they would like to have happen. Two priorities for change were identified by the end of Cycle Two. The need to reconceptualize preceptorship for the Ghanaian context became the first priority (see Chapter Three for the relevant manuscript), and, therefore, the focus as we moved into Cycle Three. The second priority, increased attention to student clinical evaluation, was put aside to be addressed at a later date.

Cycle Three:

I returned to Canada after Cycle Two to work on manuscripts. Work with the Collaborative Research Team continued through internet connections. Further analysis of Cycle Two data was done using the interpretive descriptive approach. A further literature review was conducted to explicate the findings of Cycle Two. A vision for change, with strategic components, was developed from a synthesis of Kotter's eight-step theory of organizational change (2012).

Cycle Four:

Planning for changes, including validation of their feasibility in the Ghanaian context, became the focus of Cycle Four (see manuscript in Chapter Three). A second trip to Ghana focused on validation of recommendations and the vision for change. A poster (Appendix D) depicting the recommended vision was used to present and discuss with stakeholders potential strategies to address the issues identified as needing change. Copies of the poster were left with the stakeholder groups and were well received. Implementation of any changes will be at the discretion of decision-makers within the School of Nursing in collaboration with clinical agency personnel and the external stakeholder groups interviewed in Cycle One.

Data Analysis

An interpretive descriptive approach was used for the analysis of the overall findings. Thorne (2008) describes interpretive descriptive research as a qualitative research approach that requires integrity of purpose derived from sources such as the actual practice goal of understanding what we do and do not know on the basis of available empirical evidence. Thus, it is an inherently reflexive process. The interpretive descriptive approach enables the research team to describe the core concepts of the data and seek embedded meanings. Interview data are analyzed for repeated phrases, codes developed to identify concepts, and both compared across interviews. Codes with similar meaning are collated and labeled to form categories. Field notes provide information on the context surrounding interviews and focus group discussions. Analysis for this project was a dialectical process as it involved moving back and forth from my independent summaries of data to discussion with the Collaborative Research Team, followed by my independent writing and then further team consultation.

Research Ethics

Ethics approval for this study was granted by ethics boards at the University of Alberta in Canada, Noguchi Memorial Institute for Medical Research at the University of Ghana, and the Korle-Bu Teaching Hospital in Accra, Ghana (see Appendix C).

Research Standards: Ensuring Credibility in Community-based Participatory Action Research

Greenwood and Levin (2007) explained the issues and principles of credibility and validity in action research. The core issue of credibility and validity in action research is that conventional social research credibility is created through generalisation of propositions, universal disjunctions and generic types. Action research on the other hand is predicated on the belief that the only credible knowledge is knowledge that is generated and tested in practice. Additionally, from the conventional social research perspective, only a group of similarly trained professionals is competent to decide issues of credibility. The defining characteristics of credibility in action research however, are focused on the stakeholders' willingness to accept and act on the collectively arrived upon results (Greenwood & Levin, 2007). These authors therefore, identified three principles required for credibility in action research; these are workability, sense-making and trans-contextual credibility. These principles, and the extent to which they were met in this CBPR project, are addressed in the final chapter of this document.

Major Findings

Findings from Cycle One (Chapter Two) included the need for: more effective clinical teaching and supervision; adequate equipment for practice; meaningful evaluation of performance; enhanced collaboration between the school and clinical settings; and, reduced travel time to clinical opportunities. External stakeholders became aware and supportive of the

research endeavour through the interviews (Asirifi, el al., 2017). Stakeholders were aware already of the clinical practice issues of nursing education in Ghana and acknowledged a need to restructure the clinical teaching approach. The first and second steps of Kotter's organisational changes, "creating a sense of urgency" and "building a guiding coalition", were achieved in the first research cycle.

Analysis of findings from Cycles Two and Three revealed a need for reconceptualising preceptorship through changing role expectations, planning for success, addressing challenges of clinical teaching in a resource-constrained context, and developing incentives for preceptors. Kotter's third step of organisational change "forming a strategic vision" was based on data from Cycles Two and Three and validated with stakeholders as we moved into Cycle Four. The new vision focused on enhanced collaboration across all stakeholders in creating optimal conditions for preceptorship as a clinical teaching model that will provide high quality clinical education. The fourth step of Kotter's organisational change theory "communicating the vision" (Kotter, 2012) occurred through debriefing with the aid of poster presentations to the stakeholders of nursing education during the Cycle Four validation trip to Ghana. The implementation of the project extends beyond my PhD program. The fifth, sixth, seventh and eighth steps, hopefully, will be achieved during the implementation of the strategies in the vison for re-conceptualization of preceptorship in Ghana. I am applying for post-doctoral support for on-going involvement in the remaining CBPR process.

Organization of this Dissertation

In this manuscript-format dissertation, Chapter One provides an overview of the CBPR project and introduces the theoretical grounding for the research. Chapters Two and Three are manuscripts based on the findings. The manuscript in Chapter Two was published in the *Journal*

of Education and Practice in 2017. The manuscript in Chapter Four is more theoretical and emerged from my recognition of the possibilities for capacity building for leadership inherent in facilitation of a CBPR process. Chapter Five provides a summary of important learnings from this project and offers suggestions for further research and potential applications to nursing education and policy. A draft of a fourth manuscript, exploring the congruencies between CBPR and Kotter's theory of organizational change, is found in Appendix E.

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CHAPTER TWO

Paper 1: Assessing Challenges of Clinical Education in a Baccalaureate Nursing Program in Ghana

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Paper 1:

Questionnaire data collection was done in collaboration with Cecilia Eliason, Gloria Ansong, Lydia Aziato, and Atswei Kwashie who formed the Collaborative Research Team. The Collaborative Research Team provided input into the clarification of concepts in Paper 1. I was solely responsible for the data collection from the individual interviews, clinical document analysis, and content analysis of the data. Linda Ogilvie, Sylvia Barton, Patience Aniteye, Kent Stobart, and Olenka Bikash contributed to multiple revisions, including development and re-structuring of concepts.

Abstract

A 2010 study of preceptorship as a clinical teaching model in Ghana revealed weaknesses related to high student-preceptor ratios and inadequate support from faculty in the educational institution. A four-cycle community-based participatory action research study was designed to further delineate clinical teaching and learning issues and partner with Ghanaian stakeholders in critical analysis of possibilities for positive change in clinical nursing education. The purpose of this paper, taken from Cycle One of the study, is to provide understanding of the challenges of the current clinical teaching model(s) used in the study institution from the perspectives of students and faculty. Early engagement of external stakeholders is described. Each university target group was invited to complete a semi-structured questionnaire. Interviews were conducted with representatives from the Ministry of Health, the Nursing and Midwifery Council of Ghana, and the Ghana Registered Nurses' and Midwives' Association. Clinical documents were examined. Clinical teaching and learning issues identified included the need for: a) more effective clinical teaching and supervision; b) adequate equipment for practice; c) meaningful evaluation of performance; d) enhanced collaboration between the school and clinical settings; and, e) reduced travel time to clinical opportunities. External stakeholders became aware and supportive of the research endeavour. Participants acknowledged changes are needed in order to improve clinical nursing education in Ghana. Clinical teaching and learning issues were identified and formed a baseline from which more in-depth discussion of resources, constraints and possibilities for change could ensue in subsequent cycles of the study.

Keywords: Clinical Teaching, Community-based Action Research, Ghana

Introduction

Clinical teaching is a vital component of nursing education worldwide because student experience in the clinical setting connects theory to practice. Ideally, students are able to achieve quality practice and safety competencies in facilitative learning environments established through collegial academic and practice partnerships (Mckown, Mckown & Webb, 2011). Setting the conditions for optimal student nurse clinical practice, however, remains challenging worldwide. Issues reported in the literature include: lack of close supervision of students by clinical staff due to nursing shortages and inadequate collaboration between clinical staff and academia (Asirifi, Mill, Myrick & Richardson, 2013); inadequate or scarce clinical placement sites, often as a consequence of increased numbers of students (Brunero, & Lamont, 2012; Gardener, 2014); reduction in traditional clinical placement opportunities related to health system changes (Gardener, 2014); competition with other health disciplines for the same practice settings (Asirifi et al., 2013; Brunero, & Lamont, 2012; Gardener, 2014); shortages of academically qualified faculty members (Asirifi et al., 2013; Jamshidi, Molazem, Sharif, Torabizadeh, & Najafi, 2016; Johanpour, Azodi, & Khansir, 2016); and, academic expectations that influence faculty workloads and make it difficult to hire and retain faculty with current clinical expertise or for faculty members to maintain their clinical expertise (Jamshidi, Molazem, Sharif, Torabizadeh, & Najafi, 2016; Johanpour, Azodi, & Khansir, 2016; Maguire, Zambroski, & Cadena, 2012). Such issues are common globally but gain in intensity in more resource-constrained national contexts such as Ghana.

There are few studies of clinical teaching in sub-Saharan Africa. A survey conducted in Cameroon revealed that clinical nurse educators lack opportunities to update their knowledge and skills, have few incentives, and often no formal clinical teaching guidelines (Eta, Atanga,

Atashili, & D' Cruz, 2011). In Ghana nursing students receive clinical supervision from faculty, preceptors, charge nurses and staff nurses (Asirifi, et al., 2013). Preceptors are the nurses/midwives designated to assume the primary clinical teaching/supervision responsibility for students assigned to their unit. The notion underlying the formal preparation of preceptors in Ghana was to create a liaison between hospitals and health educational institutions to facilitate the connection of theory to practice. Qualitative research to explore and gain insight into preceptorship from the perspectives of nursing students, preceptors, and nurse educators revealed that preceptorship was not well established and was not actualized or understood in ways described in the preceptorship literature. In addition, clinical teaching was influenced substantially by external stakeholders involved in nursing education (Asirifi, et al., 2013). The external stakeholders are the policy makers of nursing such as the Ghana Nursing and Midwifery Council (GNMC) and the Ministry of Health (MOH), as well as the Ghana Registered Nurses' and Midwives' Association (GRNMA). In order to address the shortage of nurses, there was a policy to increase the intake of students in nursing schools by more than 200% between 2007 and 2011(WHO & Global Force Alliance, 2008), with little increase in human and material resources allocated to nursing education. Supervision of students in the clinical setting, always a challenge, became more difficult. For example, one preceptor may supervise more than five students at a time while still carrying a full patient load. Inadequate preceptor support, lack of equipment in clinical settings (sometimes as basic as lack of blood pressure equipment), and inconsistencies in the evaluation process were challenging for the provision of optimal clinical education. To add to the challenge, laboratories for skill acquisition prior to entering the healthcare environment are poorly equipped in most schools of nursing and access to simulation resources is rare (Asirifi, et al., 2013). Thus, a four-cycle community-based participatory action research (CBPR) endeavour

was launched in 2016 to further delineate clinical teaching/learning issues and collaborate with Ghanaian stakeholders to develop more effective clinical teaching strategies, tools and models. The purpose of this paper, taken from Cycle One of the study, is to understand the challenges, including strengths and weaknesses, of the current clinical teaching model(s) used in the study institution from the perspectives of students and faculty. Early engagement of external stakeholders, another aim of Cycle One, is described.

Method

The purpose of the study was to engage stakeholders in a research process that will ascertain the strengths and weaknesses of the current model(s) of clinical education in one undergraduate baccalaureate nursing program in Ghana; and offer strategies to enhance clinical teaching effectiveness that will meet or surpass national standards and are feasible within current and potential resources. A four-cycle CBPR approach was used to inform and guide this study. Community-based participatory action research is a research approach that includes both the researcher and representatives from the participant group (community) in collaborative, egalitarian, and partnership processes to assess and problem solve an issue that, in ideal circumstances, is chosen by the community (Caine & Mill, 2016; Minkler, 2000; Stringer, 2007). Four faculty members at the Ghanaian School of Nursing, therefore, agreed to partner on a Collaborative Research Team to plan and respond to data collection as the research process unfolded. They reviewed the research proposal including the questionnaires and interview guides, provided feedback before the data collection instruments were finalised, and are participating in ongoing data analysis and interpretation, guiding any agreed upon changes, and participating in publications. Community-based participatory action research (CBPR) also involves iterative and cyclical processes or routines of looking, thinking and acting. Looking

(observation) involves collection of relevant data for describing the situation. Thinking (reflection) involves data analysis and theorizing about "What is happening in this situation?" through reflective process of interpreting and explaining the situation. Acting in CBPR means planning, implementing and evaluating a change (Caine & Mill, 2016; Minkler, 2000; Stringer, 2007). These cyclical processes occur in a spiral manner which result in reiterating routines, repeating processes, restructuring procedures, reconsidering interpretations and sometimes instituting radical actions for positive change (Caine & Mill, 2016; Minkler, 2000; Stringer, 2007).

Focus on Cycle One

The intent of Cycle One of data collection was to gain a preliminary appreciation of how clinical practice experiences in nursing education are viewed by nursing students and faculty, as well as identify gaps in what is almost exclusively rich country literature, in order to revise the guiding questions for the subsequent cycle individual and focus group interviews if needed. The inclusion of student feedback is unusual in Ghana and was, therefore, an important aspect of this research. Ghana Nursing and Midwifery Council (2), MOH (2) and GRNMA (2) representatives were interviewed as a strategy to inform those agencies of the research, enlist their support, and incorporate their perspectives and insights. Clinical practice documentation was examined. Feedback presentations following analysis of data kept stakeholders informed and provided opportunities to correct inaccuracies, seek clarification, and engage in conversation that could add more information or provide additional interpretive insight.

Convenience sampling was used to recruit 128 questionnaire respondents. Graduate students were included as participants as many of them are experienced nursing teachers. Collaborative Research Team members in Ghana recommended the distribution of hard copies of

questionnaires instead of electronic data collection because of limited student access to computers. Completed questionnaires were returned in sealed envelopes. Participants and response rates included 79 (71%) final year undergraduate students, 21(16%) nurse interns, 19 (31%) graduate students, and nine (47%) faculty members. The low response rate from the nurse interns, who were in a required fifth clinical practice year, was because they were gaining experience in practice settings across Ghana. The nurse interns remaining in Accra were most accessible for participation in the study.

The content of questionnaires focused on positive and negative clinical teaching and learning experiences of students and faculty members, perceptions of strengths and weaknesses of clinical teaching/learning in Ghana, and suggestions for enhancing the effectiveness of clinical education. Content validity of the questions was ascertained by sharing the questionnaires with the PhD supervisory committee and the two examiners at the Candidacy Examination, the Ghanaian faculty in the Collaborative Research Team, and four graduate students in nursing who are from Ghana and engaged in study at the University of Alberta. University of Ghana masters-level students at the University of Alberta for a short academic practicum completed the questionnaires for faculty and graduate students and provided feedback regarding clarity and the time needed to respond. These activities constituted the pilot testing done before general distribution to potential respondents. Questionnaire items were similar for all target groups.

Ethical Considerations

Participation was voluntary and consent was implied by completion of the questionnaire and through signed consent of interview participants.

Analysis

Simple content analysis was used to identify and categorize concepts from the open-ended questionnaire data. Content analysis is a research technique for analysing empirical text or data of an exploratory and descriptive nature (Dannapfel & Nilsen, 2006), and involves examining the content of narrative data to determine prominent themes and patterns among the themes (Loiselle, Profetto-McGrath, Polit, & Beck, 2007). Each questionnaire response was read and listed followed by categorisation of strengths and weaknesses of current clinical education experiences, in order to identify salient issues and challenges. Recommendations for change were documented. Examples of responses were selected to illustrate what were reported as the most positive and most negative clinical teaching and learning experiences as students or as clinical teachers**.** Additional information and interpretive comments from the feedback sessions were incorporated and findings were shared with the Collaborative Research Team, in order to glean further perspectives related to the findings. Interviews with GNMC, GRNMA, and MOH representatives were audio-taped and transcribed verbatim. Preliminary analysis related to the issues/challenges of clinical education in nursing was completed to get a sense of policy-maker and professional association perspectives. Further analysis of this interview data fits better with subsequent cycles of the project. Clinical practice documentation was reviewed for content and appraised for its comprehensiveness.

Results

Results relate to the presentation of clinical practice documents examined, background of participants in relation to this study, stakeholder support for the need for changes in the current clinical teaching approach, issues/challenges related to clinical teaching and learning, and recommendations for effective clinical teaching in Ghana.

Clinical Education Documents

The clinical practice documents examined were: a) nursing school curriculum; b) clinical schedule books and logbooks developed by GNMC; and, c) clinical performance and conduct form developed and used by the School of Nursing. The clinical documents revealed that clinical supervision is an expected standard for students at all levels of clinical education. The curriculum outlines clinical practice hours required for each specialty area in order to complete the nursing program. The GNMC policies specify the minimum practice hours. Clinical evaluation documents developed by the GNMC, such as clinical schedule books for undergraduate students and logbooks for nurse interns, were the focus of clinical evaluation of students. The clinical schedule book outlines clinical objectives and expected areas of competencies for nursing procedures to be accomplished through classroom teaching, demonstrations, and achievement of clinical proficiency at specific periods of time in the nursing program. Faculty clinical teachers and clinical staff who teach or supervise students on any of the nursing procedures outlined in the scheduled book sign when competencies are met. The logbook contains clinical objectives, required nursing specialty areas, and hours required to complete clinical nursing practice in those specialty areas before becoming a Registered Nurse. In addition to the clinical schedule book used to evaluate students' clinical performance, the school of nursing also has an evaluation form to assess the clinical performance and conduct of students. The evaluation form consists of a rating scale of 1 (poor), 2 (fair) and 3 (satisfactory) to evaluate dress code/general appearance; punctuality; communication; relationships with seniors/colleagues; relationships with nurses, clients and families; general performance; initiative; and, reliability. Evaluation occurs at the end of each clinical rotation and may be

completed by preceptors, staff nurses, charge nurses, or unit managers and is then sent to faculty clinical teachers at the School of Nursing. Thus, there is summative but no formative evaluation of student nurse clinical practice and much clinical evaluation responsibility is placed on clinical agency staff. Student involvement in the formal clinical evaluation is negligible and there is little focus on clinical knowledge or overall quality of care provided to patients.

Sample Characteristics

Before presenting the content analysis of the questionnaire and stakeholder data, salient features of the sample are described. Of the 79 undergraduate student respondents, 27 had completed five to nine clinical placements while 52 had experienced more than 10 clinical placements. Seventy-five students had received clinical supervision and teaching from staff nurses, 40 from unit managers or charge nurses, 46 from preceptors, 42 from clinical faculty members, and one from a medical doctor. Thirty-seven students had never received clinical teaching and supervision from a clinical faculty member and 33 had not been mentored by a preceptor by the fourth year of their undergraduate program. Staff nurses remain very involved in the clinical education of undergraduate students. These data, when explored further, revealed a limitation of the study. Both generic undergraduate students and post-registered nurse students take very similar baccalaureate nursing programs and our data could come from either category of student. We neglected to ask the relevant question. It could be that the students with the fewest clinical rotations are the post-registered nurse students. Thus, there is some difficulty in the interpretation of results.

Nurse interns were asked how they felt about their readiness for the clinical expectations of the internship year. Post-registration baccalaureate nursing students are not required to do the internship year. While 21 nurse interns returned questionnaires, only 20 responded to the

question of preparation and only18 specified the number of units on which they had gained the experience. Respondents reported a range of four to 12 months in the internship program. Thirteen nurses reported that they were very prepared while seven stated that they were somewhat prepared. Respondents had received internship year experience on three to eight units at the time they completed the questionnaires and most, if not all, specialty units were named. It would be useful to have more detailed information from this group prior to moving forward with major changes in clinical teaching strategies and models. For example, what were the gaps in their preparation? What were the strengths? These findings cannot be interpreted without reference to the qualitative data from the questionnaires. Most of the nurse interns who reported that they were well prepared for their internship program indicated they prepared themselves psychologically about the realities of the clinical settings from the clinical experience they received from school and from part time nursing jobs. Most of the nurse interns responded that they were well prepared; however, they also indicated that more adequate preparation before clinical practice would have been helpful. The nurse interns who were somewhat prepared indicated that the lack of equipment both in the clinical settings and in the school posed challenges in relation to the development of clinical competencies required to meet internship clinical expectations. These nurse interns indicated that they received inadequate hands-on practice before the internship program.

The clinical experience and the teaching experience of both graduate student respondents and faculty respondents were captured. Of the 18 graduate students who responded to these questions (missing data from one student who answered the qualitative questions), three had graduated from their first nursing program less than five years earlier whereas the remaining graduate students had been registered nurses from six to 20 years. Eleven of these students had

less than five years since completion of the undergraduate degree program and the remaining graduate students reported six to ten years with a baccalaureate degree; so, it can be assumed that most, if not all, of them were post-registered nurse baccalaureate graduates. All of them had more than five years of clinical experience with a range of six to 15 years. Five of the graduate student respondents had taught in schools of nursing, all had guided students while they were staff nurses, 11 had been preceptors, and six who had taught in schools of nursing had taught clinically. Of the nine faculty members who responded, two were less than five years after graduation from their initial nursing education, with the years since graduation ranging from six to 20 years for the remaining respondents. Seven of the nine faculty member respondents had completed their undergraduate degrees more than 10 years earlier. A graduate degree is required for a faculty position. All faculty members reported at least six years of clinical practice experience, all had supervised/taught students when they were staff nurses, two had preceptor experience, and eight had taught clinically as part of their faculty position. It is clear that faculty and graduate student respondents had substantial numbers of years of experience in nursing practice as well as in clinical teaching.

Perspectives on the Current Clinical Teaching Approach in Ghana

All participants, including the policy-makers and influential external stakeholders of nursing education in Ghana, supported the need for changes in the current clinical teaching approach in order to facilitate effective clinical teaching and supervision in Ghana. Themes emerging from the data describe the need for: a) effective clinical supervision and teaching for patient safety and to build students' competencies, b) adequate equipment for clinical teaching and learning, c) meaningful evaluation of students' performance, c) positive clinical teaching

environments, d) collaboration between school and clinical settings, and e) reduced travel time to clinical practice opportunities.

Stakeholder Support

Support from external stakeholders for change and for the study was enthusiastic and demonstrated their awareness of deficiencies in the current models of clinical practice in nursing education. Comments from GNMC, GRNMA, and MOH representatives included:

Support

"I want Ghana to attain the high education standard like any other country. I do not want the standard of nursing education in Ghana to be dropping so if there are any changes through a research-based project I will support it" (GRNMA).

Awareness of the Need for Change

"Yes, we need a change and the change will work. What I will encourage you to do is to get the clinical nurses involved in coming out with a model that will fit the Ghanaian system of nursing education. If the policy makers support it, I believe we will all benefit from it" (GNMC).

Readiness to Act

"At the MOH level, policy is influenced by evidence-based practice. We are ready to influence change and if we are able to present our case which is evidence-based like yours then it will be easier to use in policy making" (MOH).

Thus, a key component of CBPR, gaining decision-maker and influential stakeholder awareness and support, was achieved in Phase One of the project.

Effective Clinical Supervision for Patient Safety and to Build Students' Competencies

Participants indicated that effective clinical supervision and teaching is needed for patient safety and to build students' competencies in relation to: a) high quality and sufficient hands on

practice opportunities; b) psychomotor skills; c) communication skills; d) integration of knowledge into practice; e) evidence-based practice; and, g) opportunities for varied clinical experiences. While aware that attention to the above-mentioned components is critical for effective clinical teaching, participants acknowledged deficits in current clinical teaching models and practices. Comments revealed that opportunities for hands-on practice or for direct supervision by a clinical faculty member were rare but valued and included some interesting key words and phrases. The most salient ones are presented. Positive experiences made students feel valued, confident and supported. They presented challenging learning opportunities.

Valued and Confident

One of the undergraduate student nurses indicated that *"I felt valued and confident when I was allowed to perform wound dressing under aseptic technique successfully."*

Supported

Another undergraduate student indicated that *"Having my lecturers come around to work directly with me and take me through some of the procedures in the unit made me feel supported."*

Challenging Clinical Experiences

One nurse intern explained that *"I detected that my patient's blood pressure was very high and his condition was critical. I immediately informed the charge nurse. The physician was contacted as well and we gave appropriate treatment and the patient was saved. I feel happy that I was able to apply my nursing skills to save a life."*

Experienced teachers found satisfaction in the clinical teaching role when they were able to engage students in meaningful learning moments and promote learning in a real-life situation.

Graduate students and faculty with clinical teaching experience also expressed satisfaction with clinical teaching roles when they were able to:

Engage Students in Meaningful Learning Moments

"As a lecturer and a clinical teacher, I was glad and satisfied that I engaged my students in a hands-on practical session and it was very successful because the students enjoyed the learning session."

Promote Student Learning in a Real-life Situation

One of the graduate students explained that, *"When I have to teach students skills acquisition on the wards/units after the student has been taught in the classroom, I feel so motivated and encouraged when the student nurse is able to return the skills taught on real patients at the clinical settings."*

Respondents expressed frustration in relation to inadequate clinical equipment, meaningless evaluation practices, lack of student input into clinical evaluations, clinical environments not conducive to teaching and learning, insufficient collaboration between academic and clinical settings, and excessive travel time/barriers interfering with time available for clinical practice.

Inadequate Equipment

Most of the participants indicated that *inadequate equipment* both in the school and clinical practice settings is a huge barrier to effective clinical teaching and learning in Ghana. In order to support student learning, some clinical settings demand that students provide their own items such as thermometers, gloves, stethoscope, and hand towels in order to engage in hands-on opportunities. These items impose financial constraints on student learning. Participants shared their frustration of providing care with limited equipment. As one nurse intern said: *"We lack*

clinical teaching and learning equipment to practice with both in the skills lab and in the wards." An undergraduate student reported that, *"The unavailability of disposable gloves on the wards made it difficult for me to practice. Also, the disposable gloves were hoarded from us (students) in the unit, creating unavailability of gloves to work with."*

Meaningless Evaluation

Students are evaluated by staff nurses, nurse preceptors, charge nurses, and unit managers. The clinical schedule books (undergraduate students) and the logbooks (nurse interns) provided by the Ghana Nursing and Midwifery Council are the focus of students' evaluations. The schedule books and the logbooks have components of nursing procedures that students are supposed to complete at a specific period of time during their clinical practice. The intent is that clinical teachers (nurse preceptor, staff nurse, charge nurse, or nurse manager) sign off students on the procedure after the students perform activities under their supervision. Thus, evaluation is driven by psychomotor skill in procedures and not by quality of patient care provided. Participants shared their concerns about how students are evaluated during clinical practice.

Students not involved in evaluation

An undergraduate student reported that *"Sometimes our clinical performances are evaluated by nurses with whom we have not worked. We are not involved in our evaluation performances."*

Lack of evaluation

A nurse intern described how ineffective clinical supervision could have negative effects on students' evaluations: *"Sometimes we practice with no supervision and our clinical performances were not evaluated at the end of the clinical practice."*

Lack of agency/academic collaboration

A faculty member suggested that: *"We need to provide support for the clinical teachers to evaluate students' performances effectively. It is important for us to discuss with the clinical teachers how we expect them to evaluate our students' performances."*

Environments Not Conducive to Teaching and Learning

Most participants indicated that there is the need for good interpersonal relationships between students and staff nurses for positive clinical experiences to occur. One of the undergraduate nurses reported that *"I will never forget my first day in the medical ward in my first year. A nurse said to me: you are a degree nurse and you don't know how to check vital signs. Diploma nurses are even better off. I nearly got discouraged if I had not received reassurance from mates."* Another student added that *"Regardless of where we are coming from in terms of academic background, the staff nurses on the ward should be willing to involve us, delegate and supervise us where necessary."* Not all students blamed clinical staff as they revealed that students' attitudes towards clinical practice could have negative impacts on their learning. Some students have habitual truancy and deliberately miss important learning opportunities during clinical rotations. This is possible because of lack of staff or clinical faculty time to always attend to whether a student is actually present in the clinical setting. This raises the question as to whether all students truly meet the NMC standards for clinical practice.

Insufficient Collaboration between Academic and Clinical Settings

A lack of collaboration between schools and clinical settings constrains effective communication and affects vital components of clinical teaching and learning. Furthermore, participants indicated that learning similar ways of performing procedures in the classroom and the clinical setting would make it easier for students to integrate and apply theoretical

knowledge. Inconsistencies were common. A graduate student with teaching experience indicated that: "*As a tutor, I feel sad when I visit the clinical sites of my students and find them doing the wrong procedure after having been taught the right thing in the classroom and the skills laboratory. It makes me feel like a failure that I could not bring a change in my students for them to copy the wrong practice on the wards."*

Excessive Travel Time for Clinical Practice Opportunities

Most of the students indicated that the school bus takes them to the clinical settings but that busy and slow road traffic keeps them stuck in the traffic for hours. Usually students are late. In addition, in order to avoid the traffic, the school bus picks them up early to return to campus. As an undergraduate student stated, *"The school bus usually comes to pick us up while we are still working in the units. This causes us to hurry and finish our nursing procedures and we miss the opportunity to perform handing over and taking over of procedures."* Thus, even the mandated hours of clinical practice experience are seldom met even by conscientious students.

Recommendations

What the positive and negative comments about the quality of student clinical practice, the clinical documentary evidence, and the external stakeholder comments reveal is important. There is awareness of the critical issues, there are faculty members who express satisfaction when positive clinical teaching occurs, students appear eager for better quality clinical opportunities, and external stakeholders, including policy-makers, seem receptive to change. What then did they recommend?

Most participants gave recommendations to enhance clinical teaching and learning in nursing education. They suggested adequate time for clinical teaching, restructuring of clinical teaching approaches, need for more clinical teachers, and increased hands-on practice

opportunities. Some of the barriers and resource constraints were revealed in the recommendations.

Participants indicated that faculty clinical teachers and clinical agency staff assuming teaching responsibility need adequate designated work time or other incentives for effective clinical teaching to occur. The clinical faculty member may be teaching in more than one clinical setting on the same day and traffic issues make it challenging, perhaps impossible, to get to all practice settings on a regular basis. Also, staff nurses, preceptors and managers in clinical settings maintain their normal roles while teaching students and role conflict with competing priorities may occur. Thus, it was recommended that: *"The workload of the faculty members responsible for clinical teaching should be reduced in order to have enough time for clinical supervision and teaching."*

Participants believe that re-structuring of the current teaching approach and acquiring more clinical faculty members in Ghana will enhance clinical teaching and learning to facilitate students' confidence in clinical practice. A faculty member indicated that: *"I believe that clinical teaching and learning is important in the undergraduate program. It should be structured in such a way that would benefit the student to build their confidence to work without intimidation and fear."* This comment about intimidation and fear is critical and an example of a recommendation yielding perhaps unintentional additional data. It may be an indicator of student-teacher hierarchy and relationship or clinical setting hierarchies. In addition, in order to make clinical teaching more effective, there should be recruitment of more faculty clinical teachers to meet the learning needs of the high numbers of students. "*If we recruit more clinical teachers and involve the clinical staff to assist with supervision of the high numbers of students who visit the clinical settings, I think clinical teaching in the nursing program will be effective".* There is a sense that

students will gain clinical competence and confidence in nursing practice if they are given the opportunity for frequent hands-on practice in the school laboratories and the clinical settings.

How can these recommendations be expanded and met with the resources available? These recommendations are common in all nursing education contexts but what would make them feasible in Ghana or are other solutions needed? Let us now turn to a discussion of the findings.

Discussion

Results suggest that there is consensus within the nursing community in Ghana that changes are needed to enhance the effectiveness of clinical teaching in nursing education. Questionnaire and external stakeholder responses indicate that there is support and readiness for change. There was much congruence in responses of all target groups in the sample as to the major challenges to be addressed. Therefore, what is needed to move forward? A basic understanding of change theory is one need within the Collaborative Research Team and the decision-makers internal and external to the School of Nursing. Agreeing on the change theory to use can be a first step. Exploring possibilities from what is done in other contexts is another necessary step and thus became the focus of Cycle Two of the research. The challenges revealed by participants, with the exception perhaps of excessive travel barriers, mirror those in the research literature on clinical teaching in nursing. The resources needed to resolve them may, however, be less available.

Kotter's eight stage theory of organizational change (Lachman, Runnacles & Dudley, 2015) is a promising approach that is congruent with the use of CBPR. The first step is creating a sense of urgency and seizing or creating a significant opportunity to sensitize people to get involved in change (Lachman, Runnacles & Dudley, 2015). Stakeholders of nursing education

expressed concern that clinical nursing standards in Ghana were dropping and attributed it to increased student nurse numbers. There was agreement that changes in clinical education in schools of nursing are needed. CBPR provided an opportunity to achieve Kotter's second stage of change, which is building a coalition. Building a coalition was achieved through creation of a Collaborative Research Team and engagement of multiple stakeholders in the research process through gaining their perspectives as research participants and providing subsequent feedback sessions to present Cycle One findings.

The high student/clinical teacher ratio is related to the proliferation of new nursing schools and increased student intakes as government policy was implemented to curb the shortage of nurses (Asirifi et al., 2013; WHO & Global Force Alliance, 2008). Growth in student nurse numbers occurred without increases in resources such as faculty, physical infrastructures, or clinical teaching equipment. Consequently, student numbers exceed classroom, library, clinical skills laboratory, and clinical agency capacity for students in many places (Mtshali, Uys, Kamansi, Kohi, & Opare, 2007). Studies have shown that the dual function or heavy patient care workload of staff nurses and other clinical agency personnel who also assume educational responsibility for students reduces the time needed for effective student supervision. Students may be expected to handle challenging clinical situations alone (Asirifi et al., 2013; Browning & Pront, 2015; Holmund, Lingren & Athlin, 2010) or, as our data reveal, miss learning opportunities and be relegated to observer roles. Ideally, in order to ensure effective clinical supervision in nursing education in Ghana: a) the workload of nursing clinical teachers both in the school and clinical settings should be reduced; b) over crowding of students at the clinical settings should be minimized by negotiations between the schools and clinical settings for appropriate times for clinical placements; c) there should be adequate support for clinical

teachers, both faculty and clinical agency staff, through collaboratively planned educational workshops and seminars, as well as verbal or monetary incentives for those who accept educational responsibility; e) more faculty clinical teachers should be recruited for full time, part-time, secondments, and adjunct positions; and, f) undergraduate or graduate students who have interest in clinical teaching should be encouraged, employed and mentored as part of their academic program. Unfortunately, most of these suggestions require additional resources that are unlikely to be forthcoming in amounts that would meet all recommendations. Thus, creativity in designing solutions and ranking of priorities are critical. Again, the CBPR approach facilitates the generation of possibilities and the setting of priorities and next steps.

Results also revealed the need for high quality and sufficient hands-on practice opportunities for students to develop psychomotor and communication skills, integrate knowledge, and engage in evidence-based practice. Well prepared clinical teachers, whether faculty or clinical agency staff, are required to expose students to challenging direct patient care opportunities in order to develop their professional clinical competencies (Lindquist, Johansson, & Severinsson, 2012). Effective clinical teachers stimulate students to integrate evidence-based theoretical knowledge into high quality, safe patient care (Stevens, 2013). Learning about research-based pedagogy motivates clinical teachers to use innovative teaching strategies to achieve the goals of clinical education (Nazik, Hanadi, & Olfat, 2014). To achieve educational goals, students and faculty members require adequate library skills to search and retrieve recent, relevant, and accurate evidence (Majid, Foo, Luyt, Zhang, Theng & Chang, 2011). Access to computers, high-speed internet, and data bases are priorities for both faculty and students. Clinical evaluation tools and processes were a major concern of students and faculty. Studies have shown that prompt constructive feedback, allowing students to construct learning

objectives, and involving them in clinical evaluation are important for learning (Delaney & Sainsbury, 2016; Jasson & Ene, 2016**)**. Participants of this study suggested that clinical evaluation reform may be a priority for which consensus may be achieved fairly easily.

Participants indicated the need for more collaboration between schools and clinical settings. Such collaboration could increase access to resources, reciprocity of roles in the clinical education of students, and facilitation of clinical environments more conducive to teaching and learning (Majid, Foo, Luyt, Zhang, Theng & Chang, 2011). Success with this strategy would enhance students' clinical learning and better prepare them for the internship year. Opportunities for paid undergraduate student nurse clinical work experience was found to positively shape the post-registration experience of newly graduated registered nurses in Hong Kong. While the researchers cautioned that employed nursing students still needed sufficient supervision, the support and time that senior nurses provided to the employed undergraduate student nurses for their further development into competent nurses were taken for granted without complaint when students were perceived as helpers rather than learners (Law & Chang, 2016). Close clinical agency and academic institution relationships could foster such student opportunities and resolve not only educational issues but also decrease challenges related to staff shortages and students' inability to provide some of their own equipment/supplies when in educational clinical rotations.

A stressful clinical teaching and learning environment increases students' anxiety and can interfere with their clinical learning (Delaney & Sainsbury, 2016; Majid, Foo, Luyt, Zhang, Theng & Chang, 2011). Stronger interagency collaboration and reciprocity, as well as attention to interpersonal relationships between students and clinical agency staff, clinical agency staff and clinical faculty members, and students and clinical faculty members can promote student-friendly clinical environments. Also, student behaviours, such as truancy and missing clinical

practice without notifying clinical teachers, is inappropriate and do not suggest high motivation to become good nurses. More collaboration, clear clinical objectives, and supportive clinical teaching and learning environments would improve students' learning outcomes in relation to critical thinking skills, clinical competencies, interpersonal communication, self-confidence, and willingness to ask questions (Biachi et al., 2016; Carlson & Idvall, 2014; Hirst, 2016; Jasson & Eve, 2016; Kristofferzon, Mårtensson, Mamhidir, & Löfmark, 2016).

While issues identified as challenging for effective clinical supervision in Ghana were similar to those in the literature, the intensity of challenges appears to exceed what is reported in more economically advantaged countries. What was not found in the literature was the need for reduced travel time for students to get to the clinical practice settings. Most students live on the university campus and take school buses to clinical agencies. Delays in traffic are expected and can decrease student punctuality and lead to pick-up times earlier than is optimal. Students can miss important patient care activities. One solution is to schedule student clinical rotations in nearby facilities as much as possible. An ultra-modern well-equipped hospital on the university campus where this study was conducted is currently under construction. A decision was made that no students will receive clinical education in that facility. An opportunity for enhanced clinical education of nurses and other health professionals seems to be lost. Proactive lobbying with policy decision makers could focus on the potential for the presence of students to enhance the quality of patient care, the possibilities for engagement in clinical and health professional educational research, and the opportunities for innovation and creativity in designing new models for clinical practice in nursing and other health professional education. An excellent example would be the development of a model of inter-professional education that could enhance care through better collaboration across health disciplines in health care settings

(Bandali, Parker, Mummery, & Preece, 2008; Bell, Rominski, Bam, Donkor & Lori, 2013; Bowers, 2006; Chau, Denomme, Murray, & Cott, 2011; Melnyk & Davidson, 2009).

Conclusion

This CBPR project highlights challenges to effective clinical teaching and learning in nursing education in Ghana. It is apparent that there is potential for improvement. Cycle One of this CBPR project revealed the challenges, created awareness, and generated support for change. In Cycles Two and Three data collection was expanded to include focus groups with clinical agency nursing staff and graduate students, in-depth interviews with faculty members, and presentation of clinical teaching models incorporating relevant research literature of clinical teaching approaches used in other national contexts. Cycle One succeeded in providing the base from which action to create more effective clinical nursing education could begin. The questionnaire data provided baseline data from which further data collection could focus on approaches and solutions for enhancing clinical nursing education in the future, as well as uncover the complexities within the Ghanaian context that could make meaningful change difficult.

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CHAPTER THREE

Paper 2: Reconceptualizing Preceptorship in Clinical Nursing Education in Ghana

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For future submission

Abstract

Clinical teaching in nursing education is a worldwide challenge that needs to be context specific in relation to health needs, nursing roles, and availability of human, fiscal, and clinical resources. Various clinical education models have been tried and all of them have strengths and weaknesses. A four-cycle community-based participatory action research (CBPR) study was initiated in a school of nursing in Ghana in 2016 to examine current issues in clinical nursing education and envision possibilities for improvement in collaboration with stakeholders. Analysis of challenges identified in Cycle One was followed by Cycles Two and Three to gather more in-depth understanding of the issues raised and come to agreement on the way forward. There was consensus at the end of Cycle Two to keep preceptorship as one of two primary clinical education models with agreement that reconceptualization of what preceptorship means and how it should be enhanced in the Ghanaian context is needed. This paper presents the rationale for reconceptualising preceptorship, changing role expectations, planning for success, and challenges of clinical teaching in a resource-constrained context. Also, the paper outlines the way forward for reconceptualization of preceptorship in Ghana in relation to: a) well planned clinical experiences with clear and relevant objectives; b) preceptor preparation and responsibilities; c) clinical agency responsibilities; d) clinical faculty member responsibilities; e) student preparation and responsibilities; f) evaluation; g) preceptor appreciation; and, h) collaboration between academia and clinical agencies for effective clinical teaching and learning.

Introduction

Clinical teaching in nursing education is a worldwide challenge that needs to be context specific (Vitale, 2014) in relation to local health needs, current and potential nursing roles within the health system, and availability of human, fiscal, and clinical resources. Various clinical education models have been tried and all of them have strengths and weaknesses. In 2016 we engaged in a four-cycle community-based participatory action research (CBPR) study to examine current issues in clinical nursing education in one school of nursing in Ghana and worked collaboratively with stakeholders in visioning possibilities for improvement. Congruent with CPAR (CBPR) process (Caine & Mill, 2016), a four-member Collaborative Research Team from the School of Nursing engaged in the study was formed to consult in the development of the research as it progressed, collaborate in data analysis, determine priorities for action, and participate in devising and implementing recommendations. Analysis of challenges identified in the Cycle One data (Asirifi, et al., 2017) was followed by Cycles Two and Three to gather more in-depth understanding of the issues raised and come to agreement on the way forward. Cycle Four involved validation of the proposed strategies through presentation, discussion, revision, and finalization of the way forward. Engagement of the key external stakeholders in Cycle One garnered support for the endeavour and could extend our work to a wider nursing education constituency across Ghana.

There was a consensus at the end of Cycle Two to keep preceptorship as one of two primary clinical educational models but there was agreement that reconceptualization of what preceptorship means and how it should be enhanced in the Ghanaian context is needed. Data from Cycle One, collected via questionnaires completed by 79 undergraduate students, 21 nurse interns, 18 graduate students, and nine faculty members at one university offering baccalaureate

nursing education supplemented by interviews with six external nurse stakeholders associated with the Ministry of Health (MOH), the Ghana Nursing and Midwifery Council (GNMC), and the Ghana Registered Nurses' and Midwives' Association (GRNMA), were analyzed and presented to interested students and faculty in Cycle Two. Findings related to needs for more effective clinical teaching, supervision, and evaluation; enhanced collaboration between educational institution and clinical agency personnel; additional availability of equipment in both clinical agencies and schools of nursing; and, reduced travel time for student engagement in clinical activities. Increasing numbers of students and nursing schools with no additional human, fiscal, and clinical resources emerged as major barriers to quality student nurse clinical practice (Asirifi, et al., 2017). The intent of this paper is to present key findings of Cycles Two, Three, and Four in order to document how such evidence became the basis from which a reconceptualization of preceptorship occurred.

Preceptorship

In the preceptorship model, final year nursing students are paired in one-to-one relationships with preceptors for clinical experience within a specific period of time with support from nursing faculty (Hilli & Melender, 2015; Oosterbroek, Yonge, & Myrick, 2017). Preceptors are supposed to be expert nursing practitioners who teach, supervise, and evaluate students' clinical performance. Furthermore, preceptors liaise between academic and clinical practice institutions (Jeggels, Traut & Africa, 2013; Walker**,** Dwyer, Moxham, Broadbent, & Sander, 2011). Preceptors guide student clinical learning, serve as facilitators of clinical teaching, and evaluate students' performance during clinical practice. Precepted students are expected to be committed to standards of nursing practice, interact respectfully with the healthcare team, and use sound judgment in clinical decision-making (Jeggels, et al., 2013; Oosterbroek, et al., 2017).

Faculty members meet regularly with preceptors and students to provide the necessary support needed for clinical teaching and learning. They also are responsible for student evaluation with inputs from both preceptor and student (Hilli & Melender, 2015; Nygren & Carlson, 2016; Oosterbroek, et al., 2017).

Preceptorship promotes: a collaborative working environment for the stakeholders involved in preceptorship; continuity in student learning as patient care opportunities can be taken as they arise; evaluation of student performance which involves both preceptor and faculty; confidence, competence, and enhanced critical thinking abilities in students; and, improvement of preceptor and student nursing practice through the teaching and learning encounter (Hilli & Melender, 2015; Nygren & Carlson, 2016; Oosterbroek, et al., 2017; Schuelke & Barnason, 2017; Walker**,** et al., 2011). Although preceptorship incorporates the above-mentioned benefits, limitations may include: preceptor lack of expertise in teaching and student evaluation; perception of teaching as an added workload or stress; dependency of students on one role model; student and preceptor incompatibility; and, preceptor ‘‘burnout’ (Budgen & Gamroth, 2008; Sedgwick & Harris, 2012**).**

Research Approach

The intent of this CBPR study was “to engage stakeholders in a research process to ascertain the strengths and weaknesses of the current model(s) of clinical education in one undergraduate baccalaureate nursing program in Ghana; and offer strategies to enhance clinical teaching effectiveness that meet or surpass national standards and are feasible within current and potential resources” (Asirifi et al., 2017, p.110). Cycle One was described earlier in this paper. Two presentations were conducted in Cycle Two. Issues of clinical teaching identified in Cycle One were shared with nursing students and faculty to provide opportunity for validation and

additional input. Additionally, separate presentations on CBPR and eight clinical teaching models identified in the literature and used in different countries in the world were presented to faculty members and graduate students. The presentation included a description of each of the clinical teaching models, including strengths and weaknesses. Feedback was obtained from participants. Also, in Cycle Two, individual and focus group audio-taped interviews were conducted and transcribed verbatim. Individual interviews were completed with seven faculty members at the School of Nursing and separate focus group interviews were conducted with six graduate students and eight clinical agency staff. Encounters began with open ended questions about participants' experiences followed by probing questions to obtain detailed data about the topic of interest. Individual interviews ranged from 45 to 90 minutes and focus group interviews from one to two hours. A personal journal and field notes recorded the researcher's feelings, observations, reflections, and insights. A summary of preliminary findings was presented to the collaborative research team members as Cycle Two progressed. Cycle Three involved further analysis of all data and preparation of the second manuscript. Interactions with the Collaborative Research Team continued via the Internet. The interpretive descriptive approach was used to conduct deeper analysis of Cycle Two data. More literature review was conducted to support and explain the findings of Cycle Two. Using Kotter's eight-step theory of organizational change (2012), a new vision for change, with strategies, was developed to guide the reconceptualization of preceptorship in Ghana. Cycle Four involved revision and validation of the way forward with key stakeholders. Ethical clearance was granted by review panels at two universities and one clinical agency.

The interpretive descriptive approach to data analysis was used to increase the theoretical sophistication of the preliminary analysis of findings. Thorne (2008) describes interpretive

descriptive research as a qualitative research approach that requires integrity of purpose derived from sources such as the actual practice goal of understanding what we do and do not know on the basis of the available empirical evidence. The interpretive descriptive approach enables the research team to describe the core concepts of the data and seek embedded meanings. Interview data are analyzed for repeated phrases, codes developed to identify concepts, and both compared across interviews. Codes with similar meaning are collated and labeled to form categories. Field notes provide information on the context surrounding interviews and focus group discussions. Preliminary data analysis for Cycle Two was conducted by the primary researcher, shared with the Collaborative Research Team and thesis committee members, and discussed in relation to meanings, implications, and where to go next in the research. As mentioned previously, preceptorship as a productive way forward received consensus at the end of Cycle Two. The goal is to improve the clinical education of nursing students in one clinical setting as an exemplar for what could be useful across other schools of nursing in Ghana.

Preceptorship in Ghana

In Ghana preceptorship has become the most common teaching approach used in clinical education in nursing. Introduced in the 1990's (Opare, 2002), preceptors receive formal preparation in clinical teaching and serve as a liaison to bridge the gap between theory and practice. Contrary to preceptorship as portrayed in the nursing literature (Hilli & Melender, 2015; Nygren & Carlson, 2016; Oosterbroek, et al., 2007; Schuelke & Barnason, 2017), preceptors in Ghana may supervise more than five students at a time with no reduction in their patient workload. Preceptors and their assigned students do not necessarily work the same shift over the entire clinical rotation (Asirifi et al., 2017; Asirifi, Mill, Myrick & Richardson, 2013) and students assigned to a preceptor may be at different levels in their education or from varied

disciplines. While preceptors are identified as the nurses primarily responsible for clinical teaching on clinical units, staff nurses, charge nurses, and in-service co-ordinators also teach and supervise students (Asirifi et al., 2017). Evaluation of student performance is done by the preceptors or the nurses who supervise students in the setting and submitted to faculty for grading (Asirifi et al., 2017; Asirifi, et al., 2013). Clinical faculty members tend to spend limited time in clinical agencies, in part because of assignment to multiple agencies and the amount of time needed to travel between agencies because of severe traffic congestion (Asirifi et al., 2017). In addition, preceptors expect extrinsic rewards, such as more pay for their clinical teaching responsibilities, and relationships with students tend to be hierarchical rather than collaborative.

Given the challenges in clinical teaching revealed in Cycle One, and the data collected in Cycles Two and Three, it became evident that changes were needed in the preceptorship model used in nursing education in Ghana if clinical nursing education was not to lapse back into features of the historical apprenticeship model where students were placed on a unit and education was incidental as students provided service. While using students for service is unlikely to happen at the university where this study was conducted, findings revealed that students may be observers rather than caregivers in the clinical setting and learning may be incidental rather than deliberative. For quality clinical education to occur, reconceptualization and strengthening of the preceptorship model within a resource-constrained environment is needed. Major findings are introduced in relation to rationale for reconceptualizing preceptorship, role expectations, planning for success, and challenges before discussion of the way forward.

Rationale for Reconceptualizing Preceptorship

The usual conceptualisation of preceptorship as one student with one preceptor who provides guidance and mentorship throughout a clinical rotation is neither reflected nor possible in the Ghanaian context. There are too many students and too few preceptors. Thus, nursing leaders are advocating that all registered nurses should receive preceptorship preparation. Innovative strategies are needed to bridge the gap between academia and practice settings. Ghanaian nurse leaders are aware of the issues and are already devising plans to strengthen clinical nursing education. An MOH representative indicated that:

> *At the policy making level… and as far as clinical teaching is concerned this topic on improvement of the quality of clinical teaching is at the center of discussion at the moment …. This is so important, it needs a lot of innovations so I am interested to see what we can do together to strategize ways to close this gap between the training institution and the clinical area.*

Currently, selected staff nurses are prepared for preceptorship through an NMC program or at nursing schools.

Role Expectations

As preceptors, faculty, students, and ward staff are all involved in clinical teaching, clarification of roles and responsibilities is critical if strong supportive relationships are to evolve. Preceptors in the study indicated that they provide feedback, ask questions, support students to grow in the care of patients, and evaluate student performance using a clinical schedule book that is primarily task focused. An NMC representative said:

> *We prepare the preceptors solely to teach the students. They organize clinical conferences with the students and provide feedback to the students about their clinical*

performance. They are supposed to liaise with schools to provide clinical teaching. This is what the concept of preceptorship is about in our context but I wouldn't say it's done 100% but at least this is how far we've brought it.

Preceptor participants indicated that they use clinical practice objectives provided by the nursing schools to foster achievement of the expected clinical teaching and learning outcomes. For example, *"When the schools bring us their letter and objectives about 6 weeks before the clinical practice, it helps us to plan our schedule and be prepared for the students".* Evaluation documents are sent to the schools for final grading.

Faculty members prepare nursing students theoretically and in the skills laboratories before placement in clinical settings. Prior to the commencement of the students' clinical experience, the faculty member is expected to submit the list of students' names, the expected areas of practice, and the clinical objectives to the Director of Nursing Services at the clinical agency and to the preceptors or the staff nurses responsible for teaching students. Clinical faculty members are expected to oversee the students' experiences and spend time with the students on the units, as well as support the preceptors and students as required during the clinical rotation but some of these expectations may not be met consistently**.** A faculty member described her role in clinical teaching as**:**

Our roles include liaising with the clinical instructors in the school's skills laboratory and drawing the schedule for the clinical placements in the various hospitals. We ensure that the clinical introductory letters are sent to the various hospitals, follow the students to the clinical settings on their first day to ensure that they are received properly, and then we leave the rest of the clinical teaching in the hands of the preceptors.

This description suggests little or no collaboration in the actual clinical teaching.

Students are expected to be respectful, punctual, dress professionally, show interest in learning, and understand the expectations as outlined in the clinical objectives. A graduate student participant with preceptorship experience indicated that:

> *Their clinical objectives are like a commitment to the students' clinical learning so I always find out by asking the students about their clinical objectives and expectations. I then give them the opportunity to select those achievable objectives to work with.*

This statement is interesting as Cycle One data revealed that students were not always provided with the clinical objectives of a practicum nor were they asked to develop their personal objectives (Asirifi et al., 2017). As well, there is a sense in the statement that the objectives may not be achievable in the specific clinical setting. Clear objectives, leveled to reflect the student's expected clinical capacity at a specific point in the program, constitute an important structural component of clinical practice. In Ghana peer teaching occurs among students during their clinical practice as post-RN students participate in the same clinical placements as other undergraduate students, generally with the same objectives. Critical thinking may not be encouraged as hierarchical relationships in health care, nursing, and society may discourage students from asking challenging questions or voicing concerns about the care patients receive.

Unit staff nurses are expected to assist preceptors in teaching students. One preceptor indicated that *"We realized that every nurse on the ward was contributing to teaching the students. We don't have to let the students sit idle so we had to give them tasks and really teach them."* Another preceptor added that *"The staff nurses were made to understand that not only the preceptors are expected to teach the students; every staff member is responsible for teaching students."* A third preceptor described how *"In my unit the head of the unit makes sure that we are all working together to help the students. The head creates the awareness that every nurse is*

a teacher." Staff nurses contribute to students' clinical learning. Still another preceptor commented: *"I know the nurses who are competent and capable of teaching. If I see students with such nurses I know they are safe and I leave the students in their hands but occasionally, I pop in to see how the students are doing and then at the end of the shift the nurses would give me report on the teaching and learning activities of the day."* Participants indicated that there are staff nurses who really have the passion to teach and whose knowledge and skills get utilized.

Planning for Success

Orientation is critical to successful student teaching and learning. Students, faculty, preceptors, and nursing staff should receive orientation in order to understand their personal roles, expectations, and responsibilities, as well of those of the other players in the setting. A graduate student participant suggested: "*I think it would be better if the students are introduced to the [School of Nursing] clinical objectives and allowed to set [add] their clinical objectives on* w*hat they are supposed to achieve. This would enable students to assess their level of performance according to the set objectives.*" Most of the preceptors agreed that they needed adequate preparation and orientation to teach students effectively. One of the preceptors indicated that: "*We need more educational support in all the processes involved in clinical teaching in the form of workshops or providing us with handouts.*" One faculty member explained the need for faculty expertise in clinical teaching: *"so that they can support the students and the preceptors in clinical practice."*

Most participants recommended increased collaboration and partnership among the internal and external stakeholders of nursing education in Ghana. One external stakeholder indicated that: *"There must be collaboration between the universities and the clinical facilities because if the clinical staff are involved in planning clinical teaching projects, the*

implementation becomes easier." Similarly, faculty members explained that: "*If we plan clinical teaching programs with the clinical agencies, supported by NMC and MOH, it will be more effective."*

Most of the faculty members and external stakeholders identified the post-RN students as experienced nurses who could contribute to teaching their generic counterparts in the clinical setting, especially in face of current staff shortages. A faculty member added that *"we usually combine the post RNs with the generic students for clinical practice so that while the senior nurses (post-RNs) are serving as students, they also help to teach the younger ones that are with them*."

Challenges

Most participants indicated the major challenges of clinical teaching as: teaching multiple students from different agencies, levels, and disciplines; heavy workload and patient care responsibilities of preceptors; preceptors' shifts not always coinciding with student clinical hours; lack of incentives to motivate preceptors to teach; lack of clarity of clinical expectations; inadequate student preparation for clinical practice; and, lack of clarity in relation to students' clinical evaluations.

Most of the preceptors indicated that they often supervised multiple students from various institutions or various healthcare disciplines simultaneously. Meeting each student's needs is complex and there is a tendency to make learning experiences similar for all students. Giving students full responsibility for the nursing care of specific patients may not fit with a unit where team nursing is practiced, but could encourage deliberative planning in relation to clinical objectives. Students could be responsible for reminding a preceptor of objectives, communicating learning needs that remain unmet, and suggesting clinical opportunities that

would enhance their learning. Genuine clinical practice, as opposed to observation, enhances skill and knowledge development. Preceptors could provide guidance about clinical opportunities in the specific unit at the onset of a student's practicum and, therefore, cue students as to the theoretical and skill review needed to provide care and integrate knowledge. While individual interview and focus group data suggested that holding clinical conferences was a preceptor responsibility, there was no corroboration that such learning opportunities were actually occurring with any regularity.

Preceptors usually have heavy clinical, as well as teaching, responsibilities. Perhaps students could assume many of the patient care activities under the supervision of the preceptor. Thus, the preceptor role could become similar to the clinical instructor role when a group of students is assigned to one or two units and each student provides full patient care for one or more patients under faculty and unit staff guidance. The preceptor ensures that patients get safe nursing care by checking and supplementing each student's knowledge and skill, providing necessary teaching, and supervising skills such as wound dressings until the student becomes competent. The students, however, share the clinical workload. A graduate nursing student indicated that *"In some clinical settings, in fact, I won't pretend, they don't really have trained preceptors because of the staff shortages. It therefore poses heavy work load for the few preceptors available to teach the students."*

Another challenge mentioned by most faculty members was that preceptors and students are not always on the same shift. For cost, convenience, and safety reasons students usually work Monday to Friday day shifts as the School of Nursing provides transportation between the university and the clinical settings. A faculty member explained that: *"students are not able to work the hour shifts with the preceptors due to the timing or the clinical schedule for preceptors*

on the ward/unit. For example, we identified three preceptors in a unit to work with our students but when it got to the time that we sent our students to the unit, we realized that two of the preceptors were on leave and the other one was on night duty. So, the preceptors are not always available for our students. But if there's a way they can be on the shift of the students, it would be very helpful." As staff nurses, preceptors are on clinical rotations, while student schedules are fixed.

Lack of clarity in relation to reasonable expectations in terms of student preparation and preceptor evaluation of students' performance were mentioned as challenges by most participants. A preceptor indicated that "*students need adequate preparation and orientation to the expectations of their clinical practice."* Another preceptor stated that "*the clinical objectives guide the areas to teach but most of the time, some of the students who come for clinical practice have not been taught or have not been exposed to their expected areas of competency and objectives before they come."* One of the graduate students added that: "*I think if the objectives are communicated to the students in class before they get to the wards, the students would be more involved in the clinical practice and that would make the teaching and learning easier."* Participants indicated that the students have limited input into their clinical evaluations.

Most participants indicated that preceptors receive inadequate to no incentives to motivate them to teach. It is seen as an added responsibility to their job rather than a professional responsibility. One faculty member stated that *"there should be some kind of reward system, not necessarily money, but if there's a way of winning points that would contribute to the preceptors' academic advancement, because there are nurses who want to further their education so if the preceptorship can give them some points for entry into schools or even contribute to their professional promotion, it would be useful."*

Two priorities for change received consensus at the end of Cycle Three. Reconceptualizing preceptorship was one. Clinical evaluation, identified as the second priority for change, will receive in-depth focus in another article.

Reconceptualizing Preceptorship in Ghana

Before discussing the way forward for reconceptualization of preceptorship in Ghana, it is important to shed light on the use of Kotter's theory of organizational change (Kotter, 2012) in relation to CBPR in this study. Change is one of the major purposes of CBPR and Kotter's eight-step theory of organizational change is congruent with CBPR. The first two steps, *creating a sense of* urgency and *establishing a guiding* coalition, were achieved in the first cycle of the study (Asirifi et al, 2017). Step three, *forming a strategic vision*, was achieved in Cycles Two and Three and involves creating and shaping a vision to facilitate the change effort and establishing strategic initiatives to achieve the vision (Kotter, 2012). Cycle Four involved validation and communication of the vision and strategies.

A New Vision

A clear vision enables the stakeholders of an organization to focus on the achievement of the set goals (Appelbaum, 2012; Kotter, 2012; Lachman, Runnacles, & Dudley, 2013). Our vision is for enhanced collaboration across all stakeholders in the creation of optimal conditions for preceptorship as a clinical teaching model that will provide high quality clinical education for student nurses in the study School of Nursing as an exemplar for what is possible across Ghana. Collaboration between clinical agencies and academia promotes generation of new knowledge from reflection, shared power, active learning, and decision making among these institutions (De Jongh, Hess-April, & Wegner, 2012; Iwasiw, Goldenberg, & Andrusyszyn, 2009). Using a

collaborative philosophy in clinical nursing education in Ghana will give preceptors, faculty, and students the opportunity to use and share experiences to enhance their practice.

Strategic Initiatives

Specific strategic initiatives guide stakeholders in an organization to work toward making the vision a reality (Kotter, 2012). Potential strategic initiatives are: central planning; faculty planning and development; enhanced preceptor development; same shift for preceptors and students; relationships, defined roles, and responsibilities of preceptors, nursing staff, clinical faculty, student peers, and students; clear clinical objectives and evaluation criteria and process; and, preceptor appreciation. Some of these strategies are already in progress.

Central Planning

External stakeholders are aware of the burden of the large numbers of students on clinical agencies and are initiating plans to address this problem. Through centralized planning, external stakeholders, namely the NMC and the MOH in collaboration with nursing schools and clinical agencies, are initiating meetings to ensure that students in reduced numbers and from fewer schools or disciplines practice on units concurrently. Such inter-agency communication should reduce the incidence of preceptor assignment to students from varying levels and with widely different learning needs at the same time and facilitate opportunities to focus on specific learning needs at appropriate levels of clinical practice (De Jongh, et al., 2012).

Faculty Planning and Development

The new Dean of the School of Nursing in this study is a Collaborative Research Team member and has recruited six additional faculty members to address the critical shortage of academic teaching staff. It is also important to provide adequate educational preparation about the roles and expectations of all players in the preceptorship relationship (Yonge, Ferguson,

Myrick, & Haase, 2011). Clinical faculty need preparation about clinical teaching and the preceptorship model. This could be accomplished through orientations, workshops, or seminars focusing on communication of expected standards of practice for various levels of students; clinical teaching strategies; clinical objectives; clinical evaluation; and, preceptor selection, guidance, and support. Development of a context-specific preceptorship handbook would enhance consistency in messages offered and a reference for everyone (Altman, 2006; Macharry & Lathlean, 2017; Odelius, Traynor, Mehigan, Wasike & Cadwell, 2016; Oosterbroek et al., 2017; Pierangeli, 2006; Yonge et al., 2011). Clinical faculty, as often as feasible, could be placed in one clinical agency for clinical supervision and collaboration with preceptors and should receive orientation to the clinical setting. Benefits of faculty orientation to the clinical setting include: increasing learning support and collegial relationships among nursing staff, preceptors, faculty, and students; involving faculty and students as team members in the practice unit; and, enhancing faculty ability to be more involved in unit activities with students as they balance classroom and clinical work (Budgen & Gamroth 2008; Dean et al., 2013; Felecia, 2013; Smit & Tremethick, 2014). This strategy could be used in Ghana to increase the retention of clinical faculty in the School of Nursing and enhance the success of preceptorship (Pierangeli, 2006).

The clinical faculty in Ghana could be more involved in students' clinical activities by setting a half day per week (or bi-weekly) for clinical seminars at the School of Nursing during clinical practice rotations to discuss clinical experiences, nursing procedures, patient care scenarios, and essential topics pertaining to the clinical practice, as well as to provide a check on students' clinical knowledge and progress (Granero-Molina, et. al., 2012). Students could be encouraged to keep a diary or journal to record clinical learning activities and opportunities to share during the clinical seminars, as well as document issues to discuss and observations they

find troubling. Seminars engage students in a way that increases their critical thinking and understanding about nursing care, as well as their ability to integrate theory and practice (Granero-Molina, et al., 2012; Hoften, Gustafsson, & Haggstrom, 2010).

Enhanced Preceptor Development

Preceptor preparation and orientation is imperative for effective preceptorship. It is therefore important for preceptors to understand the expectations, goals, and pedagogical processes involved in clinical education (Krampe, L'Ecuyer, & Palmer, 2013; Yonge et al., 2011). Faculty could organize workshops or seminars to orientate preceptors to the course outline, course objectives, clinical teaching strategies, stimulation of critical thinking through questioning, provision of feedback, and evaluation of students' performance (Krampe, et al., 2013; Warren & Denham, 2010; Yonge, et al., 2011).

Preceptor and Assigned Students on Same Shifts

Negotiation would be needed to ensure students and assigned preceptors share the same shifts. If students cannot change from a day shift due to reasons of safety or transportation issues, this strategy may be difficult to implement. Perhaps two preceptors who work different shifts could share a group of students so that there is greater consistency than tends to occur now. Chuan and Barnnet (2012) suggest that students who work closely with the same preceptor during their clinical experience are most likely to receive adequate supervision and a positive pedagogical atmosphere in their clinical practice.

Preceptor Selection

Criteria for preceptor selection help with identification of nurses with the required knowledge and skills needed to teach students. Participants in this study indicated that student teaching is a professional responsibility of registered nurses. Therefore, all staff nurses should be

prepared as preceptors to help teach the large numbers of students who practice in the clinical setting. Since staff nurses contribute to students' clinical learning (Asirifi, et al 2017; Chuan & Barnnet, 2012; Myrick & Yonge, 2005), they should all be given adequate preparation. Altmann (2006), however, believes that preceptor selection should be based on length of service or experience in nursing practice, attitude towards student teaching, and educational background. While some nurses should never preceptor a student because of lack of competence or positive role modelling, there is a need to strive to create and locate students in clinical settings where care is good.

Preceptorship training could be integrated into post-RN baccalaureate and graduate nursing programs. Our study revealed peer learning among students when post-RN students are mixed with other undergraduate students and become involved in peer teaching. Currently, both types of students are in the same program and have the same prescribed clinical objectives but their needs and potential learning trajectories are different. Making peer clinical teaching an objective for post-RN students would enrich their program and they would already have preceptorship training on graduation. They could attend preceptorship training as part of their program and graduate with this additional qualification. Since most of the graduate students teach in nursing schools in Ghana, they could take advantage of such educational preparation to ensure effective clinical education and preceptorship in their schools. Such a strategy would increase numbers of competent preceptors. Ideally, preceptors should be selected based on their passion to teach students, baccalaureate or higher degree in nursing, excellent team playing skills, ability to stimulate critical thinking through provocative questioning, competence in nursing practice, willingness to receive educational preparation in preceptorship, excellent

communication skills, and respectful human relationships (Altmann 2006; Davis, et al., 2009). While not practical currently, this could be a future goal.

Relationships, Roles, and Responsibilities of Preceptors, Nursing Staff, Clinical Faculty, Student Peers, and Students

Apart from preceptors, nursing staff teach students and peer teaching also occurs among students during clinical practice. Most of the participants indicated that nursing staff and students also require preparation to understand their roles and responsibilities in order to foster a positive relational environment in preceptorship. This is congruent with Lehmann and Brighton's (2005) statement that students require orientation about their roles and expectations in preceptorship in order to both meet their learning goals and take advantage of learning opportunities that may allow them to exceed their goals. In order to fully engage students in preceptorship in Ghana, faculty should orientate them on the clinical course objectives, evaluation criteria, and rationale for seminars and pre/post conferences. Preceptors and staff at clinical agencies should also orientate students on clinical site routines and agency policies and procedures (Lehmann & Brighton, 2005). Perhaps junior staff nurses could be paired with senior nursing students or post RN students for teaching, with the official preceptor serving as a facilitator of the experience and mentor of the more junior staff nurses. This team learning approach can promote supportive relationships among students, nursing staff, and preceptors during clinical teaching and learning experiences (Brathwaite, & Lemonde, 2011; Cele, Gumede, & Kubheka, 2002).

Respectful human relationships in clinical teaching and learning promote development of personal and professional growth and encourage active student participation. (Haitana & Bland, 2011; Matua, Seshan, Savithri, & Fronda, 2014). Congruent with a humanistic approach to teaching and learning, processes that foster student achievement of learning goals include: a respectful environment or relationship between learners and teachers; interactive participation,

questioning, and sharing of thoughts by students; and, teachers assuming primarily a facilitator role (Bracarense et al, 2014; Diekelmann & Lampe, 2004; Freire, 2001).

The primary focus of humanism as an educational philosophy is the autonomy and dignity of individuals involved in teaching and learning as well as assisting the learners to become more of who they are (Billings & Halstead, 2007; Bracarense, et al, 2014; Helskog, 2014). Humanism promotes critical thinking, application of knowledge to practice, authentic being in nursing, experiential learning, and the ability of students to establish and meet their own goals (Billings & Halstead, 2007; Bracarense et al., 2014). Using humanism as a philosophical underpinning in clinical nursing education promotes student-centered learning whereby students take responsibility for their own learning; respectful relationships exist among students and clinical agency staff, preceptors, and students; and, teaching strategies promote full engagement of students. This approach could reduce the risk of students maintaining passive roles in learning.

Clinical Objectives and Evaluation Criteria

Clinical objectives address clinical learning needs, knowledge, and skills to be mastered in clinical nursing practice (Lehmann, Brooks, Popeo, Wilkins, & Blazek, 2012). Students should be allowed to supplement faculty mandated objectives with personal objectives related to their specific learning needs and interests. This approach encourages students to assume responsibility for their own learning. Also, clinical objectives from both the faculty and students should be communicated to the preceptors to guide their clinical teaching and evaluation (Billing & Halstead, 2007).

Preceptor Appreciation

Preceptors need to be appreciated and motivated to increase their interest and satisfaction in teaching. Preceptors in Ghana could be motivated by monetary incentives, appreciation from

management and colleagues, and incentives such as workshops or conference sponsorship (Asirifi, et al., 2013; Campbell & Hawkins 2007; Germano, Schorn, Phillippi, & Schuiling, 2014; Penprase, 2012). Preceptorship could become a recognized competency for renewal of professional nursing registration in Ghana. Schools of nursing could sponsor events such as teas, free educational offerings, or a token such as a pin which, when worn on a uniform, would identify a nurse as an excellent clinician and a designated preceptor.

Potential Barriers or Threats to Change

Acknowledging and alleviating actual and potential barriers to organizational change is critical in enabling people within an organization to function efficiently (Kotter International, 2017; Lachman, et al., 2013). Potential barriers to effective implementation of a reconceptualized preceptorship model in the Ghanaian context include addressing a tradition of hierarchical relationships, continued lack of fiscal and human resources, and resistance to change. All stakeholders need to acknowledge that clinical education can be improved through many of the suggested strategies and embrace the possibilities. While some strategies are easy to assume, others may need tweaking. Some may stimulate organizational shifts while others may be tried but not work within the context.

In Ghana, traditional hierarchical relationships between teachers and students create an educational environment in which truly active participation of students is discouraged (Bohmig, 2010). Teachers are authority figures and students are expected to adhere to teaching authority with minimal or no questioning (Bohmig, 2010). This traditional hierarchical relationship limits the promotion of the student-centred learning that is critical to successful adoption of a preceptorship model that produces caring and critical-thinking professional nurses. Professional hierarchies in health care limit the critical thinking and questioning by nurses that produce a

patient-centred and inter-professional collaborative environment in which excellence in patient care flourishes. This challenge can be addressed through the lens of a humanistic approach to teaching that could filter into clinical practice after graduation.

Also, the critical social theory perspective used in this study enabled empowerment of all the stakeholders of nursing education including students (silent voices) to engage in critical discourse and collaborative decision making which led to the identification of the need for reconceptualizing preceptorship, and the development of the collaborative vision and strategies for the implementation of effective clinical education in Ghana. This is similar to Sumner & Danielson's (2007) postulation that critical social theory promotes questioning of the historical norms or structures and power relationships in terms of whose voices or marginalized or silenced.

Communicating the Potential Strategies for Change

The fourth step of Kotter's organizational change theory focuses on ensuring that most people in the organization accept and understand the vision (Kotter, 2012). Thus, communication of the vision to key stakeholders in nursing education in Ghana occurred in Cycle Four. The research findings and the strategies for reconceptualizing preceptorship where presented to the key stakeholders of nursing education (faculty members; NMC, GRMNA, and MOH representatives; clinical agency staff) for further input of ideas to strengthen the effectiveness of preceptorship in Ghana. The stakeholders agreed that the recommended strategies would enhance the effectiveness of clinical education in Ghana. Their Cycle Four suggestions included the need for a specific country-level policy document as a guide for effective preceptorship, the merit of advocating for official engagement of part-time preceptors, and the possibility of NMC having the power to determine student nurse entry quotas annually.

Conclusions

The choice of a clinical teaching model in a particular context depends on available resources and the ability to use the clinical teaching approach effectively. In a CBPR project conducted in Ghana, nursing education stakeholders agreed that preceptorship in a reconceptualised form is the most feasible clinical teaching approach to improve student nurse learning. Drawing on Kotter's organizational theory of change, strategic approaches for reconceptualising preceptorship in the Ghanaian context are recommended. The vision includes enhanced collaboration among all stakeholders to promote optimal environments for clinical teaching in nursing education. The CBPR approach, by engaging stakeholders from policy, clinical, and educational levels from the very beginning, incorporated knowledge translation to decision-makers as part of the research process. Formation of a Collaborative Research Team within the School of Nursing, from where much of the change needs to be initiated, has hopefully stimulated the motivation and energy needed to implement the suggested strategies.

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CHAPTER FOUR

Paper 3: Reflecting on Leadership Development through Community Based Participatory Action Research

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Abstract

The need for leadership in nursing is well-documented and Domain Six of the doctoral section of the *National Nursing Education Framework* of the Canadian Association of Schools of Nursing (CASN) is Leadership. While there are likely many paths to achievement of these leadership components, the intent of this paper is to share my journey through iteration of and reflection on my PhD dissertation research that involved the development and implementation of a four-cycle community-based participatory action research study (CBPR) related to clinical teaching in nursing education in Ghana. The focus of CBPR is to engage the researcher and representatives from the participant group (community) in collaborative, egalitarian, and partnership processes in order to assess and problem solve an issue that, in ideal circumstances, is chosen by the community. Similarly, leadership promotes collaborative interpersonal relationships among leaders and followers in identifying, planning and implementing change strategies, as well as effecting change policies. These processes involved in CBPR and leadership promote leadership development. In this paper, I present my experiences in building leadership capacity through this scholarly endeavor (PhD thesis) in relation to the CASN guideline. This CPBR project enabled me to practice leadership styles relevant to nursing practice such as resonant, relational leadership and renaissance leadership which are rooted in transformational leader styles through qualities such as confidence, commitment, effective communication skills, motivation of others, demonstration of respect for people's contributions to the team, encouragement of collaborative decision making, promotion of evidence-based practice, advocacy, risk-taking and creativity.

Introduction

The need for leadership in nursing is well-documented (Cummings, 2012; Scully, 2014) and Domain Six of the doctoral section of the *National Nursing Education Framework* of the Canadian Association of Schools of Nursing (CASN, 2015) is Leadership. The guiding principle states: "Programs prepare graduates to be leaders in advancing the discipline of nursing" (p. 17). Three essential components that PhD graduates should demonstrate are identified as:

- Leadership through scholarly inquiry and the scholarship of discovery, integration, application and teaching.
- Leadership in the development, implementation, knowledge translation and mobilization of an intra/interdisciplinary program of research.
- Leadership in building scholarly capacity, policy development, and creating change within organizational systems.

What is not provided, are guidelines as to how these goals may be achieved in a doctoral program in nursing. Is education sufficient or is practice needed? While there are likely many paths to achievement of these leadership components, the intent of this paper is to share my journey through iteration of and reflection on my PhD dissertation research that involved the development and implementation of a four-cycle community-based participatory action research study (CBPR) related to clinical teaching in nursing education in Ghana. It was as I reflected on what I had learned after the completion of Cycle Three that I realized the connection between CBPR and capacity building for leadership. In this paper my experiences are preceded by brief reviews of literature pertaining to CBPR, leadership, and the connections between them in building leadership capacity.

Community-based Participatory Action Research

Community-based participatory action research (CBPR) is a research process that engages the researcher and representatives from the participant group (community) in collaborative, egalitarian, and partnership processes to assess and problem solve an issue that, in ideal circumstances, is chosen by the community (Bomar, 2010; Caine & Mill, 2016). The term "community" in this case may not refer to a suburb or a neighborhood but rather a community of interest (Stringer, 2007) or a unit of identity that is identified by the target group in collaboration with researchers (Bomar, 2010). Features of CBPR include: the centrality of community to the research; a commitment to changing the balance of power by the researcher; a different role for the researcher from that in traditional forms of research; active participation of participants in all stages of the research process; production of useful knowledge; and, a commitment to action (Northway, 2010a). The community is placed at the heart of the research rather than the researcher or the research question which the community seeks to address.

Participatory research often involves engaging communities whose voices have been marginalized or who have experienced a form of oppression (Greenwood & Levin, 2007; Koch, Sellim, & Fralik, 2002). Examples of such groups are people with learning disabilities and mental health problems (Northway, 2010a). Healthcare professionals, nurses in particular, are also viewed as people whose voices have been marginalised (lacking a voice) in the healthcare community (Holmes & Gastaldo, 2002; Koch et al., 2002). Northway (2010a) explained further that communities could be geographically bounded (a group of people living in one locality) or geographically dispersed (a group of people living in different localities but who share a common identity or interest) and cautioned that group members in the community may have different views as to the best way to address issues. These different views need to be carefully

addressed within the research system. Similarly, there could be repercussions in terms of power dynamics within the community where the research is being undertaken (Israel et al, 2010; Stringer, 2007). For instance, local leaders or chairs of local action groups or patient groups are often chosen to facilitate activities in the research process. There is the risk of marginalising people who are not opinion leaders or chairs of the group (Northway, 2010a). It is therefore important that participatory action researchers pay attention to the voices of both leaders and members within the community.

The primary difference between CBPR and other research methods lies in the power relations within the research process. In traditional research, the researcher is considered to be a powerful expert. This can be disempowering for participants who are assigned to play a passive role in the research process (Baum et al., 2006). On the other hand, CBPR seeks to challenge this type of power (Northway, 2010a). One of the aims of CBPR is to recognize power dynamics and to use these to explore ways to empower community members to effect change (Israel et al, 2010; Northway, 2010a). In traditional research, researchers are expected to play an objective role by separating themselves from the research process (Northway, 2010a). In CBPR, however, researchers are expected to be committed participants. It is important to note that CBPR is an educational process and as the researcher and the community work together they all, including the researcher, become educated through the process (Northway, 2010a). The researcher has expertise about the topic and the research process but the community members are the experts about their social situation (the context).

Participants are involved in decision making in all stages of the CBPR research process. Community involvement is needed during the definition of research questions to be addressed (Northway 2010b). Participants are invited to take an active part in designing the research

process, seeking ethical approval, securing funding, implementing the research design, analysing the research data, reporting the research findings/interpretations and acting on the research results, although an analysis of four case studies revealed that community partners appear to be less frequently involved in data analysis and interpretation than in other research activities (Cashman et al., 2008). To promote the involvement of all participants in data analysis and interpretation in all phases of the study, six strategies are suggested: open dialogue and consensus regarding participants' specific roles in data analysis and interpretation; use of participants' prior experiences in research endeavors; engagement of community members in an explicit iterative experience; simplification of the data to aid understanding (for example, having trained academics to take the first step in structuring data analysis, while the community members contribute by sharing insights into realities reflected in the raw data); a longer time-line for the study; and, use of experiential learning approaches to engage all partners in data analysis and interpretation of findings (Cashman et al, 2008). While roles of community members and academic partners are different, they are complementary. Involving participants in all the stages of the research process enriches the interpretation of findings of the study. Such strategies are likely to promote participants' sustained involvement as "active participation is seen as the gateway into a CBPR project, whereas knowledge attainment and power are the stimuli for continuing participation" (van der Velde et al., 2009, p. 1293).

Information gathered in the CBPR process often has practical application in the day to day lives of participants. Three types of knowledge have been identified: instrumental knowledge, relational knowledge and critical knowledge (Northway, 2010a). Instrumental knowledge is technical knowledge used to control the physical environment. This type of knowledge is usually produced by traditional research. Relational knowledge is acquired from interaction with and

learning from people. Critical knowledge is acquired from critical reflection and action. All of these knowledge types are generated in CBPR and one should not be viewed as more valuable than another. For example, interviewing increases awareness of an issue through listening (relational knowledge). Information may be gained about an intervention such as techniques of taking medication (instrumental knowledge). Finally, reflection is fostered about the need for change (critical thinking) (Northway, 2010a).

While the primary focus of traditional research is to test hypotheses, CBPR seeks to provide the community with knowledge and tools that bring about social change (Stringer, 2007; Northway, 2010a). Action can be undertaken in different forms. It can take the form of health promotion initiatives valuable to community members or development of theatre or other art-based representations to create awareness of issues in the community (Northway, 2010a). Therefore, CBPR is focused on active engagement of the people in a community in a research process that provides an enabling ethos for all-inclusive decision making to facilitate changes for the enhancing achievement of goals identified by the community. The collaborative processes in CBPR promote leadership. Also, CBPR involves an iterative process of cycles.

Community-based participatory action research involves working collaboratively with participants through an iterative process of cycles of observation, reflection and action. As Stringer (2007) commented, basic routines of CBPR are looking, thinking and acting. Looking (observation) involves gathering relevant information (data collection) and describing the situation. Thinking (reflection) involves analyzing the data and thinking about "What is happening in this situation?" This reflective process involves interpreting and explaining why and how things are as they are (theorizing). Acting in this context means planning, implementing and evaluating a change. These processes happen in a spiral manner and can mean working

backwards through routines, repeating processes, revising procedures, rethinking interpretations and sometimes making radical changes in direction.

The iterative processes through the four cycles in this CBPR project are depicted in Figure 1 (p. 106). The research planning and the implementation of the proposed changes phases are not depicted within the cycles. The planning phase incorporated the development of a four-member Collaborative Research Team in Ghana. The team members were faculty members at the selected school of nursing. They are also the team designated as the change agents for implementation of change strategies arising from the research. These team members reviewed the initial research proposal and made suggestions for change based on their contextual knowledge prior to my PhD candidacy examination and the approval of the proposal. They also assisted with the ethics review process in Ghana. Thus, collaboration began before Cycle One of the research. The implementation phase has yet to occur and will be led by the Collaborative Research Team. Manuscripts related to Cycles One, Two and Three can be found in Chapters Two and Three of this document.

Leadership

Leadership is manifested in our day to day lives and practices. The leadership approach used in an organisation is critical in determining the outcomes of the vison and goals to be achieved. Leadership is therefore a necessary component of identifying, planning and implementing change strategies, as well as in effecting change policies (Cummings, 2012; Day, Fleenor; Atwater, Sturm, & McKee, 2014; Tourish, 2014). Leadership style describes how leadership is accomplished, how a preferred future is achieved and the approach to accomplish the work to be done (Cummings, 2012). There is a proliferation of definitions of leadership and leadership theories. Thus, leadership is perceived as "being able to see the present for what it really is, see the future for what it could be and then take action to close the gap between

today's reality and the preferred future of tomorrow" (Cummings, 2012, p. 3325). It is processual in nature (Tourish 2014), and utilizes appropriate leadership styles and theories with a vision for future change (Cummings, 2012; Dinh, et al., 2014; Khan et al., 2016; Maxwell, 2017). It is also a collaborative endeavor (Scully, 2013) that promotes good interpersonal relationships among leaders and followers (Groeneveld, 2003; Maxwell, 2017), influences group members towards the achievement of set goals (Maxwell, 2017; Wolinski, 2010), and develops through practice experience (Cummings, et al., 2008), nurturing in practice (Groeneveld, 2003), and/or educational development endeavor (Canadian Association of Schools of Nursing (CASN) 2015; Cummings, et al, 2008; Day et al., 2014; Donner & Wheeler, 2004).

Leadership theories are evolving continuously. Early leadership theories included great man theory, trait theory, and situational theory (Cumming, 2014; Khan, et al., 2016; Scully, 2014; Wolinski, 2010). More recently, skills theory is a rejection of the earlier leadership theories and postulates that leadership skills or styles are learned, developed and acquired through knowledge (Wolinski, 2010). Thus, skills theory is congruent with recent work on the importance of leadership development through education and experience in practice (CASN, 2015; Cummings et al., 2008; Dinh, et al., 2014; Scully, 2014).

Contemporary leadership theories such as path-goal, transactional, servant, transformational and charismatic leadership theories focus on the contributions of followers in achieving organizational goals (Khan et al., 2016; Scully, 2014; Wolinski, 2010). The path-goal leadership theory lays emphasis on the importance of motivating or developing followers (Wolinski, 2010). Similarly, transactional theory focuses on exchanges that take place between leaders and followers. Clear expectations and structures are laid down for followers and

consequences apply for meeting or not meeting expectations (Scully, 2014; Wolinski, 2010). Transactional theory appears more akin to management theory than leadership theory (Scully, 2014). Leadership is not a hap-hazard occurrence; it involves vision, communicating the vision, and planning to make the vision a reality. The leader is perceived as a symbol and source of energy for the team. Management involves controlling and maintaining situations according to the "status quo" of the organization. This includes exercising formal authority over working practices. Currently, in nursing practice there is a paradigm shift in scholarly focus from management to leadership (Cummings, 2012; 2008; Grossman & Valiga, 2017; Scully 2014). These two concepts however play very important roles in the workforce, as Scully (2014) asserted that managers need leadership and leaders need management to manage their time and schedules. Servant leadership theory holds that an effective leader must be a servant first by attending to the needs of followers, customers, and the community before the leader's interest. Transformational theory on the other hand seeks to meet the needs of both the leader and followers through a relational process. Transformational theory, mentioned in the literature as one of the leadership theories appropriate for nursing practice (Cumming, 2012; Cumming et. al., 2008; Registered Nurses Association of Ontario (RNAO), 2013; Scully, 2014), holds that leadership is a process which involves engaging and connecting with others to increase motivation and morality in both followers and leaders (Wolinski, 2010). The Registered Nurses' Association of Ontario (RNAO, 2013) iterates the five main practices of transformational leadership as building relationships/trust, creating an empowering work environment, creating a culture that supports knowledge development and integration, leading and sustaining change, and balancing the complexities of the systems through managing competing values and priorities. Leadership style in transformational leadership involves attention to the needs of followers to

motivate them to attain self-actualisation and self-esteem (Khan et al., 2016) and enable them to initiate, develop and implement important changes in an organization (Wolinski, 2010).

Contemporary theories of leadership appropriate for nursing practice include resonance leadership where leaders are expected to have knowledge of contemporary issues in nursing and understanding of factors which may promote or inhibit the future of nursing (Scully, 2014) and connective leadership or shared leadership which is a leadership approach that allows for sharing or distribution of activities among members of a team to address the needs of a situation. These types of leadership mirror transformational leadership theory and function effectively in today's interdisciplinary and inter-professional education and practice settings. Emotional intelligence, awareness of one's own emotions, how well such emotions are managed, and the sociopolitical relationships in the workplace, community and government, is a major attribute of a renaissance leadership style (Scully, 2014).

Cummings et al. (2008) conducted a literature review to examine the factors that contribute to nursing leadership and the effectiveness of educational interventions in developing leadership behaviors among nurses. Findings suggested that practice of leadership skills and roles significantly influences leadership development, traits and characteristics of individual leaders. Leadership experience and education levels had positive effects on observed leadership ability whereas context and practice settings had a moderate influence on leadership effectiveness. Of all examined factors, participation in leadership development programs was reported as having the most significant positive influence on observed leadership ability. These findings are relevant for my discussion of the connections between CBPR and the development of leadership capacity.

Connecting CBPR and Capacity Building for Leadership

An integral part of CBPR is the promotion of leadership through active engagement or involvement of all members involved in the research process (Bish, Kenny, & Nay, 2013; Tucker, Williams, Roncoroni, & Heesacker, 2017). In other words, the collaborative processes involved in CBPR promote the development leadership abilities in the researcher. The researcher's leadership role in this study was as a facilitator whose focus was not to impose decisions on participants but to promote collaborative decision making among stakeholders involved in nursing education in Ghana towards effective clinical teaching and learning (Caine & Mill, 2017; Greenwood & Lewin 2007). In this study the researcher and the participants, particularly the Collaborative Research Team members, were viewed as co-researchers in the CBPR process (Northway, 2010a). This perception provided an enabling environment for the researcher to exercise her leadership role as a facilitator in the study. The promotion of respectful and collaborative relationships with stakeholders is an important leadership ability that facilitates teamwork towards a common goal (Graebe & Shinners, 2017; Grindel, 2016; Lekan, Corazzini, Gilliss, & Bailey, 2011).

Furthermore, CBPR provides an environment conducive to capacity building of team leadership skills of all participants through active involvement, consensus decision making, collaborative problem solving, and an enabling ethos that combines unique knowledge, skills, and resources (Bish, Kenny, & Nay, 2013; Tucker, Williams, Roncoroni, & Heesacker, 2017). It demands that the facilitator (researcher) utilize leadership skills that move the project forward. This connection to leadership development is recognized by other researchers engaged in action research (Ailey, Lamb, Friese, & Christopher, 2014; Asadizaker, Abedsaeedi, Abedi, & Saki, 2016; Crosby, Parr, Smith & Mitchell, 2013; Fowler, Wu, & Lam; 2013; Ha & Pepin, 2017;

Lindo et al., 2013; Matson, Lake, Bradshaw, & Matson, 2014; Yang, Chao, Lai, Chen, Shih, & Chiu, 2012)

Leadership Opportunities in the CBPR Project

I now turn to my experiences facilitating a CBPR project for my PhD research and the influence of this experience in furthering my leadership capacity. This discussion will be organized in relation to the three components of leadership articulated in the CASN PhD-level Leadership Domain: leadership through scholarly inquiry and the scholarship of discovery, integration, application and learning; leadership in the development, implementation, knowledge translation and mobilisation of an intra/interdisciplinary program of research; and, leadership in building scholarly capacity, policy development, and creating change within organisational systems (CASN, 2015). First, however, is a brief description of the CBPR research design. As previously mentioned, the research purpose was to build on my MN research on preceptorship in clinical nursing education in Ghana (Asirifi et al., 2017; Asirifi, Mill, Myrick & Richardson, 2013) through engagement of stakeholders in a research process that would "assess the strengths and weaknesses of the current model(s) of one undergraduate baccalaureate nursing program in Ghana; and offer strategies to enhance clinical teaching and effectiveness that will meet or surpass national standards and are feasible within current and potential resources" (Asirifi et al., 2017). Four cycles (see Figure 1, p.106) were completed – Cycle One incorporated surveys, interviews and document analysis; Cycle Two involved feedback of Cycle One analysis for further input, educational presentations on CBPR and potential clinical teaching models, individual and focus group interviews, and initial manuscript preparation; Cycle Three included further literature review, data analysis, creation of a vision for change with strategies, and development of a second manuscript; and, Cycle Four focused on validation of the vision and

strategies for change with all participants, with inclusion of their suggestions for further change strategies, insights gained and discussion of resources needed. All cycles involved planning, implementation and evaluation in collaboration with the Collaborative Research Team.

Leadership through Scholarly Inquiry and the Scholarship of Discovery, Integration, Application and Teaching

As a doctoral student, it is an expectation to gain knowledge and skill in scholarly inquiry. Through courses, research leading to new knowledge, and the ability to synthesize, apply and communicate scholarly work, all doctoral students should achieve this component of the leadership domain. While my CBPR project assisted me in achieving the capacities outlined in this goal, other research methodologies would have served this purpose equally well with a few exceptions. The CBPR process has a greater emphasis on practical application than most other research methodologies. There was also a greater emphasis on collaboration and teaching in the implementation of the research process. This approach mirrors Scully's (2014) explanation of renaissance leadership style where the leader takes the initiative to identify the current issues and to understand circumstances that inhibit or promote the future of nursing practice. Also, it is worthwhile to note that CBPR has been successfully applied in nursing education programs to improve teaching and learning outcomes for quality care through active engagement and equitable collaborative partnership among stakeholders of nursing education and, within the collaborative process, increased the leadership abilities of all parties involved (Asadizaker, et al., 2016; Lindo, et al., 2013; Yang, et al., 2012).

Leadership in the Development, Implementation, Knowledge Translation and Mobilisation of an Intra/interdisciplinary Program of Research

Through this research experience, I had the opportunity to implement the iterative processes and activities involved in the four cycles of this CBPR project. None of these activities in terms of skills acquired are different from other research methodologies. What was different was acting as facilitator of an intra-disciplinary Collaborative Research Team. This team needed to understand the CBPR research process. They added contextual knowledge and facilitated the research process through assistance in the ethics approval process in Ghana, implementation of the survey data collection process, interpretation and clarification of meanings within the data findings, and decision-making regarding the priorities for change. The approach of engaging and building relationships with the stakeholders reflects resonant leadership, which is critical in achieving partnership and collaborative decision-making in the research process (Cummings, 2014). Furthermore, the CBPR project enabled me to use a strategic approach to purposefully identify and engage the key stakeholders to assess, as well as identify, current issues in clinical nursing education. This is congruent with the assertion that leaders use strategic means to identify challenges and problems that their project will address (Skelton-Green, Simpson & Scott, 2007). Similarly, Maxwell (2017) observed that successful leaders know how to get along with people, incline their ears to the voices of the people and encourage followers to tell what the leader needs to know but not what the leader wants to hear. The collaborative approach embedded in the CBPR project increased my communication skills and promotion of respectful collaborative decision-making with stakeholders, which provided understanding about the situation of clinical nursing education and resources needed to enhance clinical teaching and learning in Ghana. This is congruent with Mayan, Lo, Oleschuk, Pauchulo, & Laing's (2016)

explanation that leadership in CBPR partnerships is demonstrated through: a) individual characteristics such as credibility, trustworthiness, and boldness; b) valuing collective partnership to push forward; and, (c) demonstration of a collective approach where the team of leaders is viewed as having a common goal.

The collaborative processes enabled me to demonstrate leadership attributes such as ability to engage stakeholders in identifying gaps, addressing needs, and assessing outcomes that support addressing of those needs (Graebe & Shinners, 2017). More importantly, through the iterative process of identifying needs and potential solutions in collaboration with stakeholders, knowledge translation is an integral part of CBPR. After consultation with the Collaborative Research Team, I also had the opportunity to promote knowledge translation and mobilization by sharing (through poster presentations) the recommended vision and potential strategies for implementing the vision with faculty members, nurses at the clinical agency, and external stakeholders of nursing education in Ghana, while seeking validation and further input from them. My practice of these knowledge mobilisation processes is congruent with development of leadership qualities such as the ability to engage with people to develop a vision (Cummings, 2012) and to lift the people's performance to a higher sight or standard through suggestion rather than dogmatic pressure (Grossman &Valiga, 2017). Through a strong desire for success and knowledge sharing, one develops the ability to influence others (Maxwell, 2017).

This CBPR project sets the foundation for development of my program of research. I am interested in clinical nursing education and the CBPR process of my doctoral work is incomplete. The implementation of the strategic plan has many dimensions. While the first priority for change identified by the Collaborative Research Team and validated by other participants is a reconceptualization of preceptorship in the Ghanaian context, a second priority –

attention to clinical evaluation – was also identified as critical. Addressing critical thinking in nursing education is another potential research project. This CBPR project, therefore, is a beginning step through which my future research program will unfold. This project facilitated skill development important for my future research career.

Leadership in Building Scholarly Capacity, Policy Development, and Creating Change within Organizational Systems

Carrying out this CBPR project enabled me to build on my scholarly capacity in research. Through this CBPR project I was able to build on my scholarly capacity through two conference presentations of the findings. Also, the first paper of this CBPR endeavor is published and the Collaborative Research Team members contributed to the manuscript and share authorship. They have also contributed to a second manuscript and will again share authorship. Thus, through CBPR, I was able to contribute to the scholarly development and academic success of my research colleagues. The presentations on clinical teaching approaches in nursing worldwide and on CBPR were to wider communities of nurse educators and graduate students and are also potential capacity building activities within the project. Within the Collaborative Research Team, there were opportunities to gain leadership and CBPR research experience. The above demonstration of scholarly capacity building reflects some of the qualities of a transformational leader and may, consequently, affect my future leadership style. Transformational leaders are motivated to develop themselves and others towards activities for professional and personal growth to achieve self-efficacy and empowerment (Khan et al., 2016).

This CBPR project has the potential to influence policy development in clinical nursing education in Ghana. From the beginning, external stakeholders of nursing education were incorporated into the research design. Thus, Cycle One interviews included participants from the

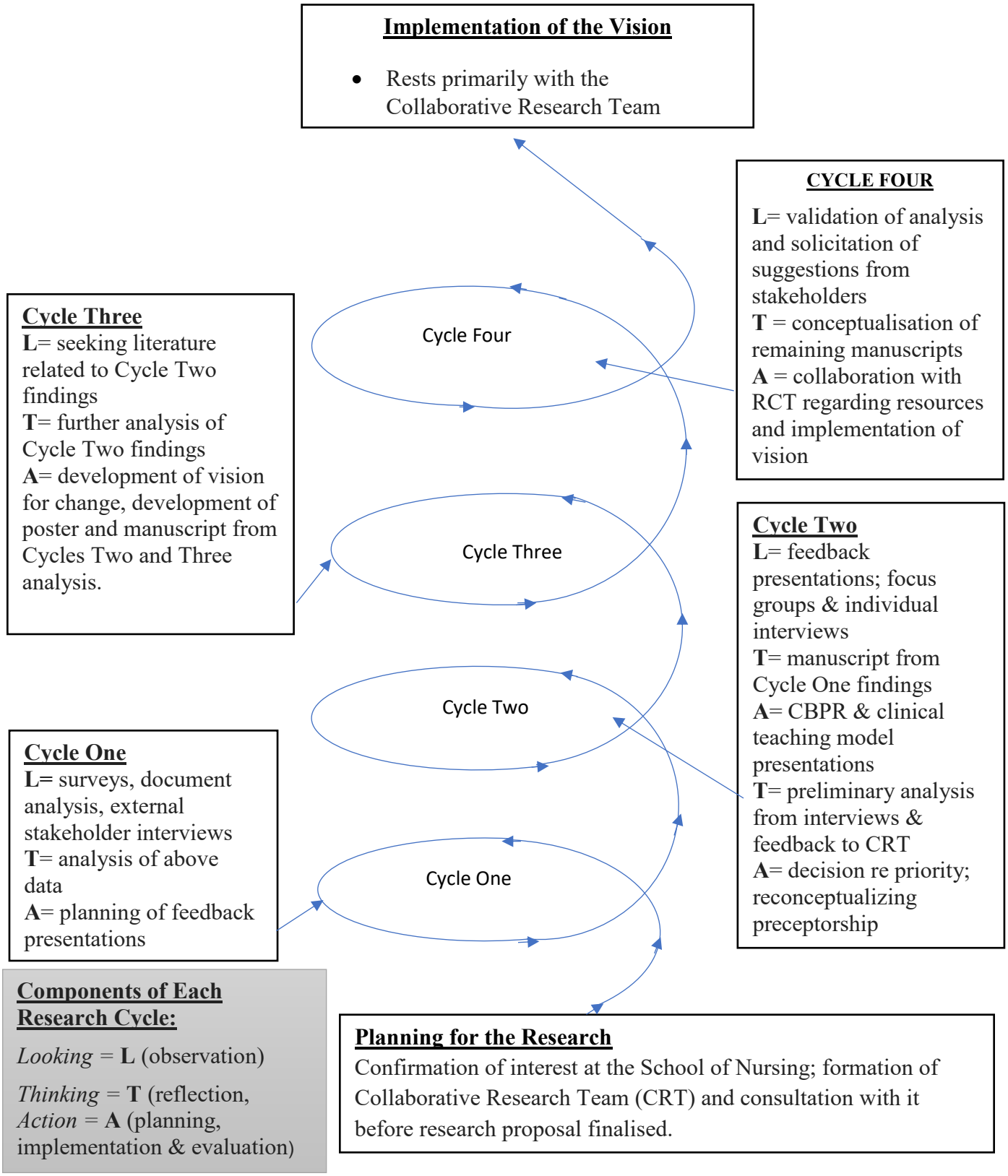
Ministry of Health, Ghana Nurses and Midwives Council, and the Ghana Registered Nurses and Midwives Association. They were aware of the research and offered support of the project. When I presented the vision and strategies for reconceptualizing preceptorship in Ghana to key stakeholders who influence policy formulation in nursing education in Ghana, they agreed with the recommendations and demonstrated interest in implementing the changes. This enabled me to promote evidence-based practice in clinical education in Ghana, which is an important dimension of nursing leadership (Cummings, 2012).

Additionally, through the CBPR project I identified that the traditional hierarchical relationship between the teacher and student could cause resistance to the creation of changes in clinical teaching in Ghana. The power relations within the traditional hierarchical relationship between the student and the faculty/clinical teacher limit active participation of students (students centered learning) in the clinical teaching and learning environment. Therefore, in order to address the issue of the traditional hierarchical relationship, I engaged the Collaborative Research Team in dialogue about strategies to promote safe environments for clinical teaching and learning. This involved taking risk to curb rooted traditions in the creation of positive change, which is a critical leadership quality in nursing practice (Scully, 2014) and is congruent with Graebes and Shinner's (2017) postulation that creating purposeful collaboration for change that makes a difference in a safe environment without hierarchy promotes clinical nursing leadership. Finally, the school of nursing in this study is likely to initiate some, if not all, of the vision. Not only are Collaborative Research Team members motivated to make a difference, one of them became the Dean during the research process.

Conclusions

In the current ever-growing changes and demands on healthcare systems, nursing education programs are putting in structures to prepare nursing leaders to function effectively at all levels in the healthcare environment to achieve optimal health outcomes for individuals and families. Some of the recommended leadership capacities for nursing practice include; coaching, mentoring, learning, listening, leading change, demonstrating organizational skills, assertiveness, effective communication, and promoting collaboration in practice. The concept of leadership in nursing practice is similar to leadership in CBPR. Just like nursing leadership, CPBR is also focused on empowering and increasing the capacity of community members to identify ways of developing new knowledge to change the situation of the community or organisation. Leadership in nursing is promoted through knowledge and skills in nursing practice, positive experience of leadership, promotion of evidence-based practice, and leadership development through educational programs. This CPBR project has enabled me to practice leadership styles relevant for nursing practice such as resonant, relational leadership and renaissance leadership which are all rooted in transformational leader styles through development of qualities such as confidence, commitment, effective communication skills, motivation of others, demonstration of respect for the contributions that people bring to the team, encouragement of collaborative decision making, promotion of evidence-based practice, advocacy, risk-taking, and creativity. These qualities are essential in nursing leadership and using CBPR for my doctoral research promoted increased capacity and practice for all of them.

Figure 1: The Four-Cycles in the Community-Based Participatory Action Research Process.



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CHAPTER FIVE

What Was Accomplished and What Is Left to Do

Community-based participatory action research allows for collaborative processes that equitably involve and recognize the contributions of all stakeholders in the study (Caine & Mill, 2017). There is a focus on a collaborative approach to identifying a problem and taking further steps to plan, implement and evaluate strategies to address the concern. Through this four-cycled CBPR project, stakeholders of nursing education engaged in the identification of challenges involved in clinical nursing education (Asirifi et al., 2017) and developed a strategic vision for a clinical teaching model likely to be effective in the Ghanaian context. In this final chapter, the benefits, potential implementation challenges, research standards, limitations, implications, and dissemination plans of the CBPR project are discussed.

Benefits of Engaging in CBPR in the School of Nursing in Ghana

The question of who benefits from a research study is a vital ethical concern in CBPR. Northway (2010b) stated that, in conventional research, it is researchers who benefit most directly through career progression. In CBPR, however, it is important that both the researcher and co-researchers benefit from the project (Northway, 2010a). Benefits of this CBPR project in Ghana accrue from the engagement of all key stakeholders, local ownership of the research, capacity building for leadership of the researcher, generation of context-appropriate knowledge for change in clinical nursing education, and career progression opportunities for the Collaborative Research Team members through research participation and joint publication.

Involving the key stakeholders of nursing education in Ghana, as well as the internal School of Nursing faculty and students in this CBPR project, was a powerful mechanism for knowledge translation. Recommendations generated from participants, many of whom are in leadership positions or positions of influence, are likely to be implemented in practice and

policy. Through self-reflection and personal experience about the current situation of clinical teaching, stakeholders were stimulated to make decisions for significant changes to enhance the quality of clinical education in Ghana. As Stringer (2007) suggests, CBPR fosters active participation and decision-making that respects and captures the diversity of ideas within and across the groups or community under study. In hierarchical societies or in marginalized populations, such participation can be empowering.

As community-based participatory action research views the participants in the community as co-researchers (Caine & Mill, 2017; Greenwood & Levin, 2007; Richards & Mousseau, 2012; Stringer 2007), they have the opportunity to share ownership of the research process and outcomes (Northway, 2010b). The community, or co-researchers, benefit from having the researcher (usually an outsider) facilitate their abilities to find solutions to the concerns they wish to address (Northway, 2010a). The Collaborative Research Team was essential to the success of this CBPR initiative and their contributions were valued. The team members are co-authors of the first publication (Chapter Two - Asirifi et al., 2017) related to the study and will be co-authors of the second manuscript (Chapter 3). They were critical in the identification of priorities and the contextualisation and validation of findings, as well as in the culturally-responsive development and implementation of the study itself. They also carry responsibility of implementation of the strategic vision, along with external stakeholders and faculty colleagues.

As indicated in Chapter Four, this CBPR project provided me with the opportunity to build on my leadership development in relation to the Canadian Association of Schools of Nursing (CASN, 2015) PhD leadership development components. Through this CBPR project I was able to practice transformational leadership skills and qualities (Cummings, 2012; Scully,

2014) to facilitate the planning, implementation and knowledge translation phases of this scholarly inquiry. The initiative enhanced my scholarly capacity through conceptualisation and implementation of the project and the development of manuscripts for publication. Early and on-going engagement with policy-makers; for example, in the Ministry of Health, demonstrated my appreciation of the need for policy-relevant research and provided experience communicating effectively with persons in influential positions. A gratifying experience occurred in the Ministry of Health during Cycle Four (validation) of the research. After sharing my poster of the strategic plan (Appendix D) with the Ministry of Health nurses engaged in the study, one of them telephoned a policy-maker in a higher position who agreed to see me immediately and who asked to keep the poster for future reference. This interest beyond the nursing level could lead to greater implementation of research findings and thus greater impact of the research. As Mayan, Lo, Oleschuk, Pauchulo, and Laing (2016) observed, community-based participatory action researchers build and demonstrate leadership qualities through the facilitation of collaborative partnerships, building of trust, establishment of mutual agreement among participants, and inspiration of commitment to development of remedies that address problems and stimulate the achievement of the set goals.

Apart from leadership development, CBPR also facilitates processes for positive change in a community (Caine & Mill, 2017; Greenwood & Levin, 2007; Stringer, 2007). One of the requirements for success in CBPR is the community's desire for innovation and change (Northway, 2010a). As Glasson, Chang & Bidewell (2008) affirm, the cyclical process involved in CBPR can bring about change that improves practice. The cyclical processes of looking, thinking and action involved in this CBPR initiative stimulated and engaged participants in reflective discourses and actions to develop new knowledge to improve clinical nursing

education in Ghana. The creation of a new vision and implementation of the recommended strategies has the potential to increase the quality of nursing education on several fronts.

Kotter's eight steps of organisational change (Kotter, 2012) are congruent with the concept of change in CBPR and his model, therefore, was selected to guide the change process in this study. While only the first five steps are accomplished to date, the Collaborative Research Team in Ghana has the information needed to continue the process. I may be able to facilitate the process through further research, depending on my success in pursuing post-doctoral study or gaining an academic appointment. It is clear to all participants that the Ghanaian collaborators have prime responsibility for implementation of the vision. Overall, the findings of this study provide strategies for strengthening clinical education in Ghana and in other countries with similar human and fiscal resource challenges.

Potential Challenges of Implementing the Strategic Vision

The lack of fiscal, material and human resources and the predominance of traditional hierarchical relationships in health care and in higher education are potential barriers to the implementation of the strategies for more effective preceptorship in Ghana. The traditional power differentials in the Ghanaian context between students and teachers could lead to resistance to the change in the psychosocial environment that is needed for optimal clinical education. Safe and non-hierarchical clinical environments promote student-centered learning, which is very important in facilitating active participation, lifelong learning, and critical thinking abilities of students (Billings & Halstead, 2007; Myrick & Yonge, 2005; Grossman & Valiga, 2017). A greater understanding of the merits of a humanistic approach to clinical teaching and learning could decrease traditional hierarchical relationships (Billings & Halstead, 2005) but may be difficult as hierarchies, while traditional, are related to cultural notions of respect and how it

manifests in human interactions. Nursing in Ghana, however, is changing. The study School of Nursing currently has 12 PhD-prepared faculty members, several of whom received graduate education in less hierarchical educational institutions. While the effects of colonialism, and the vestiges that remain as post-colonialism, have not been addressed in this research, such theoretical understanding might be particularly useful in future related research. Confidence in one's own abilities is required in order to enact meaningful change. Can CBPR build such confidence?

Another threat to implementation of the strategic plan came to light in discussion with one of my co-supervisors. The need for planning seems obvious, but what this means in the Ghanaian context may differ from Western conceptualisations of the process. We were discussing faculty planning and development and how it might fit with preceptors and students scheduled for the same shifts. I mentioned that clinical units receive letters announcing the arrival of students only a week or two before they start. My co-supervisor was surprised that student clinical schedules for an academic year were not planned and communicated to the relevant clinical agencies prior to commencement of classes. This is just one example of how assumptions can cause errors, misinterpretations, and disruptions in plans for change. Contexts may differ more than expected and meaningful conversations across differences are essential to progress.

Ensuring Credibility of Community-Based Participatory Action Research

Greenwood and Levin's (2007) three principles of ensuring credibility in action research guided this study. The three principles are workability, making sense and trans-contextual credibility. Explanations of how these principles were met in this CBPR project are addressed below.

Workability means that actions taken in a research study solve a problem (Badger, 2000). The workability of action research focuses on actions towards the solution of a problem under examination locally. The workability test is to find out whether the integration of action and reflection in the action research process results in a solution to a problem (Greenwood & Levin, 2007). While there is strong agreement on reconceptualization of preceptorship and the vision and strategies likely to be effective, the implementation and evaluation of key strategies are needed to fully assess the workability of the proposed solutions.

This second criterion involves making sense out of the research results. How meaning is constructed through a deliberative process is central to this topic (Greenwood & Levin, 2007). The authors view deliberative situations as free from domination whereby actors involved in meaning construction exchange arguments without coercion, and each actor seriously and honestly judges the arguments presented and comes back with the best judgement made in the response to the arguments. Greenwood and Levin (2007) describe Gadamer's (1982) hermeneutics processes used to test deliberations in action research. Gadamer sees the ideal speech situation as a complex combination of dialogue and mutual interpretation with a goal of 'fusion of horizons'. He, therefore, respects the historicity of the knowledge, interpretations and experiences that influence actors' contributions. Gadamer holds that hermeneutics is a form of acting and not merely a method of thinking (Greenwood & Levin 2007). Stringer (2007) affirmed that the basic action research routines are "look, think and act" (p. 8). In this study, making sense out of the tangible results was facilitated through collaborative decision-making, dialogue and respect for differing perspectives and interpretations of findings. It was critical to respect the clinical teaching expertise that participants brought to the research process, contribute insights gleaned from the literature, and integrate my current experiences as a clinical faculty

member in Canada when incorporating varied perspectives into the meanings attached to findings and to the creative process of generating a vision and strategies for change.

The accounts produced have trans-contextual meaning when they have relevance to others, not just in an abstract sense but when the historical factors of the contexts (of both the reader and the writer) are taken into account (Badger, 2000). Greenwood and Levin (2007) believe that there exists the possibility of trans-contextual modelling of situations. Thus, "in action research, meanings created in one context are examined for credibility in another situation through conscious reflections on similarities and differences between contextual features and historical factors" (p. 70). This is the way action research can extrapolate knowledge and insights gained from one situation or context to another similar context. In terms of ensuring trans-contextual credibility for this study, the findings of the study provided vision and strategies for implementing an effective clinical teaching model to fit into the present context of nursing education in Ghana. Trans-contextual credibility will be assessed through communication to others through publications and presentations, with solicitation of input as to how findings, interpretations, and recommendations resonate with nurse educators from other similar contexts.

Reflections on Ethical Considerations

CBPR involves complex relationships of power and accountability that raise distinctive ethical challenges related to developing and maintaining partnerships, ensuring anonymity and navigating unclear boundaries between the researcher and the researched (e.g. community researchers researching their own communities) (Armstrong et al., 2011). In this research relationships were likely eased because all participants were nurses. I was both an insider and an outsider. I am Ghanaian, completed my undergraduate degree at the participating school of nursing, was a student with some of the participants, was taught by some others, nursed clinically

in Ghana, and was a nurse educator in Ghana. On the other hand, I am now a Canadian citizen, am employed as a nurse in Canada, and have done all of my graduate education in Canada at a university that has close partnership ties in Ghana. Ghanaian faculty members and external stakeholders, with few exceptions, have graduate degrees in nursing. There was already recognition that clinical teaching in nursing needs improvement. My study was welcomed and me with it.

Anonymity cannot be ensured with focus groups and everyone knew who the Collaborative Research Team members were. As most participants were known to Collaborative Team members, no raw data were shared with them. I made detailed summaries of the findings and shared the summaries with the team for analysis and interpretation. While not ideal, this strategy did preserve confidentiality of what individual participants shared.

In terms of the issue of unclear boundaries between the researcher and the researched, the Collaborative Research Team were co-investigators in the study. I served as principal investigator and facilitator of the research process. I ensured that the reflective discourses and decisions taken were on topic and directed towards the enhancement of clinical nursing education in Ghana and took care not to impose my decisions on the collaborative team but rather motivated them to share their input throughout the study. As Armstrong et al. (2011) counselled, I was cognizant that CBPR researchers who conduct research in their own community require high levels of self-awareness to make sure that privacy and confidentiality are not breached, and must take care to prevent damage to participants' professional or personal endeavours.

Other ethical issues pertaining to CBPR include the approach to community involvement in ownership and dissemination of data procedures, findings and publication of results

(Amstrong et al., 2011; Quigley, 2006). As many community research partners may not anticipate these issues, it is particularly important to negotiate such possibilities before commencement of the study (Armstrong et al., 2011). Thus, before the research started, the Collaborative Research Team members were informed about their roles in all the cycles of the research and that inclusion of each of them in the authorship of two manuscripts for publication was anticipated.

Thoughts on Integrating Critical Social Theory into the Community Based Participatory Action Research Process

The focus of critical social theory in nursing science involves recognizing and addressing issues of domination, oppression, power relations and political actions or structures that influence nursing practice through reflective discourse and social action (Browne, 2000; Sumner & Danielson, 2007). Additionally, critical social theory calls for liberation from sociopolitical forces or conscious constraints through mutual dialogue and negotiations that promote the collective identity of a community (Browne, 2000; Ekstrom, 2002; Sumner & Danielson, 2007). This section provides a valuable lens on how perspectives integral to critical social theory were used in this four cycle CBPR project to encourage critical dialogue, reflective thinking, capacity building and collaborative decision making towards the alleviation of the influence of sociopolitical forces that pose challenge to the effectiveness of clinical education in Ghana.

Integrating critical social perspective into this four cycle CBPR project promoted collaborative engagement of all the stakeholders of nursing education, including nursing students (who are usually the hidden voices), in reflective dialogue and decision making to enhance clinical nursing education in Ghana. Students, faculty and external stakeholder were engaged in reflective thinking (completion of questionnaires) and dialogue (interviews with external

stakeholders) in Cycle One to identify issues in clinical education in Ghana. The feedback presentation on the challenges of clinical teaching, the presentation of clinical teaching models and CBPR, the individual and focus group interviews, and the sharing of power with the Collaborative Research Team in Cycle Two engaged participants in reflective dialogue and collaborative decision making to choose preceptorship as the preferred clinical teaching model and reconceptualize it within the Ghanaian context. This led to the development of a collaborative vision and strategies for implementation of the vision (Cycle Three) to enhance clinical teaching and learning.

In order to empower and actively engage participants in reflective decision making, they were viewed as co-researchers and the primary researcher served as a facilitator. As a facilitator, I refrained from imposing my preferred decisions on the participants. I promoted participants' capacity building through the provision of resources (such as presentations on clinical teaching models and CBPR in Cycle Two and poster presentation in Cycle Four) to increase their understanding in making critical decisions towards the choice of the appropriate clinical teaching strategies or approach for nursing education in Ghana. The collaborative research team was consulted at all cycles for their input throughout the study and their involvement in the future implementation of the strategies would increase their responsibility and capabilities in taking actions for effective clinical education in Ghana.

The traditional hierarchical relationship which was identified between the students and the clinical teachers limits students' freedom in asking questions and active participation in clinical teaching and learning. Therefore, I discussed with the collaborative research team the importance of using teaching strategies that could alleviate the traditional hierarchical relationship to foster better connection of concepts to alleviate the theory and practice gap, and

promote student-centered learning. This strategy is congruent with Danielson's (2007) observation that critical social theory enables exploration of social construction in relationships within the power constraints of a community; seeks to identify gaps and marginalized voices, and provides the opportunity to question and confront cultural or historical norms in the community or institution.

Limitations of the Study

As community-based action research involves working together with community members to identify a problem in the community, take further steps to plan and implement strategies to address the problem, and evaluate the effectiveness of the implemented strategies to address the situation, participants in CBPR are expected to be involved in decision making in all the stages and cycles of the CBPR research process. This implies that community involvement is needed during the definition of research questions to be addressed (Northway 2010b). In this CBPR project, however, I as a PhD student (researcher) developed the research questions in collaboration with my supervisory committee based on the findings obtained from my master in nursing thesis project which, while conducted in Ghana, involved a different school of nursing. I did inform the participating school of nursing about my intent to study clinical nursing education in Ghana and ascertained their interest and support prior to development of the proposal. The proposal for this research endeavour was submitted to the Research Collaborative Team for suggestions for revisions and approval before my Candidacy Examination, supervisory committee approval of the proposal, and submission for ethics review.

A second limitation of the study is the inability to implement and evaluate the effectiveness of the strategies for reconceptualizing preceptorship in nursing education in Ghana. This was due to the time limitation for me (PhD student) to complete my program. Northway

(2010b) indicated that CBPR is a very time-consuming process and time required for the project may be greater than the researcher can give. It is important that the researcher communicates this to co-researchers and potential funders. Some factors that make CBPR so time consuming are: a) time to establish trusting relationships between the researcher and the co-researchers; b) time for collective decision making; c) time for preparing participants to better understand CBPR; and, d) time for the researcher to undertake training to better understand the community issues. Northway (2010b) attested that it took a period of five years to develop relationships, develop a study design, and deal with rejections related to funding and finally securing a funding for one project to progress and cautioned that this could be detrimental to students who have the interest to use CBPR as an approach for their research or thesis project. This project was doable because both I and one of my supervisors already had close relationships with faculty in the study School of Nursing and all Collaborative Research Team members had a graduate degree and, therefore, familiarity with research. None of them had engaged previously in a CBPR study. In addition, a PhD-prepared faculty member at the study institution joined my supervisory committee. It was clear from the beginning that the implementation and evaluation of the changes would be the responsibility of the Research Collaborative Team.

A third limitation was the need to conduct much of the study at a distance. Luckily, the study institution has good Internet capacity and all Collaborative Research Committee members have computer skills. Conducting CBPR at a distance is a major limitation as it is not ideal for in-depth discussion.

Implications for Nursing Education, Nursing Education Policy and Research

There are implications for nursing education, nursing education policy, research and the academy implications emanating from this CBPR initiative. Each area will be discussed briefly.

Nursing Education Implications

This CBPR project substantiated the need for additional fiscal and material resources (such as clinical teaching and learning equipment) for effective clinical teaching and learning, and for more preceptors or clinical teachers to teach and supervise the large numbers of students in the clinical settings. Findings also expressed the need for faculty and preceptor development in terms of educational preparation to teach effectively. The stakeholders mentioned the need to encourage students to develop their own clinical objectives to complement the main objectives for their clinical practice. Furthermore, the external stakeholders of nursing education in Ghana acknowledged the need for restructuring the current approach to clinical teaching and learning and agreed with the approach of reconceptualizing preceptorship as the preferred clinical teaching model and the best fit for the Ghanaian context. They were already beginning a process of centralized planning for clinical experiences of nursing students across agencies and schools prior to the onset of this research so that recommended strategy is currently underway.

The implementation of the new collaborative vision and strategies would enhance the effectiveness of clinical teaching and learning in Ghana. Because faculty, clinical agency staff, and influential external stakeholders involved in policy decisions participated in the research, and because the Collaborative Research Team members are designated as the internal change agents, knowledge translation into clinical education practice of at least some of the strategies is likely.

Policy Implications

What policy directions does this research infer? There are several, some of which may already be occurring. Policies may be at the levels of the Ministry of Health, the Ghana Nursing

and Midwifery Council, or the specific School of Nursing. Suggestions include but are not restricted to:

- Criteria for preceptor selection and preparation
- Maximum number of students per preceptor
- Educationally sound selection of which clinical areas and which levels of students for which preceptorship will occur and which clinical areas or levels of students will remain under the supervision of clinical faculty members.
- Amount of time before arrival of students that clinical agencies must be informed.
- Requirement that students and preceptors receive information regarding specific clinical objectives and criteria for clinical evaluation for each clinical rotation.

Research Implications

Through the CBPR project, I gained in-depth understanding of the importance of the collaborative processes involved in research translation. The collaborative processes allowed inclusive decision-making, an important facilitator of change initiatives. Through the research planning phase, I gained in-depth understanding of various clinical teaching models used worldwide and, from the research, the clinical teaching and learning approaches used in nursing education in Ghana. The CBPR project enabled me to build on my leadership capacity through experience developing respectful partnership and collaborative processes and to increase my understanding of change theory and implementation. The participants, particularly the Collaborative Research Team members, gained knowledge and experience with CBPR and may be motivated to use the methodology to address other educational concerns.

At the end of Cycle One, it became evident that the nurse interns (a fifth year comprised of practice experience after completion of the school of nursing program but prior to licensure)

are a potential target group for future research regarding their preparation for practice and their suggestions for change. The implementation of strategies in the vision could be an extension of the CBPR process and a follow-up research endeavour after completion of my PhD. Exploration of critical thinking in nursing and nursing education is another research possibility. Clinical evaluation is another priority for development identified by the Collaborative Research Team and could be a future CBPR study. A group of University of Alberta fourth year undergraduate students complete a clinical practicum in Ghana most years. Research of their experiences and perhaps a project to pair them with Ghanaian fourth year students or nurse interns would be of research value.

Academic Implications

Implementing CBPR increased my scholarly capacity in research. I was able to engage in multiple data collection strategies and enhance my group facilitation skills, as well as engage in collaborative work with a research team. These are all important experiences for future involvement in independent and interdependent research. The decision to do a manuscript dissertation was a wise one as I learned much from the article development and manuscript evaluation process. I now have three publications related to nursing education and have received requests to review manuscripts for other journals based on my academic visibility through these publications. Post-doctoral study, if available, will further my academic ability and future career.

Dissemination and Way Forward

Dissemination of this CBPR initiative is already in progress. In addition to my validation trip to Ghana in Cycle Four for which the presentations were described previously, I have presented at two internal Faculty of Nursing events – a research conference and a conference focused on education. Cycle One findings are published in the Journal of Nursing Education and

Practice. Three additional manuscripts are in progress (Chapter Two and Three; Appendix E). Abstracts will be submitted for presentations at one national and one international conference. In addition, a manuscript will be developed for publication in the recently launched nursing journal in Ghana. It is my plan to continue my research collaboration with faculty members in the study School of Nursing.

Final Reflections

Effective clinical nursing education facilitates the preparation of student nurses to become professional health practitioners who contribute safe and quality professional nursing care to society. The iterative and cyclical processes involved in this CBPR project enabled me to collaborate and engage with stakeholders in critical observations, reflections and planning for effective clinical education in Ghana. Inherent to the above statement is that this research enabled us (the stakeholders and researcher) to identify challenges of clinical education in Ghana. Based on the challenges identified, a new vision and strategies to implement the new vision were developed in collaboration with the stakeholders for effective clinical education in Ghana. Going through these processes involved in the research study, I realized that CBPR is a powerful tool for ensuring partnership, building leadership capacity, promoting evidence-based practice, and fostering collaborative decision making among key stakeholders to address the theory/practice gap in nursing. The collaborative processes used in this research mandated a high ethical standard and made me reflect on research ethics at a deeper level than in my earlier research. I believe that the implementation of the strategic vision proposed by this thesis project could lead to more equitable balance of the traditional hierarchical relationships between students and clinical teachers or faculty and facilitate movement toward student-centered learning in clinical nursing education in Ghana. This would, I am convinced, contribute to

improvement in the quality of nursing education and lead to higher student, faculty and clinical teacher satisfaction and the preparation of more confident and competent nurses.

This dissertation could be used to address the "Lancet Report on Health Professional Education for the Twenty-First Century" about the need for professional education, including nursing education, to keep abreast with the challenges in the healthcare system and redesign new instructional strategies that incorporate transformative and inter-dependent education (Frenk, et al., 2010). The world needs educated and knowledgeable healthcare practitioners with leadership capabilities and enlightened change agents who engage in critical reasoning to competently participate in patient and population centered health systems and work as members of locally responsive and globally connected teams. This CBPR initiative, while designed to address a deficit in clinical nursing education in Ghana, also engaged nurse leaders across different interest groups in a collaborative process with the potential to build research and collaborative capacity. If even one of them grasps on to the leadership and change possibilities inherent in CBPR, the impact could be significant. Finally, this project has shaped my knowledge and skills in research and relational practice and will serve as a strong foundation for my future academic, education and practice endeavors.

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Appendix A

Data Collection Instruments

Questionnaire for Undergraduate Students (Year 2, 3 or 4)

Study Title: *Using Action Research to Optimize Clinical Teaching in Baccalaureate Education in Ghana*

Researcher: Mary Asirifi, RN, MN, PhD Candidate
Co-Supervisors: Dr. Linda Ogilvie and Dr. Sylvia Barton, Faculty of Nursing, University of Alberta

I am a PhD student in the Faculty of Nursing at the University of Alberta in Edmonton, Canada. I am inviting you to participate in my study by completing this questionnaire. This is a community-based action research study to explore the strengths and weaknesses of the clinical teaching models(s) in your nursing program with the intent of making changes to improve the clinical component of your program.

If you answer this questionnaire, you are giving consent for your information to be included in the findings of this research. Information from all responses will be put together in one document and will be included in presentations and publications. You are not required to complete this questionnaire and there is no penalty if you do not submit it.

Your name is not needed. You may respond by printing the document and returning it in an envelope to Mary Asirifi , collecting a hard copy that you can fill in from Gloria Achempim Ansong, or completing it electronically and returning it to asirifi@ualberta.ca. Completing the form electronically will be easier for me to read.

Once we have the information collected from all participating students and faculty members, I will invite all students to a presentation of the overall findings. What you write will be confidential and the presentation will not include any comments that could identify you. No one except the researcher will see any completed questionnaire.

1. I am in year _____ of my nursing program.
2. I am: female _____ male: _____
3. I have completed _____ nursing practice placements.
4. I am currently in a nursing practice placement: yes _____ no _____
5. In my clinical practice experiences I have been guided, supervised and/or evaluated by (please tick all that apply): no one ____ staff nurses ____ unit managers _____ preceptors ____ faculty clinical teachers _____ others (please specify) _____

Please think about your clinical placement experiences in answering the following questions.

6. Describe your most positive clinical practice experience. Include what made it good.

7. Describe your most negative clinical practice experience. Include what made it bad and what would have made it better.

8. What positive things that promote learning have you experienced in your clinical experiences?

9. What negative things or experiences have inhibited learning in your clinical experiences?

10. How could things be made better?

11. Do you have anything more that you would like to add?

Thank you for your participation!

Questionnaire for Nurse Interns (Year 5)

Study Title: *Using Action Research to Optimize Clinical Teaching in Baccalaureate Education in Ghana*

Researcher: Mary Asirifi, RN, MN, PhD Candidate
Co-Supervisors: Dr. Linda Ogilvie and Dr. Sylvia Barton, Faculty of Nursing, University of Alberta

I am a PhD student in the Faculty of Nursing at the University of Alberta in Edmonton, Canada. I am inviting you to participate in my study by completing this questionnaire. This is a community-based action research study to explore the strengths and weaknesses of the clinical teaching models(s) in your nursing program with the intent of making changes to improve your clinical learning.

If you answer this questionnaire, you are giving consent for your information to be included in the findings of this research. Information from all responses will be put together in one document and will be included in presentations and publications. You are not required to complete this questionnaire and there is no penalty if you do not submit it.

Your name is not needed. You may respond by printing the document and returning it in an envelope to Mary Asirifi, collecting a hard copy that you can fill in from Gloria Achempim Ansong, or completing it electronically and returning it to asirifi@ualberta.ca. Completing the form electronically will be easier for me to read.

Once we have the information collected from all participating students and faculty members, I will invite all students to a presentation of the overall findings. What you write will be confidential and the presentation will not include any comments that could identify you. No one except the researcher will see any completed questionnaire.

1. I am: female _____ male _____
2. I have been in my internship for _____ months.
3. The units that I have worked on in my internship are (for example, general surgery, pediatrics, etc.):

_____

Please think about your student clinical placements and your internship practice when answering the following questions.

4. How prepared were you for the clinical realities of your internship.

very prepared ____ somewhat prepared ____ poorly prepared ____ not prepared ____

Please explain your answer.

5. Describe your most positive clinical experience as a student nurse. What made it so positive?

6. Describe your most negative clinical experience as a student nurse. What made it so negative?

7. Now that you are in your internship year, what were the strengths of the clinical practice experiences you had as a student nurse?

8. Now that you are in your internship year, what were the strengths of the clinical experience you had as a student nurse?

9. What would have been helpful in making your student clinical experiences more effective?

10. What changes do you recommend for the organization, teaching and evaluation of clinical experiences in undergraduate nursing education?

11. Do you have anything else that you would like to add?

Thank you for your participation!

Questionnaire for Graduate Students (Year 1) and Faculty Members

Study Title: *Using Action Research to Optimize Clinical Teaching in Baccalaureate Education in Ghana*

Researcher: Mary Asirifi, RN, MN, PhD Candidate
Co-Supervisors: Dr. Linda Ogilvie and Dr. Sylvia Barton, Faculty of Nursing, University of Alberta

I am a PhD student in the Faculty of Nursing at the University of Alberta in Edmonton, Canada. I am inviting you to participate in my study by completing this questionnaire. This is a community-based action research study to explore the strengths and weaknesses of the clinical teaching models(s) in your nursing program with the intent of making changes to improve your clinical learning.

If you answer this questionnaire, you are giving consent for your information to be included in the findings of this research. Information from all responses will be put together in one document and will be included in presentations and publications. You are not required to complete this questionnaire and there is no penalty if you do not submit it.

Your name is not needed. You may respond by printing the document and returning it in an envelope to Mary Asirifi, collecting a hard copy that you can fill in from Gloria Achempim Ansong, or completing it electronically and returning it to asirifi@ualberta.ca. Completing the form electronically will be easier for me to read.

Once we have the information collected from all participating students and faculty members, I will invite all undergraduate students to a presentation of the overall findings. The graduate students and faculty members will be invited to a separate meeting. What you write will be confidential and the presentation will not include any comments that could identify you. No one except the researcher will see any completed questionnaire.

1. When did you graduate from nursing? _____
2. When did you complete your undergraduate nursing degree? _____
3. For how many years did you practice as a nurse in a clinical setting? _____
4. Have you worked in a school of nursing? Yes _____ No_____. If yes, for how many years _____
5. When you worked in a clinical agency, did you ever guide student nurses as part of your staff nurse/nurse administrator role? Yes _____ No _____
6. Have you been a preceptor for student nurses? Yes _____ No _____
7. Have you been a clinical faculty member or taught students clinically as part of a faculty role? Yes _____ No _____
8. Please indicate your current status in the School of Nursing at the University of Ghana: Graduate student _____ Faculty Member _____ Both roles _____

Please think about your clinical teaching experiences and your experiences in clinical settings as a student nurse when you answer the following questions.

9. Describe your most positive teaching/learning moment in a clinical setting. Were you the student or the teacher? What made the situation so positive?

10. Describe your most negative teaching/learning moment in a clinical setting. Were you the student or the teacher? What made the situation so negative?

11. What do you perceive as the strengths of clinical experiences/teaching in undergraduate nursing education?

12. What do you perceive as the weaknesses of clinical experiences/teaching in undergraduate nursing education?

13. What do you recommend to improve the effectiveness of clinical education in undergraduate nursing program?

14. Do you have anything that you would like to add?

Thank you for your participation!

Cycle One Individual Interview Guides

Ghana Nurses' and Midwives' Council
Ghana Nurses' Association
Ministry of Health

Note: These participants will receive the information sheet and will sign informed consents. The interviewing will use an open-ended approach.

Opening Question:

Please tell me about your role and/or your interest in nursing education.

From your perspective, what are the most important issues in undergraduate nursing education today?

What are your thoughts about the clinical component of undergraduate nursing education?

Are changes needed?

If so, what would you recommend?

What barriers would you anticipate?

If you do not think a change is needed, would you support a research-based project to implement a change and evaluate the outcome?

Cycle Two Focus Group Interview Guides

Preceptors
Staff Nurses with Experience Supervising Students Clinically
Nurse Administrators in Clinical Agencies

Note: These participants will receive the information sheet and will sign informed consents. The interviewing will use an open-ended approach.

Opening Question:

Please tell me about your experiences teaching, supervising and evaluating undergraduate students for their clinical practice.

Topics to probe if not raised by participants:

- What do you find satisfying?
- What do you find difficult?
- Can you give me examples of satisfying and difficult situations?
- How much responsibility do students assume for patient care?
- Tell me about your relationships with teaching staff at the university.
- What could be done better?
- In an ideal situation, with no resource constraints, how would you organize the clinical teaching of student nurses?
- What are the barriers to your vision?
- Under current constraints, can you think of a better way to organize student nurse clinical education?
- Is there anything else that you would like to add?

Thank you for your participation.

Cycle Two Individual Interview/Focus Group Interview Guides

Faculty
Graduate Students
Note: These participants will receive the information sheet and will sign informed consents. The interviewing will use an open-ended approach.

Introduction: You have already had opportunities for participation in this research through completion of a questionnaire and invitations to attend presentations on: a) Phase One data collection results; and, b) an introduction to eight clinical education models that are used in nursing education. In this meeting, I am interested in whether you think that a change would be useful in your organization of how clinical education is organized and/or implemented in this School of Nursing?

1. First, could you please give me your reaction to the findings from the initial information that I presented?

Topics to probe if they are not introduced:

- What surprised you?
- What did you agree with?
- What did you disagree with?
- Are there issues that you would like to add?

2. Let's discuss the teaching models that I presented?

Topics to probe if they are not introduced:

- Which models have you used already?
- Did any of the models not currently used in the School of Nursing interest you? Let's discuss them further.
- Do you think that any of the models presented but not currently used have potential in Ghana (and in this School of Nursing)?
- A new university hospital is being constructed on this campus. What are your thoughts about clinical teaching/learning possibilities in the new environment?
- What would you like to see happen next? What are the resource barriers? How might they be overcome?
- What would you like to do next?
- Do you have anything to add?

3. Do you have any thoughts about the CBPR process used in this research?

Appendix B

Recruitment Notices

Presentation Flyers

What are the Clinical Teaching and Learning Experiences Like in Ghanaian Nursing Education?

Research Study

Seeking Undergraduate Students, Nurse Interns (Year 5 of Clinical Experience), Graduate Students, Faculty

Who am I?
I am a PhD student in the Faculty of Nursing at the University of Alberta in Canada. My research is titled *Using Action Research to Optimize Clinical Teaching in Baccalaureate Nursing Education in Ghana*. I am inviting different groups of people who have an interest in nursing education to participate in my study. You are receiving this message so that you will be aware of my study before you receive the questionnaire via e-mail.

For what?
To share your thoughts about clinical teaching in nursing education in Ghana.

Undergraduate Students, Graduate Students, Nurse Interns (Year 5 of Clinical Experience) and Faculty Members will be invited to complete a questionnaire with questions about clinical teaching in Ghana.

When and where?
You will receive a questionnaire via email. Your responses will be put together to provide a summary of the current strengths and weaknesses in the way students currently receive their clinical practice experiences.
Please contact me at asirifi@ualberta.ca if you would like more information.

Investigator:	**Supervisors**	
Mary Asirifi MN, RN	Dr. Linda Ogilvie, PhD, RN	Dr. Sylvia Barton, PhD, RN
E-mail: asirifi@ualberta.ca	linda.ogilvie@ualberta.ca	sylvia.barton@ualberta.ca
Phone: (780) 752 2181	Phone: (780) 430 9221	Phone: (780) 492 6253

Recruitment Notice for Cycle One Data Collection
What are the Clinical Teaching and Learning Experiences Like in Ghanaian Nursing Education?

Research Study

Seeking Preceptors, Staff Nurses with Experience Supervising Students Clinically, and Nurse Administrators in Clinical Agencies

Who am I?
I am a PhD student in the Faculty of Nursing at the University of Alberta in Canada. My research is titled *Using Action Research to Optimize Clinical Teaching in Baccalaureate Nursing Education in Ghana*. I am inviting different groups of people who have an interest in nursing education to participate in my study.

For what?
To share your thoughts about clinical teaching in nursing education in Ghana.

As Preceptors, Staff Nurses with Experience Supervising Students Clinically, and Nurse Administrators in Clinical Agencies, you are invited to be in a focus group interview to talk about clinical teaching and learning in Ghana. A focus group is a small group of 4 to 10 people who will be part of a group interview. If you are concerned about being in a group interview but are interested in participating, please let me know. It may be possible to arrange an individual interview.

When and where?
The individual interview or focus group interview will be conducted at a convenient time and place for around 45 to 90 minutes.

Please contact me at asirifi@ualberta.ca for more information or to express interest in being part of the study.

Investigator:	**Supervisors**	
Mary Asirifi MN, RN	Dr. Linda Ogilvie, PhD, RN	Dr. Sylvia Barton, PhD,
RNE-mail: asirifi@ualberta.ca	linda.ogilvie@ualberta.ca	sylvia.barton@ualberta.ca
Phone: (780) 752 2181	Phone: (780) 430 9221	Phone: (780) 492-6253

Recruitment Notice for Cycle Two Data Collection

What are the Clinical Teaching and Learning Experiences Like in Ghanaian Nursing Education?

Research Study

Seeking Faculty Members and Graduate Students

Who am I?
I am a PhD student in the Faculty of Nursing at the University of Alberta in Canada. My research is titled *Using Action Research to Optimize Clinical Teaching in Baccalaureate Nursing Education in Ghana*. I am inviting different groups of people who have an interest in nursing education to participate in my study.

For what?
To share your thoughts about clinical teaching in nursing education in Ghana.

You are invited to be in a focus group interview to talk about clinical teaching and learning in Ghana. A focus group is a small group of up to 4 to 10 people who will be part of a group interview. If you are concerned about being in a group interview but are interested in participating, please let me know. It may be possible to arrange an individual interview. There will be separate focus group interviews for graduate students and faculty members.

When and where?
The interview or focus group interview will be conducted at a convenient time and place for around 45 to 90 minutes.

Please contact me at asirifi@ualberta.ca for more information or to express interest in being part of the study.

Investigator:	**Supervisors**	
Mary Asirifi MN, RN	Dr. Linda Ogilvie, PhD, RN	Dr. Sylvia Barton, PhD, RN
E-mail: asirifi@ualberta.ca	linda.ogilvie@ualberta.ca	sylvia.barton@ualberta.ca
Phone: (780) 752 2181	Phone: (780) 430 9221	Phone: (780) 492 6253

The Flyers for First Presentation

Presentation

Title: Challenges Related to Clinical Teaching in Nursing Education in Ghana.

Targeted Audience:

- **University of Ghana Undergraduate students, year five nursing interns, graduate students, and faculty members.**
- **representatives from Ghana Nurses' and Midwives' Council, the Ministry of Health and Ghana Nurses' Association**
- **People associated with the school of Nursing**

Who am I?

I am a PhD student in the Faculty of Nursing at the University of Alberta in Canada. My research is titled *Using Action Research to Optimize Clinical Teaching in Baccalaureate Nursing Education in Ghana*. If you belong to the above group of audience, I am inviting you to a presentation of the "challenges of clinical teaching in nursing education in Ghana". This presentation represents the reflections and thoughts of stakeholders of nursing education in Ghana. The audience will be given the opportunity to provide feedback and comments on the presentation. The audience will benefit from gaining insight into the strengths and weaknesses of nursing education in Ghana revealed from questionnaire and interview information collected from some of you.

When and where?

This presentation will take place on July 26th, 2016 in the first floor classroom for undergraduate students at the School of Nursing in the University of Ghana.

Please contact me at asirifi@ualberta.ca if you would like more information.

Investigator:	**Supervisors**	
Mary Asirifi MN, RN	Dr. Linda Ogilvie, PhD, RN	Dr. Sylvia Barton, PhD, RN
E-mail: asirifi@ualberta.ca	linda.ogilvie@ualberta.ca	sylvia.barton@ualberta.ca
Phone: (780) 752 2181	Phone: (780) 430 9221	Phone: (780) 492 6253

The Flyers for Second Presentation

Presentation

Title: Types of Clinical Teaching Models used in Nursing Education Internationally.

Targeted Audience:

- **Faculty members and graduate students**
- **Preceptors, nursing administrators, staff nurses, charge nurses**
- **representatives from Ghana Nurses' and Midwives' Council, the Ministry of Health and Ghana Nurses' Association**

Who am I?

I am a PhD student in the Faculty of Nursing at the University of Alberta in Canada. My research is titled *Using Action Research to Optimize Clinical Teaching in Baccalaureate Nursing Education in Ghana*. If you belong to the above group of audience, I am inviting you to a presentation of the "various types of clinical teaching models used internationally for clinical teaching and learning". The audience will be given the opportunity to provide feedback and comments on the presentation. The audience will benefit from gaining insight into the various types of clinical teaching models used in nursing education internationally.

When and where?

This presentation will take place in August 1st, 2016 in the main floor staff conference room at the School of Nursing in the University of Ghana.

Please contact me at asirifi@ualberta.ca if you would like more information.

Investigator:	**Supervisors**	
Mary Asirifi MN, RN	Dr. Linda Ogilvie, PhD, RN	Dr. Sylvia Barton, PhD, RN
E-mail: asirifi@ualberta.ca	linda.ogilvie@ualberta.ca	sylvia.barton@ualberta.ca
Phone: (780) 752 2181	Phone: (780) 430 9221	Phone: (780) 492 6253

The Flyers for Third Presentation
Presentation

Title: Community Based Action Research.

Targeted Audience:

- **School of Nursing faculty members and graduate students at the University of Ghana.**

Who am I?
I am a PhD student in the Faculty of Nursing at the University of Alberta in Canada. My research is titled *Using Action Research to Optimize Clinical Teaching in Baccalaureate Nursing Education in Ghana*. All faculty members of the School of Nursing in the University of Ghana are invited to attend a presentation on the "Community Based Action Research".
The audience will be given the opportunity to provide feedback and comments on the presentation. The audience will benefit from gaining insight into community based participatory action research and benefits of using action research to enhance current clinical teaching and learning strategies in nursing education in Ghana.

When and where?
This presentation will take place in August 1st 2015 in main floor staff conference room at the school of Nursing in the University of Ghana.

Please contact me at asirifi@ualberta.ca if you would like more information. Investigator:

Supervisors

Mary Asirifi MN, RN	Dr. Linda Ogilvie, PhD, RN	Dr. Sylvia Barton, PhD, RN
E-mail: asirifi@ualberta.ca	linda.ogilvie@ualberta.ca	sylvia.barton@ualberta.ca
Phone: (780) 752 2181	Phone: (780) 430 9221	Phone: (780) 492 6253

Appendix C

Information Sheets

Consent Forms

Ethics Approval Letters

Title of study: Using Action Research to Optimize Clinical Teaching in Baccalaureate Nursing Education in Ghana

Information Sheet for Research Collaborative Team

My name is Mary Asor Asirifi. I am a PhD nursing student in the Faculty of Nursing at the University of Alberta. I am interested in gaining insight into clinical teaching and learning experiences of student nurses in Ghana. I would like to identify how clinical teaching and learning could be enhanced. I am interested in getting the perspectives of Ghanaian undergraduate students, nurse interns (year 5 of clinical experience), graduate students and faculty, as well as representatives of the Ghana Nurses' and Midwives' Council, Ghana Nurses' Association and Ministry of Health and nurses in clinical agencies who have been involved in the clinical supervision of student nurses.

Clinical teaching forms an integral part of nursing education worldwide. It gives nursing students the opportunity to acquire knowledge and skills in nursing practice. Evidence from research studies indicates that use of effective clinical teaching models enhances clinical learning. Strategies to enhance clinical teaching in nursing education in Ghana have not been studied. Because you are one of the stakeholders of nursing education in Ghana, I am inviting you to partner with me in conducting this study. The important information you possess and could share with me will contribute to learning more about clinical teaching and learning issues and potential clinical education strategies in Ghana. The intent is the improvement of student nurse clinical learning.

Purpose of the study: The purpose of this study is to engage stakeholders in a research process that will ascertain the strengths and weaknesses of the current model(s) of clinical education in one undergraduate baccalaureate nursing program in Ghana; and offer strategies to enhance clinical teaching effectiveness that will meet or surpass national standards and are feasible within current and potential resources.

Data Collection Procedures: This is a community-based action research study that has four phases.

1. Questionnaires will be completed by undergraduate students, graduate students, nurse interns (Year 5 of clinical experience) and faculty members.
2. Individual interviews or focus group interviews will be held with members of Ghana Nurses' and Midwives' Council, Ghana Nurses' Association, and Ministry of Health, graduate students, faculty, and clinical staff agency involved with student nurse clinical education.

Your Participation: You are invited to participate as a member of the Research Collaborative team for this study. I will consult with you through scheduled meetings to discuss and give input about the research proposal, data collection tools and strategies, recruitment of participants, preparation of presentations, data analysis and overall strategies to enhance clinical teaching in Ghana. As a member of the Research Collaborative you will receive a full copy of the research proposal.

Initials ……

Consent: If you agree to participate you will sign a consent form voluntarily. You are free to withdraw from the research process. You are free to refuse to answer any questions or to ask for clarification at any time during the research process.

Discomforts or risks: There are minimal known discomforts or risks expected with this study. Whenever you feel uncomfortable, need a break, require clarification or need to stop, you are free request to do so.

Cost: There are no costs, except for your time commitment, for participating in this study. You will be expected to participate in six meetings over a four month period. Early meetings will last approximately two hours but the last two meetings could last three to four hours. You may choose to be involved in presentations and/or focus group interviews.

Benefits: You might develop greater understanding about clinical teaching and learning in Ghana. You will gain expertise in community based action research. Findings from this study can generate new knowledge about potential strategies that could enhance clinical teaching in Ghana. You will be included in at least one of the publications of this study.

Confidentiality and anonymity: A members of the Collaborative Research Team, I am notifying you that **t**he signed forms and information will be stored separately in locked cabinets in a separate location than in which the data will be stored. The names and identifiers of study participants will be eliminated from the transcript to preserve anonymity of the research participants. The researcher (me) alone shall have access to the names of the participants. The researcher (me) shall preserve the research study materials appropriately to maintain confidentiality. The members of the supervisory committee will have access to summaries of the data during the study for the purpose of assisting me in the research process. The information or data that shall be obtained from the study shall be stored by the researcher (me) for at least five years after the study has been completed. You will agree to maintain confidentiality about sensitive material that may be discussed within the Collaborative Research Team and what happens in any focus group interview that you choose to be a part of.

Freedom to withdraw: You are free to withdraw from the study at any time. You do not need to give a reason for withdrawing. There will be no effect on your employment.

Future use of the study: Preliminary findings of the study will be shared with stakeholders at meetings. Recommendations arising from discussion about the findings shall be presented to the appropriate decision-makers. The findings of the study shall be presented at local and international conferences, workshops and seminars on nursing education.

Additional contacts:
If you have any question or concerns about any part of the study, please contact Professor Alex Clark (Associate Dean; Research; Faculty of Nursing, University of Alberta. Tel: 780-492-6764: E-mail: alex.clark@ualberta.ca

Please put your initials here to indicate that you have read this information sheet……

Consent Form for Collaborative Team Members

Title of project: *Using Action Research to Optimize Clinical Teaching in Baccalaureate Nursing Education in Ghana*

Investigator:	**Supervisors**	
Mary Asirifi MN, RN	Dr. Linda Ogilvie, PhD, RN	Dr. Sylvia Barton, PhD, RN
E-mail: asirifi@ualberta.ca	linda.ogilvie@ualberta.ca	sylvia.barton@ualberta.ca
Phone: (780) 752 2181	780 430 9221	780 492 6253

Description of the project: The purpose of this study is to engage faculty members, students, preceptors and other stakeholders in nursing education in Ghana in a research process that will ascertain the strengths and weaknesses of the current model(s) of clinical education in one undergraduate baccalaureate nursing program in Ghana; and offer strategies to enhance clinical teaching effectiveness that will meet or surpass national standards and are feasible within current and potential resources. This project will involve your participation through schedule meetings to discuss and give input about the research proposal, data collection tools and strategies, recruitment of participants, preparations of presentations, data analysis and overall strategies to enhance clinical teaching in Ghana. You have agreed to participate in th Collaborative Research Team for this study.

Do you understand that you have been asked to be in a research study?	Yes	No
Have you received and read a copy of the attached information sheet?	Yes	No
Have you had an opportunity to ask questions and discuss the study?	Yes	No
Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason.	Yes	No
Has the issue of confidentiality been explained to you?	Yes	No
Do you agree to keep all sensitive material discussed within the Collaborative Research Team or any focus group that you may be a part of confidential?	Yes	No
Have you had a chance to read the entire research proposal?	Yes	No
Are you comfortable assuming a role in the Collaborative Research Team?	Yes	No
Copy of consent form to be left with participant		

This study was explained to me by: _____

I have read and understood the above information, and agreed to participate in this study.

_____ _____ _____

Signature of Participant: Print Name Date

I believe that the person signing this consent form understands what is involved in the study and voluntarily accepts to participate.

_____ _____ _____

Signature of Investigator Print Name Date

Informed Consent Materials

Title of study: Using Action Research to Optimize Clinical Teaching in Baccalaureate Nursing Education in Ghana

Information Sheet – Focus Group Interviews

My name is Mary Asor Asirifi. I am a PhD nursing student in the Faculty of Nursing at the University of Alberta. I am interested in gaining insight into clinical teaching and learning experiences of student nurses in Ghana. I would like to identify how clinical teaching and learning could be enhanced. I am interested in getting the perspectives of Ghanaian undergraduate students, nurse interns (year 5 of clinical experience), graduate students and faculty, as well as representatives of the Ghana Nurses' and Midwives' Council, Ghana Nurses' Association and Ministry of Health and nurses in clinical agencies who have been involved in the clinical supervision of student nurses.

Clinical teaching forms an integral part of nursing education worldwide. It gives nursing students the opportunity to acquire knowledge and skills in nursing practice. Evidence from research studies indicates that use of effective clinical teaching models enhances clinical learning. Strategies to enhance clinical teaching in nursing education in Ghana have not been studied. Because you are one of the stakeholders of nursing education in Ghana, I am inviting you to take part in this study. The important information you possess and could share with me will contribute to learning more about clinical teaching and learning issues and potential clinical education strategies in Ghana. The intent is the improvement of student nurse clinical learning.

Purpose of the study: The purpose the purpose of this study is to engage stakeholders in a research process that will ascertain the strengths and weaknesses of the current model(s) of clinical education in one undergraduate baccalaureate nursing program in Ghana; and offer strategies to enhance clinical teaching effectiveness that will meet or surpass national standards and are feasible within current and potential resources.

Data Collection Procedures: This is a community-based action research study that has four phases.

3. Questionnaires will be completed by undergraduate students, graduate students, nurse interns (Year 5 of clinical experience) and faculty members.
4. Individual interviews or focus group interviews will be held with members of Ghana Nurses' and Midwives' Council, Ghana Nurses' Association, and Ministry of Health, graduate students, faculty, and clinical staff agency involved with student nurse clinical education.

Your Participation: You are invited to participate in a focus group interview. The focus interview will last around 45 to 90 minutes. The interview will be audio-taped and then typed word for word by me. Only my supervisors and I will see the typed document.

Initials ……

Consent: If you agree to participate you will sign a consent form voluntarily. You are free to stop the focus group interview at any time in order to withdraw from the interview process. You are free to refuse to answer any questions or to ask for clarification at any time during the focus group interview.

Discomforts or risks: There are minimal known discomforts or risks expected with this study. Whenever you feel uncomfortable or need a break or need to stop, you are free request to do so.
Cost: There are no costs for participating in this study.

Benefits: You might develop greater understanding about clinical teaching and learning in Ghana. Findings from this study can generate new knowledge about potential strategies that could enhance clinical teaching in Ghana. You will be invited to attend a presentation on the preliminary findings.

Confidentiality and anonymity: The signed forms and information will be stored separately in locked cabinets in a separate location than in which the data will be stored. The names and identifiers of study participants will be eliminated from the transcript to preserve anonymity of the research participants. The researcher alone shall have access to the names of the participants. The researcher shall preserve the research study materials appropriately to maintain confidentiality. The members of the supervisory committee will have access to the data during the study for the purpose of assisting me in the research process. The information or data that shall be obtained from the study shall be stored by the researcher for at least five years after the study has been completed. Because this is a group interview, the other nurses in the interview will hear what you say. Participants should maintain confidentiality regarding what is said in the group but the researcher cannot guarantee what all participants do.

Freedom to withdraw: You are free to withdraw from the study at any time. You do not need to give a reason for the withdrawing. There will be no effect on your employment (or graduate student status).

Future use of the study: Preliminary findings of the study will be shared with stakeholders at meetings. Recommendations arising from discussion about the findings shall be presented to the appropriate decision-makers. The findings of the study shall be presented at local and international conferences, workshops and seminars on nursing education. I may wish to use your interview again in a future study but, if that happens, I will get further ethical approval.

Additional contacts:
If you have any question or concerns about any part of the study, please contact Professor Alex Clark (Associate Dean; Research; Faculty of Nursing, University of Alberta. Tel: 780-492-6764: E-mail: alex.clark@ualberta.ca

Please put your initials here to indicate that you have read this information sheet……

Consent Form for Focus Group Interviews

Title of project: *Using Action Research to Optimize Clinical Teaching in Baccalaureate Nursing Education in Ghana*

Investigator:

Mary Asirifi MN, RN
E-mail: asirifi@ualberta.ca
Phone: (780) 752 2181

Supervisors

Dr. Linda Ogilvie, PhD, RN
linda.ogilvie@ualberta.ca
780 430 9221

Dr. Sylvia Barton, PhD, RN
sylvia.barton@ualberta.ca
780 492 6253

Description of the project: The purpose of this study is to engage faculty members, students, preceptors and other stakeholders in nursing education in Ghana in a research process that will ascertain the strengths and weaknesses of the current model(s) of clinical education in one undergraduate baccalaureate nursing program in Ghana; and offer strategies to enhance clinical teaching effectiveness that will meet or surpass national standards and are feasible within current and potential resources. This project will involve completion of questionnaires, interviews and focus group. The interview and focus group will last for about 45 to 90 minutes. The interviews and focus group will be audio-taped. You have agreed to participate in a focus group interview.

Do you understand that you have been asked to be in a research study?	Yes	No
Have you received and read a copy of the attached information sheet?	Yes	No
Have you had an opportunity to ask questions and discuss the study?	Yes	No
Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason.	Yes	No
Has the issue of confidentiality been explained to you?	Yes	No
Do you consent to be interviewed (in a focus group)?	Yes	No
Do you consent to being audio taped?	Yes	No
Do you give permission to me to revisit your data for future analysis pending ethics approval or review?	Yes	No
Copy of consent form to be left with participant		

This study was explained to me by: _____

I have read and understood the above information, and agreed to participate in this study.

_____ _____ _____

Signature of Participant: Print Name Date

I believe that the person signing this consent form understands what is involved in the study and voluntarily accepts to participate.

_____ _____ _____

Signature of Investigator Print Name Date

Title of study: Using Action Research to Optimize Clinical Teaching in Baccalaureate Nursing Education in Ghana

Information Sheet – Individual Interviews

My name is Mary Asor Asirifi. I am a PhD nursing student in the Faculty of Nursing at the University of Alberta. I am interested in gaining insight into clinical teaching and learning experiences of student nurses in Ghana. I would like to identify how clinical teaching and learning could be enhanced. I am interested in getting the perspectives of Ghanaian undergraduate students, nurse interns (year 5 of clinical experience), graduate students and faculty, as well as representatives of the Ghana Nurses' and Midwives' Council, Ghana Nurses' Association and Ministry of Health and nurses in clinical agencies who have been involved in the clinical supervision of student nurses.

Clinical teaching forms an integral part of nursing education worldwide. It gives nursing students the opportunity to acquire knowledge and skills in nursing practice. Evidence from research studies indicates that use of effective clinical teaching models enhances clinical learning. Strategies to enhance clinical teaching in nursing education in Ghana have not been studied. Because you are one of the stakeholders of nursing education in Ghana, I am inviting you to take part in this study. The important information you possess and could share with me will contribute to learning more about clinical teaching and learning issues and potential clinical education strategies in Ghana. The intent is the improvement of student nurse clinical learning.

Purpose of the study:

The purpose the purpose of this study is to engage stakeholders in a research process that will ascertain the strengths and weaknesses of the current model(s) of clinical education in one undergraduate baccalaureate nursing program in Ghana; and offer strategies to enhance clinical teaching effectiveness that will meet or surpass national standards and are feasible within current and potential resources.

Data Collection Procedures:

This is a community-based action research study that has four phases.

1. Questionnaires will be completed by undergraduate students, graduate students, nurse interns (Year 5 of clinical experience) and faculty members.
2. Individual interviews or focus group interviews will be held with members of Ghana Nurses' and Midwives' Council, Ghana Nurses' Association, and Ministry of Health, graduate students, faculty, and clinical staff agency involved with student nurse clinical education.

Your Participation:

You are invited to participate in an individual interview. The interview will last around 45 to 90 minutes. The interview will be audio-taped and then typed word for word by me. Only my supervisors and I will see the typed document. *Initials ……*

Consent:

If you agree to participate you will sign a consent form voluntarily. You are free to stop the interview at any time. You are free to refuse to answer any questions asked in the interview. You are free to ask for clarification at any time during the interview.

Discomforts or risks:

There are no known discomforts or risks expected with this study. Whenever you feel uncomfortable or need a break or need to stop, you are free to do so.

Cost:

There are no costs for participating in this study.

Benefits:

You might develop greater understanding about clinical teaching and learning in Ghana. Findings from this study can generate new knowledge about potential strategies that could enhance clinical teaching in Ghana. You will be invited to attend a presentation on the preliminary findings.

Confidentiality and anonymity:

The signed forms and information will be stored separately in locked cabinets in a separate location than in which the data will be stored. The names and identifiers of study participants will be eliminated from the transcript to preserve anonymity of the research participants. The researcher alone shall have access to the names of the participants. The researcher shall preserve the research study materials appropriately to maintain confidentiality. The members of the supervisory committee will have access to the data during the study for the purpose of assisting me in the research process. The information or data that shall be obtained from the study shall be stored by the researcher for at least five years after the study has been completed.

Freedom to withdraw:
You are free to withdraw from the study at any time. You do not need to give a reason for the withdrawing. There will be no effect on your employment (or graduate student status).

Future use of the study:
Preliminary findings of the study will be shared with stakeholders at meetings. Recommendations arising from discussion about the findings shall be presented to the appropriate decision-makers. The findings of the study shall be presented at local and international conferences, workshops and seminars on nursing education. I may wish to use your interview again in a future study but, if that happens, I will get further ethical approval.

Additional contacts:
If you have any question or concerns about any part of the study, please contact Professor Alex Clark (Associate Dean; Research; Faculty of Nursing, University of Alberta. Tel: 780-492-6764: E-mail: alex.clark@ualberta.ca)
Please put your initials here to indicate that you have read this information sheet ……

Consent Form for Individual Interviews

Title of project: *Using Action Research to Optimize Clinical Teaching in Baccalaureate Nursing Education in Ghana*

Investigator:	**Supervisors**	
Mary Asirifi MN, RN	Dr. Linda Ogilvie, PhD, RN	Dr. Sylvia Barton, PhD, RN
E-mail: asirifi@ualberta.ca	linda.ogilvie@ualberta.ca	sylvia.barton@ualberta.ca
Phone: (780) 752 2181	780 430 9221	780 492 6253

Description of the project: The purpose of this study is to engage faculty members, students, preceptors and other stakeholders in nursing education in Ghana in a research process that will ascertain the strengths and weaknesses of the current model(s) of clinical education in one undergraduate baccalaureate nursing program in Ghana; and offer strategies to enhance clinical teaching effectiveness that will meet or surpass national standards and are feasible within current and potential resources. This project will involve completion of questionnaires, interviews and focus group. The interview will last for about 45 to 90 minutes. The interviews and focus group will be audio-taped. You have agreed to participate in an individual interview.

Do you understand that you have been asked to be in a research study	Yes	No
Have you received and read a copy of the attached information sheet?	Yes	No
Have you had an opportunity to ask questions and discuss the study?	Yes	No
Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason.	Yes	No
Has the issue of confidentiality been explained to you?	Yes	No
Do you consent to be interviewed?	Yes	No
Do you consent to being audio taped?	Yes	No
Do you give permission to me to revisit your data for future analysis pending ethics approval or review?	Yes	No
Copy of consent form to be left with participant		

This study was explained to me by: _____

I have read and understood the above information and agreed to participate in this study.

_____ _____ _____

Signature of Participant: Print Name Date

I believe that the person signing this consent form understands what is involved in the study and voluntarily accepts to participate

_____ _____ _____

Signature of Investigator Print Name Date

Ethics Institutions Letters

Ethics Application has been Approved

ID:	Pro00058691
Title:	Using Action Research to Optimize Clinical Teaching in Baccalaureate Nursing Education in Ghana
Study Investigator:	Mary Asirifi
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. **Note**: Please be reminded that the REMO system works best with Internet Explorer or Firefox. 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

Amendment/Renewal to Study has been Approved

Amendment/Renewal ID:	Pro00058691_REN2
Study ID:	MS2_Pro00058691
Study Title:	Using Action Research to Optimize Clinical Teaching in Baccalaureate Nursing Education in Ghana
Study Investigator:	Mary Asirifi
Description:	The amendment/renewal to 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

NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH
Established 1979 A Constituent of the College of Health Sciences

University of Ghana

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NMIMR-IRB

P. O. Box LG 581

Legon, Accra

My Reference: DF 22

August 31, 2018

Mary Asor Asirifi, PhD Ca

University of Alberta, Edmonton Clinic Health Academy

11405-87 Avenue

Edmonton T6G1C9

RE: Our Study # 082/15-16 **At:** NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH-IRB

Dear Mary Asor Asirifi, PhD Ca:

Meeting Date: 3/7/2018 **At:** NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH-IRB

Protocol Title: Using Action Research to Optimize Clinical Teaching in Baccalaureate Nursing Education in Ghana

This is to advise you that the above referenced Study has been presented to the Institutional Review Board, and the following action taken subject to the conditions and explanation provided below.

Internal #: 1953
Expiration Date: 3/6/2019
On Agenda For: Renewal
Reason 1: Progress Report **Reason 2:**
Description:
IRB ACTION: Renewed
Condition 1:
Action
Explanation:

Yours Sincerely,
NMIMR-IRB
IRB Administrator

NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH

Established 1979 A Constituent of the College of Health Sciences
University of Ghana

INSTITUTIONAL REVIEW BOARD

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E-mail: nirb@noguchi.mimcom.org
Telex No: 2556 UGL GH

My Ref. No: DF.22
Your Ref. No:2nd
March, 2016

ETHICAL CLEARANCE

FEDERALWIDE ASSURANCE FWA 00001824 IRB 00001276

NMIMR-IRB CPN 082/15-16 IORG 0000908

On 2nd March 2016, the Noguchi Memorial Institute for Medical Research (NMIMR) Institutional Review Board (IRB) at a full board meeting reviewed and approved your protocol titled:
TITLE OF PROTOCOL:Using Action Research to Optimize Clinical Teaching in Baccalaureate Nursing Education in Ghana

PRINCIPAL INVESTIGATOR: Mary Asor Asirifi, PhD Cando.

Please note that a final review report must be submitted to the Board at the completion of the study.
Your research records may be audited at any time during or after the implementation.
Any modification of this research project must be submitted to the IRB for review and approval prior to implementation.
Please report all serious adverse events related to this study to NMIMR-IRB within seven days verbally and fourteen days in writing.
This certificate is valid till I st March, 2017. You are to submit annual reports for continuing review.

Signature of Chair.....

Mrs. Chris Dadzie

(NMIMR - IRB, Chair)

[CORLE BC TEACHL\CJ' HOSPITAL

In case of reply the
And the date of this KORLE BC, ACCRA.
Letter should be quoted

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pr(å kbth.gov.gh
Website: www.kbth.gov.gh

My Ref: No. .

Your Rcd.' No

16th August, 2016

MARY ASIRIFI M N

FACULTY OF NURSING

UNIVERSITY OF ALBERTA

CANADA

SCIENTIFIC AND TECHNICAL COMMITTEE APPROVAL

PROTOCOL IDENTIFICATION NUMBER: KBTH-STC 00061/2016

The Korle Bu Teaching Hospital Scientific and Technical Committee (KBTH-STC), on 16th August, 2016 approved your submitted study protocol.

TITLE OF PROTOCOL: "Using Action Research to Optimize Clinical Teaching in Baccalaureate Nursing Education in Ghana',

PRINCIPAL INVESTIGATOR: Mary Asirifi M N

This approval requires that you forward your approved document to Korle Bu Teaching Hospital — Institutional Review Board (KBTH-IRB) for the ethical aspect of the proposal to be assessed before the project can be initiated.

This STC approval is valid till 30 th September, 2017.
You may, however, request extension of the approval period, or renewal as the case may be, should the study extend beyond the stated period.

Upon completion, you are required to submit a final report on the study to the STC This is to enable the STC ensure among others that, the project has been implemented as per the approved protocol. You are also required to inform the KBTH-STC and Research Directorate of any publications that may emanate from the research findings.

Kindly note that, should the need arise, the KBTH-STC or IRB may institute appropriate measures to satisfy itself that study is being conducted according to the highest scientific and ethical standards.

Please note that any modification to the study protocol without Scientific Technical Committee (STC) approval renders this approval invalid.

Sincere

Prof. G. Obeng Adjei
Chairman, KBTH-

STC cc: The

Chairman, KBTH-

IRB

NB: please see attached comments from the next page

MEDICAL DIRECTORATE

KORLE BU TEACHING HOSPITAL

22nd August, 2016

THE DIRECTOR

NURSING SERVICES

KORLE BU

LETTER OF INTRODUCTION - MARY ASIRIFI M N
"USING ACTION RESEARCH TO OPTIMIZE CLINICAL TEACHING IN BACCALAUREATE NURSING EDUCATION"

I have the pleasure to introduce to you the above named Principal investigator from the Faculty of Nursing, University of Alberta, Canada. Mary Asirifi M N sought and has been granted approval to conduct a study entitled "Using Action Research to Optimize clinical Teaching in Baccalaureate Nursing Education",

She is to contact you to discuss the commencement date of the study.

Kindly accord her the needed assistance.

Attached is the Scientific and Technical Committee and Institutional Review Board approval which specifies the terms.

Sincere regards,

Lamptey 22/08/2016

DR. ROBERTA LAMPTEY

DEP. DIRECTOR OF MEDICAL AFFAIRS

FOR: DIRECTOR OF MEDICAL AFFAIRS

22 nd August, 2016

MARY ASIRIFI M N

FACULTY OF NURSING

UNIVERSITY OF ALBERTA

CANADA

USING ACTION RESEARCH TO OPTIMIZE CLINICAL TEACHING IN BACCALAUREATE NURSING EDUCATION IN GHANA

KBTH - IRB /00061/2016

Investigator : Mary Asirifi M N

On 22nd August, 2016 the Korle-Bu Teaching Hospital Institutional review Board (KB TH IRB) reviewed and granted approval to the study entitled "Using Action Research to Optimize Clinical Teaching in Baccalaureate Nursing Education in Ghana"

Please note that the Board requires you to submit a final review report on completion of this study to the KBTH- IRB

Kindly, note that, any modification/amendment to the approved study protocol without approval from KB TH IRB renders this certificate invalid.

Please report all serious adverse events related to this study to KBTH-IRB within seven days verbally and fourteen days in writing.

This IRB approval is valid till 3 1 st July, 2017. You are to submit annual report for continuing review.

Sincere regards,

OI<YERE BOATENG
(MR) CHAIR (KBTH-
IRB)

Cc: The Chief Executive Officer

Korle Bu Teaching Hospital

'The Director of Medical Affairs
Korle Bu Teaching Hospital

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1 6th August, 2016

MARY ASIRIFI M N

FACULTY OF NURSING

UNIVERSITY OF ALBERTA

CANADA

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PRINCIPAL INVESTIGATOR: Mary Asirifi M N

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Kindly note that, should the need arise, the KBTH-STC or IRB may institute appropriate measures to satisfy itself that study is being conducted according to the highest scientific and ethical standards.

Please note that any modification to the study protocol without Scientific Technical Committee (STC) approval renders this approval invalid.

ere regards.

Sincer

Prof. G. Obeng Adjei
Chairman, KBTH-STC cc: The

Chairman, KBTH-IRBNB

22 nd August, 2016

MARY ASIRIFI M N

FACULTY OF NURSING

UNIVERSITY OF ALBERTA

CANADA

USING ACTION RESEARCH TO OPTIMIZE CLINICAL TEACHING IN BACCALAUREATE NURSING EDUCATION IN GHANA

KBTH -- IRB /00061/2016

Investigator : Mary Asirifi M N

On 22nd August, 2016 the Korle-Bu Teaching Hospital Institutional review Board (KBTH IRB) reviewed and granted approval to the study entitled "Using Action Research to Optimize Clinical Teaching in Baccalaureate Nursing Education in Ghana"

Please note that the Board requires you to submit a final review report on completion of this study to the KBTH- IRB.

Kindly, note that, any modification/amendment to the approved study protocol without approval from KBTH IRB renders this certificate invalid.

Please report all serious adverse events related to this study to KBTH-IRB within seven days verbally and fourteen days in writing.

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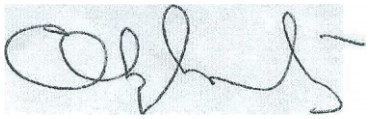
Sincere regards,



OKYERE BOATENG (MR) CHAIR
(KBTH-IRB)

Cc: The Chief Executive Officer
Korle Bu Teaching Hospital
The Director of Medical Affairs
Korle Bu Teaching Hospital

22nd August, 2016

MARY ASIRIF M N

FACULTY OF NURSING

UNIVERSITY OF ALBERTA

CANADA

INSTITUTIONAL APPROVAL: KORLE BU TEACHING HOSPITAL-SCIENTIFIC AND TECHNICAL COMMITTEE/INSTITUTIONAL REVIEW BOARD (KBTH-STC/1RB/00061/2016

Following approval of your study entitled "Using Action Research to Optimize clinical Teaching in Baccalaureate Nursing Education" by the Korle Bu Teaching Hospital-Scientific and Technical Committee/lnstitutional Review Board. I am pleased to inform you that institutional approval has been granted for the conduct of your study in Korle Bu Teaching Hospital.

Please contact the Director, Nursing Services, Korle Bu to discuss the commencement date of the study.

Please note that, this institutional approval is rendered invalid if the terms of the Institutional Reviewed Board/Scientific and Technical Committee approval are violated.

Sincere regards,

Lamptey 22/08/2016.

Dr. Roberta Lamptey

Dep. Director of Medical Affairs
For: Director of Medical Affairs

MEDICAL DIRECTORATE

KORLE BU TEACHING HOSPITAL

22 nd August, 2016

THE DIRECTOR
NURSING SERVICES

KORLE BU

LETTER OF INTRODUCTION - MARY ASIRIFI M N
"USING ACTION RESEARCH TO OPTIMIZE CLINICAL TEACHING IN BACCALAUREATE NURSING EDUCATION"

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Kindly accord her the needed assistance.

Attached is the Scientific and Technical Committee and Institutional Review Board approval which specifies the terms.

Sincere regards,

Lamptey 9J(oR/257 6

DR. ROBERTA LAMPTEY

DEP. DIRECTOR OF MEDICAL AFFAIRS
FOR: DIRECTOR OF MEDICAL AFFAIRS

Appendix D

Poster Presentation: Reconceptualizing Preceptorship in Clinical Nursing Education in Ghana.

Poster on Reconceptualizing Preceptorship in Clinical Nursing Education in Ghana

Reconceptualizing Preceptorship in Clinical Nursing Education in Ghana

Mary Asor Asirifi, PhD Candidate
Collaborative Research Team: Dr. Lydia Aziato, Mrs. Adzo Kwashie, Mrs. Cecilia Eliason, Mrs. Gloria Achempim-Ansong.
Supervisory Committee: Dr. Linda Ogilvie, Dr. Sylvia Barton, Dr. Kent Stobart, Dr. Olenka Bilash, Dr. Patience Aniteye

Purpose of Study

- To engage stakeholders in a **four- cycle community-based participatory action research (CBPR) process** that will ascertain the strengths and weaknesses of the current model(s) of clinical education in one undergraduate baccalaureate nursing program in Ghana; and offer strategies to enhance clinical teaching effectiveness that will meet or surpass national standards and are feasible within current and potential resources.

Research Approach

- **Cycle One:** ***Qualitative survey*** *distributed to* 79 undergraduate nursing students, 19 graduate students, 9 faculty members, and 21 nurse interns; ***individual interviews*** with six stakeholders - 2 representatives each from MOH, NMC and GRNMA and one representative from GCNM.

Recommendations of Cycle One included the need for: a) more effective clinical teaching and supervision; b) adequate equipment for practice; c) meaningful evaluation of performance; d) enhanced collaboration between the school and clinical settings; and, e) reduced travel time to clinical opportunities. External stakeholders became aware and supportive of the research endeavour through the interviews (Asirifi et al., 2017).

- **Cycle Two:** Presentations on Cycle One findings, clinical teaching models and CBPR.
- **Cycle Three:** Individual interviews with six faculty members, separate focus group interviews for six graduate students and eight clinical agency staff including preceptors.

***This poster is focused on Cycles Two and Three ***

- **Cycle four:** Validation of findings and communication of vision.

Change is one of the major purposes of CBPR and Kotter's' eight step of theory of organizational change, which guided this study, is congruent with CBPR (Caine & Mill, 2016; Kotter, 2012).

Purpose for Cycles Two and Three: ***To examine current issues in clinical nursing education and envision possibilities for improvement in collaboration with stakeholders***

Outcome of Cycles Two and Three: ***Decision to focus on a reconceptualized model of preceptorship as the preferred clinical teaching model***

New vision: ***Enhanced collaboration across all stakeholders in creating optimal conditions for preceptorship as a clinical teaching model that will provide high quality clinical education .***

Findings for Cycles Two and Three revealed a need for:

- **Reconceptualising preceptorship:** *Example: Preceptors may have concurrently more than 5 students from a mix of institutions disciplines and/or levels.*
- **Changing role expectations:** *Example: Faculty share clinical objectives with preceptors but not necessarily with students and students have no input into their objectives. Post-RN students have identical clinical objectives as other undergraduate students and are in the same practice areas.*
- **Planning for success:** *Example: Collaboration across clinical and academic agencies and inclusion of regulatory, professional and policy representatives in planning of clinical placements (* already initiated).
- **Addressing challenges of clinical teaching in a resource-constrained context.** *Example: In recent years the Ministry of Health has increased student nurse intakes with no increase in school of nursing budgets or faculty. Equipment and other resources needed for patient care are inadequate in clinical agencies and in school of nursing laboratories.*
- **Incentives for preceptors:** *Example: There are few rewards for taking responsibility for the clinical education of student nurses. It is perceived as an extra workload.*

Proposed Strategies

- **Central planning:** Stakeholders planning coordination to reduce numbers and diversity of students on the units/wards at the same times.
- **Faculty planning and development:** Educational preparation for teaching.
- **Enhanced preceptor development:** Adequate preparation for clinical teaching.
- **Preceptor and assigned students on same shifts:** Negotiate for students and preceptors to run the same shift.
- **Preceptor selection:** Interest to teach, and create preceptor certification for post-RN students as part of their undergraduate degree program.
- **Clarify relationships, roles, and responsibilities of preceptors, faculty, nursing, staff, student peers, nursing staff and students:** Respectful relationships.
- **Clinical objectives and evaluation criteria:** Encourage students to supplement faculty objectives with personal objectives related to learning needs/interests.
- **Preceptor appreciation:** Monetary incentives; preceptorship recognized as a competency for renewal of professional registration.

Potential Barriers or Threats to Change: Fiscal and human resource constraints; traditional hierarchical relationships; resistance to change.

Communication of Strategies: Solicitation of feedback, and revision planning in progress; to be followed by implementation and evaluation of changes.

References:

- ***Asirifi, M., Ogilvie, L., Barton, S., Aniteye, P., Stobart, K., Bilash, O., Eliason, C., Ansong, G., Aziato, L & Kwashie, A. (2017). Assessing Challenges of Clinical Education in a Baccalaureate Nursing Program in Ghana. Journal of Nursing Education and Practice. 7(10); 109-118.***
- ***Caine, V.& Mill, J (2016). Essentials of community-based research. U.S.A: Left Coast Press Inc.***
- ***Kotter, J. P. (2012), Leading Change. Boston, MA: Harvard Business Review Press.***

Appendix E

Draft of Paper 4: Reflections on Change Theory and Community-based Participatory Action Research: Congruent, Similar or Different?

Reflections on Change Theory and Community-based Participatory Action Research: Congruent, Similar or Different?

While change is acknowledged as integral to all action research, literature linking them theoretically merits exploration. Are some theories of change more congruent to principles of action research than others? Does congruence depend on which type of action research and which change theory are compared? As I implemented a four-cycle community-based participatory action research (CBPR) project in nursing education in Ghana, such questions arose. This paper is my attempt to grapple with those questions. While I chose Kotter's eight-step theory of organizational change to guide my study, it became obvious that I was in fact integrating elements of various change theories as the study progressed.

The Relationship of Action Research to Change

The historical roots of action research emanated from the works of Kurt Lewin in the 1940's, as well as the experiences of Paulo Friere and Bell hooks. Action research was started in 1946 by Kurt Lewin, a German-American social psychologist, as a means to solve social problems such as social inequalities and exploitation. There was focus on promoting independence, equality, cooperation and establishment of democracy for social change (Caine & Mill, 2017; Maksimović, 2010). Paulo Freire was a Brazilian philosopher whose works are entrenched in emancipatory pedagogy, issues of power, and conflict. Freire believed that the community owns knowledge and can create knowledge through experience (Caine & Mill, Freire, 2001). Bell hooks is a feminist and social activist whose works are rooted in race and gender issues that result in oppression. She focuses on the concept of intersectionality with the perception that gender, class and race are interrelated. Bell hooks believes that communities are capable of solving issues within them and, in addition, focuses on power structures in classroom

and educational settings. These three historically important scholars share views related to promoting collective problem solving by the community, addressing issues of inequality, and advocating all-inclusive decision-making for social change. These views are congruent with Stringer's (2007) description of action research as a systematic approach to investigation that enables people in schools, businesses, community organizations, and health and human services to find effective solutions for the problems they confront in their work. Similarly, Haug (2010) perceives that action research is an orientation to knowledge creation that arises in a context of practice and requires researchers to work with practitioners. Unlike conventional social science research, the purpose of action research is not principally the understanding of social arrangements but the desire to effect change for empowerment and knowledge generation by the community. This enables action researchers to take knowledge production beyond the gate-keeping propensities of professional knowledge-makers (Stringer, 2007).

Investigators engage in action research for professional, personal and political purposes (Feldman, 2002). The researchers who engage in action research for professional purposes acknowledge that action research generates new educational knowledge and aims at connecting theory to practice. Furthermore, researchers engage in action research for personal purposes to attain greater self-knowledge, fulfillment in one's work, and a deeper understanding in one's own practice. The objective of researchers who engage in action research for political purposes is to create social change towards greater social justice (Feldman, 2002; Helskog, 2014; Yahui, 2011). Action research can be done by individuals or with teams of colleagues. When action research is conducted in a team, it is called "collaborative inquiry" (Morale, 2016).

Community-based participatory action research (CBPR) is a typical approach to collaborative inquiry and is an approach that enables researchers to form partnerships with

people affected by an issue, with the aim of taking action or effecting social change (Bush, Hamzey & Macaulay, 2017). It may be conducted to connect academic research to a community (Caine & Mill, 2017) or community members could conduct CBPR without academic support.

While some researchers perceive that the concepts of CBPR and action research are the same, others differentiate them. As the concept of action research expanded, scholars used different terms such as "participatory research" (Northway, 2010a; Northway, 2010b), "community-based participatory action research" (Bomar, 2010; Foster & Stanek, 2007; Hill, Mullett & Caroll, 2007; Minkler, 2010) and "participatory action research" (Baum, et al, 2006; van derVelde, Williamson & Ogilvie, 2009) to describe their particular research approach. Although the terms have different names, they share many of the same meanings and features (Bomar, 2010; Northway 2010a). Caine & Mill (2017) perceive differences between community-based research and participatory research (PAR). To them, community-based research is a philosophical approach to research and used to answer both qualitative and quantitative research questions whereas participatory action research is a methodology that shares many similarities with CBPR. Participatory action research (PAR) is focused on challenging power imbalances, changing community systems or structures, and achieving social justice and, therefore, usually includes policy makers, decision makers and people linked to socio-political processes in the research process. Both CPBR and PAR, however, share the same principles of maintaining collaboration, authentic engagement of researcher and community members, empowerment of community members, capacity building, flexibility of the research methodology due to the iterative nature of process, knowledge generation beneficial to the community, and system development (Caine & Mill, 2017; Blair & Minkler, 2009; Branon, 2012; Greenwood & Levin, 2007; Northway, 2010a, 2010b; Stringer, 2007). Stringer (2007) described the characteristics of

action research as democratic (participation of all), equitable (acknowledges people's worth), liberating (providing freedom from oppression and/or debilitating conditions) and life enhancing, (enabling the expression of full human potential).

While all types of action research are oriented to change, are they all emancipatory and related to societal change? Can action research be more related to individual change as opposed to societal change? For example, Voigt, Hansen, Glindorf, Paulsen, & Williang (2014) engaged health practitioners such as diabetes educators in collaboration with researchers, to develop and implement a participatory, group-based diabetes education program in a diabetes clinic in the Danish health care system. The authors reported that the action research approach contributed to the development and change of diabetes education practice and increased the knowledge of participants in the action research community. The above explications indicate that CBPR promotes enabling environments for the researcher to engage, discuss and encourage collaborative decision making with participants to plan or implement changes to address barriers that inhibit the progress of the community. Would it be accurate to suggest a continuum of action research from focused on increasing knowledge and well-being to emphasis on social activism and challenge of oppressive practices? This is an important question as this discussion now moves to theories of change.

Theories of Change

Change is a natural phenomenon that happens in our everyday lives. Various change theories exist to explain the processes such as steps or phases through which change could occur. These theories include Lewin's three steps of change theory, social cognitive theory, Lippitt's phases of change theory, Prochaska and DiClemente's change theory, theory of reasoned action and planned behavior to one another, and Kotter's theory of organizational change. The main

features of these six change theories are presented below. What becomes obvious is the neutrality within which these theories are situated. The socio-political underpinnings of much action research are missing. As well, the theories are similar in process but not necessarily in details or amount of guidance for implementation of change. Most of them focus on individual change rather than societal or organizational change.

Lewin's Three-Step Change Theory

Kurt Lewin, the pioneer of action research and change theory, introduced a three-step change model (Kristonis, 2004; Mitchell, 2013). Lewin believed that the drive to effect change is related to action. The manifestation of behavior is as a result of the dynamic balance between driving forces which facilitate change and restraining forces which inhibit change. When in balance, the forces are in a state of equilibrium or status quo. The Lewin's three-step model shifts the balance towards the direction of the planned change. The three steps involved in Lewin's change model include unfreezing, movement and refreezing (Kristonis, 2004; Mitchell, 2013). "Unfreezing" occurs when there is the perception that change is needed (Mitchell, 2013) and the behavior change is focused on unfreezing the status quo by overcoming individual resistance and group traditions (Kristonis, 2004) and thus, decreasing the restraining forces. Activities that facilitate the unfreezing step include: driving forces such as preparing participants for change through motivation; building trust and awareness for the need to change; and, actively engaging participants in identifying the problems and deciding on solutions by the group. This step, not too surprisingly, resonates strongly with all types of action research. "Movement" occurs when change is instituted (Mitchell, 2013) and it is focused on moving the status quo to a new level (Kristonis, 2004). This could be facilitated by persuading participants to disagree with the existing situation, viewing the situation from a new perspective, working together to obtain

relevant information for the new direction, and conveying the new perspectives of the of group to respected leaders whose support could be influential in actually making the change. Refreezing occurs when the equilibrium is re-established (Mitchell, 2013) after the implementation of the change. The purpose of the refreezing is to integrate the new change into the traditions and customs in the group. The most effective way to maintain a change in a group or organization is through integration into organizational policies and procedures (Kristonis, 2004; Mitchell, 2013).

Lippitt's Phases of Change Theory

Lippitt's change theory is similar to the nursing process (Mitchell, 2013) and consists of seven phases: a) diagnosing the problem; b) assessing the motivation and capacity for the change; c) assessing the resources and motivation of the change agent; d) selecting progressive change objects; e) choosing the role of the change agent; f) maintaining the change; and, g) the change agent gradually terminating from the helping relationship (Kritsonis, 2004; Mitchell, 2013). The role and responsibility of the change agent is more emphasized in Lippitt's change theory than the development of the actual change (Kristonis, 2004). There is also focus on an individual change agent as opposed to a participatory or community oriented process. The change agent has a more directive role than that of the facilitator in different forms of action research.

Prochaska and Diclemente's Change Theory

Prochaska and DiClemente's change theory focuses on individual behavioural change and envisions a spiral model of the five stages that individuals pass through when change occurs (Kristonis, 2004). *Pre-contemplation* precedes the individual's awareness of the need for change. *Contemplation* exists when the individual realizes a need for behavioral change but is not yet ready for change. *Preparation* generally follows within two weeks and is manifested by an

individual's readiness to change through seeking assistance from support systems. *Action* involves an individual's coping mechanisms and engagement in behavioural activities. Finally, *maintenance* includes the establishment or adoption of new behaviours to an individual's lifestyle, which usually lasts from six months to life (Kristonis, 2004; Mitchell, 2013). This model has limited utility for community-based participatory action research but could be a good fit for a theoretical orientation to program planning by a participatory group such as the previous diabetes educator example. Interestingly, however, action research is commonly depicted in a spiral.

Social Cognitive Theory

The concept of social cognitive theory, previously known as social learning theory, emanated from operant theory which holds that individuals react as a result of the consequences (rewards) of their behavior (Kristonis, 2004). Social cognitive theory holds that learning occurs through direct experiences, human dialogue, interactions, and observation. Learning and behavior change are influenced by environmental influences, personal factors, and attributes of the behaviour itself. The perception of an individual's ability to achieve self-efficacy is central to social cognitive theory. Self-efficacy can be achieved through the provision of clear instructions, provision of skill development, and modelling of the desired behaviour (Kristonis, 2004). Again, this is primarily an individual change theory. It does, however, provide guidance for the individual-level capacity-building component of CBPR.

The Theory of Reasoned Action and Planned Behavior

Similar to social cognitive theory, the theory of reasoned action and planned behaviour holds that the exhibition of an individual's behaviour is dependent on the intentions of that individual. Positive attitude towards the desired behaviour and the influence of social

environment shape the individual's attention. An important part of the behavioural change process in reasoned theory is behavioural control over opportunities, resources, and skills necessary to perform a behaviour (Kristonis, 2004). As in social cognitive theory, the theory of reasoned action and planned behavior provides guidance for engagement in capacity building but little guidance for social or organizational change.

Kotter's Organizational Change Theory

Kotter's (2012) eight-step organizational change theory involves: 1) creating a sense of urgency to sensitize the group to get involved in the change process; 2) building a guiding coalition by bringing together people with power to lead and support a collaborative change; 3) forming a strategic vision; 4) communicating the vision through sharing the vision and strategies with the people who are willing to effect the change; 5) enabling action by removing barriers that threaten the accomplishment of the vision by empowering people through training and information required for the change; 6) generating short term achievements; 7) sustaining 'accelerations' through developing structures and policies to sustain the change; and, 8) instituting the change. Each of Kotter's steps are explained in detail and provide clear guidance. Therefore, as part of the design of my CBPR project in Ghana, a decision was made to integrate his theory as part of the conceptual framework of the study. In hindsight, elements of some of the other aforementioned theories were used, albeit unconsciously.

My Research Experience: Mapping Congruencies, Similarities and Differences of CBPR and Kotter's Theory of Organizational Change

My CBPR research project of working together with stakeholders of nursing education in Ghana to plan and develop a clinical teaching model that would fit best into the Ghanaian nursing education system has been described elsewhere (see Asirifi et al., 2017 [Chapter Two];

Chapter Three; Chapter Four). As this was my PhD research, a limit was placed on my responsibility for generating a process of change. Thus I facilitated, through CBPR, the first four action research cycles. A Collaborative Research Team (CRT) from the study site were involved as partners for the entire research process and are responsible, in collaboration with me as is feasible, for the actual implementation of the collaboratively developed strategic vision. The four CBPR cycles fit nicely with the first four steps of Kotter's theory of organizational change. The congruencies are depicted in Figure 1 (p. 199).

Cycle One of my CBPR project involved data collection from various stakeholders, including strategic interviews with influential stakeholders in the Ministry of Health and other policy groups. The clinical education issues were revealed and inspired the students, faculty and the external stakeholders (nurse representatives from Ministry of Health [MOH], Nurses and Midwives Council for Ghana [NMC], and the Ghana Registered Nurses and Midwives Association of Ghana [GRNMA]) to acknowledge the need for restructuring or modifying the clinical teaching approach to enhance clinical nursing education in Ghana (Asirifi et al., 2017; Chapter Two). A key aspect of Kotter's change theory is that the leaders and the community members must agree with the change and a number of leaders who have the capabilities and power are selected to form a team to lead and support the change. Thus the first two steps of Kotter's theory, creating a sense of urgency through awareness of issues and building a guiding coalition, were achieved.

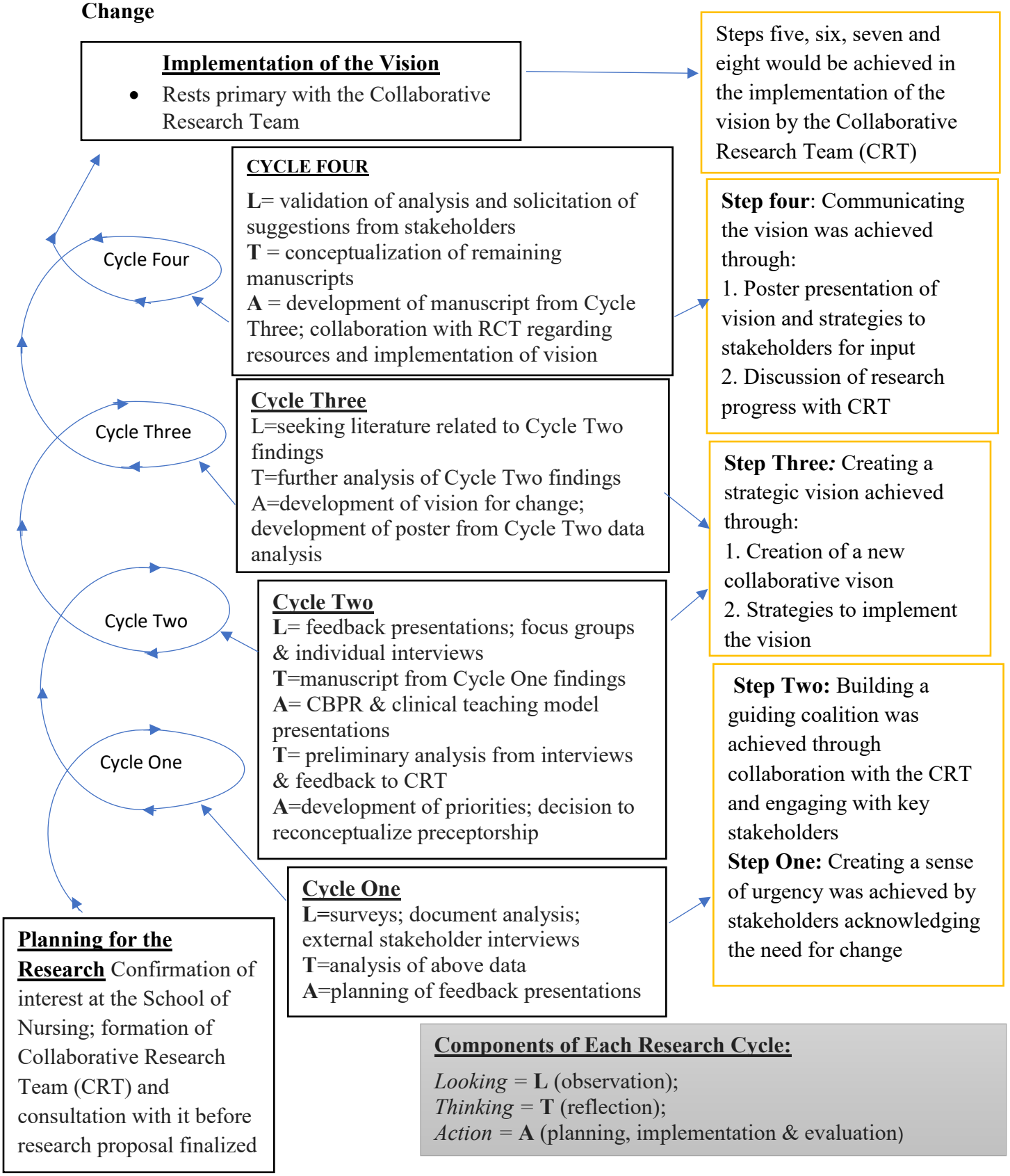
Feedback and capacity-building presentations in Cycle Two, allied with individual and focus group interviews to add depth to Cycle One surveys and seek solutions, along with further data analysis, additional literature search and CRT discussions in Cycle Three, led to the development of priorities for change, selection of the issue to be addressed first, and

development of a strategic vision. Thus, Cycles Two and Three of my CBPR project are congruent with Step Three of Kotter's organizational change theory – creation of a strategic vision through creation of a collaborative vision and development of strategies to implement the vision (see Chapter Three). It was decided to reconceptualize preceptorship to better fit the Ghanaian context. Several strategies were planned.

Through Cycle Four of the CBPR process, validation of the strategic plan and solicitation of further suggestions through poster presentations and conversations with stakeholders and research participants, Step Four of Kotter's theory, communicating the vision, was implemented. Not depicted in Figure 1 is the current plan for Cycle Five of the CBPR process. The CRT has decided that the initial strategy implemented will be the creation of a context-specific preceptor manual. This task fits with Steps Five and Six of Kotter's theory through enabling action by removing barriers that threaten the accomplishment of the vision by empowering people through training and information required for the change and by generating a short-term achievement. The remaining two steps are a logical progression. Therefore, Kotter's theory of organizational change has proven useful in my CBPR experience. The question now is: is it sufficient?

Kotter's change theory, while highly relevant for my CBPR study, lacks some of the insights that arose from my experiences in Ghana and Canada, my findings, my discussions with the CRT, and the literature on action research. It is a politically neutral change theory with strong collaborative and leadership components, and would allow for radical or transformative change, but only if infused with critical social theory and a perspective on social change. It is, therefore, congruent with CBPR, shares some aspects, but also has differences. What, therefore, do some of the other change theories add?

Figure 1: **Example of Congruencies between CBPR and Kotter's Theory of Organizational Change**



Adding Complexity to My Notions of Theories of Change Related to CBPR

Lewin's conceptualizations of changing status quos, dynamic equilibrium, freezing, movement and unfreezing precede Kotter's work and are not in contradiction to it, but also add depth to thinking about the implementation of change. The critical dimensions of social change permeate Lewin's work and fit nicely with CBPR. The notion of levels fits with the idea of ever higher spiralling cycles in CBPR. As in Kotter's change theory, Lewin's change theory proposes that the new perspective should be communicated to respected and powerful leaders who support the change. What was not mentioned in Lewin's theory was the recruitment of leaders to support and lead the change as postulated by Kotter (2012) and was done in my CBPR project. Although Lewin's theory was developed to guide change in action research, some of its processes are not congruent with this study. This indicates that the change theory used in an action research project depends on the approach or collaborative processes involved in the research, the approach must be congruent with the change theory.

Lippitt's phases of change theory, share some similarities with Kotter and Lewin's change theories but they are different. The theory is also focused on diagnosing of a problem and using a change agent to facilitate the change. The change agent is however, required to withdraw from the study relationship at a point in time. On the contrary, in Kotter's and Lewin's change theories, the change agents (stakeholders) stick to the implementation and evaluation of the project. The change processes involved in Prochaska and DiClemente's change theory, social cognitive theory, social cognitive theory, theory of reasoned action and planned behavior to one another are individually focused, which is different from the collaborative processes involved in CPBR project as well as Kotter's Lewin's change theories.

Next Step: Managing Change

Change management is essential in the implementation and sustenance of change in all organizations. Davidson (2015) cautioned about the risk of downplaying the importance of change management and argued that it needs to be incorporated in all the activities of administrators of organizations. Similarly, in Ghana, effective change management is needed for the implementation of the new strategic vision for effective clinical education. Although the implementation of the new vision and strategies is the responsibility of the CRT, it is worth noting that careful planning is needed for the adoption, sustenance and sustainability of the implemented strategies. A successful change management plan involves planning, analyzing, engaging, thinking, and doing with the aim of successful implementation of strategies that will accomplish sustainable results (Davidson, 2015). Velmurugan (2017) added that problems usually arise when change is forced on people. Therefore, change must be realistic, achievable and measurable to effectively adopted and diffused into the organizational system. Discussion of change management is beyond the scope of this paper. It needs careful consideration and an implementation plan will be needed for successive cycles of this CBPR initiative. Kotter's theory of organizational change will continue to offer guidance for the implementation cycles of this CBPR initiative.

Conclusions

Changes occur almost all the time in a community or organization to improve on the aim and outcomes of the group. The aim of action research is to promote collaborative decision making for change in a community. The implementation of change process, however, requires reflection and planning to ensure effective sustenance of the implemented change. The choice of a particular change model to guide a study depends on the approach used for the study. In other

words, congruence depends on the approach used in the research process. It is also important that nurses who lead or facilitate change processes should promote active engagement of all people involved in the change and establish clearly outlined measures to evaluate the progress and outcomes of the change for safe and quality care.

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