Preceptorship: The Process of Guiding Reflection in Clinical Teaching and Learning

by

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Abstract

Since the 1970s, preceptorship has become the leading approach to clinical teaching in nursing programs across Canada, with 70 percent to 85.9 percent of North American baccalaureate nursing programs employing preceptorship programs. Considering the present faculty shortages, the benefits of preceptorship for student learning and development, the student demand, and the flexibility of implementing a preceptorship program to meet the needs of small, rural and northern clinical settings, the dependence on preceptorship for clinical teaching of nursing students will most likely increase. Thus, it became prudent to examine how preceptorship provides an effective learning environment. Although a considerable amount of research has been conducted concerning preceptorship, to date, no studies have been conducted specifically to examine the process involved in creating an environment conducive to student learning in the preceptorship approach to clinical teaching. Thus, a grounded theory method was utilized to examine the social psychological process involved in creating an environment conducive to student learning in preceptorship. Participants comprised nursing students, preceptors, faculty advisors and staff nurses were drawn from a small town in northwestern Canada.

Findings from this study revealed that a preceptored clinical learning environment is one which entails a process of *guiding reflection* which is informed by the following ambient conditions: a) the *balancing act*; b) *making time*; c) *belonging*; d) *paying tribute* and e) *grappling with challenges*. As a result of these findings, several implications for nursing education emerged. These include: 1) the process of guiding reflection is influenced by teaching/learning pedagogy and thus can be facilitated by a variety of educational theories such as those posited by Schön and Dewey. With that said, from a pedagogical perspective, it is important that

preceptorship be informed by a variety of educational theories that support the process of guiding reflection in the clinical setting; 2) considering the findings of this study demonstrate that all members of the nursing team with whom students participate in preceptorship have an enormous impact on the process of guiding reflection, it is incumbent upon nurse educators to develop and provide preceptorship orientations and preparatory sessions that are inclusive of all members of the nursing unit; and 3) taking into account one of the challenges that impeded the process of guiding reflection in the preceptorship was bullying, the preparation of nursing students in preceptorship settings requires an understanding of horizontal violence and how students can effectively identify and confront bullying behaviours.

Preface

This thesis is an original work by Vicki Zeran. The research project, of which this thesis is a part, received research ethics approval from the University of Alberta Research Ethics Board, Project Name “Preceptorship: Creating an Environment Conducive to Student Learning”, Study ID: Pro00020400, June 20, 2011.

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Chapter 1: Introduction

Context

Taking into consideration the fact that nursing is a practice-based profession, the quality of clinical nursing education for learners is elemental to successful preparation for a nursing career. In recent years there has been an emphasis on improving practice placements and student participation with adequate support and supervision for nursing students (Altmann, 2006). The quality of clinical placements constitutes the most significant influence on the learning process, with most student satisfaction being found in clinical practice (Cahill, 1996). Clinical practice placements represent the context in which theoretical perspectives learned in the classroom are applied to the realities of nursing practice. Thereby, clinical placements provide the student with the opportunity to expand their understanding of nursing experientially in the complex world of clinical nursing. Students are immersed in the work of nursing through a variety of clinical settings early in their education, acquiring beliefs, practices and behaviours which are role modeled by the professionals in the clinical practice setting (Croxon & Maginnis, 2009). Ultimately, students learn to be nurses by participating in the care of others.

According to Benner, Sutphen, Leonard and Day (2010) the clinical component of any professional education must ensure students acquire and use knowledge and science in their practice, use clinical reasoning and complex technical skills, and above all possess a good understanding of ethical behavior in a variety of nursing situations. Learning in the clinical environment provides the context for nursing students to develop the knowledge, skills, attitudes and values of a registered nurse (Gaberson, Oermann & Shellenbarger, 2015; Levett-Jones & Lathlean, 2008). Benner (1984) asserts, practical exposure to nursing care, with complex decision-making and interpretation of comprehensive clinical situations is mandatory for

expertise to flourish. Students are enabled to flourish in the clinical setting when nurse educators provide a safe environment in which students are inspired to creatively learn and think (Adelman-Mullally et al., 2013)

Experiential learning is a student-centered approach to teaching in which learners are actively engaged in building knowledge, skills, and competencies for professional practice (Peters, 2000). Student-centered approaches to teaching and learning, such as experiential learning, are derived from the tenets of constructivism in which learning is assumed to be best facilitated by providing students with opportunities to construct knowledge in the context of social environments (Young & Maxwell, 2007). In the constructivist epistemology, previous learning by students is considered a foundation upon which to modify, build, and expand new knowledge. Sociocultural influences in the learning process are valued. People build knowledge on previous understanding, thus new knowledge is continuously being developed. According to Fenwick (2003) constructivism posits that a learner constructs, through reflection, a personal understanding of meaning derived from his or her action in the world. Learners continuously adapt their understanding of the world based on their interpretation, perception and actions to situations surrounding them.

The pedagogy of experiential learning is viewed as an active process that does not occur in isolation, but rather occurs through person-environment interactions which extend beyond formal learning situations into life-long work experiences (Kolb, 1984). Experiential learning is dependent on an environment in which activities and feedback are bountiful and the opportunities for articulating and reflecting on the situations are deliberately planned (Benner et al., 2010). Many students perceive experiential learning in terms of clinical learning. The clinical setting is a place where students are able to reflect on what they do and make constant

adjustments to their personal knowledge, thereby allowing them to modify their actions as the clinical setting requires (Burnard, 1992). According to Kolb (1984), students can achieve higher levels of learning and educational outcomes when a climate conducive to learning is established, participative activity is structured, assessment and evaluation of learning needs is formulated, and learning activities are developed and implemented. A vital role in this preparation is that of preceptorship, an approach to clinical teaching and learning in which students are taught by professionals with practical and recent experience.

Since the 1970s, preceptorship has become the leading approach to clinical teaching in nursing programs across Canada (Myrick & Yonge, 2005). Myrick and Barrett (1994) found that 70 percent of Canadian university schools of nursing use preceptorship programs, and Altmann (2006) found that 85.9 percent of American baccalaureate schools of nursing employ preceptorship programs. Preceptorship is routinely used in the final year of undergraduate nursing programs to facilitate student acquisition of professional competence prior to graduating and becoming a registered nurse. Preceptorship is an experiential teaching/learning method, in which students (preceptees) are assigned to expert nurses (preceptors) in the practice setting, with the support of a university faculty member (faculty advisors). The preceptorship connects clinical practice with theory and fosters professional growth in students. The student is paired one-to-one with a registered nurse who, in addition to supervising and validating the students' actions, observations, and decisions (Bashford, 2002), is expected to support, teach, and exemplify safe and competent patient care while enhancing the student's socialization into the unit culture (McNiesh, 2007). The preceptor model is not only used as a means by which to bridge the connection between education and practice, it enables students to achieve confidence and facilitates the transition of student to professional nurse in their final program year (Bain,

1996). Furthermore, it is conceivable to employ preceptorship earlier in nursing programs to ensure students are exposed to the realities of clinical nursing with a knowledgeable and competent registered nurse in their beginning professional encounters.

Problem Statement

In the 1970s, according to Myrick and Yonge (2005), preceptorship was acknowledged as a viable teaching method and heralded as fulfilling a teaching void that nurse educators were unable to fill owing to the increasing demands of academia. As the demands for scholarship and research increased for nurse educators, their ability to provide clinical teaching decreased and the use of preceptorship expanded. It is conceivable to suggest, therefore, that as Canada endures a nursing shortage it will also encounter a shortfall of nurse educators and thus more reliance on preceptorship may occur. In 2009, 52.6 percent of nursing faculty were 50 years of age or older (Canadian Nurses Association & Canadian Association of Schools of Nursing, 2010), with only 0.2 per cent of the registered nurses in 2010 being educated at the doctoral level (Canadian Nurses Association, 2012). The Canadian Nurses Association and the Canadian Association of Schools of Nursing (2009) suggest that faculty retirement projections indicate a need for 3,673 nurses with master's degrees and 650 nurses with doctoral degrees annually. In 2009, 786 RNs graduated from master's program and 42 RNs graduated from PhD programs (Canadian Nurses Association & Canadian Association of Schools of Nursing, 2010). Considering the present faculty shortages, the benefits of preceptorship for student learning and development, student demand, and the flexibility of implementing a preceptorship program to meet the needs of small, rural and northern clinical settings, the dependence on preceptorship for clinical teaching of baccalaureate nursing students will most likely increase. It became prudent, therefore, to examine preceptorship with respect to the process involved in creating an environment

conducive to student learning. Although much research has been conducted regarding preceptorship, to date no studies have specifically investigated the social psychological process involved in creating an environment conducive to student learning, thus the impetus for this study.

Significance and Potential Impact

Student involvement in practice is one of the most important aspects of their educational preparation for entry into the nursing profession (Pellatt, 2006). Participation in a clinical setting is the means by which students acquire practical knowledge and learn to identify relationships in a situation, recognize the context of the actual situation, anticipate potential problems, and perceive the situation as a whole (Freiburger, 2002). According to Benner (1984) practical experience is mandatory for the development of expertise. Involvement with complex decision-making and interpretation of multifaceted clinical situations provides the foundation for expertise to flourish. Expertise can only occur when clinicians are able to test and refine ideas, assumptions, and theory based expectations in actual practice settings. A vital component for students to obtain knowledge and expertise in clinical practice is that of preceptorship, where students acquire the knowledge and know-how of nursing with the one-to-one assistance of professional nurses with practical and recent experience. The findings from this study have advanced nursing knowledge in the clinical context and have enhanced preceptorship as an approach to clinical teaching and learning. Specifically the findings have: a) added to the empirical evidence as to how preceptorship contributes to student knowledge and professional growth in the clinical setting; b) enhanced understanding of the complexities regarding the social psychological processes that occur in preceptorship; and c) augmented the teaching/learning practices inherent in preceptorship.

Underlying Assumptions

It is the belief of the researcher that:

1. Preceptorship: a) is grounded in constructivism in which nursing students construct a personal understanding of nursing which is derived from their involvement in the clinical setting; and b) requires an environment conducive to student learning which serves to facilitate the transition of nursing student to professional nurse in their final year of school.
2. The preceptor is critical to providing students with a safe and supportive environment in which they can learn and evolve as professionals.
3. In addition to being both responsible and accountable for his/her individual professional actions in the clinical setting, the student/preceptee is also responsible for communicating his/her learning needs and contributing to a positive relationship with the preceptor.
4. The faculty advisor is an important liaison between the educational and clinical practice environments and provides support, educational input and developmental activities for both the preceptor and the student/preceptee.

Purpose of the Study

The purpose of this study was to examine the social psychological process involved in creating an environment conducive to student learning in preceptorship.

Research Questions

1. In preceptorship, what is the process involved in creating an environment conducive to student learning in the clinical setting?
    a) How do preceptors perceive that they create such a learning environment?

b) How do students/preceptees perceive their preceptors create such a learning environment?

c) How do faculty advisors perceive that they contribute to creating such a learning environment?

2. How are preceptors supported in creating an environment conducive to student learning in the clinical setting?
3. How does the context in which preceptorship takes place contribute to a clinical setting conducive to student learning?

Chapter 2: State of Knowledge

Preceptorship

Preceptorship may be defined as a one-to-one reality-based, intensive, time-limited clinical experience in which the nursing student is taught directly by a staff nurse with the support of nursing faculty (Barrett & Myrick, 1998; Luhanga, Billay, Grundy, Myrick & Yonge, 2010). During the preceptorship the student is expected to gradually progress from shadowing the preceptor to assuming more responsibility for the care of the preceptor's patient assignment (Bashford, 2002). This arrangement is designed to ensure that students acquire practical knowledge with a role model and resource person who is immediately available to them in the practice setting (Myrick, 2002). Nehls, Rather and Guyette (1997) assert that nursing students value the one-to-one relationship with the preceptor inasmuch as it provides more time to learn to think as a practicing nurse. Preceptorship serves as a bridge from the relatively safe environment of the classroom to the reality of professional practice (Billay & Yonge, 2004). Thus, the preceptorship provides an opportunity to socialize students into the professional role of a registered nurse and enhances previous learning by enabling students to apply theoretical knowledge to current clinical situations which, in turn, leads to increased confidence in the provision of nursing care (Bashford, 2002; Byrd, Hood & Youtsey, 1997).

A substantial body of literature exists that supports the many benefits preceptorship affords nursing students in their transition from the student role to that of a professional nurse. The value of preceptorship in preparing students and novice nurses for clinical practice has been identified in numerous studies (Altmann, 2006; Chung, Wong & Cheung, 2008; Henderson, Twentyman, Heel & Lloyd, 2006; Lockwood-Rayermann, 2003; Rush, Peel & McCracken, 2004). The merit of preceptorship has been recognized as strengthening the students' knowledge

base and clinical skills (Hardyman & Hickey, 2001), improving critical thinking (Myrick, 2002; Myrick & Yonge, 2002), enhancing self-confidence (Freiburger, 2002; Gaberson et al., 2015), nurturing practical wisdom (Myrick, Yonge & Billay, 2010) and providing role socialization (Kaviani & Stillwell, 2000; McCarty & Higgins, 2003). The quantitative study undertaken by Henderson, Twentyman et al. (2006) compared three models of clinical learning which included the facilitation model, the clinical education unit model and the preceptorship model, and found that preceptorship was indeed highly valued by students. While the findings suggest students perceived that preceptorship afforded them the opportunity to build strong relationships with the preceptors, which supported their learning needs in the clinical setting, a significant limitation of this study was the fact that only 16 students responded from the precepted group compared to 269 and 114 from the other two groups. As well, students' perceptions of the clinical practicum may not have been based entirely on the type of model used for clinical learning as much as it was about the type of unit or kind of patients to which the students were exposed for their practical knowledge. This study may have been strengthened had the researchers controlled for the hospital unit variable. Although an earlier quantitative study conducted by Ridley, Spence-Lashinger and Goldenberg (1995) also suggests that preceptorship contributes significantly more to student competency development than their weekly clinical participation, the validity of the study must be questioned as the researchers used a convenience sample of 55 third year nursing students from the same community college versus a larger random sample.

It is widely accepted that during preceptorship, the preceptors and the students benefit from the shared interaction, with research findings indicating that the preceptorship model is a more effective means of creating a positive learning environment. One mixed method study conducted by Croxon and Maginnis (2009), however, found that students prefer the clinical

facilitator model over the preceptorship model. A major limitation to this study is that a convenience sample of 20 second year nursing students were recruited for the study, thus questioning the validity and transferability of the findings. In addition, the researchers did not expand upon their definition of preceptorship, thus leaving the reader with questions concerning whether they had truly utilized a preceptorship model for their investigation.

While preceptorship is regarded as an effective means of creating a positive learning environment, according to Ralph, Walker and Wimmer (2009), the implicit power differential that exists between the students and their preceptors must be recognized. When students are exposed to controlling preceptors (those who need to know every move of their students), in which they perceive their views are less important, rather than expend time and energy into the acquisition of nursing knowledge, they strive to maintain a quality relationship with their clinical educator as a means to mitigate the power differential (Best, 2005; Myrick & Yonge, 2004). Indeed, students view a quality relationship as the single most important factor related to clinical success. Although Myrick and Yonge corroborate that participants of preceptorship are cognizant of the inherent power differential, they also suggest that it is primarily at the discretion of the preceptor whether this differential is acted upon. It is important that preceptors be conscious of the intrinsic power that they possess with regard to their role of evaluator and ensure that they do not exploit the vulnerability of student learners. They must strive to ensure a learning environment that is democratic rather than oppressive, one that "cultivates rather than curtails, liberates rather than oppresses, and honors rather than dismisses" (Myrick & Tamlyn, 2007, p. 300). The preceptor's ability to create a supportive learning environment and establish a trusting relationship with students may be one important approach to mitigate the power differential that is inherent in the preceptorship (Best, 2005).

Preceptors. The preceptor is an essential member of the preceptorship triad in that they set the tone for an optimal learning environment. A preceptor is an experienced nursing professional who possesses excellent clinical skills and facilitates learning through caring, respect, compassion, understanding, nurturing, role modeling, and the use of excellent interpersonal communication skills (Crawford, Dresen & Tschikota, 2000; Gray & Smith, 2000; Öhrling & Hallberg, 2001). According to Ferguson (1996), nurses view the role of precepting as their professional responsibility to nurture new or incoming members. Preceptors believe that teaching students avails them of an opportunity to engage in professional growth and knowledge development, and gratification is achieved for being part of someone else's learning (Lillibridge, 2007). Ultimately, the preceptor engages in teaching, communicating and sharing the practical realities of being a registered nurse (Yonge, Hagler, Cox & Drefs, 2008a). The registered nurses with whom students work, on a day-to-day basis, are considered the single most important influence with regard to belonging, confidence building and learning (Charleston & Happell, 2005a).

The preceptor role is a crucial link among academic learning, practical skill acquisition, and student competence in assessment, intervention, and evaluation of patient care (Paton & Binding, 2009). Preceptors strategize how to support specific student learning goals, create safe learning environments, assure ideals of ethical practice, and evaluate student competence (Paton, Thompson-Isherwood & Thirsk, 2009). Two qualitative studies conducted by Bourbonnais and Kerr (2007) and Öhrling and Hallberg (2001) found that preceptors view their role as helping students to grow, protecting them by assisting them through difficult times, teaching them good decision-making, providing guidance and information, assisting in setting priorities, providing as many diverse situations as possible, and instilling a professional attitude. Considering these

studies were conducted six years apart and in different countries, Canada and Sweden, respectively; utilized different methods for data analysis, grounded theory and phenomenology, respectively; and were limited to one large teaching hospital each; it is encouraging that the findings were similar and preceptors viewed their role similarly regardless of the setting.

The teaching practices of role modeling, facilitating, guiding, and prioritizing are viewed as influential for learning to occur in the precepted environment (Coates & Gormley, 1997; Myrick, 2002). Byrd et al. (1997) and Coates and Gormley (1997) indicate that preceptors perceive knowledge and expertise as their greatest assets to student learning. They also acknowledge that approachability and possessing good communication skills is also imperative. Myrick (2002) found that preceptors who maintain a trusting relationship; use questions to direct, stimulate, and challenge the students' thinking processes; set the tone for learning; and promote discussion and evaluation of student learning are fundamental to the enhancement of critical thinking among nursing students. Furthermore, Carlson, Pilhammar and Wann-Hansson (2010b) found that preceptors were able to socialize their students into the world of nursing through role modeling professional behaviours such as the application of technical skills, administrative ability and a caring approach.

According to Kaviani and Stillwell (2000) and Yonge et al. (2008a), the attributes of a preceptor include: a) a willingness to share knowledge and skills with those entering practice; b) an understanding as to how nursing students integrate into a new practice setting; c) an ability to assist in the teaching/learning process; and d) the capability of facilitating the transition from pre-registration student to registered and accountable practitioner. Foy, Carlson and White (2013) and Smedley (2008) acknowledge that in addition to preceptors being knowledgeable about adult learning theories, various learning styles, and teaching and learning in a clinical

context, they must also display positive attitudes toward students and others in the workplace, and exhibit patience and a desire to motivate others to learn. Preceptors and nursing staff who demonstrate the attitudes of approachability, openness, consistency, genuineness and respect provide the bases of a caring relationship and create a supportive learning environment (Cahill, 1996; Heffernan, Heffernan, Brosnan & Brown, 2009; Yonge, Myrick, Ferguson & Luhanga, 2005). Furthermore, Hegenbarth, Raw, Murray, Arnaert and Chambers-Evans (2015) suggest that an ideal learning environment is one in which preceptors exhibit characteristics of openness, protectiveness and facilitation of the exchange of ideas and information.

Precepting a student involves valuing preceptees as individuals, and providing a safe and supportive environment in which they are sufficiently challenged (Crawford et al., 2000; Myrick, 2002). Haitana and Bland (2011), Hilli, Melender, Salmu and Jonsén (2014) and Sandvik, Eriksson and Hilli (2015) all concur that an environment in which caring and supportive relationships exist between the preceptor and student, enhances student learning and development. Spence-Laschinger (1992) suggests that an effective clinical learning environment should integrate reflective and conceptual approaches to learning to encourage nursing students to question and seek innovative approaches to patient care. Providing an effective learning environment offers nursing students a space for learning and time for reflection, thus creating a secure environment for learning to occur. The findings of a grounded theory study conducted by Yonge (2009), indicate that a successful relationship is developed and maintained when preceptors act in the capacity of a supervisor and friend, and respect the student's reasoning and emotions. She further suggests that honesty, respect, personality and attitude, rather than skill level, impact the preceptor/preceptee relationship. Although this study was conducted in a rural setting, the results are consistent with investigations that were conducted in larger urban areas.

The criteria most often used for selecting preceptors have been: clinical competence, commitment to the clinical preceptor role, excellent communication skills, use of the nursing process, responsible professional conduct, the ability to make decisions, and the ability to provide feedback (Altmann, 2006). Registered Nurses who demonstrate strong teaching skills are often encouraged to seek or accept precepting opportunities (Ferguson, 1996). Andrusyszyn and Maltby (1993) recommend that during the selection of preceptors, the emphasis should be placed on matching student learning needs with the knowledge and expertise of the preceptor. Students must feel adequately supported and accepted to ensure they utilize and maximize clinical learning opportunities (McBrien, 2006). The selection of preceptors to serve as role models for students should not be limited to clinical skill alone (Lockwood-Rayermann, 2003); the attitude and professional behaviours of the preceptor can have an important influence on student learning and the perceived worthiness of the clinical placement. Leners, Sitzman and Hessler (2006) identify that preceptors are chosen for their ability to provide high quality role modeling, for their ideal positive attitude toward nursing, and their ability to recruit for the health organization.

Based on the literature reviewed, the most compelling reasons for becoming a preceptor reveals that preceptorship affords an opportunity to teach and assist students to integrate into the nursing unit, provides the means to improve teaching ability, enables the sharing of knowledge and ideas, and offers the opportunity to gain personal satisfaction (Dibert & Goldenberg, 1995; Hyrkäs & Shoemaker, 2007; Stevenson, Doorley, Modderman & Benson-Landau, 1995; Usher, Nolan, Reser, Owens, & Tollefson,1999). Furthermore, Yonge, Myrick, Ferguson and Grundy (2013) found that some preceptors request to be assigned students owing to the fact that it provides a venue for mutual growth; not only do the students benefit from the relationship, but the preceptors learn new ideas and current practices. The Australian study conducted by Usher et

al. (1999) replicated the Canadian study conducted by Dibert and Goldenberg (1995), both of which had similar results. Although both had limitations owing to a convenience sample of 134 and 59 participants respectively, they both concluded that most preceptors portray a clear commitment to the preceptor role and believe that both material and non-material benefits are derived from acting in the role. The qualitative study undertaken by Stevenson et al. (1995) seemed to depict preceptors as having a more altruistic view of the benefits associated with the preceptor role, that is, satisfaction from sharing knowledge and expertise, stimulation of personal growth, honor and recognition, and gratification from observing the professional growth of the student.

Conversely, a variety of studies have identified the following as disadvantages of becoming a preceptor: the role is time-consuming, the workload is heavy, there is added stress due to the additional responsibility of monitoring someone else's actions, and the loss of patient contact (Coates & Gormley, 1997; Leners, et al., 2006; Stevenson et al., 1995). The literature is replete with studies which reflect that precepting can be stressful, with the most common reasons including workload, skill level of the student/preceptee, organizational support, and preceptor confidence (Elliott, 2002; Hautala, Saylor & O'Leary-Kelley, 2007; Lillibridge, 2007; Yonge, Myrick & Hasse, 2002). Moreover, Bourbonnais and Kerr (2007) and Kaviani and Stillwell (2000) suggest a lack of recognition by nursing staff and administration, and lack of support from faculty advisors contribute to a non-supportive preceptorship. For nurse preceptors to support, guide, and evaluate the learning and clinical competence of students in a manner that preserves students' professional integrity and esteem, patient safety, the objectives of academia, the policies within health care organizations, and the competencies identified by professional regulatory bodies; the academic institution, the health facility and colleagues must endorse and

champion the preceptor and preceptorship. Unfortunately this occurrence is not the reality for many preceptors; studies indicate that preceptors are neither adequately prepared nor supported to assume the role of preceptor.

In a quantitative study conducted by McCarthy and Murphy (2008), they found that, ultimately, preceptors are required to determine if a student is fit to practice, usually with minimal understanding of the undergraduate curriculum and evaluation criteria, minimal teaching expertise and lack of clinical or academic support. Overall, many preceptors are inexperienced, do not fully comprehend the assessment process and do not apply all of the university recommended assessment strategies when assessing students. The qualitative study conducted by Yonge, Myrick and Ferguson (2011b) resulted in similar findings in which preceptors indicated that providing informal, formative feedback to the student was much easier to deliver than providing the formal summative evaluation at the end of the preceptorship. They advised that they found the formal evaluation process especially challenging when dealing with unsafe students and identified the need for more support from faculty advisors. It is clearly articulated in the literature that preceptors have an ethical responsibility to address unsafe student practice, however, their ability to evaluate the students' progress and make recommendations is severely hampered when they are not supported by faculty (Earle-Foley, Myrick, Luhanga & Yonge, 2012; Luhanga, Myrick & Yonge, 2010).

While McCarthy and Murphy (2008) and Warren and Denham (2010) suggest that preceptor preparation programs are essential, Altmann (2006) and Yonge and Myrick (2004) advise that insufficient time is allocated to preceptor orientation, thereby devaluing the preceptorship. According to Heffernan, et al. (2009) and Henderson, Fox, and Malko-Nyhan (2006) the success of preceptorship orientation programs is dependent on both educators and

clinicians working in partnership and a supportive practice setting in which greater support is furnished through the provision of continuing education, effective scheduling, and adequate time for learning and providing feedback in the clinical environment. Although some limitations are noted with the Heffernan et al. study (i.e., the utilization of a new questionnaire), thus questioning the reliability of the results, and the response rate of 33.6% by the preceptors; Hallin and Danielson (2008), Hyrkäs and Shoemaker (2007), Yonge et al. (2008a) and Yonge, Myrick and Ferguson (2012) all had similar findings and concur that a quality orientation program which provides systematic support and assistance with evaluations, and acknowledgment of each member of the preceptorship, seem to increase the preceptors' confidence and critical awareness of the role. In addition, preceptorship orientation programs enhance preceptors' knowledge base, improve patient care, improve self-esteem, and increase awareness of self as a role model (Smedley, Morey & Race, 2010; Stevenson et al., 1995). Ultimately, preceptor preparation is ongoing and requires preceptor support networks, follow-up with education updates and ongoing evaluation (Kaviani & Stillwell, 2000).

Although a number of studies have recognized the importance of preceptor preparation and orientation to their role, further studies have determined that preceptors require a variety of supports to fulfill their responsibility. Henderson and Eaton (2013), Mårtensson, Engström, Mamhidir and Kristofferzon (2013), McCarthy and Murphy (2010) and Omansky (2010) found that preceptors require feedback concerning their performance and additional support and recognition from managers and colleagues with regard to the complex and challenging role of the preceptor. A mixed methods study conducted by Panzavecchia and Pearce (2014) discovered that preceptors suggested a lack of preparation and increased workloads resulting in a lack of time, contributed to feelings of frustration and ultimately, presented as barriers to an effective

preceptorship. Although many limitations are noted in this study (i.e., the selection of 30 preceptors from three hospital sites, rather than a random sample; the utilization of a new unpiloted questionnaire; and only five of the thirty participants agreed to one interview) many researchers agree that preceptor preparation and a reasonable workload is crucial to a successful preceptorship (Hallin & Danielson, 2008; Hautala et al., 2007; Kalischuk, Vandenberg & Awosoga, 2013; Madhavanpraphakaran, Shukri & Balachandran, 2014; Myall, Levett-Jones & Lathlean, 2008).

Students/Preceptees. Positive outcomes for nursing students engaged in a preceptorship relationship are well documented. The identified benefits emerging from the literature include: being self-directed, learning new nursing skills and organizational activities, applying nursing knowledge and skills to patient care activities, and increasing and expanding nursing knowledge and social skills in the clinical setting (Atack, Comacu, Kenny, LaBelle & Miller, 2000; Chung et al., 2008; Kim, 2007; Merrill, 1998). Indeed, student confidence and competence increases as a result of preceptorship, whereby students are enabled to consolidate their skills and familiarize themselves with the role of a registered nurse.

The primary role of the preceptee is that of learner and collaborator (Lambert & Lambert, 2004). As a learner, the onus is on the preceptee to be both responsible and accountable for their professional actions in the clinical setting. The findings of the study conducted by Gidman, McIntosh, Melling and Smith (2011) suggest that students believe it is their responsibility to learn and acquire new skills, act professionally, be accountable and provide quality care for their patients. Furthermore, as a collaborator, the student is responsible to contribute to a positive relationship with the preceptor and communicate learning needs and patient concerns in a timely and proactive manner. Positive relationships with preceptors prepare students for the realities of

the professional world of nursing practice and enhance student learning in the clinical setting (Atack et al., 2000; Yonge, Krahn, Trojan, Reid & Haase, 2002). Pront, Kelton, Munt and Hutton (2013), likewise found that both the student and preceptor highly valued the positive relationship and expressed that it was the most significant relationship with respect to student learning. A learning environment in which positive interactions are promoted and in which there is a caring sensitivity and a committed attitude serves as an incentive for success. Bain (1996) suggests that the attitude of the preceptors and hospital nursing staff is critical to socializing students into the hospital setting and assisting them to adjust to their new role. Poor staff relationships, negative attitudes, and a lack of acceptance contribute to students' negative perceptions of the clinical learning environment and threaten the student's self-concept (Ralph et al., 2009).

As acknowledged in a variety of studies, students identify ineffective preceptors as those who break promises, lack knowledge and expertise, have poor teaching skills, are unapproachable, are intimidating, are impatient, are judgmental, have unrealistic expectations of students and delegate their unwanted tasks to students (Gray & Smith, 2000; Ralph, et al., 2009). According to Ralph, et al. students perceive they receive unfair evaluations because the faculty advisors provide the final grade; however the results of a study conducted by Ferguson and Calder (1993) suggest that, generally, preceptors and educators use similar nursing values when evaluating the acceptability of a student's clinical performance. Thus students can be assured evaluations are fair when faculty advisors and preceptors collaborate with respect to student evaluations within the preceptorship model. Furthermore, a study conducted by Yonge, Myrick and Ferguson (2011a) revealed that students found the informal evaluation or feedback received from the preceptor as ongoing dialogue was far more valuable than the formal mid-term and final

evaluation. Some students further articulated that they found the formal evaluation process to be completely redundant following regular and effective feedback.

Numerous researchers have reported students' perceptions of effective preceptors. Cahill (1996) and Gray and Smith (2000) suggest students recognize superior preceptors as genuine, enthusiastic, friendly, approachable, patient, understanding, and respectful. In addition to those findings, Kelly and McAllister (2013) and Tang, Chou and Chiang (2005) found that students respect and value preceptors who have a sense of humor. Students also identify helpful nurses as those who are welcoming, supportive, and who do not take over a clinical situation (Atack et al., 2000; Merrill, 1998). Furthermore, students pronounce effective preceptors as being professional, organized, good communicators, caring, self-confident, they involve the student in activities, make an effort to spend time with students, are genuinely interested in the student, have confidence and trust in the student's abilities and gradually withdraw supervision as the student progresses through the practicum (Gray & Smith, 2000; Zilembo & Monterosso, 2008). Students perceive effective preceptors and faculty advisors as those who support them in their learning endeavors, are willing to share knowledge and expertise, and treat them as team members (Ralph, et al., 2009). Similarly, Cope, Cuthbertson and Stoddart (2000) and Vallant and Neville (2006) report that student acceptance into the workplace culture could increase student confidence, thereby increasing professional competence. Öhrling and Hallberg (2000b) conducted a phenomenology study and suggest, in keeping with the findings of other researchers, that effective preceptors create a space for learning in which students feel secure, thus allowing them to reflect on what they are doing so they can learn, grow, mature and acquire professional competence. Öhrling and Hallberg should be applauded for the rigour employed in their study.

As the literature supports, maintaining a trusting relationship is pivotal to creating an optimal teaching/learning environment for students to learn and grow as professionals. Registered nursing staff, nurse managers, and patients have an enormous influence on student satisfaction within the clinical learning environment (Koontz, Mallory, Burns & Chapman, 2010; Pearcey & Elliot, 2004). Students feel more empowered and enabled to capitalize on the available learning opportunities when they are acknowledged as having a legitimate place in the nursing team. Students prefer nursing units in which they are recognized for their individuality and are permitted some degree of flexibility within sensible limits, as compared with highly structured wards with a rigid and strict hierarchical system (Chan, 2004; Kim, 2007). Being acknowledged, included in unit activities, and engaged in a nurturing relationship with the preceptor generates positive feelings and provides the nursing student with the confidence to enhance their learning (Chan, 2004; Sedgwick & Rougeau, 2010; Vallant & Neville, 2006). It is recognized that the values, beliefs and attitudes of educators, regardless of whether they are professors, clinical instructors, or preceptors, are paramount to the feelings of alienation expressed by nursing student. Attention to educational strategies which address the adverse incidents students encounter must focus on relational development which can support and sustain the nursing students in the educational process (Wilson, Andrews & Leners, 2006).

Myrick and Barrett (1994) suggest students often encounter communication and interpersonal problems with their preceptors that can lead to conflict if left unresolved. Mamchur and Myrick (2003) found students and preceptors in nursing reported less conflict than in other faculties; however the incidence of conflict was greater than anticipated. While students determined conflict was related to preceptor expectations and/or personality, preceptors alleged that conflict occurred when they perceived a lack of competency on the part of the student

related to the student's: a) inability to demonstrate knowledge and skills; b) poor attitude; c) unprofessional behavior; and d) poor communication skills (Luhanga, Yonge & Myrick, 2008a; Mamchur & Myrick, 2003). The results of a study conducted by Byrd, et al. (1997) depict the importance of effective communication between preceptor and preceptee to ensure successful partnerships develop. It is somewhat interesting when students and preceptors identify conflicting factors that contribute to a positive learning situation, for example, preceptors identified the ability to give and receive constructive feedback and clinical competences as being the most important; whereas students identified these factors as being the least important. Students highlighted knowledge of the preceptorship process and compatibility as the most important factors, whereas these were considered the least important for preceptors. These findings highlight the importance of members of the preceptorship to convey role and performance expectations to one another prior to the commencement of the practical placement.

Faculty Advisors. The faculty advisor, as a member of the preceptorship triad, is the university professor assigned to the preceptor and student and is responsible for providing the critical communication link between the educational and practice setting. The role of the faculty advisor is designed to contribute to the learning environment by providing support, educational input and developmental activities, and to ensure that nursing students are provided a valuable learning experience during practice placements (Carlisle, Calman & Ibbotson, 2009; Yonge, Ferguson, Myrick & Haase, 2003; Zawaduk, Healey-Ogden, Farrell, Lyall & Taylor, 2014). Faculty advisors are essential in creating relevance for students, helping them apply theoretical knowledge to practice situations, and bridge the ideal with the real (Corlett, 2000). Faculty advisors also play a pivotal role in ensuring the participants of the preceptorship are cognizant of the teaching/learning process in the clinical setting. Preceptors perceive faculty members to be

the best source of information concerning program expectations and realistic student performance for patient care. Hsieh and Knowles (1990) suggest that faculty advisors facilitate the relationship between preceptor and preceptee by encouraging both the student and the preceptor to express their concerns, frustrations, and successes; they help alleviate student anxiety, ease the adjustment period, and help the preceptor to develop sensitivity to the student's stresses and concerns. A study conducted by Ferguson (1996) emphasizes the importance of faculty accessibility prior to and during the preceptorship; however, preceptors preferred that advisors make periodic visits rather than extended visits on the unit. When faculty members were present for extended periods, preceptors conveyed it interfered with the preceptor/preceptee relationship, as students would revert to the previous faculty/student clinical relationship at the expense of the preceptorship relationship.

Albeit, many researchers posit that faculty advisors are essential for the success of the preceptorship, a number of studies have highlighted the difficulties preceptors and students encounter when the faculty advisor is not available or accessible. A mixed methods study conducted by Broadbent, Moxham, Sander, Walker and Dwyer (2014) found that preceptors perceived a lack of support from faculty advisors and expressed they required more information regarding the process of preceptorship prior to commencement of the practicum. They articulated the importance of the faculty advisor being more available during the preceptorship and that it is incumbent upon the university to provide preceptorship preparation. Although some limitations are noted with this study, for example, a purposive sample strategy, a response rate of 28%, and a survey method which permitted participants to express their ideas about their endeavours with precepting nursing students, a number of researchers agree that faculty involvement in preceptorship needs to be increased and improved to meet the learning needs of students

(Bourbonnais & Kerr, 2007; Luhanga, Dickieson & Mossey, 2010; Luhanga, Yonge & Myrick, 2008b; Sedgwick & Yonge, 2009). However, as articulated by Myrick, Caplan, Smitten and Rusk (2011) and Zournazis and Marlow (2015), the use of e-learning technology could enhance information sharing, networking and support for preceptors in general, but particularly for members of the preceptorship triad who reside in rural or remote areas of the country.

Summary

Although there is an abundance of literature regarding preceptorship, much of it is anecdotal and academic in nature. Of the published research articles, many of the studies reviewed were methodologically sound, whereas, others were limited by sample size and a lack of overall rigour. While the majority of studies focused on the benefits of preceptorship, the attributes of preceptors, reasons for becoming a preceptor, challenges of being a preceptor, preceptor preparation and student perceptions of the preceptorship, there is limited research studies with respect to the role and contribution of faculty advisors and the student/preceptor conflicts that may occur within the preceptorship. Even more surprising is the lack of research which specifically investigates the social psychological process involved in creating an environment conducive to student learning in the precepted clinical placement, thus the impetus for this study.

Chapter 3: Method

Research Design

The underlying supposition of grounded theory is symbolic interactionism (Wuest, 2007); a theory regarding human behaviour and an approach to inquiry regarding human conduct and group behaviour. Essentially, it is a frame of reference for understanding how humans, in collaboration with one another, create symbolic worlds and how these worlds shape human comportment (LaRossa & Reitzes, 1993). As articulated by Blumer (1969), symbolic interactionism is derived from three suppositions: 1) people act toward a situation on the basis of meanings that they ascribe to that situation; 2) meaning is derived from social interaction; and 3) meaning is ascertained through an interpretive process employed by the individuals involved in the situation. Thus, symbolic interactionism focuses on the connection between shared meanings and interaction in a social environment.

As people discern the meaning of phenomena, they do so in the context of social interaction. "Social interaction is a process that forms human conduct instead of merely being a means or a setting for the expression or release of human conduct" (Blumer, 1969, p.8). As individuals participate in situations or events, it is not necessarily the factors of the situation to which they react, rather, it is primarily in response to the meaning people ascribe to such events. In other words, meaning is derived through interaction with others, in which people act towards each other in relation to the phenomena for which meaning is being generated. And, not only do people acquire meaning from social interaction, they likewise derive meaning from the process of self-reflection. According to Blumer (1969), self-interaction, otherwise known as self-reflection, is a process by which individuals are able to engage in self-talk, a mechanism which is used to form meaning or guide conduct. Overall, as individuals strive to understand or make

meaning of situations or events, they continually engage in the process of defining and interpreting phenomena, through a process of conversing with one's self and interacting with others.

In keeping with symbolic interactionism, grounded theory allows for the identification of social, emotional, and/or cognitive change as it emerges by focusing on what is going on in a particular social context (Wuest, 2007). It explains what is actually happening in practical situations at a particular time, rather than describing what should be happening (McCallin, 2003). Grounded theory is a means to understand how people actively construct and reconstruct the meaning of their lives in light of their circumstances (MacDonald & Shreiber, 2001). It is an inductive process of data collection in that the researcher has no preconceived ideas to prove or disprove. Rather, issues of importance emerge from the narrative of the participants (Ghezeljeh & Emami, 2009). Grounded theorists endeavour to interpret and construct the order embedded in the process of interaction, as revealed through the data, in order to construct a plausible theory (MacDonald & Shreiber, 2001). Glaser and Strauss (1967) identify theory generation as a process that should be used with the assumption that theory is an ever developing entity, not a finished product. They acknowledge that the meanings assigned to data by the researcher are not fixed representations of truth but are temporary moments in an ongoing process of interpretation.

Grounded theory was used to conduct this study not only owing to the fact that it enabled the researcher to recognize patterns of behaviour and is a method which has been firmly established over the past three decades as being relevant to the evolution of nursing science (Hutchinson & Wilson, 2001), but most significantly because it offered a qualitative approach that took into account the participants' sociocultural context and the meaning they ascribed to the preceptored process in which they were engaging. Moreover, grounded theory offered a

systematic, legitimate method to study the richness and diversity of human encounters, interactions, and meanings to generate a relevant, plausible substantive theory that could be used to understand the reality of problems and processes (Glaser, 1978). This particular method best answered questions about the process involved in creating an environment conducive to student learning in the preceptored clinical setting, a process which focused on the specific perspectives of participants, through analyses and identification of complex social processes.

The grounded theory research approach captured social processes in social context, and was most useful for the researcher to develop a model that explained human behavior in the context of preceptorship (Glaser, 1978). This grounded theory study resulted in the generation of a model with concepts connected together in explanatory relationships that elucidated how participants resolved their basic social problems, while accounting for the variation in the data (Schreiber, 2001). Glaser (1992) maintains that the theory must have fit, in that the categories of the theory must fit the data; must be relevant because it represents what is going on in the area of inquiry; must work because it explains, predicts, and interprets what is happening in the area of inquiry; and must be modifiable in that it has the capacity to change in response to new data. The resultant substantive model, as generated by the data provided insights and understanding into the major behavioural and interactional variations of students, preceptors, faculty advisors, and staff nurses in their endeavour to create a preceptored environment conducive to students' growth and development to that of a professional nurse.

Sample and Setting

Sampling within grounded theory is described as theoretical rather than purposeful in that it is driven by the emerging theory (Glaser, 1978). According to Morse (1995) the selection of an adequate and appropriate sample is critical in qualitative research and that the ensuing research

results are contingent upon the appropriateness of the sample. The sampling process in this study was initiated by interviewing individuals who had the knowledge and expertise relevant to the preceptorship phenomena, were able to reflect and were able to articulate their ideas (Cutcliffe, 2000). Since the researcher was concerned about uncovering the processes embedded in the social context of the phenomenon being studied, it was important that the participants selected for the study shared and were engaged in the same social processes. According to Glaser and Strauss (1967), if the intention is to develop a substantive theory, then sampling is narrow and data are collected from participants of the same substantive type. Whereas, if the researcher is concerned about inducing a formal theory, then sampling becomes more broad and data are collected from diverse, dissimilar groups. Considering this study was concerned with a particular model of clinical teaching and learning vis a vis preceptorship, the sample of participants was narrow and included only individuals from the nursing profession.

In keeping with the grounded theory method, the researcher collected data by theoretical sampling until theoretical saturation was achieved (Glaser & Strauss, 1967); therefore the number of participants was not fixed at the outset. Although sample size was determined by the data generated and analysis of such, Morse (1998) suggests 30 to 50 interviews are needed in a grounded theory study. Participants were recruited through information posters placed throughout the hospital and the university (Appendix A). In addition, a university instructor organizing student placements approached the students, preceptors, faculty advisors and staff nurses regarding the opportunity to participate in the study. She provided them with some detail about the study and researcher contact information. When potential participants displayed interest in participating they were encouraged to correspond with the researcher.

Participants in the study were recruited based on the following criteria, they: a) spoke and understood English; b) were current or recent preceptors for the fourth year students of the university undergraduate nursing program; c) were current or recent students in the fourth year of the undergraduate nursing program and assigned to a preceptor for their final clinical practicum; d) were current or recent faculty advisors assigned to preceptors and students during the final clinical practicum of the undergraduate nursing program; and e) were current or recent nurses working in the clinical setting where preceptorship took place. As a caveat, recent was interpreted as participation in the preceptorship within one year of commencement of the study. Once participants met with the researcher and agreed to take part in the study they received an information letter (Appendix B) and were offered an opportunity to discuss any questions or concerns they had about the study. In addition, after review of the consent form (Appendix C), both the researcher and the participants signed the consent.

A final sample of 16 participants were recruited for this study; six students, five preceptors, three faculty advisors, and two staff nurses. Each participant was interviewed two times for a total of 32 interviews. All of the students were female and ranged in age from 20 to 30 years, with the exception of one student who was 31 to 40 years of age. Four of the students were successful in being assigned to their first choice of clinical placement, whereas two students received their second choice of placement for their senior practicum. All of the preceptors were female, with the exception of one male. Their ages varied with one preceptor being between 20 and 30 years old, two being between 31 and 40 years, one 41 to 50 years and one 51 to 60 years. All of the preceptors were prepared at the baccalaureate level with the exception of one who was prepared at the diploma level. Two of the preceptors had less than three years of nursing experience, one had less than five years of experience and two had over 20

years of experience. The two preceptors with less nursing experience were precepting for the first time, whereas the three other preceptors had precepted 6 to 18 times. All of the faculty advisors were female, with two ranging in age between 41 and 50 years and the other ranging between 51 and 60 years of age. Two of the faculty advisors were educationally prepared at the baccalaureate level and one was prepared at the master's level. Two of the faculty advisors had in excess of 27 years of nursing experience and one had seven years of experience. The advisor with the most nursing experience also had the most teaching experience, totaling 23 years. The other two advisors had less than six years of teaching experience. Both staff nurses ranged in age between 20 and 30 years; one was female, the other male; they both had less than five years of nursing experience; and both were baccalaureate prepared. Although the staff nurses who participated in this study had never fulfilled the role of preceptor, they had worked on the same rotation as the preceptorship triad approximately five times. Furthermore, both of the staff nurses who participated in this study were employed on different units within the hospital, however, they worked the same rotation as that of the preceptor and thus interacted with the student and the preceptor consistently throughout the preceptorship.

The hospital where the preceptors and staff nurses were recruited consisted of 40 beds and was located in a small town in northwestern Canada with a population of approximately 5000; was funded through the regional health authority; employed approximately 70 registered nurses; and provided care for a diverse population of which approximately 50% were of Aboriginal descent. The hospital consisted of four units where students completed their fourth year final practicum with their assigned preceptors. The units included the Emergency Room, the Obstetrical Unit, and the Acute Care In-Patient Unit.

Data Collection

Theoretical sampling was the process of data collection whereby the researcher simultaneously collected, coded, and analyzed data, and decided what data to collect next in order to generate the emergent grounded theory (Glaser & Strauss, 1967). This process of data generation, also known as constant comparative analysis, commenced with the first interview and continued into the analysis phase of the research process (Speziale & Carpenter, 2007). As new data emerged they were compared to existing categories as it related to the evolving theory. The process of theoretical sampling took place by interviewing new participants who had relevant experiences, by making comparisons to data already collected, and by returning to participants to member check and ask new questions (Glaser, 1978).

Data were collected via semi-structured interviews at a mutually agreed upon time and location. Each interview was digitally recorded and ranged from 16 to 85 minutes. An interview guide comprised of open-ended questions (Appendices D, E, F and G) was utilized during data collection. These questions served as a beginning guide only and were revised as data emerged. Field notes were prepared after each interview and documented what the researcher heard, saw, thought, or encountered during the interviews. Field notes were notations made by the researcher and described observations and assumptions about what was being heard or observed, or a personal narrative about what the researcher perceived during a particular encounter; they then became part of the data analysis (Speziale & Carpenter, 2007). In addition to interviews and field notes, demographic data were obtained from all participants prior to their interviews (Appendices H, I, J and K).

Data Analysis

Data analysis in this grounded theory study was aimed at generating a theoretical, as opposed to a descriptive, account of patterns of behaviour in the learning environment (Wuest, 2007). While conducting the grounded theory analysis, the researcher constantly scrutinized the data for the main concern or problem for the participants and for the substance of what was going on in the data (Glaser, 1978). The essential relationship between data and theory was a conceptual code. There were basically two types of codes generated: substantive and theoretical.

Substantive coding involved two levels of coding: open coding and selective coding. Open coding was a detailed grounding of systematically analyzing data sentence by sentence using constant comparative analysis until a core variable emerged (Glaser, 1978). It involved the process of breaking down the data into discrete parts, in order to conceptualize and categorize codes (McCann & Clark, 2003). Patterns in the raw data were coded or designated conceptual labels through examination of the data line-by-line. This process of open coding generated approximately 873 substantive codes. The two types of substantive codes reflected in the data included: a) those from the language of the people who were interviewed, which are referred to as in vivo codes, for example, *"she guides the situation if you do not understand," "reflect on what you have done, what you have learned, how you can improve,"* and *"it is not my job to tell them how;"* and b) implicit codes, constructed by the researcher which were derived from the concepts generated from the data, for example, *"safe to ask questions," "part of the team," "like a sponge"* and *"puzzles pieces"* (Speziale & Carpenter, 2007). The goal of open coding was to generate an emergent set of categories and their properties which fit, worked, and were relevant for integration into a substantive theory (Glaser, 1978). A number of questions guided the researcher with the substantive coding process, for example: What is going on within the process

of creating a preceptored clinical learning environment? What does the data indicate and how does it fit with the categories? What are the basic social psychological processes happening or occurring in the preceptored clinical learning environment?

The second feature of substantive coding involved selective coding, which described or generated the central theme or core variable, in this case *guiding reflection*. The main process at this stage of analysis was to examine the relationships between and among the categories (Schreiber, 2001). Coding was restricted to only those categories directly related to the core variable, which assisted in directing the researcher in additional data collection and theoretical sampling. The researcher formulated hypotheses or hunches and tested them through further data collection and analysis. Analysis of data from ongoing interviews was focused to purposefully develop and integrate the model (Glaser, 1978). In addition to interviews, the researcher consulted the literature as a means to determine similarities and differences with the emerging substantive model. This literature review was guided by the emerging theoretical concepts (Wuest, 2007). Data collection continued until the data being collected did not produce any new variation in the emerging model. The resultant model which emerged from the data, was constructed around the core variable, *guiding reflection*, and accounted for the pattern of behaviour as identified by the participants in this study. A number of questions guided the researcher with the selective coding process: What is the basic social psychological process going on in the preceptored clinical learning environment? What is the focus of the study and the relationship of the data to the study?

Once the first level of coding was complete, the second level, known as theoretical coding began. This phase of coding involved putting the data back together in a different way, through categorizing the data and making links between a category and its substantive codes.

Theoretical codes focused the researcher to enable her to conceptualize how the substantive codes related to each other as interrelated hypotheses which accounted for resolving the main concern as identified by participants (Glaser, 1998). A challenge for the researcher during the analysis phase of the study was to know if a thought originated from the researchers' understanding or from that of the participant. The choice of which facts and lines of inquiry to follow and which not to follow were guided, to some extent, by the researcher's subconscious perceptual and intellectual ability (Cutcliffe, 2000) and the researcher's ability to process theoretical memos.

Theoretical memoing was a vital part of the analysis and emphasized the researcher's thought processes and ideas. It comprised the ongoing written account of ideas and questions that occurred to the researcher throughout the process of data collection and analysis (Schreiber, 2001). It preserved the emerging hypotheses, analytical schemes, hunches, and abstractions during the process of theory development (Speziale & Carpenter, 2007). Foundational to generating theory was the constant process of writing theoretical memos, which commenced at the beginning stages of coding the data and carried through to the development of the substantive model (Glazer, 1978). Memo writing captured the operational and analytical thinking of the researcher as she endeavoured to complete all aspects of the grounded theory study.

From the onset of the study the researcher reflected upon her pre-existing assumptions and relationships with the participants of the study. This type of reflection ensured that the researcher was able to stay true to the data and not to influence the data collection process. Through memo writing the researcher was able to make note of ideas and substantiate hunches regarding the data. Capturing the operational data through memo writing allowed the researcher to better understand how to progress with data collection, for example, the researcher considered

the following questions: How can I draw out information from participants who are hesitant to share their stories? How can I better reveal the substance of what participants are conveying? When is the best time of day to interview preceptors, considering they work twelve hour shifts? As the researcher engaged in analytical memo writing, a number of other questions guided the process: What is going on with the codes? What is the relationship between codes? How does one code affect another code? What codes constitute categories? How do the categories fit with the core variable?

As one engages in qualitative research, it becomes incumbent upon the researcher to safeguard the rigour of the study. Rigour is a means of demonstrating the legitimacy of the research process and ultimately ensures that the data collected represents the reality of the situation.

Rigour

The four criteria in which rigour in this qualitative research study was ensured included credibility, fittingness, auditability and confirmability (Chiovitti & Piran, 2003). Credibility, also known as trustworthiness of the findings, included activities that increased the probability that credible findings were generated (Lincoln & Guba, 1985). One of the best ways credibility was established was through the process of constant comparative analysis and prolonged engagement with the subject matter. Secondly, member checking was completed to ensure credibility. Considering member checking is the single most important criterion to ensure creditability of the findings of this study, the researcher summarized the findings of the first interviews and shared these findings with each participant during the second interview. The participants were asked whether the researcher had captured the intent of what the participants conveyed or to clarify if they perceived the researcher had misinterpreted what they had intended to say. Throughout the

process, the researcher sought feedback from the participants as to the accuracy of the themes and findings of the study.

Fittingness or transferability refers to the probability that the study findings have meaning to others in similar situations (Speziale & Carpenter, 2007). Ensuring transferability in this grounded theory study involved comparing study findings to the current literature. By highlighting similarities between the findings of this study and previous theoretical constructs in the literature, it was possible to illustrate the potential transferability of these findings to other situations in nursing education (Chiovitti & Piran, 2003).

Auditability refers to the manner in which the researcher carefully documented the conceptual development of her project over time (Speziale & Carpenter, 2007). The recording of activities, such as written material, code development/selection notes, field notes and memos, also referred to as an audit or decision trail, enables other researchers to reconstruct the process by which this researcher reached her conclusions (Morse, 1998). The objective of auditability was to illustrate as clearly as possible the evidence, decisions, and thought processes at every stage of data analysis that led to the study conclusions (Chiovitti & Piran, 2003).

Confirmability of a study is ensured when credibility, fittingness, and auditability are established and demonstrated throughout the course of the research process. Throughout this study, strategies such as memo writing, field notes, theoretical sampling, constant comparative analysis and guidance from the researcher's supervisor contributed to enhancing the rigour of this investigation.

Ethical Considerations

This study received ethical review and approval from the research ethic boards of two universities. In addition, permission to conduct interviews with the preceptors was granted by the

local regional health authority. Not only did this study receive ethical approval, the researcher ensured that the ethical principles of autonomy, beneficence, and justice were maintained at all times throughout the process. To safeguard the principle of autonomy, participant participation was voluntary and the researcher obtained informed consent prior to commencement of data collection. Further, participants who chose to take part in the study were informed: a) that their participation was completely voluntary; and b) it was entirely within their right to withdraw from the study at any time without fear of reprisal. Participants were aware they could refuse to answer any question or refuse to discuss any topic, and could request to have the digital voice recorder turned off at any time during the interview. Participants were treated with dignity and respect and their wishes were respected at all times.

Using the principle of beneficence ensured participants were not harmed in any way during the research process. Although there were no identified risks for participating in this study, if the researcher sensed that the interview was causing emotional discomfort, participants were given the option of discontinuing the particular course of inquiry that may have caused undue stress. In addition, the principles of beneficence and justice were preserved when the researcher confirmed confidentiality and anonymity were respected (Speziale & Carpenter, 2007). To ensure confidentiality, the digitally recorded interviews were stored in a locked cabinet in the researcher's office when not in use for transcription purposes. During transcription the data were temporarily stored on the researcher’s laptop, which was password protected, and then stored on a USB memory stick, all of which were stored in the locked cabinet in the researcher's office. As well, all field notes and memos were locked in the same cabinet. To protect anonymity, the participant’s name or any other identifier did not appear on any document; rather initially codes and then pseudonyms were assigned to each participant and such

codes were used on all documents that pertained to the study. The document linking the participant's name with his/her code was stored separately from the digital recordings, transcriptions and field notes, in a locked filing cabinet within the researcher's locked office.

Once data analysis was completed and dissemination of the findings began, all digitally recorded transcriptions were deleted from the researcher's laptop and all USB memory sticks storing recorded interviews, field notes and memos were stored in the locked cabinet in the researcher's locked office. As required by the General Faculties Council (GFC) Policy 96.2 Research and Scholarship Integrity Policy the stored data will be kept secure for a minimum of five years and all documents containing identifiers and the participant linking codes have been destroyed to protect the anonymity of the participants.

Dissemination of Findings

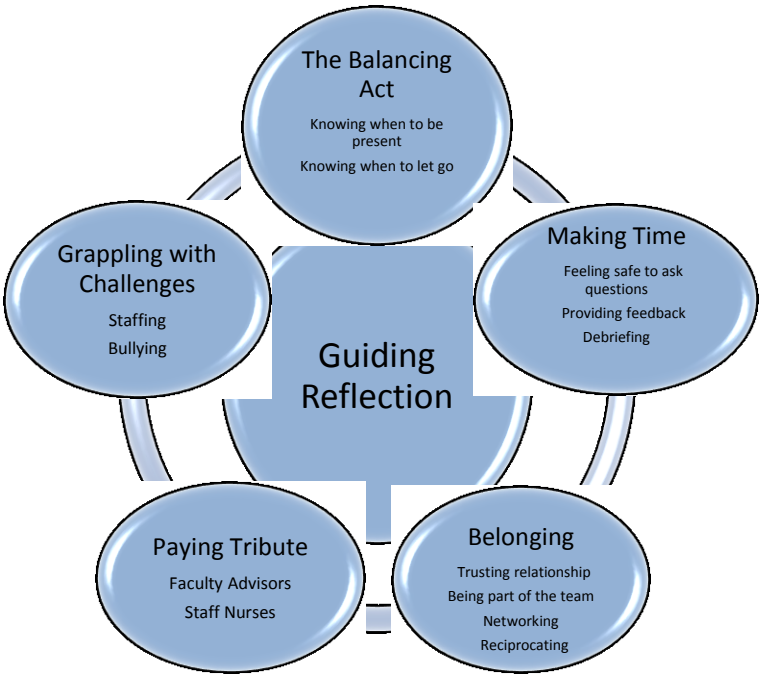
To date, presentations of preliminary findings have been made at a number of local, provincial and national conferences. The final results of the research findings will be shared with the participants in the study as well as with the regional health authority. Papers will be submitted for publication in refereed journals such as the Journal of Nursing Education, International Journal of Nursing Education Scholarship, Journal of Advanced Nursing and Nurse Education Today. Furthermore, given the nature of the study, the findings will also be shared with those in academic environments and practice settings in which preceptorship takes place.

Chapter 4: Findings and Discussion

Guiding Reflection

Through analysis of semi-structured interviews conducted with preceptors, nursing students, staff nurses and faculty advisors, concepts and relationships surfaced that explained what was occurring in the preceptored clinical learning environment. Foremost, *guiding reflection* emerged from the data as the social psychological process involved in creating an environment conducive to student learning in the preceptorship experience. The findings of this study revealed that a preceptored clinical learning environment is one which entails a process of *guiding reflection* which was informed by the following ambient conditions: a) *the balancing act;* b) *making time;* c) *belonging;* d) *paying tribute;* and e) *grappling with challenges* (Figure 1.0).

Figure 1.0: Preceptorship: Guiding Reflection in Clinical Teaching and Learning



Intrinsically, the process of *guiding reflection* is informed by the concept of reflective learning, which is derived from the theory of experiential learning as pioneered by Dewey in the 1930s. Learning, as conveyed by Dewey (2011 *version*) encompasses a purposeful self-guided activity in which the learner interacts with the world and interprets situations and/or events. He further asserts that reflection is essential for a genuine educative encounter. Dewey posits that reflection is dependent upon the following criteria: a) a continuous activity or situation; b) a genuine problem within the situation; c) student possession of the requisite knowledge and ability to assess the situation to manage the problem; d) capability on the part of the student to think about possible solutions to the problem; and e) student opportunity for applying possible solutions to the situation, thereby validating her/his ability to solve the problem. As such, genuine reflection permits a student to assess a situation, critically think about options and discover a new idea or conclusion. Ultimately, reflective learning enables students to make connections and consider implications, a process which inevitably enhances the meaning of the learning event.

While the process of *guiding reflection* evokes Dewey's theory of experiential and reflective learning, it also resonates with the work of Schön (1987) who proposed a theory about how professionals think and learn in the practice environment, a theory which provided further insight into the process of *guiding reflection* in the preceptorship. He emphasizes that the world is not governed by formal, academic knowledge. Rather, problems are solved through the process of simultaneously applying and creating knowledge through reflective practices. Schön asserts that practitioners constantly need to define what they need to learn and to understand the context in which they gain such knowledge. He further maintains that practitioners acquire knowledge through the following processes: a) knowing-in action, which entails knowledge

acquisition during every day routine actions; b) reflection-in-action, otherwise known as thinking about the action as it is performed; and c) reflection-on-action, or thinking about a situation in hindsight, after the fact. As one ponders Schön's educational theory, it becomes evident that his theory underpins the reflective conversations in which professional knowledge is explicated and developed. Furthermore, it can be considered the linchpin to the process of *guiding reflection* in the preceptorship learning environment.

As described by Chapman, Dempsey and Warren-Forward (2009), reflective learning is a deliberate cognitive and affective exploration on the part of the student in which they learn from their encounters. Reflective learning in the clinical environment provides the context for nursing students to develop the knowledge, skills, attitudes and values of a registered nurse (Levett-Jones & Lathlean, 2008). Benner (1984) asserts that practical participation with nursing care is mandatory for the development of nursing expertise. Indeed, engaging in a process of complex decision-making and interpretation of multifaceted clinical situations provides the foundation for expertise to flourish. Spence-Laschinger (1992) suggests that an effective clinical learning environment should foster the integration of reflective and conceptual approaches to learning in order to encourage nursing students to question and seek innovative approaches to patient care. Furthermore, successful reflection is profoundly difficult without the guidance and support from a qualified nurse (Duffy, 2009).

Guiding reflection emerged in this study as the process in which students were facilitated to deliberate thoughtfully upon their learning, thereby empowering them to realize desirable and effective nursing practice attributes. In other words, as part of the process of *guiding reflection,* precepting students involved valuing them as individuals, and providing a safe and supportive environment in which they were sufficiently challenged in their learning (Crawford et al., 2000;

Myrick, 2002). Creating a productive clinical environment offered nursing students an authentic space for learning with time for reflection, thus safeguarding a secure environment in which learning could occur. Guiding a reflective learning environment embraced a mutually supportive relationship whereby the student was challenged, enabled and supported to undertake the process of self-inquiry, allowing the acquisition of meaning from their practice (Duffy, 2009). Guidance enabled the student to identify and consider the consequences of responding in new ways to practice situations (Johns, 2010). The process of *guiding reflection* that emerged in this study involved listening carefully, being particularly sensitive to cues and reflecting back thoughts as questions, thereby prompting the student to explore issues more intensely. Moreover, the preceptor acknowledged, supported and valued the student, thereby providing a means by which the student felt comfortable to ask questions or share their ideas and thus, ultimately gain confidence.

According to preceptors and staff nurses who participated in this study, their role was to monitor and provide support when required. They indicated it was not their intention to dominate any situation. Rather, they preferred to act as a guide in observing the students' progress and interjecting only when necessary. Preceptors assessed students' progress by paying particular attention to what the students were actually saying and doing, ultimately for the purpose of ensuring that the students were providing safe care. As one preceptor reflected:

> When you're watching a student do anything, let's say it's medication preparation, just to kind of stand back but watch and then if they are making an error, maybe let them make a little bit of an error and then explain to them let's not do it that way, let's do it a different way. Guidance in terms of, if they [the student] go and do an assessment and then they ask me, "what are my norms or what should I be looking for in particular?" Guidance in

> terms of just being there for them and watching them do dressing changes, watching them do anything to do with patients or anything that they want. Lots of students will say, "come and watch me, I just need you to see this" and that's great. I think preceptors should be open to that, I know that sometimes, some are not, they're like no, just go do it. You can do this. But the student needs that reassurance the first couple of times that, "yeah, you're doing this absolutely correct so you're great, keep going" (Jamie, Preceptor Interview #2, p2, 49-63).

Another preceptored stated:

> I don't think it's my job to tell them [students] how to do stuff, I think it's my job more to encourage them to trouble shoot and walk through it and develop their own way of providing patient care within the boundaries that are governed by our ethics; but everybody does things differently and I don't think telling anybody how I do it is necessarily appropriate for them. I want them [students] to become comfortable in how they learn to do things and how they're doing it (Alex, Preceptor Interview #1, p1, 31-41).

The process of *guiding reflection* involved ensuring that relevant questions were being asked that encouraged students to reflect critically, thereby assisting them in understanding what was actually occurring in a situation. Preceptors and staff nurses play an important role in preceptorship, essentially, by engaging in a process of guiding the students to ensure they are progressing, by probing them to reflect and to ask questions. According to Schön (1987), student supervisors, in this case preceptors, communicate information, advocate theories of practice and share examples of practice; however their primary role is to demonstrate, advise, question and provide feedback. Guiding students in a reflective manner enabled the preceptors and staff nurses

in this study to develop a trusting supportive relationship with the students, and in so doing facilitated them to critically make sense of problems, concerns or difficult situations; essentially, helping them to gather meaning through reflective thought (Dewey, 2011, *version*; Duffy, 2009). According to Benner et al. (2010) and Myrick and Yonge (2002) preceptor questioning can help validate students' observations and encourage further opportunities to discuss and think through situations. Furthermore, Öhrling and Hallberg (2001) maintain that when preceptors ask questions and listen, they obtain more insight into the students' previous knowledge and level of confidence, thus, being better prepared to identify their learning needs. One preceptor shared:

> Guiding to me means asking them what they know about that procedure and about that disease process and what you would expect to see and what you don't expect to see and then saying, "Okay, so you've outlined what you expect to see, but your patient doesn't have that – why do you think that your patient doesn't show that or your patient has this and these symptoms, but that doesn't fit your diagnosis – what do you think that is and what else do you think is going on with this patient?" Making them think and use those critical thinking skills that they've been taught, because not everybody fits in that little box and you have to think beyond what you see and what your patient exhibits and says, and what your disease process is. I think part of that is by making them think and listening to what they say. The whole idea is to make them think about why their patient is the way they are (Alex, Preceptor Interview #2, p15, 663-681).

Another preceptor commented:

> I prompt her with her medications, asking why she is giving it or why she would hold that one, what kind of side effects she would be seeing. The different diagnosis, something

> that maybe she should be watching for, that doesn't generally pop into your mind right away (Dallas, Preceptor Interview #1, p2, 58-62).

A third preceptor expressed:

> I question them and make them find the answers and if they're having trouble finding a resource or something, I tell the students that we have tons of literature, read it, and read it and read it, and best practice is what we follow. So read it and come to me and I'll tell you if I think it's a great plan or not, and if I don't know, we'll both look for stuff. I do ask them first "Well what would you do?" or "What do you think you should do?" I will never let a student go into a situation and do it wrong; that compromises patient safety (Jamie, Preceptor Interview #1, p16, 702-721).

One staff nurse explained:

> I want them to learn. I'm questioning them rather than saying well, you should've looked at this, this, this and this. Are you going to remember it next time because I've told you this, this, this and this? Or are you going to have an easier time remembering it because you came up with the answer through those guided questions. I think they're going to have an easier time if they know it, rather than trying to memorize how to do it (Morgan, Staff Nurse Interview #1, p18, 798-807).

The preceptors and staff nurses who participated in this study were very cognizant of guiding the learning process by asking reflective questions. According to Todd and Freshwater (1999), the use of open-ended, clarifying, probing and challenging questions is central to the process of reflection and guiding discovery. Both the preceptors and the nursing staff in this study displayed an innate understanding of the fact that students needed to be questioned in order to consolidate their ideas, perceptions and ultimately gain confidence. As suggested by Myrick

and Yonge (2002) questions assist the students to ascertain significant aspects of practice situations. “By questioning the preceptees’ actions, preceptors not only spark intellectual curiosity, but promote recognition of inconsistencies in nursing care, and foster awareness of irregularities and differences between patient situations” (Myrick & Yonge, 2002, p. 180). Similarly, Forneris and Peden-McAlpine (2007) found, through guided questions, preceptors are able to challenge the context of the students’ thinking. One staff nurse stated:

> I think it is important to communicate with your student when they do something they’re learning for the first time. You need to allow time for them to reflect back on it and ask “How did that go; is there any way we could’ve done it differently to make it more smooth; did you have any difficulties?” (Darren, Staff Nurse Interview #2, p13, 549-553).

One preceptor shared:

> After things are said and done and calm, and there is no chaos going on, it’s like “What did you do today and is there anything new that you did today and how did you feel when you were doing that? Did you feel that you didn’t know what you were doing or did you feel that you were comfortable?” Making them focus back on themselves and how they felt and how they dealt with that situation and so, “What do you think you could’ve done better and is there something that you think you did right and you don’t think you got credit for?” If there was something they did wrong that we should work on and making them look back at themselves, and me (Alex, Preceptor Interview #2, p16, 702-716).

Although the preceptors and staff nurses indicated that they engaged in the process of *guiding reflection* to ensure the students could think critically about specific situations to gauge the impact they may have on their practice, students were also encouraged to engage in the process of reflecting upon their own actions and performance. According to the students who

participated in this study, engaging in the process of reflection enabled them to recognize their progress towards becoming a more independent nurse and provided direction as to what they needed to learn further. As articulated by Schön (1987), when students possess a general understanding of how to practice in familiar situations, which he refers to as knowing-in-action, they are able to spontaneously provide care without conscious deliberation. When something out of the ordinary occurs, however, students then begin the process of reflection-in-action or reflection-on-action. Reflection-in-action is the process in which students endeavour to solve a problem by thinking critically about the situation as it is occurring. Whereas, reflection-on-action is thinking back about the situation after the fact and striving to discover what may have contributed to the situation or problem. Students thus begin the process of questioning the assumptions as to what they know or understand with regard to that particular situation. Throughout the study, it was found that as students engaged in the process of reflection-in- or on-action, they were better able to: a) restructure strategies of action; b) understand the phenomena; and c) reframe the situation or problem in a different manner. Similarly, Dewey (2011 *version*) posited that meaningful learning is impossible without some element of thought or reflection. Students need to engage in meaningful reflection, so that learning is enhanced. The process of reflection is connected to the notion of learning and thinking – people reflect in order to learn and they learn as a result of reflecting (Moon, 2004). Reflective practice enables students to learn to value themselves as significant people, with values and feelings that are important factors in caring for others (Johns, 1995). One student claimed:

> When you have an experience and then you look back on it, well, you're constantly evaluating yourself and other people are evaluating you. So you're thinking okay, did I do that right? Should I have done that? Why did I do this? Did it work out, like what was

> my end result? If I had done that, what would have happened (Robin, Student Interview #2, p13, 594-599).

Another student shared:

> You reflect back on your day and think of how it went, what did I struggle with, what would I change, and what do you need to improve on and the next day you just keep doing the same thing. You don't realize at the time the things that you're missing, so you really do have to go back and sit down at the end of the day and ask, how did that go? What would I do differently? Because during it you're not going to know, [because] everything happens too quickly. So you really have to go back and look at it and I think that's where I learned the most, from going back and thinking how did that go? What did I learn? What do I need to do? (Taylor, Student Interview #2, p15, 644-654).

Guiding reflection emerged as the process of providing students with suggestions of what to do, what to look for, but not necessarily telling them what to do. The participants in this study indicated that their goal was to encourage the students to approach them with ideas as to what they thought was appropriate care and provide a rationale as to what they intended to do, rather than asking what they should be doing. Accordingly, the preceptors and the staff nurses encouraged the students to approach them with their ideas and thoughts, rather than asking questions about what to do. Moreover, the preceptors and staff nurses facilitated the process for students to think about what patient care was appropriate for the situation or what care they actually provided and what they might have missed when providing such care. In other words, the preceptors and staff nurses provided guiding questions rather than answering the students' questions. Indeed, they indicated that the best learning occurred when the students themselves generated the answer, not when the answer was provided for them. One preceptor asserted:

> The student might be in a situation where they think this is what they should do, and they would come to me and say, "This is my plan, what do you think of this". And then I would give them my opinion, and ask what else do they need? Do they need anything else to be able to provide this care or what do they need (Jamie, Preceptor Interview #1, p33, 1483-1489).

Another preceptor stated:

> Guiding doesn't mean I am going to tell you how to do it. It just means that I am going to listen and pick up on the queues you are telling me and what you are saying is going to queue me to where we need to go next and where you need to go next (Alex, Preceptor Interview #2, p15, 685-692).

One staff nurse indicated:

> If they can't get to the answer through reflective questions and hints and everything then for sure, I'll say it's in this book, let's look it up and this is what I'm trying to teach you. But if I can make you think around it and guide you to what the right answer is through that previous knowledge you may have, then you're going to remember probably easier than me telling you to do this, do this, do this. Like, if I tell you do this, you do this, and you do this - have I told you why? No, if you've thought about why you're going to do this, this, this, and this, then you're going to understand it better (Morgan, Staff Nurse Interview #1, p18, 812-821).

One student explained:

> You are asking them [preceptors] questions but you are also explaining why. Giving them a rationale as to why you're doing it and why you think this and they're [preceptor] there to give you more things to think about, more knowledge to keep you on your toes and

> give you more depth to what you're learning and understanding (Gerry, Student Interview #2, p9, 380-385).

The preceptors who participated in this study, indicated that integral to student success, it was important for students to communicate their individual learning needs. Specifically, they encouraged the students to identify their goals and objectives and highlight their areas of strengths and areas requiring improvement. Recognizing students' accountability as adult learners, exploring their comfort level, and discussing their personal and professional goals was integral to enabling preceptors to structure a learning process that would facilitate the student's growth and success (Hegenbarth et al., 2015). The majority of preceptors identified that it was difficult to guide students and build upon their strengths if the preceptors were unaware of the students' learning needs. Similarly, Lambert and Lambert (2004) suggest that the student is indeed responsible for contributing to a positive learning environment in conjunction with their preceptor and for communicating their learning needs in a timely and proactive manner, thus ensuring preceptor confidence in the student's capabilities. One preceptor shared the following excerpts:

> I want them to tell me what kind of skills they are looking for, when they are not comfortable with certain assessments, or there's a diagnosis they are not understanding, or medications that they just aren't getting, I want them to tell me or anybody on the floor what their issues are. Like are you having trouble with this, do you need more practice starting IVs, do you feel uncomfortable with it, do you have trouble looking through our medication binders on how to mix up medications (Dallas, Preceptor Interview #1, p17, 598-605).

> I want them to be able to say you know what I don't understand the lay out of this. I don't understand why we have to do this, I don't understand this. I think it is up to the student to really question it and bring it to the preceptor on what you want to get out of it. Because if you are going to tell me [preceptor] that everything is fine and you seem to be doing ok, I don't know where else to push you to (Dallas, Preceptor Interview #1, p17, 611-617).

Another preceptor suggested:

> Students should be comfortable to say they don't know something, identify the goals they want to achieve, be open about what they have and have not done; what they want to do. I want them to think the process through, "what would you do" or "what do you think you should do?" Apply the knowledge they learned in school (Jamie, Preceptor Interview #1, p15).

One staff nurse expressed:

> I expect them to tell me what they want to do or what they know; what they want to learn, what they want to achieve and if they're satisfied, if they have any questions after whatever we've done (Darren, Staff Nurse Interview #1, p16, 705-708).

The students who participated in this study shared that preceptors and staff nurses guided learning in various ways, depending on the timing of the practicum. For example, initially, when the students first began their preceptorship, they perceived the preceptor as a role model whom they would observe carry out nursing care and then integrate what they had learned into their own practice. Yonge (2007) found that students view preceptors as guides who model nursing practice and professional behavior. Having time to be with the preceptor and observe and listen prior to carrying out nursing actions allowed the students in this study to acquire the confidence

to act independently (Öhrling & Hallberg, 2000a). Once the student gained more confidence, the preceptor would then channel their learning by enabling the student to work independently with appropriate responsibilities. However, even though they were practicing more independently, it was found that the students still preferred the preceptors or staff nurses be available for questions and direction if and when they required or requested such support. According to Sandvik et al. (2015), a safe place to learn is one in which students are able to work independently, with the continuing support and endorsement of the preceptor. One student expressed:

> A learning process is where – the student is kind of guided, maybe not blatantly but kind of put in a situation and then – questions are given or [the student is] steered in directions that make the student ask the questions and take on the learning experience (Robin, Student Interview #2, p13, 555-559).

Another student shared:

> They're there to guide you, they're there to give you the guidance that you need to go out and do your job. It's like they're not there to hold your hand or babysit you, they're there to support you and help you through what you need. If you don't have any problems that day, you don't need as much guidance, but if you're struggling or if you're having a lot of questions they're there to help you do that. They're there to say, "in my experience" or to act as that sort of a guide (Taylor, Student Interview #2, p6, 245-255).

A third student indicated:

> [Preceptors] provide guidance, but at the same time letting your student be independent on what they've learned in school and letting them do what they know how to do but being there to provide the assistance and the guidance and just to interject when needed if they've forgotten something or if they are forgetting a vital part of the skill or procedure

> or assessment. I think it's just kind of forcing the student to be more independent on their own, however, providing guidance and assistance when needed (Casey, Student Interview #2, p11, 481-491).

Although most students who participated in this study valued the process of reflective questioning, a number of students were uncomfortable, at the outset when preceptors and staff nurses challenged their thinking and asked numerous questions. Nonetheless, in hindsight, they did acknowledge the importance of questioning and how it improved their ability to reflect and problem-solve. Forneris and Peden-McAlpine (2006) found that engaging learners in critical dialogue with the use of questions that challenge their knowledge served to help learners identify problems which in turn determined aspects of the care. Two students expressed:

> I just thought they were being overly critical of me and asking me redundant questions and things I didn't know the answer to and I kind of thought they were picking on me but it's kind of made me problem solve and think through the problem more. I realize now almost a year post-graduation [why they did it] (Casey, Student Interview #2, p5, 205-210).

> There is so much to learn that you'll never know enough. I guess that's everywhere in nursing you're always learning but I found that I didn't have a huge knowledge base going in, and it was very overwhelming at the start but once you figured things out, oh this is why we're doing this and then you'd look into it and it got better as you went along (Gerry, Student Interview #1, p16, 716-722).

As the process of *guiding reflection* further emerged from the data, it became evident that preceptors needed to ascertain when students were ready to practice independently. Increasingly, it became apparent that the preceptors were striving to balance the process of when to provide

student supervision with when to permit students to practice more independently. In other words, the *balancing act* proved to be a vital characteristic in the process of *guiding reflection* in the preceptorship.

The balancing act. The *balancing act* of *knowing when to be present* in a situation and *knowing when to let go* was found to be significant in the process of *guiding reflection*; owing to the fact that preceptors needed to ascertain when students were ready for more independence. Similar to a number of studies (Haitana & Bland, 2011; Hilli et al., 2014; Sedgwick, 2011), many of the participants in this study identified the key factor that determined whether or not the students were ready for more autonomy was based on their skill level and whether the preceptors perceived they could trust the students with more independence in that regard. A primary responsibility for the preceptors of this study was knowing how to balance student independence with student supervision, so that students were enabled to increase their clinical skills without being too overwhelmed or not challenged enough. As proposed by Johns (2010), too much challenge can overwhelm, whereas too much support can lead to dependency and complacency. Thus, preceptors grappled with the notion of *knowing when to be present* in a situation and *knowing when to let go*.

Knowing when to be present. As data emerged from this study, *knowing when to be present* in a situation surfaced as an element vital to the process of *guiding reflection*. Many of the preceptors and students described a sink or swim phenomena. For example, a number of students were assigned a full patient assignment on the first or second day of their practicum and expressed feelings of being overwhelmed and anxious about providing safe care. As identified in the study conducted by Kelly and McAllister (2013), students conveyed feelings of being unprepared for situations when they were thrown in the deep end, primarily because they

perceived they had inadequate knowledge, skills, and confidence to provide care independently at the beginning of their practicum. The students who participated in this study expressed concern that they were not supervised enough when the preceptors left them to provide autonomous care within the first few days of the practicum. Even though the preceptors provided assistance if the students sought help, the students still expressed feelings of vulnerability when they were providing care on their own. They did not know if the preceptors were observing their performance or supervising them enough. Consequently, they perceived that they were not receiving the feedback they required to gain confidence in their nursing practice. They expressed the need to be reassured that they were providing competent care. Moreover, when they were required to perform on their own too quickly they tended to worry excessively about what they may be doing incorrectly, rather than building confidence in their ability to provide safe competent care.

The students who encountered a full patient assignment on their second or third shift articulated feeling overwhelmed with the workload and worried about not having the opportunity or time to meet with their preceptors to discuss concerns, issues or just to share the events of their day. They elaborated that there was not enough time during the day to reflect and question, therefore, similar to the findings by Yonge (2007), students spent time at home reflecting and evaluating the events of the day after completing their shift. As conveyed by Schön (1987), reflection-on-action provides an opportunity for students to make new sense of uncertain, unique or conflicted situations. However, when students perceived they were too overwhelmed to reflect on clinical situations, they began to express feelings of vulnerability and inadequacy which, in turn, had the potential of eroding their confidence. In some cases, students expressed that they did not necessarily understand why they were providing specific care, however, they completed

the task as requested, without having the time to reflect or think about why they may be performing the action. According to Dewey (2011 *version*) when students are required to complete a task passively without actively thinking about what they are doing, the vital meaning of the experience is destroyed. He further articulates that thinking enables students to make connections between actions and consequences; thus students can determine the significance of their actions. As indicated by Duffy (2008), students need time to assimilate their thoughts and refine their skills to undertake the journey of professional development. Similarly, Oermann and Heinrich (2005) claim that nurse educators, or preceptors in this case, are obliged to teach nursing students how to learn rather then what to learn. They further elaborate that "focusing on what to learn, does not prepare nurses to practice in today's ever-changing health care setting" (p. xiv). One student expressed the following two points:

> Sometimes it just feels like I'm just doing it, and sometimes it's like I'm not fully mindful because I am just so busy on trying to get [the task done], so maybe I missed something important. To me it's I'm not understanding it, I'm just doing it. It's like they're telling you…ok this is what we need to do. You put this this way and…and it's like ok I did all that but do I understand sometimes why I did all that (Devon, Student Interview #1, p5, 201-209).

> At the beginning you are learning and I didn't have any [transition time] at the beginning [of the rotation], I took a full patient load right off the bat. She [preceptor] said this is the only way you're going to learn. So I struggled for a bit. But I got it halfway through and I was good to the end, but it was a struggle (Devon, Student Interview #2, p253-256).

Another student expressed the following:

> When I was working with my preceptor that was the one thing that I would actually like, is time to catch up. You want to go look up something on your own during your break, sit in a room with a little book and look up you know those things that you need to ask questions about. So it would be nice at the end of the day to just take 15 minutes out and catch up on your day. I just feel like sharing what I struggled with today with her [preceptor], maybe we can work on that for tomorrow. Just trying to weed out all those questions because before you know it the day is done, you're going home and you still have those questions and you still have those patients tomorrow, which you are still having those same questions. So yeah, that I thought would help a lot more for me, just to clarify things at the end of the day because you think that you feel like you are doing well, you're on the right tract; yes I'm doing my day well. But do they really know what you are struggling with or what your questions are at the end of the day, unless you have time to do that (Taylor, Student Interview #1, p10, 392-411).

> But she didn't come [to do care with me], that's the sink or swim. She's there for me if I need her but she's not going to come with me into the room and make sure I'm getting all my stuff done for the day, this is what you're supposed to do, just do it and come to me if you need and I'll be there (Taylor, Student Interview #2, p8, 345-349).

Some of the participants in this study expressed that being confronted with an overwhelming workload in the beginning of the practicum had the potential of setting them up for failure. Students shared they did not have the time to provide the care they would have liked. They worried about making clinical errors because they were not provided the time to think through a situation prior to acting. When students are plunged into performing actions without the prerequisite knowledge or confidence, they perceive loss of control and a lack of competence

which leads to feelings of vulnerability (Schön, 1987). Similar to the feelings of sink or swim, Kelly and McAllister (2013) found that the students in their study who perceived a sense of being thrown into the deep end without supervision, caused feelings of fear for the students. In keeping with the findings of this study, a number of participants expressed the following:

> Having a full patient load in the beginning, mistakes get made and it is unsafe for the patients. Medications for example, say you're not familiar with all of them so then you are looking them all up. The less familiar you are with it, the more chance of making a mistake. Having to juggle multiple medications at once, you could have a medication error that way. Giving the wrong medication to somebody. Forgetting doses. It just puts you in a position where you could fail, which I think would make your learning experience negative and set you back (Robin, Student Interview #1, p7, 277-285).
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> Being able to provide the care that you feel the patient needs and deserves without basically running in there, slapping on [the med] and being impersonal and maybe not completing as thorough of an evaluation as you would if you had more time (Robin, Student Interview #2, p9, 391-395).
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> The student's preceptor who threw her in with a six patient load on her first day, that's not an example of a supportive student learning environment, especially when [the preceptor] wasn't there with [the student] doing the six patient load. If the two of them had taken it on together and she was going to guide her through it, that would be one thing but to throw her out there, sink or swim without even another nurse there with her. I thought that was cruel and unusual punishment (Terry, Faculty Advisor Interview #1, p4, 141-15).

The preceptors who gave the students a full workload very early into the preceptorship, indicated they thought that such an approach was the best way to learn time management and priorization of skills. They believed that because the students had not cared for more than two to three patients prior to their senior practicum, they needed to learn that skill and the best way to do so was to immerse the students into a full patient assignment of five to eight patients. Congruent with these findings, Kelly and McAllister (2013) found that some preceptors have internalized the sink or swim practice owing to the fact that they feel such an approach is the way students and new graduates learn. One preceptor expressed:

> When I do my initial meeting I'm very, very, clear we will not be doing an entry level of any sort. We do whatever the patient load is for me or the particular nurse they are with. They will assume that role and have four, five even seven or eight [patients] right off the bat because of that unrealistic factor coming in, where the student has only had two patients maximum (Corey, Preceptor Interview #1, p1, 19-27).

Another preceptor stated:

> Sometimes students need to be pushed because they will stay with what they are comfortable with and what they have experience with and if we don't push them to stand outside that box, then they are not going to get the experience that they should (Alex, Preceptor Interview #2, p6, 246-250).

One faculty advisor indicated:

> I think most [nurses] have the expectation that the student will hit the ground running and all will be well. They give them a full patient load on day one. There's not really any transition there at all. It's, 'Bang'. [Even though], it's all nicely laid out in the syllabus for the student that they start out with a couple of patients to build their [confidence], in

> reality I don't think that is the way it's done very often (Terry, Faculty Advisor Interview #2, p12, 530-538).

Although the students who were exposed to sink or swim situations were extremely anxious in the beginning of their preceptorship, by the completion of the practicum they actually indicated it was the best way to learn owing to the fact they had gained so much confidence and had become very independent. With further questioning, however, the students did concur that they most likely would have gained confidence and independence without the anxiety, had they been allowed to work up to a full patient assignment more slowly. One student expressed:

> I kind of wanted, when I first got there as a student, someone to take me under their wing and show me, go with me to every room and do assessments with me with the patients and things like that. That's what I kind of thought I would be doing as a student. But when I got there it was a little bit different. They just [said] "get to it" its independent sink or swim sort of thing and it freaked me out. But, I think I definitely learned the best that way, otherwise I probably would have leaned more on them, even though I didn't need to. You get more confidence when you do it yourself. So it was actually better for me learning that way than it was for someone to take me around and baby me just because I'm a student (Taylor, Student Interview #1, p1,27-39).

Another student shared:

> My preceptor contributed to my learning in so many ways; at the beginning I wasn't too sure, I was a little nervous, she wasn't there all the time, you know I expected someone to watch me all the time and she didn't. She gave me that full rein right at the beginning…you don't start with a couple [of patients]. And it seemed like pressure, like

> this is it' I need to do it right at the beginning; by the end it was amazing (Devon, Student Interview #1, p2, 60-66).

A third student articulated:

> I had five or six patients of varying degrees of difficulty. It was chaos. Yeah, it was - but at the end of the experience I know that I can handle a lot (Robin, Student Interview #1, 6, 250-253).

Many of the participants believed the students needed to assume a full patient assignment but not until further along in the practicum. All preceptors concurred, however, that the students needed to be able to assume a full patient assignment upon termination of their preceptorship inasmuch as the expectation was they would be required to care for up to eight patients. Similar to the findings by Yonge (2007), a number of the preceptors and students who participated in this study engaged in a three step process, whereby initially the preceptor performed the task and the student observed, then the student performed the task and the preceptor observed and when the student was comfortable and the preceptor had trust in the student's capabilities, the student would perform the task independently. One staff nurse expressed:

> I try not to put the student in the scenario where they don't feel comfortable, where it's almost as if they think I'm setting them up for failure, I don't want that for the student, I'd like to just show them, you know. If at any time you're uncomfortable we can - I can help you get past it or I can take over for you (Morgan, Staff Nurse Interview #1, p8, 338-343).

Another staff nurse shared the following:

> Students need time to learn organizational skills and how to prioritize first before they take on a big patient load. You can't rush your student; you have to be there for them to

> answer questions. You don't put them in situations they're not comfortable with (Darren, Staff Nurse Interview #1, 35, 1559-1562).
>
> And if you've got eight patients or seven patients and you don't have the time management that you do build as you do it over and over again, then that's just a set up for failure and disaster because you go home and you feel that you've missed everything and you haven't provided the care that you need (Darren, Staff Nurse Interview #1, p34, 1517-1525).

One preceptor commented:

> So the first day I would probably ask that she would just follow me to see how I do assessments and to go over your norms so that you know what's normal and so you would know what to report that's not normal and we just kind of go from there. I don't make any students take on a full patient load or anything like that at all. I try to go slow (Jamie, Preceptor Interview #1, p2, 50-54).

Another preceptor stated:

> I always go and watch them do it before I let them go off on their own to do it, like a needle or a neb or you know, any of those skills. I always watch them do the first couple before I say that they can do that on their own (Alex, Preceptor Interview #2, p4, 162-165).

One student observed:

> I was fortunate in the fact that during the first part of my senior practicum, my preceptor hadn't put that pressure on me about the client case load. I was able to gain some confidence in that way, with putting all the pieces together. In the beginning you are

> juggling all the different aspects of your client and by the end of it you're actually juggling many clients and their whole care (Brett, Student Interview #1, p20, 754-761).

Another student articulated:

> I started slowly. I started off with four patients but the preceptor was with me just to make sure that I was comfortable and I had my skills down pat and then slowly throughout the experience I got more and more [patients] as I became comfortable (Gerry, Student Interview #1, p1, 39-43).

The students who participated in this study articulated that they needed the preceptors and staff nurses to assist them when they required, however, they did not need to be overly supervised, especially as they gained more practical knowledge and confidence. Students expressed that some nurses and preceptors hovered too much, thus making them feel anxious and self-conscious. Similarly, Schumacher (2007) found that preceptors who actually did everything for the student, repeated the work or hovered over them watching their every move made the student feel as if they were regressing rather than progressing. Similar to these findings, the students in this current study perceived that the preceptor did not trust them or have confidence in their ability to perform when the preceptor supervised too closely. Furthermore, students conveyed the importance of allowing them to make their own choices and complete nursing actions without interference and time restrictions, a finding which is similar to that of Öhrling and Hallberg (2000a). One student expressed:

> I like [my preceptor] to let [me] know that they know what's going on, but giving me independence at the same time; because how am I supposed to go from, this is my last day of clinical and you are checking my meds, to, ok two weeks from now, how am I going to do this by myself. It's not giving the person the self-confidence to know that in

> two weeks they [will be] efficient and self-sufficient to do this and I'm competent to do this (Devon, Student Interview #1, 12, 464-470).
>
> The preceptor who watched my every move made me more nervous, made me feel like I was going to make a mistake, made me second guess things (Devon, Student Interview #1, p11, 426-427).

Another student shared:

> She would just check on me throughout the day. She would come up to me and say how are you doing? She gave me independence but she was still there, but she wasn't hovering all around you, making you nervous and asking you a thousand things. But she was there to ask questions and was there to guide you if needed, but for the most part you were on your own (Taylor, Student Interview #1, p3, 113-129).

As *the balancing act* emerged, it became evident that preceptors needed to ascertain when students were actually ready to assume more independence in their practice. Indeed, it became apparent throughout the study that the majority of preceptors did in fact foster more student independence, indicating that the development of a professional rapport with the student was also integral in their *knowing when to let go*. The data revealed that the preceptors equated *knowing when to let go* with their ability to be able to trust the student in providing safe, competent nursing care.

Knowing when to let go. Embedded in the process of *guiding reflection* in the preceptored clinical learning environment was the importance of providing a professional space for students to gain independence and confidence. K*nowing when to let go* signifies the challenge preceptors faced when they determined how to ascertain when a student was actually ready for more independence. The challenge entailed the ability to gauge when their students

were ready for more independence and when they needed more supervision. The findings by Haitana and Bland (2011) highlight the internal conflict preceptors undergo when deciding the appropriate time to allow the student to practice more autonomously. Similar to various studies (Haitana & Bland, 2011; Hilli et al., 2014; Sedgwick, 2011), many participants in this study conveyed that the key determinant to whether or not the student was ready for more autonomy was, as previously alluded to, based primarily on the skill level of the student and whether the preceptors themselves perceived they could trust the student with more independence. Preceptors further asserted that students were considered trustworthy and safe when they knew how to assess patient acuity and when to report significant findings. Sedgwick, Kellet and Kalischuk (2014) similarly found that preceptors considered students competent when they had acquired strong assessment, communication and psychomotor skills. In keeping with their findings, the majority of the preceptors in this current study would not permit students to practice autonomously until a trusting professional rapport was established and they perceived the student was practicing in a safe fashion. One preceptor expressed the following two thoughts:

> Well I feel like I want to know where they're at, at the start – like I never worked with her before that so I want to see her assessment skills or how she managed her time, how she prioritized stuff (Kelly, Preceptor Interview #1, p25, 1100-1103).
>
> Prior to full work load I want to have some trust and some confidence in her; I don't want to give her six patients right off the bat and have her overwhelmed and like second guessing herself (Kelly, Preceptor Interview #1, p25, 1107-1109).

Another preceptor shared:

> I think a lot of it comes back to if I've seen them do their assessments and I know that they are capable of doing a full head to toe and when I cannot go in to the room with

> them for their first time and they can say that they already did the assessment and I can ask what their assessment covered and they can give me a full head to toe assessment and not just say that their vital signs are stable. I want to know that they checked everything and not just a set of vitals because that's not a full assessment to me (Dallas, Preceptor Interview #2, p9, 374-382).

Another preceptor articulated:

> When they have performed a skill or have dealt with a patient two to three times in an appropriate manner. If you are giving a skill, and if you are giving IV morphine, do you have the technique, do you have the policy, do you have the rate of delivery, do you know what signs and symptoms to look out for, and do you know when enough is enough, especially if it's a range, and when they've proven to me by me going with them two or three times that they have the concepts and they are able to do that technique safely and correctly, then I will say, "Okay you go and do it" (Corey, Preceptor Interview #2, p4, 146-157).

Yet another preceptor reflected:

> It's based mostly on what the student's comfortable with and you kind of get a feel for your student after a couple of shifts how comfortable they are, how grounded they are with their assessments and how competent they are with their medications (Jamie, Preceptor Interview #1, p2, 54-59).

One staff nurse expressed:

> When you're comfortable – when you see that they're providing like safe care. When they are safe with their patients, that they know how to do an assessment, they know how to do vital signs, they know how to look up medications, that they know what the

> medications are, they know things about their patient. So it just depends on the person how quick they're learning or their adaptability (Darren, Staff Nurse Interview #1, p13, 558-565).

While the students conveyed, similar to their preceptors, the notion that skill level and trust was a precursor to their increased independence, many of them equated safe practice to the acquisition of confidence in their ability to perform skills or procedures. In other words, prior to performing independently, without the supervision of their preceptors, students conveyed they needed to possess confidence in their own ability to perform. They identified that it was their responsibility to inform the preceptor or staff nurse when they lacked the knowledge or confidence to perform an action independently. In keeping with these findings, Öhrling and Hallberg (2000a) found that student maturity was a factor in determining when they perceived they were ready for more independence. Invariably, when students demonstrated more confidence in their ability to perform nursing actions, they developed a level of security and maturity which, in turn, enabled them to assume more responsibility independently. Concurrently, as students gained more confidence in their ability to perform nursing actions, their sense of competence also increased, thereby providing the venue to developing knowledge independent of their preceptor (Öhrling & Hallberg, 2000b). One preceptor indicated:

> They let you know. Most of them will say, "I want to do this, I'm ready". Some of them will say they aren't ready for this and I say that's okay let's refer to our literature that's available. Let's look at all the information we have on how to do this dressing change or let's look at all the information we have on how to do a catheter. Maybe we'll just get all the supplies together, we'll run through this once, and then you can tell me if you're comfortable to do this or not (Jamie, Preceptor Interview #1, 4, 171-178).

One student expressed:

> [I did everything] unless I felt it was something I wasn't capable of doing or I wasn't confident enough to do or I felt it was unsafe (Casey, Student Interview #1, p2, 47-49).

Another student shared the following two excerpts:

> Just feeling that I wasn't either prepared, skilled, or have read enough [information] about it, or watched one yet. If I'd never done one and never seen one done and I was very unfamiliar with it, I'd rather watch one first before performing (Robin, Student Interview #1, p1, 29-33).
>
> Because they're somewhat responsible for your actions. So if they don't know if you're competent to do something, they kind of discuss what kind of experience you've had with that and what you're comfortable with doing and what they're comfortable with letting you do (Robin, Student Interview #2, p1, 25-29).

As *guiding reflection* further emerged from the data, it also became evident that *making time* was critical to the process. Moreover, it became obvious from the data that the participants found it vital to make time for questions, to provide feedback and to debrief throughout the preceptorship.

Making time. *Making time* to ask questions, to seek and receive feedback and to debrief following difficult or distressing situations was found to be successful to the learning process. As highlighted in the study conducted by Öhrling and Hallberg (2000a), the students in this current study required a space for learning that allowed them to reveal their feelings of uncertainty, to discuss feedback, to reflect on events and to develop a sense of confidence about nursing practice. According to Clynes and Raftery (2008), sufficient time and space should be allocated to ensure that all aspects of practice can be discussed without interruption. This type of dialogue

is essential in providing direction for student growth and, in turn, increases confidence and self-esteem. Myrick (2002) found that preceptors who promote discussion and feedback set the tone for enhancement of reflective thinking among nursing students. Öhrling and Hallberg (2000a) contend it is important that students be afforded the time to discuss their learning needs directly with the preceptor, thereby, guiding appropriate direction for the attainment of learning goals and objectives. Although several preceptors and students expressed concern with regard to the lack of time to partake in such dialogue, essentially, it was found that overall time was reserved to discuss questions, to provide feedback and to debrief.

Making time ensured that: a) students felt safe to ask questions; b) preceptors and students engaged in the exchange of feedback; and c) students were provided an opportunity to engage in *debriefing* sessions as warranted.

Feeling safe to ask questions. *Feeling safe to ask questions* surfaced as being key to *guiding reflection*. Many of the participants discussed the importance of students *feeling safe to ask questions* throughout the preceptorship. Most, if not all, of the students provided feedback with regard to how their preceptor and staff nurses were readily available to answer questions, especially when they indicated uncertainty concerning an assessment or intervention for the purposes of patient care. The students conveyed that the majority of the preceptors and staff nurses were approachable and available when they pursued answers to their questions. Students identified the importance of being able to communicate effectively and establishing rapport with all members of the team. They further elaborated that building rapport provided them with the confidence required to more readily approach their preceptor and staff nurses to discuss and question. According to Myrick and Yonge (2004), for students to progress and think critically, they need to feel a sense of security in sharing their ideas and points of view. In addition,

students needed to trust that their preceptors were accepting and supportive of their questions, prior to seeking support or assistance. When students perceived a safe and supportive learning environment, they expressed a sense of freedom to ask questions, the ability to reflect upon situations and to share their ideas (Hilli et al., 2014). One student shared:

> If you have any questions or you're unsure, they are there to support you in any time of need. Learning-wise, they're willing to help you, they're willing to be there and just – they don't have that wall up that they don't want to help you, like a leave me alone kind of deal (Gerry, Student Interview #1, p2, 85-89).

Another student expressed:

> I just keep asking questions, keep on it and having the time to tell them you know I don't know what this is, I have to look this up or you know structuring your day according to you. And it is 10 o'clock and you know that you have meds to do for all your patients and you know you have to have half hour before hand to look them all up. You have to let them know that, you know I need to do this and ask for help when you need help cause I think that was the biggest thing…is your learning, your adjusting and they know that. You just have to let them know when you actually need the time to learn and need help (Taylor, Student Interview #1, p2, 69-78).

As identified in the following excerpts, preceptors maintained it was their role to ensure students were encouraged to ask questions. They further elaborated that it was essential for students to feel safe and confident that their questions would not result in a judgement or question about their capabilities or performance. According to Paten (2010) supportive preceptors spend a considerable amount of time and energy encouraging students to ask questions and engaging them through the process of questioning. In the learning context,

questioning can be considered a form of understanding as opposed to a tool with which to highlight student incompetence. The preceptors in this study encouraged questions for learning purposes. Indeed, they indicated that, when students hesitated to ask questions, they were unable to assess the students' skill level or to identify their learning needs. Similarly, Yonge et al. (2011b) found that when preceptors were cognizant of the types of questions students ask, they were afforded insight into the student's critical thinking ability, attitudes towards learning, and the extent of their knowledge. One preceptor expressed:

> I like to put them at ease by explaining my experiences and my expectations of them and I also tell them don't ever be afraid to ask me a question. There's no such thing as a dumb question. If you don't know it, it's not dumb. And don't ever feel that you can't stop me and say I don't understand, I don't want them to be intimidated (Alex, Preceptor Interview #1, p3, 102-108).
>
> Well, non-judgmental is non-judgmental and I always tell the students that there is no such thing as a stupid question and if you don't know it, you ask it. I don't care what you ask, and I am not going to hold it against you because you don't know how to do something or you don't know what something is, but I may go tell you to look it up, but I am not going to hold it against you if you don't know something (Alex, Preceptor Interview #2, p2, 81-87).

Another preceptor shared the following:

> Make students feel safe by, they can ask you any question, safe if they did do something in error you're not going to berate them, you're not going to belittle them, you're going to take the time to explain to them what they did that was maybe not so appropriate and how they can change that in the future. Just so that they don't feel like – scared to be at work

> or scared to interact with patients or scared to interact with other members of the health care team. Safe so that they have confidence and just so that they feel safe to question (Jamie, Preceptor Interview #2, p1, 35-44).
>
> Comfortable and safe to ask questions; that if they were to maybe do something wrong or explain something wrong that they would know that the response wouldn't be a negative response that would cause fear or anything or that they would feel like, "yeah I did that wrong and that's okay though I feel okay about it because I am secure and I am safe in this environment right now because I have my preceptor here who's here to support me and be there for me for this beginning part of my career." That would be my goal (Jamie, Preceptor Interview #1, p10, 447-456).

As *making time* further emerged from the data, it became apparent that preceptors and students alike valued the importance *providing feedback*. As the data unfolded, participants acknowledged that feedback was particularly conducive to student growth and confidence.

Providing feedback. As conveyed by participants in this study, *providing feedback* was vital to the process of *guiding reflection*, inasmuch as it afforded students the opportunity to increase their confidence and competence. The students expressed the importance of receiving feedback, indicating they valued feedback that identified specifically the areas in which they performed well and areas which required further improvement. Similarly, Yonge et al. (2011a) found that students rely on preceptors for insight and perspective on their strengths and areas requiring improvement. According to the students in this study, preceptors continuously provided feedback in a positive non-judgmental fashion, for example, when preceptors shared a suggestion with regard to areas needing improvement they would endeavour to provide positive comments as well. Ideally, as conveyed by Henderson and Eaton (2013) when students engage in

learning opportunities and receive constructive feedback from their preceptors, they excel with competence and confidence. The students who participated in this study, indicated that daily or weekly informal feedback sessions were predominantly helpful for their growth and confidence. In particular, some students acknowledged and valued preceptors who made it a priority to discuss student progress each day. Similarly, Yonge et al. found that students perceived effective feedback as an ongoing dialogue about progress and expectations. According to Clynes and Raftery (2008) feedback is vital to improve student confidence, motivation and self-esteem. One student expressed:

> She was very good at saying, "oh maybe you need to work on this, but you're also doing really good at this." It wasn't just a negative comment to make you feel, "oh my goodness I am horrible," she would also give a positive so that when she talked to me it was very good. I was never down on myself saying, "oh this is not good" (Gerry, Student Interview #1, p14, 595-600).

Another student stated:

> It was the whole part, you know, the positive and then the constructive criticism. "Ok, we can do it like this", but nobody made you feel negative, it was never really negative. It was still positive even if it was a suggestion to do it otherwise. It was really good and then I guess just all the rest of the staff did the same thing as my preceptor (Devon, Student Interview #1, p3, 100-105).

Another student shared:

> Feedback was provided all the time in a positive fashion. She gave little hints about how to do it better, try this, try that, or this is an easier way of doing it. It was just building on the skills I already had. It wasn't necessarily negative like "oh my goodness you did a

> horrible job on this." It was just a comment, "ok let's try this this time on the IV start, or don't pull your tourniquet so fast, or …" It was never negative it was positive, like building on the skills I already had. Or like, "you did this great, but let's try doing it this way" (Casey, Student Interview #1, p6, 225-232).

One preceptor commented:

> I always know what's going on and ask her how she's doing and if she needs anything or if she needs to talk about anything (Kelly, Preceptor Interview #1, 23, 1033-1035).

According to the study preceptors, while feedback was provided formally and informally, they tended to value the informal process of *providing feedback* far more than the formal evaluation. While the preceptors recognized the importance of the formal mid-term and final evaluation, they believed the most meaningful feedback occurred on a daily sometimes hourly and minute by minute basis. Similarly, Yonge et al. (2011b) found preceptors valued the informal, spontaneous, ongoing evaluation far more than the formal written evaluation. Although one preceptor verbalized dislike about completing the formal paper work and evaluation forms, other preceptors conveyed that keeping notes about their students' progress provided them with a framework by which they could organize their thoughts and ideas, a finding which is similar to those of Yonge et al. According to the preceptors, keeping ongoing notes regarding student progress enabled them to provide relevant and succinct student feedback. One preceptor shared:

> I like to just talk with them about like, that was really great, you did wonderful or next time let's do that, what do you think about the situation; what do you think you could've done different or better or do you think you did that right (Jamie, Preceptor Interview #1, p32, 1458-1464).

Another preceptor expressed:

> I like encouraging questions, encouraging the reading time, the research time. Because it's not all about just being with the patient, they have to have that time too. And just being available I guess. You know giving them my experiences and my failures and mistakes. And getting them to learn from that and just letting them know that we aren't all perfect all the time and you know you pick yourself up and you move on and you learn from it and you do better next time (Alex, Preceptor Interview #1, p12, 460-468).

A third preceptor commented:

> I also keep a journal on every one of my students, which they are presented with at the end of their senior practicum. And basically it's what skills they have done during the day, how their organizational technique have progressed during their day, maybe little mistakes that they have made, successful VL starts or NG tube, something that is out of the ordinary, maybe they had a particularly demanding patient, maybe they had a frustrating day. I will record that, not only for them but for myself for when I go through evaluations (Corey, Preceptor Interview #1, p2, 46-54).

A fourth preceptor elaborated:

> I like to keep little notes about each day. So it was kind of how I kept track of her skills and what she had done, what kind of assessments she'd done, if she had done admissions and discharges (Dallas, Preceptor Interview #1, p20, 714-717).

As *making time* further emerged, it also became apparent that preceptors and students alike valued the importance of *making time* for *debriefing* sessions. Indeed, the participants acknowledged that *debriefing* was particularly effective for students and preceptors to discuss and reflect upon difficult situations.

Debriefing. Essential to the process of *debriefing* were the relationships amongst the students, the preceptors and the members of the nursing team. Critical to those relationships was the establishment of rapport to ensure that the students felt free to express their thoughts and ideas. The preceptors and the students identified *debriefing* as a time for discussing and pondering upon situations that did not progress as well as anticipated. Students alluded to difficult cases and conveyed how they found it preferable to share their perspectives with the preceptor or staff nurse, thereby enabling them to validate what they were experiencing was appropriate and similar to the more seasoned nurses. When the students found they shared similar perceptions to those of the preceptors and staff nurses they became assured that they were progressing as they should, a process that subsequently was found to foster a greater sense of confidence. Hilli et al. (2014) also found that in such sessions students sought out their preceptors to reflect upon ethical issues together. *Debriefing* provided the kind of communication that created an opportunity for sharing and challenging multiple perspectives. It provided a venue to gain a more extensive understanding of the contextual elements involved in providing patient care (Forneris & Peden-McAlpine, 2007). One student shared:

> I think it was just an open line of communication when you had a critical case where there was something where someone had died, or something was extreme – like someone with high acuity, we would discuss things after the fact and after everything was pretty much done with and say, "Why didn't we do this; this was good we did this; I feel like this" or "Why did the doctor do this." There were open lines of communication after [the event], and I think because I had a good relationship with my preceptor that I could bring that up at any moment to vent and be like, "Hey this is how I felt afterwards" (Casey, Student Interview #2, p3, 131-141).

Another student expressed:

> We had one case that was really ethically distressing and a lot of us would get together and talk about that case. Like four or five of us nurses. A number of times, even after the patient had left we still managed to debrief in that way. Just to figure out where everybody stands with certain things and to how they feel about things and that we are all on the same page (Brett, Student Interview #1, p8, 276-284).

A staff nurse conveyed:

> I think it is important to debrief after a critical incident; I had a student and we had a code, the person unfortunately did not make it, and so after we sat down, we discussed what happened. I said, you know, "we did all the vital signs, we did all the checks we were supposed to, we looked through the medications – was there something that we shouldn't have given?" We kind of re-evaluate the whole situation, ran through it back again just to talk about it, because it's a big shock the first time it happens (Darren, Staff Nurse Interview #1, p7, 285-293).

One preceptor expressed:

> Debriefing is kind of an on-going thing. If the [student] is reflecting on a situation from four shifts ago and they're talking about it now, it means it impacted them somehow, and they want to discuss it and I should always be open for discussion for all of their experiences that they're having while they're precepting on the ward (Jamie, Preceptor Interview #1, p31, 1386-1394).

While students considered *debriefing* to be a time to discuss stressful or challenging situations, they also described *debriefing* as a time to converse about the successes or frustrations of their day, a time to share their feelings. *Debriefing* provided an occasion for students to

discuss their learning capabilities and learning needs. Furthermore, it afforded time for students to share struggles, challenges and victories in their day-to-day practice. It was considered a time to explore why various phenomena functioned in a certain way, why a patient was presenting with different issues or why preceptors and staff nurses performed differently in different situations. The students elaborated that sharing perceptions, achievements and disappointments, however, did not necessarily need to occur only with their preceptors. They sought this type of dialogue with any of the nurses on the unit who were receptive to student engagement. They further articulated that they, ultimately, desired assurances that they were putting all the pieces together and were functioning as a competent nurse. Many of the participants recognized the importance of taking the time to provide opportunities for discussion to occur throughout the day. When students were afforded the time and space to engage with their preceptors to reflect on the different alternatives, solutions and outcomes, they found they acquired a deeper understanding of nursing practice (Öhrling & Hallberg, 2000b). One student shared her thoughts:

> I went to her and the other nurses a lot. My senior practicum was all about kind of putting all the pieces of the puzzle together and so when I would get a patient case where maybe I hadn't seen something like that, or I was trying to figure out why their nutrition status was the way it was, or maybe the symptom they were having could be the drugs. You know I would always go to the other nurses to collaborate and just to talk things out. And they were really good at that (Brett, Student Interview #1, p7, 263-271).
>
> It was a chance to express when you found things challenging or you couldn't understand why things ran a certain way or why this patient was having trouble with this or why you were doing things a different way (Brett, Student Interview #2, p3, 130-134).

Another student expressed:

> We were always talking. We were always very open in communication and sometimes during the end of the day when we're just sitting there for downtime after taping we would just talk about it (Gerry, Student Interview #1, p24, 1052-1055).

One preceptor elaborated:

> We talked about, how do you think your day has gone, any concerns you have today, anything we can do better tomorrow, or anything you want to focus on (Alex, Preceptor Interview #1, p13, 488-491).

Throughout the process of *guiding reflection* it also became evident that *belonging* was a key condition of the process and vital to the preceptorship learning environment.

Belonging. Students expressed the importance of an authentic sense of *belonging* and in fact coveted the opportunity to become a genuine member of the team. Cope et al. (2000) and Vallant and Neville (2006) report that student acceptance into the workplace culture tends to increase student confidence, thereby increasing professional competence. A learning environment in which inclusion is valued, serves to decrease student anxiety and increases the opportunity to engage in more effective learning. Such an environment is one in which students can flourish (Schumacher, 2007). Students in this study found they were assured they belonged when they: a) participated in a *trusting relationship*; b) were accepted as part of the team; c) could network with other nurses; and d) when their preceptors and the staff nurses sought feedback from them with regard to how to plan and proceed with patient care.

Trusting relationship. As with a sense of *belonging*, a *trusting relationship* with the preceptors and staff nurses was also found to be a critical factor in the process of *guiding reflection* in the learning environment. Essential was that trust be developed between the students and all the team members. As noted by Myrick and Yonge (2005), an environment that is most

effective in promoting and enhancing student learning is one in which students are supported and not made to feel threatened.

The students in this study conveyed the importance of perceiving preceptors and staff nurses as being friendly, accepting and receptive to engaging with them during their learning journey. Furthermore, they articulated it was essential to establish a *trusting relationship* with their preceptor and staff nurses so that they could readily approach them for assistance when required. Students who engaged in a *trusting relationship* with their preceptors were found to be more inclined to seek out new experiences, to question their own decision making and actions, and ultimately to think reflectively about their nursing situations (Myrick & Yonge, 2001). Positive relationships with preceptors prepare students for the realities of the professional world of nursing practice and enhance student learning in the clinical setting (Atack et al., 2000; Yonge et al., 2002). As suggested in the literature, maintaining a *trusting relationship* is pivotal to creating an optimal teaching/learning environment for students to learn and grow as professionals. Furthermore, nursing staff and preceptors wield enormous influence on student success within relationships (Hilli et al., 2014; Myrick & Yonge, 2005; Pearcey & Elliot, 2004).

The students in this study conveyed the importance of the preceptor's presence to address their learning needs, specifically, by being available to approach and ask questions, share ideas and to reflect upon their day. According to Gray and Smith (2000) effective preceptors are described as those who involve students in activities, make an effort to spend time with students, are genuinely interested in the student, and maintain confidence and trust in their students' abilities. Furthermore, as reflected in the literature, preceptors and nursing staff who demonstrate approachability, openness, consistency, genuineness and respect provide the basis of a caring relationship and thus create a supportive learning environment (Cahill, 1996; Heffernan et al.,

2009; Yonge et al., 2005). The following excerpts exhibit how comfortable and at ease the students were with their preceptors:

> The first day we – well even our first meeting she was very open and just saying, "if you have any questions or any problems you can always come to me". We sat down and went through my goals and how I can achieve those goals. Throughout my experience it was always very open communication and she didn't intimidate me enough that I didn't want to go talk to her. She made me very comfortable – no stupid questions (Gerry, Student Interview #1, p6, 233-240).
>
> [Building a relationship with your preceptor] by just expressing your feelings and concerns to your preceptor and just telling her your apprehensions or if you are scared of doing something or if you have confidence in one skill or if you need further elaboration on a skill or procedure. Often on procedures I hadn't done very much of, I would often ask my preceptor to come with me and to just be a second witness to stand there and let me do everything by myself and if I am doing something wrong she can interject at any moment or provide comments and suggestions and feedback (Casey, Student Interview #2, p1, 44-53).
>
> I would just be comfortable asking questions, going to my preceptor, getting to know her personally. My first couple of days I would go to lunch with them to make sure to understand what they talked about at lunch on their off time, off the floor (Taylor, Student Interview #1, p2, 58-62).
>
> She never seemed to get frustrated with it. She always had a smile on her face and was there if I needed her. I was never afraid, or thinking, "oh, jeeze, I'm going to have to ask

> her the same questions I asked last week." Like she was always welcoming and warm (Brett, Student Interview #1, p11, 398-402).

The preceptors articulated that treating the students with respect was pivotal to developing the student/preceptor relationship. They also indicated that the student needed to exhibit a willingness to learn and to be eager and excited about learning. One preceptor identified that students must be eager, able to accept feedback, treat patients with dignity and respect and not refuse any available experiences. Such findings are similar to those of Charleston and Happell (2005b), whereby they found that preceptors indicated that students must present with genuine interest and a desire to learn if a successful relationship was to develop. Similarly, Lillibridge (2007) contends that preceptors sense it is critical for students to be prepared and willing to learn. Moreover, while preceptors perceived their role as teachers they also perceived that as long as the student readily availed of their wisdom, worked hard and demonstrated insight into the learning process, student outcomes would be successful. One preceptor shared:

> I want students to show me that they are engaged in the experience and I would like them to instead of me saying, "the patient needs this" I would like them to keep track and say, "I'd really like to do that" or "Do you think I could do that?" and show that willingness to jump in (Alex, Preceptor Interview #2, p8, 330-334).

Another preceptor conveyed:

> Basically their willingness to participate, their punctuality, their communication factor with the preceptor or other staff members when something's a little wonky or whatever. It is trust again, I'm trusting them to be accountable for their actions and if they feel unsure ask the questions and that is such a big factor (Corey, Preceptor Interview #1, p20, 737-742).

Preceptors and staff nurses alike also expressed the importance of trust when establishing the student/preceptor relationship. They identified that trust develops relatively quickly as long as students are honest with what they know and accurately identify how much knowledge they have had with regard to skills and patient situations. Similar to the work of McGregor (1999), the findings from this study indicate that students tended to gain their preceptors' trust when they: a) demonstrated initiative in ensuring that learning objectives were clearly conveyed and met; b) willingly assumed responsibility for communicating effectively with the preceptors; and c) demonstrated accountability for their professional behavior. Similarly, Yonge's (2009) findings, revealed that most preceptors believe honesty and respect are key factors that promote a positive student/preceptor relationship. Furthermore, Yonge et al. (2011b) also found that a collegial relationship is one which is built on honesty and trust. One staff nurse articulated:

> What I want to see that makes me able to trust a student is if they can identify when they're in over their head, like beyond their level of skills and knowledge. And that they are honest. They're not going to say to me well I'm giving this medication because the doctor told me to or because of this reason and make something up. I want to know that I can trust you that when you're the student, you're going to ask me when you have a problem. I want to know that if you're going to tell me the truth about a scenario, if you tell me that you've done ten, 11, 12 catheterizations and you haven't done any, I'm not going to trust you. Whereas if you identify that right off the hop, I've done one with a lot of assistance or I've watched one, great. I'll show you how to do it. We'll go right through it together and it's not a problem that way (Morgan, Staff Nurse Interview #1, p12, 535-553).

A preceptor shared:

> I think trust comes in the first couple of weeks of the experience when you are observing them and how they interact with clients and how comfortable and confident they seem in doing their skills and also looking back at what they've already done on their ward experiences during being a student because you can kind of gauge just by watching and talking to them where they are at (Alex, Preceptor Interview #2, p6, 261-267).

To ensure a good relationship was established with their preceptors and the staff nurses, students expressed the fact that they needed to: a) be prepared to understand and articulate what they wanted to learn; b) not be frightened to participate in nursing activities; c) seek out their own learning experiences; and d) not refuse any learning opportunities. According to Sedgwick and Rougeau (2010), students who were able to demonstrate the ability to think critically and make sound nursing judgments were more likely to establish successful professional relationships with preceptors and staff nurses. Conversely, Yonge, Hagler, Cox and Drefs (2008b) found that students who exhibited a lack of motivation, initiative, preparation and unwillingness to learn gave rise to questions regarding the students' ability to provide safe patient care, which, indeed, can compromise a *trusting relationship*. As conveyed by Kalischuk et al. (2013), the most common challenge faced by preceptors is working with uninterested, unmotivated students or students who are perceived to possess less than adequate skills. One student expressed:

> You need to take advantage of all learning opportunities because once you're done, [you're] on your own. When you're on your own you should know certain things. [The student] role is to soak up as much as you can and to take advantage of what you can because you're not always going to be lucky in getting that later on (Gerry, Student Interview #1, p20, 901-907).

Another student shared the following:

> The way I kind of sum it up is to be like the sponge, to take in everything that you learn, you know. You are just there more or less like a sponge to take in everything from the experience; IV start, learning new tricks, methods of how to do things effectively, how to assist your doctor, how to assist nurses, and how to work properly and work flow, how to contribute to the greater good of the department and just be like one big sponge. Take it all in (Casey, Student Interview #1, p1, 23-31).
>
> I honestly did not turn down anything. If I was asked to do a soap suds enema I went and did it. If I was asked to do anything invasive or anything that made me somewhat squeamish I did it. I didn't turn anything down because you need all those experiences. If there was an IV start and I was busy, I would say ok I'll get there just give me two minutes to finish up what I'm doing and I'll go do it. I did not turn down anything. So I maximized my experience in the department by making sure I didn't turn anything down; I participated in everything (Casey, Student Interview #1, p1, 34-45).

As the ambient condition of *belonging* further emerged from the data, it became evident that preceptors and students alike truly valued the importance of *being part of the team*. As data unfolded participants acknowledged that being accepted as members of the team provided the students with a sense of *belonging* which served to further their confidence and competence.

Being part of the team. Both students and preceptors valued students as members of the team and found it extremely important for the students' sense of *belonging* to be appreciated as a team member. Similar to the findings by Chan (2004), Charleston and Happell (2005a) and Vallent and Neville (2006), the participants acknowledged that being accepted, being included in unit activities, and being engaged in a nurturing relationship with the preceptor generated

positive feelings and provided the student with the confidence to enhance their learning. As corroborated by Rush et al. (2004) the findings also reflected that once accepted as part of the team, the students began to relate as colleagues with the preceptors and staff nurses, a process which, in turn, provided them with the confidence and freedom to learn and advance. As suggested by Chan (2004), Kim (2007) and Sedgwick and Rougeau (2010) students are more empowered and enabled to maximize the available learning opportunities when they are acknowledged as having a legitimate place in the nursing team. Furthermore, students preferred nursing units in which their individuality was recognized and they were afforded some degree of flexibility within reasonable limits, as compared with highly structured wards in which a rigid and strict hierarchical system prevailed.

The preceptors conveyed that accepting students as team members was an important component of *belonging*, one which contributed to the students' confidence and knowledge base. They considered it critical to acknowledge students as genuine members of the team and to treat them no differently than they would other nurses on the unit. For example, they involved students in down time conversation, invited them to functions outside of work, valued their input, respected what they had learned in school, and appreciated new ideas. Similarly, in a study conducted by Crawford et al. (2000), they found that preceptors deliberately acted to make students feel comfortable as a member of the larger team. As articulated by Charleston and Happell (2005a), once students become comfortable and perceive they have a legitimate place within the nursing team, they are able to relax and focus more on the available learning opportunities. Similarly, Levett-Jones and Lathlean (2008), found that students who perceived themselves as members of the nursing team they were more self-directed and independent in their approach to patient care and ultimately more confident in negotiating their learning needs.

The preceptors and staff nurses who participated in this study confirmed that students were indeed part of the team. To that end, they engaged in a process which encouraged the students to provide information and address questions about their assigned patients during rounds, facilitated the student to provide patient reports to other health care providers and by assigning the student more responsibility when deemed appropriate. According to Kaihlanen, Lakanmaa and Salminen (2013), students value preceptors who treat them like colleagues and provide them with opportunities to assume more nursing responsibilities. Similar to these findings, the students in this study wished to be treated the same as other nurses on the unit. The following excerpts reflect how the preceptors and the staff nurses provided opportunities for the student to become involved and act as a member of the team. One preceptor artfully stated:

> The way that we foster them on the unit is how they will work. So if we're kind and caring and supportive, we'll get a kind, caring, supportive co-worker in the end (Jamie, Preceptor Interview #1, p3, 120-124).

A second preceptor shared:

> I introduce them to everybody and encourage them to (engage). Everybody sits in report and talks and encourages them to participate in that and they usually go for coffee with us. Also, I think getting them to work with all the different staff doing stuff makes them feel more part of the team rather than they are stuck with me and aren't allowed to go…yeah I think getting them to work with everybody does that (Alex, Preceptor Interview #2, p18, 813-819).

A third preceptor articulated:

> I just involved them with everything. They have to learn so it might as well be when you're a student. Get them talking with physio and ask for their input on the patients,

> with physio, with the doctor, with everybody. Just get them involved. "You know about your patient, you talk to the doctor that wants to know questions and stuff". Just include them, take them on breaks, show interest in their personal life and ask for their input on cases (Kelly, Preceptor Interview #1, p21, 941-946).

One staff nurse expressed:

> When they first start you make them feel welcome and introduce yourself and if they have any questions to let me know and don't be afraid to ask any questions because that's what we're here for and to teach you. Just be warm to them and it helps them out a lot to become part of the team and once their assessments, knowledge, and skills develop, not second-guessing them (Morgan, Staff Nurse Interview #2, p22, 969-975).

Students perceived acceptance as *being part of the team* when the other team members accepted them, for example, when they included them in breaks, sought to know them as people, not just students, took an interest in their personal life and asked for feedback with respect to patient care. In turn, being accepted as part of the team was found to increase the students' confidence by instilling in them a sense of independence, and self-assuredness that they could truly become a nurse. According to Rush et al. (2004) when students are accepted as part of the team, they feel free to learn, rather than focus their energy into contending with feelings of being intrusive, uncomfortable, unwelcomed and excluded from nursing opportunities. Similarly, Pront et al. (2013) found that students who engage in a non-positive student/preceptor relationship tend to invest more time and energy into managing the relationship rather than achieving their learning outcomes. Moreover, students are more relaxed and able to learn when the attitudes, behavior and support of the preceptors and staff nurses are welcoming, nurturing and inclusive (Charleston & Happell, 2005a). As advocated by Schön (1987), when students are composed and

perceive minimal anxiety they are more receptive to learning. They are free to perceive, compare and manage different meanings of a situation, thereby gaining a richer understanding of the phenomena. As students gain more knowledge, they gain more confidence, thus, they are better able to reorganize and restructure the meaning they ascribe to their nursing encounters and situations. One student expressed:

> The supportive part is the team work. You don't want to feel that you can't go to somebody that you are working with, another nurse, preceptor and feel that ok am I going to be stupid are they going to cut me down you know are they going to say just go look in a book which I mean is a great example for starters ok go look in the book and come back to me. Feeling like you are part of the team, welcomed; you are not an outcast (Devon, Student Interview #1, p1, 24-31).

Another student shared:

> They included me in like everything – just even general conversation they would include me in it so it made me feel as a part of the group, I wasn't just an outsider. They involved me in asking questions or say if they have something going on and they're just asking everybody's opinion, they would also include me. They would also be there for me if I – like I could go to them and ask them a question if my preceptor was busy or wasn't around and they were always willing to help (Gerry, Student Interview #1, p3, 98-106).

A third student articulated:

> The staff made me feel like part of the team by inviting me for lunch instead of secluding me to the student area. You know, involving me and treating me like I'm an actual nurse on their floor and not just someone there to learn and leave sort of thing (Taylor, Student Interview #2, p10, 414-419).

A staff nurse articulated:

> So we all try and work together to get the student the time they need to be learning the skills and be familiar with the area so that they can get everything they need and all other patient care needs are met safely (Morgan, Staff Nurse Interview #1, p5, 247-251).

The students who participated in this study shared that the preceptorship enabled them to appreciate the bigger picture. For example, as the practicum progressed, students were enabled to think more broadly owing to the fact they were not as focused on attaining specific skills or understanding a precise diagnosis. In other words, they were able to think about the patient holistically with needs that transcended a diagnosis. The value, as expressed by the students, of being able to perceive the bigger picture, was the feeling of genuine acceptance it generated as a member of the team, which they found served to increase their knowledge level and provided them with the confidence to share their thoughts and ideas about patient care without fear of rejection. Putting the pieces together and working as a team member enabled the students to develop a sense of confidence that they could actually be a bona fide nurse. Such findings are in accordance with those of Cope et al. (2000) and Vallant and Neville (2006) who reported that student acceptance into the workplace culture could increase student confidence, thereby increasing professional competence. One student shared:

> I found I was putting all the puzzle pieces together. Like it all makes sense now, I'm competent, I can do this. I'm not as proficient as someone who has been in the career for 20 years, but I am like a sponge and I'm taking it all in and I'm building on my skills and I'm slowly…I'm advancing. And you can see the improvement and like I even had ah ha moments like oh my goodness I get it, oh my goodness I can do this, you know, just the improvement of everything. I can see my progression. And I've noticed that through the

> course of my final senior practicum, how much I have progressed as a student (Casey, Student Interview #1, p23, 877-888).

Another student expressed:

> I think it's just like going from – when you're a student in like fourth year or third year and you don't have that independence and you don't have the whole picture? It's like you only have a little snippet, like say you have two patients, three patients and you just kind of – not completely looking after them. You just have little bits and pieces but to get the whole idea of what nursing is really like (Robin, Student Interview #2, p12, 523-529).

The students indicated that they sensed they were genuinely a member of the team when they began to contribute more to the dynamics of the team, especially when they could contribute to discussions regarding patient care. Many of them perceived they were truly a part of the team when the preceptors and the nurses sought their input regarding patient care. In other words, the students truly perceived they belonged when they were included in the discussions and their opinions were valued with respect to how to proceed with patient care. According to Levitt-Jones and Lathlean (2008) students tend to feel more empowered and enabled to maximize the available learning opportunities when they feel they have a legitimate place on the nursing team, and are more self-directed and independent in their approach to patient care. They are also more confident in negotiating their learning needs, when asking questions and in questioning practice. One student shared:

> As the semester progressed I found I contributed more to the team work and the greater good of the department because I was more able to work independently. So I could go off and triage by myself or I was assigned my own patient. And the one day I always refer back to was the one day I kind of put all the puzzle pieces together, is when I triaged a

> man with chest pain, got him into his room, hooked him up to cardiac monitor, you know started an IV by myself and then I referred back to the doctor. So it was very independent and the follow through of ok chest pain, ok this is what we do next, ok this is what we do next (Casey, Student Interview #1, p3, 98-109).

Another student expressed:

> You start to really feel like you're contributing and you're starting to see patients get better and you're starting to see the outcomes of your interventions and…that's what gives you that boast too; that you're actually helping somebody (Brett, Student Interview #1, p10, 354-358).

As the data unfolded, the participants also came to acknowledge that *networking* had the potential of optimizing student learning during the process of *guiding reflection*.

Networking. *Networking*, within the context of preceptorship, was described by the study participants as a process of seeking out relationships with other health care team members in order to achieve learning goals and objectives for the student. Generally, *networking* occurred for the purpose of accessing diverse situations/encounters in alternate areas of the hospital or to cultivate relationships with the nurse or health care team member with the most expertise.

Both the preceptors and the students expressed the importance of optimizing learning opportunities by seeking out the nurse with the most expertise or knowledge. For example, a number of participants sought out nurses, other than the preceptors, who were perceived to have the most knowledge and/or experience with specific patient care situations. These findings are corroborated by those of Sedgwick, Yonge and Myrick (2009) who noted that students in their study identified the importance of building relationships with other team members in order to seek out and integrate nursing knowledge into their practice. One student expressed:

> I sought out the nurse who would meet my needs, some were better teachers—they would go through the details and take the time, and give rationale for what they were doing (Brett, Student Interview #1, p24-25).

Another student commented:

> If there was something that my preceptor and I were approaching that the preceptor wasn't that familiar with or felt that somebody else would give me a better experience, then we would approach that person, or I would approach that person, or he would approach that person (Robin, Student Interview #1, p5, 200-204).

One preceptor acknowledged:

> I'm not saying I'm the best nurse or anything. I know my limitations and I know who's good at what. And if she wants help with something, she might as well learn from the best (Kelly, Preceptor Interview #1, p26, 1143-1146).

An important variable found to underpin the process of *networking* was the preceptors' ability to communicate with other departments to locate additional learning opportunities for the students. In turn, the staff in other departments would then call to inform preceptors of potential opportunities on their unit and subsequently invite the students to participate. Similar to the process of *networking*, Kleinpell et al. (2002) found that collaborating provides an added value to patient care owing to the on-going communication that occurs among members of the team. One student expressed:

> They were all so excited to have a student and almost fighting over you. If I was working on the third floor, they'd be phoning from emergency, "come down, I've got this that you can do", because everybody knows that there's a student here now. As well, the preceptor

> did that a lot of times, she would make sure that everybody was aware the student was there and to call if something came up (Brett, Student Interview #1, p3, 98-105).

One preceptor shared:

> Even though the student is solely with me, I always tell the other staff with their patients that if they have something that they want or they think the student would like to do, to just ask me and we'll see where we're at and if we have time to do that or not, so it's not only me that's looking for new experiences; I also have the staff that I'm working with looking for new stuff as well (Alex, Preceptor Interview #2, p4, 139-146).

Another preceptor suggested:

> Maybe [different experiences] aren't available on our ward, let's start investigating other wards, let's see what they have. Is there anything out of the ordinary? To make them [other nurses on different units] aware to phone me and make that opportunity available to the student (Corey, Preceptor Interview #1, p2, 59-63).

Keeping with the notion of *belonging*, it also became evident that preceptors and students alike valued the importance of *reciprocating*. As data emerged, participants in this study acknowledged that *reciprocating* contributed significantly to the students' sense of *belonging*.

Reciprocating. A number of the preceptors and staff nurses who participated in this study shared that, although they were responsible for facilitating the students' learning, they also learned from the student. It was found that the preceptors and staff nurses either were seeking information from the students to evaluate what they knew or they were seeking information to confirm they themselves were current in their own practice. For example, the preceptors and staff nurses requested that the students demonstrate skills to ascertain current practice. They inquired about the content students had been taught in school and they consulted with the students

concerning the new literature pertaining to patient care. In other words, some preceptors were actively seeking new ideas and up-to date practices from the nursing students. These findings are similar to Yonge et al. (2013) who found that some preceptors request to be assigned to students because it provides opportunities for mutual growth. Moreover, not only do the students benefit from the relationship, but the preceptors benefit as well with regard to the acquisition of new knowledge and becoming up-to-date on the current practices. One student expressed:

> There have been some instances where they [preceptors] weren't sure of the most current reasoning or they would ask me what I was being taught and then compare it to what they would do, what they had been taught to do or what their policies and procedures were (Robin, Student Interview #1, 9, 373-379).

Another student shared:

> Some of these nurses have been in the field for fifteen, twenty years, right? And when we're in school we're getting taught these new procedures and new ways of doing things and it's like, this is recommended now as opposed to this, so they are learning from us as well because things have changed and evolved over the years and there are new practices and policies for doing things and they might not be as up to date on (Casey, Student Interview #2, p9, 379-387).

Yet another student articulated:

> [Some nurses are] keen and it was because we were learning things now in our nurse training that she hadn't learned twelve years ago and she was still very keen to learn and she was very into staying up-to-date and wanting to take on those new learning experiences and she was wonderful. From day one she approached me and she told me

> that she was so excited that they had a student on her rotation because she always learned so much (Brett, Student Interview #2, 16, 716-724).

The preceptors and staff nurses stated they were more likely to remain current with their nursing practice when they were assigned to students inasmuch as it required they role model best practices. When the students asked them questions or sought clarification about the various aspects of patient care, preceptors perceived that it was their professional responsibility to teach best practices and not demonstrate short-cuts that they had acquired over their years of practice. Yonge et al. (2013) similarly found that preceptors who use short-cuts in their practice, take care to teach the students procedures that are based on current evidence. One preceptor shared:

> I learn too, it's not only the student learns, I learn too. Because we don't all know everything and if they come to me with a question that I don't know, I'll say I don't know let's find out. So if forces me to stay current and it really forces me to stay up to date and on top and I learn too (Alex, Preceptor Interview #1, p19, 729-734).

One staff nurse expressed:

> I mean, you get out of school and you are by the book and then you start working on the ward and you start skipping steps to make it easier and it kind of takes you back and it's like, well now you have to teach by the book and research. The students – I mean you are researching the lab work and you are researching diseases and you are making care plans…it's a good refresher and you do learn a lot of new knowledge (Darren, Staff Nurse Interview #2, p15, 678-685).

Another staff nurse articulated:

> Students are the ones with the most current knowledge. If they are a good student, they ask really good questions. If they are asking a lot of questions that are difficult ones I am

> not going to say, "I don't know" and not go and find the answer. We'll go find the answer together and if we can't then it's a really good question (Morgan, Staff Nurse Interview #2, p28, 1266-1269).

The preceptors conveyed they learned how to be better teachers and how to communicate more succinctly owing to their role within the preceptorship. They communicated that facilitating student learning provided them a means of understanding and acceptance of alternate perspectives when providing patient care. In other words, some preceptors came to the realization that their way was not necessarily the only way to provide nursing care. According to Yonge et al. (2008b), precepting affords preceptors the opportunity to improve teaching skills and provides the satisfaction of knowing that the student has developed and ultimately benefited from the process. Similarly, Lillibridge (2007) found that preceptors benefit from the preceptorship owing to the fact that it provides a means for professional growth, knowledge development, the opportunity to teach and the satisfaction of being involved in someone else's learning. When preceptors and staff nurses are receptive to students and their ideas they themselves are provided a window for introspection through which they can ascertain who they are within the context of their practice, thus enabling them to envision new ways with which to provide care (Johns, 1995). One preceptor found:

> [Thinking of] different ways of helping people learn, that helps me learn and it's finding a different way for them to come across it: "Okay you aren't getting it – what am I saying that you don't understand" – then find something…a different way to relate it to them and they're like, "Oh that makes sense" and that helps me because now I know another way of explaining it (Dallas, Preceptor Interview #2, p17, 763-769).

Another preceptor expressed:

> You learn how to handle yourself better. Like, learn how to try to be a better teacher out of it. You learn communication skills from the students and stuff (Kelly, Preceptor Interview #2, p9, 400-402).

A third preceptor shared:

> You learn how to work with people and to talk with people and you learn that people learn in all different types of manners and it's just – I think it's great, yeah. It's rewarding, you just feel a sense of self-satisfaction knowing that you're able to essentially train a nurse kind of in a manner that you think a nurse should be. I think that's a good thing (Jamie, Preceptor Interview #2, p14, 631-639).

As data were analyzed, it became apparent that *paying tribute* was a significant aspect of *guiding reflection*. Participants in this study conveyed that *faculty advisors* and *staff nurses* were vital to the process of *guiding reflection* in preceptorship and *paying tribute* emerged as a means of recognizing the contribution of the *faculty advisors* and the *staff nurses* to preceptorship.

Paying tribute. Invariably, in addition to the preceptors, it was found that, throughout the study, *faculty advisors* and *staff nurses* were key to creating an environment conducive to the process of *guiding reflection*. Indeed, they proved to be vital resources to safeguarding the preceptored clinical learning environment. *Faculty advisors* were perceived as integral to providing students and preceptors with the necessary supports to engage in essential opportunities for the advancement of student knowledge, skill and confidence.

Faculty Advisors. The faculty advisor, also known as the university liaison or nurse educator, was the instructor assigned to work with the preceptor/student dyad. Participants perceived the faculty advisor as providing support to both the preceptors and students and identified them, specifically, as vital resources to the facilitation of the preceptorship placement.

These findings are corroborated by those of Luhanga et al. (2008a) and Sedgwick and Yonge (2009), who contend that the faculty advisor is key to determining the success of a preceptorship program and must be available to both the preceptor and student alike. The participants in this current study conveyed that throughout the preceptorship the *faculty advisors* were present to: a) oversee the entire preceptorship; and b) ensure the students were progressing in skill development, application of the nursing process, communication and independence. This finding is similar to those of Carlisle, et al. (2009) who found that the role of faculty advisor is integral to the learning environment through the provision of ongoing support, educational input and ensuring that nursing students are provided with valuable learning opportunities.

The students and preceptors in this study indicated that the faculty advisor was consistently available and would monitor periodically to ensure the placement was proceeding smoothly. They were accessible when required and responded to questions or concerns in a timely manner. Furthermore, the *faculty advisors* were diligent in providing both the preceptors and the students with contact information and indicating that they were available anytime, day or night. In a study by Zawaduk et al. (2014), they found that *faculty advisors* are committed to being available to support preceptors and students even though such commitments require the *faculty advisors* to be available twenty-four hours a day and seven days a week. Overall, the *faculty advisors* provided the venue for students and preceptors to express any concerns or to share their successes and struggles. Again, this finding is similar to those of Zawaduk et al. who also found that the role of the faculty advisor is to develop, maintain and facilitate communication that promotes preceptor and student development. Unlike the findings of the studies conducted by Bourbonnais and Kerr (2007), Ferguson (1996), Luhanga, Dickieson and Mossey (2010) and Luhanga et al. (2008b), in which they found a lack of communication and

support from the faculty advisor led to low morale and resentment among preceptors, the findings from this current study revealed that the preceptors and students had confidence in the faculty advisors' ability to communicate and support the preceptored placement. The findings from this study differ from those of other research findings owing to the fact that the faculty advisors are also clinical instructors for second and third year, thereby establishing a relationship prior to the preceptorship practicum. One preceptor shared:

> The faculty advisor is always available. They usually contact me before the senior practicum starts, and then usually within the first day or two the students are on the ward, they either drop by or call to see if there's any concerns. And then they usually meet at midterm and then they usually drop in again after midterm. So I haven't seen it as being a problem and they always make sure I have all the email, phone numbers, contact information and stuff (Alex, Preceptor Interview #1, p16, 623-630).

Another preceptor expressed:

> If I had any questions I knew I could go to her for help, she was always available to assist me with anything. She would guide me through the evaluations. She also helped me with student concerns, how to discuss feedback with the student (Kelly, Preceptor Interview #2, p 3, 95-97).

One student articulated:

> [The faculty advisor] is just to be there for you, like to check up to make sure you're progressing or if you need extra help or if you're having problems there's always someone to go to which I think is really good to have (Gerry, Student Interview #1, p7, 318-321).

One faculty advisor elaborated:

> I'm a sounding board if the student has, not so much even questions about her experience, but maybe she wants to talk with somebody about the relevance of her experience, that's my job. Or it's her first death or if she's feeling overwhelmed or maybe disillusioned or excited, I think that is part of my role as well (Jordon, Faculty Advisor Interview #1, p1, 42-47).

Many of the participants communicated that the faculty advisor was available to guide and facilitate the preceptorship through regular interaction with the preceptor and the student. From the faculty advisors' perspective it was important to cultivate a good relationship with both the preceptors and the students to ensure that communication was readily forthcoming, a process which allowed them to understand the dynamics of a situation, which, in turn, afforded them the opportunity to intervene prior to any problem escalating. Consistent with those of Bourbonnais and Kerr (2007), the findings from this study suggest that regular contact amongst the triad was deemed essential to the success of the preceptorship. *Faculty advisors* who took the time to develop the relationships and endorse opportunities for the sharing of problems, concerns and frustrations served to enable preceptors to focus their energy on facilitating student growth (Hsieh & Knowles, 1990). One student expressed:

> [The faculty advisor is there to] oversee what is going on and to keep in touch with the preceptor and the student and to make sure both of them are having a positive experience. To ensure they are all getting what they need out of the experience and able to voice concerns to the faculty. So, I think she is kinda like the go between. In some situations she goes between me and the preceptor, especially if the preceptor had any concerns that she didn't feel she could voice to me (Casey, Student Interview #1, p16, 602-609).

Another student conveyed the following:

> [The faculty advisor's] role is pretty much to facilitate [the experience]. I mean, making sure that this is where you are going and this is who you are with. I know that she checked in with my preceptor quite a bit and she stopped in to see me a few times asking me if it was ok, how it is going, you know you can call me (Devon, Student Interview #1, p16, 597-601).
>
> She provided a lot of support in that she had talked to everybody and a lot of the nurses. And said you know, "you're doing a good job, they like you" that kind of stuff. Keeping you positive throughout the whole thing, you're doing great, they say you're doing great. Those kinds of things. (Devon, Student Interview #2, p9, 412-416).

One preceptor articulated:

> Their role is to make sure everything is going smoothly, kind of checking in with me to see if there any issues that are arising that need to be talked about. She also checks with the student because if the student has a concern about the preceptor they are not always going to go to the preceptor and say hey you know what you aren't doing this for me (Dallas, Preceptor Interview #1, p19, 695-700).

Preceptors expressed the need for support and advice from the faculty member on an ongoing basis in order to enable them to make determinations regarding student competence. Similarly, the findings from the study conducted by Luhanga et al. (2008b) suggest that preceptors perceive faculty should make themselves readily available, especially in the event of challenging situations. Furthermore they suggest that preceptors are enabled to make critical decisions about student performance when they are supported and guided by faculty. One faculty advisor shared her thoughts:

> If you had a real conflict between preceptor and student, the student would then have a neutral person to turn to (Terry, Faculty Advisor Interview #1, p17, 658-660).

One preceptor expressed:

> If your student is having issues in an area, I think that the faculty advisor can provide ideas on how to deal with that need and because we are nurses and we're not always educators or have that background and they can give us tips on how to deal with that and steer us in the right direction (Alex, Preceptor Interview #2, p9, 403-408).

Another preceptor elaborated:

> I think they're an advocate for both. I think that they're goal is to have a student in an environment where they will learn and be successful and finish the practicum and do very well. I think they're an advocate for both. I've never felt like the facilitator is just all about their student (Jamie, Preceptor Interview #1, p14, 621-625).

One student thought:

> She is a mediator, in the middle, like between me and my preceptor. As long as everything is going smoothly then their job is good (Devon, Student Interview #1, p16, 608-611).

The preceptors found that the faculty advisor was a valuable resource for providing historical context regarding the skill level of the student and for sharing expectations concerning students' performance at various stages of the preceptorship. According to Corlett (2000), preceptors perceive faculty members to be the best source of information concerning program expectations and realistic student performance. Similarly, the *faculty advisors* who participated in this study perceived it was their responsibility to ensure that the preceptors comprehended the importance of assigning students appropriate opportunities that were conducive to his/her skill

level and that the learning opportunities were progressively challenging. As emphasized by Zimmerman (2002), it is imperative that *faculty advisors* and preceptors converse about the expected level of student progress, appropriate scope of practice and timely introduction of complex clinical opportunities. One preceptor reflected:

> They're available whenever you need to have them and they can provide whatever other information about your student, like how they learn this and have they gone over that. I'm finding once you've experienced the student and their past, they are very good. And they are knowledgeable (Jamie, Preceptor Interview #1, p14, 611-616).

Another preceptored elaborated:

> She was able to give me some things, like you know, she knew the student longer than I had, kind of what the background is, and if she was like that before. Stuff to help me maybe to keep her on her toes (Dallas, Preceptor Interview #1, p7, 241-244).

One faculty advisor expressed:

> The faculty advisor role is to ensure preceptors understand their role. I've run into that where a student has come to me and they feel that they are just on their own and they aren't getting the guidance, and I go in and I talk to the preceptor and tell them that [the student] doesn't feel comfortable at this point – they are starting out or whatever and they want a little more guidance and they want to be with them to make sure they are doing it properly (Francis, Faculty Advisor Interview #2, p2, 71-77).

Another faculty advisor shared:

> I make sure that the preceptor is comfortable, comfortable with the student, understands what the student's capabilities are, what their boundaries are, and if they have any questions to ask me (Jordon, Faculty Advisor Interview #1, p2, 55-58).

Furthermore, according to the participants in this study, *faculty advisors* provided guidance regarding the evaluation process, such as suggesting how to document notes concerning student performance, providing hints with regard to appropriate approaches to providing feedback, how to respond effectively to student concerns and what exactly to observe when assessing the student's progression. As proposed by Bourbonnais and Kerr (2007) and Yonge et al. (2011b), communication between the faculty advisor and preceptor is vital to ensure that preceptors are supported in the evaluation process of students. One faculty advisor articulated:

> I will help them fill out the evaluation form if they have trouble as well if they're new at it, I've even taken them out to lunch. If they want, we just sit down and have a look and – if it's a new preceptor I've actually sat down with them and went okay, this is what we're looking for and here, what kind of examples and stuff (Jordon, Faculty Advisor Interview #1, p2. 64-70).

One preceptor shared:

> When you try to evaluate someone, and you are kind of like, "where do I start?" It's really good to have someone to go to and ask and they can be like, "This is what I've seen" and just like…kind of where does that fall if I am not quite sure. Just to be able to say that this is what they are supposed to be able to do and go from on top of that (Dallas, Preceptor Interview #2, p9, 405-411).

The one consistent message shared by all the participants was the fact that they did not require the faculty advisor to be present all of the time. Rather, the preceptors and students preferred assurances that the faculty advisor would be consistently available to provide support when needed. The *faculty advisors* contended that their responsibilities were minimal depending

on whether: a) the preceptor was knowledgeable; b) the preceptor possessed an accurate understanding of the preceptor and student roles; and c) there was conflict within the preceptorship relationship. Similarly, Papp, Markkanen and von Bonsdorff (2003) found that the faculty advisor's role can be considered limited and peripheral, especially when the preceptorship is occurring without incident. A study conducted by Ferguson (1996) emphasizes the importance of faculty accessibility prior to and during the preceptorship; however, preceptors who participated in this study preferred that advisors make periodic visits rather than extended visits on the unit. Moreover, Ferguson found, when faculty members were present for extended periods of time, preceptors perceived them to be interfering with the preceptor/preceptee relationship, inasmuch as students would revert to the previous faculty/student clinical relationship at the expense of the preceptorship relationship. One preceptor shared:

> I haven't had too much involvement with the faculty advisors. Basically, they know if I run into a problem I will contact them. They have come to the ward a couple of times and had meetings with me and the students. If everything is working fine, then they seem to trust me enough to know that I will do something if something is not working as it should (Corey, Preceptor Interview #1, p22, 835-841).

One student expressed:

> I knew she was there, you know, so I wouldn't really need to talk to her. I'd just sort of update her as I needed and she would give me feedback right away so to me that was supportive. If I called her or emailed her she got back to me within a few hours or so (Taylor, Student Interview #1, p5, 182-186).

One faculty advisor stated:

> A fairly hands off position in that the students interact primarily with the preceptor and report to me or ask me when there are problems. (Terry, Faculty Advisor Interview #1, p1, 8-9).

While the students in Sedgwick and Yonge's (2009) study conveyed asking the question, 'how is it going' did not facilitate an in-depth exploration of their practicum, participants in this current study acknowledged that saying hello and asking 'how is it going' was a precursor to a far more comprehensive discussion about the progress of the student. The *faculty advisors* sought information about the students' progress and they generally concluded students were progressing when the students and preceptors indicated the student was gaining confidence, had an increased patient load, and was becoming more efficient at completing tasks. The following excerpt highlights how one faculty advisor used questioning to ascertain the progress of the student:

> [My role is to assess] whether they're doing well or not and ask questions. I don't just go say hi, how are things doing, I ask very specific questions, [such as] what are assessment skills like, are they improving, could she prioritize, is she becoming a more independent thinker or is she coming up with some conclusions. (Jordon, Faculty Advisor Interview #1, p10, 441-446).

The *faculty advisors* indicated they sought feedback from both staff and preceptors alike. Formally, they met with the preceptor and students to complete midterm and final evaluation forms, however, informally the *faculty advisors* also met with the nurse managers and *staff nurses*. Although the *faculty advisors* did not necessarily seek formal feedback from the nurses on the unit, they did take opportunities on their site visits to informally discuss with the nurses how the preceptorship was progressing. As suggested by Sedgwick et al. (2009), when *faculty*

advisors seek input from nurses on the unit about student performance, they gain valuable insight into the preceptorship. Two faculty advisors shared:

> I don't go seeking them out. But if they're sitting there and I'll just go well how are the girls doing? How are our students doing? Just in general conversation because I'm not going to walk by them and not have a conversation. And it kind of gives you a little hint. You know, if they're all happy and they'll be "oh great" because the preceptor and the student might be down the hallway and I'm going to sit at the desk until they come back, I'm not going to go find them in the room. I'll just sit down and chit chat with the people that are there. And say, "how are things" in general. "How are things going?" you know, "how are the students doing" (Jordon, Faculty Advisor Interview #2, p12, 536-546).
>
> We'll just start talking or whatever and the nurses will say things like, "you're student is doing really well", and she's doing this or that (Francis, Faculty Advisor Interview #2, p10, 446-449).

As *paying tribute* further emerged from the data, it also became apparent that preceptors and students valued the contribution of *staff nurses.* As the data unfolded, participants acknowledged that *staff nurses* made a considerable contribution to the process of *guiding reflection*.

Staff Nurses. As identified throughout the literature, preceptorship is defined as a triad, or the relationship among a nurse preceptor, faculty member and a nursing student. According to the findings of this current study, however, all of the nurses working directly or indirectly with the preceptorship have an enormous influence over the learning process. Similarly, Myrick and Yonge (2001) found that nursing staff had a significant impact on the learning environment. They further articulated that staff attitude and the relationship between the preceptor and staff

was a major factor that served to influence the success of the preceptorship. Considering some of the preceptors who participated in this study valued the sink or swim approach, it was comforting for students to be able to approach *staff nurses* when providing patient care. One student conveyed:

> It was good to learn from a variety of nurses because different nurses do things differently. And the preceptor would tell you how to do something but wouldn't go with you whereas other nurses went with you to show you how to do things (Taylor, Student Interview #2, p10, 436-439).

One staff nurse expressed:

> I think [the preceptorship is] kind of gone away from just the three, that it's more of a team, we're more of a team nursing, that we kind of help each other out, it's not just you and your nurse and that's the only person you can ask. You can ask anybody. Anybody on the floor, and if you need help, any of us will help you. I think it's – instead of a more individual, it's more team nursing now than it has been (Darren, Staff Nurse Interview #1, p24, 1091-1097).

One faculty advisor shared:

> I think it is definitely a better learning environment [when staff nurses are considered part of the preceptorship]. That way, when special things happen, [the student] is taken aside to [partake in the experience]. It's kind of a collaborative thing where it's a given that the preceptor's partner is part of the preceptorship. Even though she is not really totally responsible for the student, she picks up all the slack so that the student gets the best experience (Terry, Faculty Advisor Interview #1, p14, 540-546).

One preceptor elaborated:

> [Nurses on the unit] are really good about giving me the extra time and kind of picking up the workload a bit if it is busy, to give me the time. Especially in the first several shifts when I do have to spend more time with the student (Alex, Preceptor Interview #1, p17, 637-640).

Although Myrick and Yonge (2005) contended that *staff nurses* play a secondary role to that of the preceptor in the preceptorship, the findings from this current study indicate that in some cases the staff nurse held a primary role in guiding the student in their transition to that of graduate nurse, especially when the preceptor was in charge, away for the day or if the staff nurse thought the preceptor was not providing enough guidance or support for the student. Furthermore, similar to these current findings, Myrick (2002) asserted *staff nurses* in the preceptored practice setting have a huge influence on the student's perceptions of acceptance and thus their ability to think critically which has been found to be essential for enabling the students to gain confidence and perceive that they could actually be a bona fide nurse. One student expressed:

> Everybody on the unit, especially when you work together on the same rotation, they would all sort of look out for you or make sure if you're having trouble to let them know; it wasn't just be my preceptor. I would go to her [preceptor] first, but if there was other people that could help me I would ask them as well (Taylor, Student Interview #2, p1, 35-42).

One staff nurse shared:

> If the student is really eager to learn and the preceptor is just sitting there or reading a book or sleeping or whatever, then you can tell the students that do want to learn and they are kind of looking at their preceptor sleeping or reading a book and it seems like they

> want to ask a bunch of questions so I just say, "Hey, do you want to go over this or do you want to learn this?" and give them the opportunity. If they say yes, then that's great and I go for it (Morgan, Staff Nurse Interview #2, p11, 477-484).

One preceptor elaborated:

> When we know there is a student on the floor, my rotation is very good by saying you know what, I have an IV start, do you want your student to come try, have they done IV starts yet. Different skills, they are very good at saying you know what, a female catheter, come with me and we'll go through it. So, other staff members are very grateful at taking on the student so they could experience different skills (Dallas, Preceptor Interview #1, p20, 731-737).

From the perspective of the participants in this study then, the role of the staff nurse was to guide the students through the process of questioning, foster an environment in which students perceived it was safe to ask questions, provide students with new opportunities and encourage them to attempt new challenges. According to the students, the *staff nurses* were nonjudgmental, patient and allowed them time to reflect and think critically prior to completing a task. Moreover, they were friendly and accommodating and provided many learning opportunities. The students further articulated that when *staff nurses* were active members of the preceptorship, they could readily participate in the diverse opportunities *staff nurses* provided. According to Myrick and Yonge (2005), *staff nurses* are key learning resources in the preceptorship owing to their expertise and knowledge. Furthermore, Carlson, Pilhammar and Wann-Hansson (2010a) emphasize that collegial support is of utmost importance for the preceptorship to be construed as providing a supportive learning environment for students. One staff nurse shared:

> I think [the students] are really nervous so I'm always there to help. I'm here to talk to you if you have any questions and I think a lot – if something happens or if they have any questions or say if we have a code or something – like somebody to talk to because lots of times we are used to the codes so I mean it's not much for us, but I think it's like the whole kind of debriefing that we talk about that we do that so I am very open to talk to people about anything, or any questions (Darren, Staff Nurse Interview #1, p5, 223-231).

One student expressed:

> All the nursing staff were the same way, approachable, easy to work with. You really got to know them and they got to know you, so it's just like having four preceptors all at once. It was really good (Devon, Student Interview #1, p4, 106-115).

Another student indicated:

> They're very open and happy to see a new member, I guess, like a new nursing student just to learn but they are very open, willing to help. They just included you to make you feel comfortable. But if I had any questions they'd be always – they could show me where to go if I needed to look something up or needed a second person to do something they would be there (Gerry, Student Interview #1, p9, 383-389).

A third student conveyed:

> I found everybody was very approachable for help. If my preceptor was busy, there was always the backup person. I felt comfortable that they could address my problems, or I felt comfortable approaching them. So, there were other people who helped me out when my preceptor was busy and I found that very beneficial (Casey, Student Interview #1, p5, 183-193).

A fourth student reflected:

> [The staff nurse did] basically the same things as [my preceptor], like finding out what I knew about things and then explaining things. They provided opportunities to learn by being available if I had questions and showed me interesting things (Robin, Student Interview #2, p7, 297-302).

As *guiding reflection* further emerged from the data, it became evident that *grappling with challenges* was also important to the process. Specifically, the participants found that challenges such as *staffing* and *bullying* had a vast impact on the process of *guiding reflection* in the preceptored clinical learning environment.

Grappling with challenges. The context in which the preceptorship takes place has an enormous impact upon the process of *guiding reflection*, and thus can have an effect on available opportunities for student learning to occur. The clinical learning environment encompasses all that which surrounds the nursing student, including the clinical setting, the equipment, the staff, the patients, the preceptor and the academic advisor. According to Papp et al. (2003) an effective clinical environment is one in which there is co-operation among the staff members, nursing students are genuinely regarded as younger colleagues, and a professional atmosphere prevails. It is a context in which students are appreciated and afforded appropriate opportunities to study in order to meet their learning goals and objectives. An environment supportive of student learning tends to be well-staffed with highly prepared nurses who welcome the opportunity to teach students; conversely, a non-supportive environment is one in which nursing staff are stressed, intimidating and unprepared to accept learners (Hartigan-Rogers, Cobbett, Amirault & Muise-Davis, 2007).

Although Cahill (1996) emphasized the fact that the quality of clinical placements constitutes the most significant influence on the learning process, Aston and Molassiotis (2003),

Benner et al. (2010) and Windsor (1987) all assert that learning in the clinical setting inheres many challenges, some of which are similar to the findings in this current study. Specifically, preceptors have limited control over environmental conditions, such as busy clinical settings with inadequate staffing levels, heavy workloads, insufficient continuing support, lack of resources for education and overcrowded placements. When participants were asked which challenges prevented them from providing a supportive learning environment, the most consistent answers were *staffing* and *bullying*.

Staffing. The findings from this study indicated that *staffing* directly impacted the process of *guiding reflection* in the preceptorship. When the units were short staffed, the students expressed they did not perceive they received the same support from their preceptor owing to the fact that the preceptor and student were assigned a greater patient assignment than would occur normally. Furthermore, the preceptors were overwhelmed and expressed concerns that they were unable to adequately monitor their students. According to McCarthy and Murphy (2010), preceptors express guilt and frustration when they are unable to facilitate their students' learning, owing to the busy wards, staff shortages, increased workloads, and staff absences. Similarly, Omansky (2010) suggests that to create a supportive learning environment respectful of both the preceptor and the student, preceptors need to be assigned a decreased patient assignment which would allow the preceptor time to be available for the student.

According to the participants, when units were short staffed preceptors were frequently assigned greater patient workloads, thereby impeding the preceptors' ability to be available and provide support for their students. These findings are congruent with those of Bourbannais and Kerr (2007), Coates and Gormley (1997), Hallin and Danielson (2008), Hautala et al. (2007), Madhavanpraphakaran et al. (2014), Panzavecchia and Pearce (2014), Yonge et al. (2008a) and

Yonge et al. (2002), who found that workload and lack of time hindered the preceptorship, leading to difficulties in engaging in meaningful clinical opportunities. According to Vallant and Neville (2006), when preceptors are too busy to answer questions or provide rationale for practice, the opportunity for learning in the situation becomes elusive. Many of the students in this current study expressed that they were left alone with too many patients when the unit was short staffed. They perceived a sense of abandonment at times owing to the fact that their preceptor was too busy to provide support. One student shared:

> When [my preceptor] was short staffed or taking charge or something like that, where she can't really be there for me, she would still try, she would check in but I knew it wasn't the same. I'd have a discharge and be searching for papers and I'd look around and there was no one on the floor to help me, so I would just kind of do my best (Taylor, Student Interview #1, p9, 352-369).

Another student expressed:

> You know the staffing issue sometimes…it's when they are short staffed, they really don't have time for the learning environment they'd like to provide. They don't have the time to wait until I am done all my stuff with my patient to be able to give me the learning experience of putting that catheter in because they need it right now (Devon, Student Interview #1, p4, 155-159).

A faculty advisor conveyed:

> Staff shortage is a challenge for every aspect of nursing, but there doesn't seem to be any special consideration for the nurse who is the preceptor. She is expected to plug and plug, do the very same things all day every day, whether she has a student or not (Terry, Faculty Advisor Interview #1, p12, 492-498).

The preceptors and students further articulated that they were assigned a greater patient assignment when the unit was short staffed owing to the fact that the student was counted as part of the nursing complement. This situation was overwhelming for the preceptor. Moreover, in addition to caring for an increased number of patients, the preceptor was still required to monitor student performance to ensure they were providing competent and safe care. As identified in a variety of studies, staff shortages invariably leads to students being used as an extra pair of hands, a position which prevents them from being exposed to opportunities to meet their learning outcomes (Epstein & Carlin, 2012; Kalischuk et al., 2013; Pront et al., 2013). In their studies, Atack et al. (2000) and Zilembo and Monterosso (2008) found that when the unit is short staffed, students are viewed as staff and the expectation is that the preceptor and the student be assigned more patients. In addition, Pront et al. also found that patient acuity, staffing levels, and sick leave directly influences the preceptor's ability to be truly present with the student to provide a safe learning environment. One of the challenges for the preceptor and student in this current study was the fact that the nurses working the opposite shift of those participating in the preceptorship were responsible for the workload assignment and they appeared to view the preceptor as having additional help when in fact the preceptor actually had additional responsibilities in the nature of their teaching role. Furthermore, according to Bourbonnais and Kerr (2007), the lack of support by colleagues has an incredible bearing on the students' ability to learn, inasmuch as the preceptor may be too overwhelmed with the patient assignment to take the time to be with the student. One student commented:

> Cross shift would make the patient assignments and give the preceptor and student all heavy patients. I don't know if they thought that was okay, because you have a student –

> you can do double or whatever because it'd be both of us doing it (Robin, Student Interview #1, p17, 773-781).

One preceptor shared:

> They think the student is extra staff and feel the preceptor is not doing anything, therefore should be helping on the ward. If your colleagues are on board with this idea that you're precepting and it makes it easier, whereas, if they're thinking well now you're just sitting there doing nothing and you should be off helping me…which is not the idea behind the preceptor role, I don't believe. You're supposed to be available for your student (Jamie, Preceptor Interview #1, p6, p252-263).

Another preceptor expressed:

> We get these really long periods of when we are really short staffed and then having a student during that time is difficult because your student, they aren't supposed to be counted in our census but a lot of times they are (Dallas, Preceptor Interview #1, p10, 372-375).

As *grappling with challenges* emerged from the data, it also became apparent that preceptors and students alike considered *bullying* to be a challenge that directly impacted the process of *guiding reflection* in the preceptorship. As data materialized, participants acknowledged that *bullying* was not necessarily pervasive, however, it did appear to be somewhat of an undertone in the clinical areas.

Bullying. The findings from this study indicated that *bullying* was not always overt, rather, it appeared to be a latent characteristic of some of the relationships between members of the nursing team. Although *bullying*, generally viewed as violent behaviour in the workplace, has been described in a variety of ways in the literature, most authors concur that such behaviour is

always counterproductive to the essence of nursing, which is caring (Thomas, 2010). Different descriptors such as lateral violence, horizontal violence, eating their young, hostile behaviour and incivility have been referenced in numerous articles and can be used to describe *bullying* in the workplace. Furthermore, *bullying* has been described by Becher and Visovsky (2012) as unwanted abuse or hostility within the workplace which may include unbecoming behaviours such as: public reprimands, ignoring, refusing to help, staring, negative comments, gossiping, frequent sighing and treating individuals as if they are invisible. As articulated by many of the participants, *bullying* was evident in the workplace, however, similar to the findings by Curtis, Bowen and Reid (2007), only a few participants were targets of *bullying*. Indeed, students did share their stories about either witnessing or hearing stories about others being bullied.

As reported, a small number of students were approached by other nurses who complained about their preceptors, indicating that she/he was not helping her enough; that the preceptor should be taking a more active role with patient care. The implication was that the preceptor assigned her/his patients to the student and thus was not pulling her/his weight on the unit. Another example of *bullying* or unprofessional behavior, as shared by the students, occurred when the cross-shift assigned heavier patient assignments to the student and preceptor and then proceeded to discuss student performance in a derogatory manner. Similar to the study conducted by Curtis et al. (2007), a student in this current study expressed feelings of invisibility when she was ignored by other nurses as she endeavoured to receive report for a patient who was being admitted to the unit. One student shared the following:

> I went to pick up my patients and not one of them gave the report to me until I said ok I'm getting report. They would give it to my preceptor, they looked past me every time (Devon, Student Interview #1, p7, 261-263).

> Not so much on my team. But on other parts of the team or the cross shift were coming on and they'd belittle students, "oh they didn't know how to do this", "why didn't they just ask". How are you supposed to go to somebody and ask when they have that attitude all the time (Devon, Student Interview #2, p2, 49-53).

Notwithstanding, most of the students expressed that they received favourable responses from the preceptors and nursing staff when they asked questions, however, there were a few instances in which the students conveyed they could not approach certain nurses owing to the fact they did not discern it was safe to approach them. They perceived they would be judged for not knowing something rather than being supported in their endeavour to engage in learning. Similarly, Kelly and McAllister (2013) found that students learned quickly that some *staff nurses* and preceptors celebrated questions and others perceived students to be a burden. Although, Charleston and Happell (2005a) found that it was important nursing staff remain welcoming and inclusive, it was ultimately the preceptor who influenced the students' preceptorship. One student expressed:

> It's their personality or their aura, what they [portray]. If they're nice and you feel comfortable with them then you can ask questions. If they're more hostile towards you or just you get that vibe off them, that they don't want to answer your questions, then that's not going to be safe because you're not going to want to go to them and ask them a question when you know they're going to judge you (Gerry, Student Interview #2, p2, 71-78).

One staff nurse observed:

> There are rotations with preceptors - the preceptor may want the student but there's other nurses on staff on that preceptor's rotation that couldn't give two hoots if the student is

> there. Which is sad. And you don't want to come into that as a student. That's just mean, you know. [The student is] not going to be thinking about learning new skills and knowledge regarding nursing and patient care, [they will] be thinking oh man, that [nurse] really doesn't want me to be here and you're going to be looking over your shoulder and you're going to be nervous about screwing up and all that kind of stuff (Francis, Faculty Advisor Interview #1, p10, 432-446).

One faculty advisor stated:

> Where there is lack of a team or when two staff members don't work well together, it makes it very difficult for the student because if the preceptor has an issue with another nurse that they are working with and the student goes to that other nurse for help for some reason or other, the student suffers in the end because she won't want to help (Terry, Faculty Advisor Interview #2, p7, 347-353).

Although many of the participants in this study did not perceive they had been bullied per say, they did express the sentiment that *bullying* was pervasive and appeared to be somewhat of an undertone in the clinical areas. Consistent with the findings of Foley, Myrick and Yonge (2013), many of the participants in this current study witnessed *bullying* or shared stories of conversations with other nurses who have encountered *bullying*. When students are exposed to *bullying* or even witness *bullying* behavior they tend to feel humiliated, disrespected, powerless and invisible (Curtis et al., 2007). Furthermore, it has been found that as victims of *bullying*, students often remain silent out of fear and embarrassment (Thomas, 2010). One student conveyed:

> Yeah, I heard people talking about it. More experienced nurses bullying the less experienced nurses. Because maybe they think they should've done it this way or they're

> not doing this, they missed all this kind of stuff. You're human, you forget things but there's bullying always going on. No matter what, even though it's the perfect, it was the best environment going, there's always bullying underneath, like an undertone (Gerry, Student Interview #2, p9, 410-418).

Another student shared:

> There are some people that are scary as nurses. They would rather pick the other people apart than do their job (Robin, Student Interview #1, p20, 898-900).

The preceptors in this study expressed how they protected their students from the bullies, either by interjecting and requesting that the bully behave appropriately, preparing the students with information about the bully, or removing them from the environment in which the *bullying* behaviours were being exhibited. According to Hegenbarth et al. (2015) preceptors provide protection for their students by limiting exposure to *bullying* behaviours. As with the preceptors in this current study, however, some participants espoused the notion that contending with nurses who were difficult was a learning opportunity in itself. One preceptor expressed:

> Bullying occurs, but I think you can deflect from it, I think you can help the student cope with it. I think because you do have your position on your unit with your colleagues, that if you're a strong preceptor or a nurse in general you just say, "hey you guys, like c'mon. Really? Give them a break, they're my student and you know you can't talk to them like that" or whatever, whatever you need to protect your student and just to let people know, they're learning, they are allowed that opportunity and berating them or whatever you're doing is just not going to facilitate them being a good productive nurse and they're not going to want to work here and we need them to work here (Jamie, Preceptor Interview #2, p14, 606-620).

Another preceptor shared:

> I think it definitely takes place in the workplace. I think it's really letting the student know that if someone is just trying to be rude or if they are just really trying to give them some constructive feedback…because I know that it all depends on whom it's coming from that it can come across both ways. So it's really just kind of helping them to understand that, "I know it sounded rude but I don't think she meant it to be rude and I've spoken to that nurse and it's not that she was trying to be rude; she was just trying to make sure that you understood" (Dallas, Preceptor Interview #2, p16, 709-718).

A third preceptor conveyed:

> I talk to the student because you are not going to change the nurse's behavior. A lot of times it's, I would say almost harassment issues. I will take that student aside, ok I have known this person a lot longer than you, this is her manner, this is what you can expect, and this is how you deal with it. I don't want you to take it personally. If you open your eyes you will see that person treats everybody exactly the same way, it has nothing to do with you being a student (Corey, Preceptor Interview #1, p21, 809-816).

While most of the participants discussed the unprofessional behaviours of nurses and coworkers, they were reluctant to label the behavior as *bullying*. They preferred to use words such as intimidating, drama, cattiness and attention-seeking. It was interesting to observe, that the preceptors seemed to think the behavior was acceptable. They appeared to excuse the actions of the bully, rather than confront them directly for their unprofessional behaviour. What was illuminating was the fact that several of the students and the preceptors did not readily recognize that *bullying* was even taking place. They tended to gloss over it as drama in the work place or as individuals attempting to gain attention. The question that such a situation poses is, has *bullying*

become so pervasive that nurses do not recognize it for what it actually is? Similar to the findings of *bullying* by Foley, Myrick and Yonge (2012), the participants in this study were prompted to question whether there is in fact a norm of such behaviour in nursing that continues to be enabled by those within the profession. One preceptor expressed:

> Well, bullying probably is a strong word but I think it does happen and sometimes I think it's more intimidation and being put on the spot and that could be construed as bullying and that does happen. I think that I have had that in the past and I always say to the student, "everyone is different and if you feel intimidated by someone, you need to tell me or we'll deal with it or tell them" because it's their learning experience too and they have the responsibility to get the best experience that you can and if someone is interfering with that (Alex, Preceptor Interview #2, p19, 829-838).

A student conveyed:

> Some of the staff had personal issues with other staff or felt like this personality is trying to get attention or whatever and like the police walk in and this nurse always jumps up and assists the police and you know? It was just like some personal comments towards other nurses and things like, some cattiness. I didn't necessarily think there was bullying, but there was just kind of like drama and comments and stuff like that (Casey, Student Interview #2, 14, 621-635).

A faculty advisor elaborated:

> There is an awful lot of bullying and stuff that goes on and it's not always recognized as bullying in the system and senior people can be very demeaning to their coworkers, there is an awful lot of ugly talk about some people and I think that is a really terrible thing to start out as a student (Terry, Faculty Advisor Interview #2, p10, 414-420).

As the study progressed and data emerged, it became apparent that one preceptor/student relationship was disparate from the others. Thus, it became important to examine this negative case to ensure that all the data were accounted for by the researcher.

The Negative Case

A negative case is one which refutes the emerging conceptualization of the data and compels the researcher to explain or account for the fullest range of the data (Schreiber, 2001). In grounded theory research, it is incumbent on the researcher to examine negative cases. Such analysis permits the researcher to analyze data which seemingly conflicts with the emerging variables and thus, the researcher is obliged to consider explanations which account for all of the data (Schreiber). In this study, a negative case was revealed in which one preceptor, who was precepting for the first time, indicated that her/his student was not performing as expected. This situation was different from the other data, owing to the fact that, according to the other preceptors, their students progressed and developed according to expectations.

As data emerged it became evident that one preceptor encountered ongoing challenges with the student. Even though the preceptor indicated a willingness to teach and share knowledge with the nursing student, the student exhibited attitudinal behaviours that frustrated and discouraged the preceptor, resulting in a less than adequate preceptorship. Similar to the findings of this current study, Luhanga et al. (2008a) found that students who appeared over-confident, displayed a know-it-all attitude, were unreceptive to feedback, lacked organizational skills and were unable to follow direction were the most difficult to teach. Correspondingly, Yonge et al. (2008b), discovered that teaching became difficult when students exhibited a lack of motivation, initiative, preparation, and displayed an unwillingness to learn. The preceptor in this negative case shared the following:

> The problems that I had were like you try to tell her something and she wouldn't listen, she was so unorganized and you'd try to set her up. She did well if you set boundaries and limits for her, but if you didn't set that for her, she would just putz around and procrastinate and stuff. It was frustrating. (Kelly, Preceptor Interview #1, p7, 293-301).
>
> A student not taking the feedback that's offered. That makes it really challenging. You go and tell them so many times and then it's like…okay do what you want then I guess. It's just tough (Kelly, Preceptor Interview #1, p18, 804-807).
>
> She was disorganized and she thought she knew more than she did (Kelly, Preceptor Interview #1, p20, 903-904).

The preceptor further articulated doubt in her/his own ability to fulfill the role of preceptor, as reflected in the following excerpt: "I was second-guessing myself. Not really second-guessing, just not knowing if I was doing everything right, like teaching them the best that I could" (Kelly, Preceptor Interview #1, p36, 1628-1630). Hrobsky and Kersbergen (2002) assert that preceptors working with challenging students express feelings of fear, anxiety and self-doubt. This particular preceptor in this current study further elaborated that assuming the role of preceptor for the first time, not fully understanding the role, and feeling particularly nervous about assuming the role, added to his/her feelings of discouragement and frustration. As illustrated by McCarty and Higgins (2003) and Warren and Denham (2010), preceptor preparation is one of the most important factors for a successful preceptorship, however, frequently preceptors are not adequately prepared for their role of teacher and evaluator. Furthermore, Hallin and Danielson (2008), Hyrkäs and Shoemaker (2007), Yonge et al. (2008b) and Yonge et al. (2012) all concur that a quality orientation program which provides systematic

support and assistance with evaluations, seems to increase preceptors' confidence and critical awareness of the role.

Although the experience of this particular preceptor was different from the other preceptors and appears to conflict with the emerging variables, upon analysis of this negative case, it was found that it was in fact an anomaly rather than the rule in this preceptorship.

Chapter 5: Summary, Conclusions, Implications, Recommendations and Limitations

Summary and Conclusions

The purpose of this study was to examine the social psychological process involved in creating an environment conducive to student learning in preceptorship. A grounded theory approach was utilized to ascertain the process involved in creating such an environment. A purposive sample of 16 participants (six students, five preceptors, three faculty advisors and two staff nurses) were recruited to engage in the research process and share their stories as to what they perceived was happening in the preceptored clinical learning environment. Through analysis of semi-structured interviews of the participants, concepts and relationships were uncovered that explained what was actually occurring in the preceptorship. Findings from this study revealed that a preceptored clinical learning environment is one which entails a process of *guiding reflection* which, in this particular instance, was informed by the following ambient conditions: a) *the balancing act*; b) *making time*; c) *belonging*; d) *paying tribute* and e) *grappling with challenges*.

The core variable of *guiding reflection* enabled nursing students to engage in reflective practice to fulfill the goal of becoming a safe and competent practitioner. While the preceptors and *staff nurses* in this study indicated that they engaged in the process of *guiding reflection* to ensure that the learners could think critically about specific situations to gauge the impact on their practice, students also were found to actively engage in the process of reflecting upon their own actions and performance. According to the students, engaging in the process of reflection enabled them to recognize their progress towards becoming a more independent and competent nurse and provided direction as to what they required to further learn.

Significant to the process of *guiding reflection* was the *balancing act*. In other words, *knowing when to be present* in a situation and *knowing when to let go*, owing to the fact that preceptors needed to ascertain when the student was ready for more independence. A primary responsibility for the preceptors in this study was knowing how to balance student independence with student supervision, so that students were enabled to increase their clinical skills without being too overwhelmed or not being challenged enough.

The element of *knowing when to be present* surfaced as being vital to the process of *guiding reflection*. Many of the preceptors and students who participated in this study described a sink or swim phenomena. The students expressed concern that they were not supervised enough when the preceptor left them to provide autonomous care within the first few days of the preceptorship. When they were required to perform on their own too quickly they tended to worry excessively about performing incorrectly, rather than building confidence in their ability to provide safe competent care. Although the preceptor would provide assistance if they sought help, the students still expressed feelings of vulnerability when they were providing care on their own. The preceptors who assigned the students a full patient assignment early into the preceptorship, assumed that students had not provided care for more than two to three patients prior to their senior practicum and were concerned they lacked time management and priorization skills. Subsequently, their approach was to immerse students into a full patient assignment early in the practicum.

Knowing when to let go signifies the dilemma preceptors faced when they determined how to ascertain when a student was ready for more independent practice. The challenge for the preceptors was the ability to gauge when their students were ready to assume more independence and when they actually required more supervision. Preceptors conveyed that the key determinant

as to whether or not the student was ready for more autonomy was based primarily on the student's skill level and whether in fact the preceptors themselves perceived they could trust the students with such autonomy. Preceptors further asserted that students were considered trustworthy and safe when they demonstrated the ability to assess patient acuity and report significant findings. While the students conveyed, similar to their preceptors, the notion that skill level and trust was a precursor to increased independence, many of them equated safe practice to the acquisition of confidence in their own ability to perform skills or procedures. In other words, prior to performing independently, without the supervision of their preceptors, students conveyed that they themselves needed to possess confidence in their own ability to perform. Overall, the participants in this study embraced a three-stepped approach to discern when students were ready to practice more independently.

Also impacting *guiding reflection* was the ambient condition of *making time*, which enabled students to ask questions, to seek feedback and to debrief following difficult or distressing situations. Many of the participants in this study discussed the importance of students *feeling safe to ask questions* throughout the preceptorship. The students conveyed that the majority of preceptors and staff nurses were approachable and available when they pursued answers to their questions. Preceptors maintained, not only that it was their role to ensure students were encouraged to ask questions, they further expressed, that they were also responsible for *providing feedback*, formally and informally. Similarly, the students conveyed the importance of receiving feedback, identifying specifically the areas in which they performed well and the areas which required further improvement. *Debriefing* was a time for students and preceptors or staff nurses to share perceptions about situations that did not progress as well as anticipated. When the students and preceptors or staff nurses shared similar perceptions, the

student conveyed confidence that they were progressing as they should. Although several preceptors and students expressed concern with regard to the lack of time to partake in such dialogue, essentially, it was found that time was reserved to discuss questions, to provide feedback and to debrief.

Vital to the process of *guiding reflection* in the learning environment also was the notion of *belonging*. Students identified the importance of perceiving a sense of *belonging.* They coveted the opportunity to become authentic members of the team. The data in this study revealed that students were assured they belonged when they: a) participated in a *trusting relationship*, a critical factor in the process of *guiding reflection*; b) were accepted as *being part of the team*; c) could engage in *networking* to optimize learning situations by seeking out the nurse with the most expertise or knowledge; and d) engaged in a process of *reciprocating* whereby the preceptors and staff nurses either sought information from the student to inform their own knowledge base or to confirm they were current in their own practice.

As the data were analyzed, it also became apparent that p*aying tribute* was a significant aspect of *guiding reflection* in the learning environment. Although *faculty advisors* and *staff nurses* have been considered valuable to the preceptorship, their role has sometimes been overlooked. The findings from this study clearly exemplified the fact that *faculty advisors* and *staff nurses* play a significant role in creating a learning environment in which the process of *guiding reflection* can flourish. Indeed, as conveyed by the participants, *faculty advisors* and *staff nurses* were recognized as significant members of the preceptorship, members who provided students and preceptors alike with the necessary supports to engage in essential opportunities for the advancement of student knowledge, skill and confidence.

As with any learning environment, the context in which the preceptorship took place had an enormous impact upon the process of *guiding reflection*, and subsequently on available opportunities conducive to student learning. Considering the clinical learning environment encompasses all that circumscribes the nursing students, including the clinical settings, the equipment, the staff, the patients, the preceptors and the academic advisors, it is not surprising participants found themselves *grappling with challenges* such as *staffing* and *bullying*. When the units were short staffed, the students expressed they did not perceive they received the same preceptor support owing to the fact that the preceptors and students were assigned a greater patient assignment than would ordinarily occur. Furthermore, in such situations, the preceptors became overwhelmed and expressed concerns that they were unable to adequately monitor their students' performance. Also articulated by many of the participants, *bullying* was a challenge that could inhibit the process of *guiding reflection*. Although *bullying* was evident in the workplace, only a few participants in this study directly encountered its occurrence. Many of the students shared their stories with regard to either witnessing others being bullied or hearing stories concerning others being bullied. There were some instances in which the students conveyed they could not approach particular nurses owing to the fact they did not discern it was safe to approach them. They perceived they would be judged as not knowing as opposed to being supported in their endeavour to engage in learning.

To conclude, although, the process of *guiding reflection* was informed by the following ambient conditions: *the balancing act*, *making time*, *belonging*, *paying tribute* and *grappling with challenges*, the process itself did not unfold in a linear or predetermined fashion. Rather, the process was found to be fluid, permeating throughout the preceptorship. The process of *guiding reflection* was fostered by collegial relationships amongst all members of the preceptorship

which, in turn, enabled the nursing student to progress towards becoming a more independent and competent nurse. Of utmost significance was the necessity for all members of the preceptorship to be cognizant of the needs of others and to recognize that the process of *guiding reflection* was integral to student growth and success.

Implications for Nursing Education

In light of the findings of this study, there are several implications for nursing education:

1. The process of *guiding reflection* is influenced by the teaching/learning pedagogy and thus can be facilitated by a variety of educational theories such as the work of Schön and Dewey. With that said, it is important that the curriculum related to preceptorship be revised to embrace various educational theories that support such a process related to clinical teaching and learning.
2. Considering the findings of this study revealed that all members of the nursing team, in which the preceptorship takes place, have an enormous impact on the process of learning, it is incumbent on nurse educators to develop and provide preceptorship orientation and preparatory sessions that are inclusive of all members of the nursing unit.
3. Considering one of the challenges in this study was bullying, the preparation of nursing students in preceptorship settings requires an understanding of horizontal violence and more especially how students, preceptors and faculty advisors can effectively identify and contend effectively with bullying behaviours.

Implications for Future Research

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

1. This research revealed an area of study in which the process of *guiding reflection* was addressed, wherein members of preceptorship engaged to foster nursing students' progress

towards becoming a more independent and competent nurse. Research then, can be conducted to address the following question:

1.1 How do members of preceptorship conceptualize the process of guiding reflection?

2. Through the findings of this study it was found that there has been limited inquiry to how staff nurses engage with and influence preceptorship. Thus, nursing researchers could endeavor to address the following questions:

    2.1 What is the process which best enables staff nurses to engage in preceptorship?

    2.2 How do staff nurses support nursing students engaged in preceptorship?

    2.3 What is the specific role of the staff nurse with regard to preceptorship?

    2.4 How do staff nurses influence the process of guiding reflection?

3. Furthermore, the findings of this study also unveiled the challenge of contending with bullying in nursing education. Although bullying is not a new concept in nursing, it was illuminating that some of the participants did not readily recognize bullying when it was actually occurring. Nurse researchers could continue to engage in studies that focus on bullying, specifically addressing:

    3.1 How does bullying occur in preceptorship?

    3.2 How do nurses perceive that bullying occurs?

    3.3 How does the culture of nursing impact bullying?

    3.4 What is the role of the preceptor, student, faculty advisor and nurse in a bullying situation?

Recommendations

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

1. Arrange for faculty advisors, students and preceptors to meet prior to commencement of the practicum to establish rapport and share expectations regarding the preceptorship.
2. Develop and provide preceptorship orientation and preparatory sessions which integrate teaching/learning theory and which is made available to all members of the nursing unit in which preceptorship occurs.
3. Ensure that the entire nursing team of the unit in which preceptorship takes place is more aware of student learning. For example, all members of the nursing team should be encouraged to:
    3.1 be cognizant of the practicum learning goals and objectives;
    3.2 recognize how teaching/learning theories contribute to preceptorship;
    3.3 value how students learn and embrace a three-step approach to discern when students are ready to practice more independently; step one, the preceptor performs the task and the student observes; step two, the student performs the task and the preceptor observes; step three, once the student is assessed as being comfortable and the preceptor trusts the student's capabilities, the student performs the task independently.
4. Workload allocation needs to be systematically planned to ensure preceptors can adequately monitor the students and more especially the students can safely participate in patient care. Although this recommendation may be difficult to implement, a number of suggestions are as follows:
    4.1 Revise course syllabi to reflect the responsibilities of the preceptor and how she/he is charged with supervising the student throughout the preceptorship.

4.2 Revise the course syllabi to reflect the expectation that students should not be expected to perform in the capacity of a registered nurse, thus they should not be counted as nurses when the units are short-staffed.

4.3 Nurse leaders in educational and health organizations should engage in on-going dialogue regarding preceptorship and expectations of both organizations.

5. Discourse with respect to horizontal violence needs to occur at all levels of the nursing profession. Specifically, bullying behaviors occurring within frontline nursing needs to be directly addressed.

Limitations

As with any research study, potential limitations can occur. Following are the limitations that need to be considered regarding this particular study:

1. Considering the participants in this study were recruited from one undergraduate program and one health care facility, findings may not be generalizable to other programs and hospitals. If one considers the relevant literature, however, some of the findings in this study are similar to those of other studies with similar settings and participants.
2. The length of time to complete data collection may be perceived as a limitation. Data were collected over a 10 month period which may have impeded or enhanced the process. When an extended period of time elapses between interviews, data may be considered enriched because participants are better able to reflect upon their thoughts and ideas. However, one may consider the elapsed time a hindrance, as some participants may not have remembered what they had said in the first interview.

3. Living and working in a small northern community inheres possible research challenges owing primarily to the close working relationship between the hospital nursing personnel and the university nursing faculty. The researcher had a working relationship as well as personal knowledge of many of the preceptors and nurses who were recruited for the study. The risks associated with this type of relationship are related to boundaries and over-familiarization with the participants and the setting in which this study was conducted. This familiarity may have led the researcher to take for granted what was going on in the data, to make assumptions without clarification, or to inaccurately recognize patterns of behavior (Bonner & Tolhurst, 2002). To circumvent such possibilities, the researcher: a) sought guidance from her supervisor; b) ensured that all participants in the study were cognizant of the role of the researcher; c) was ever mindful of the pitfalls; and d) critically examined assumptions and actions in relation to data collection and analysis.
4. Owing to the close working relationship of the researcher and the participants it is possible that the participants in this study may have provided information they perceived the researcher wanted to hear, rather than what was actually occurring in the preceptored environment. To avoid such a possibility, considerable care was taken to ensure the participants were not exposed to researcher assumptions or beliefs about the preceptorship. Furthermore, prior to each interview the researcher clarified the roles and reiterated the responsibilities of both the participants and the researcher.

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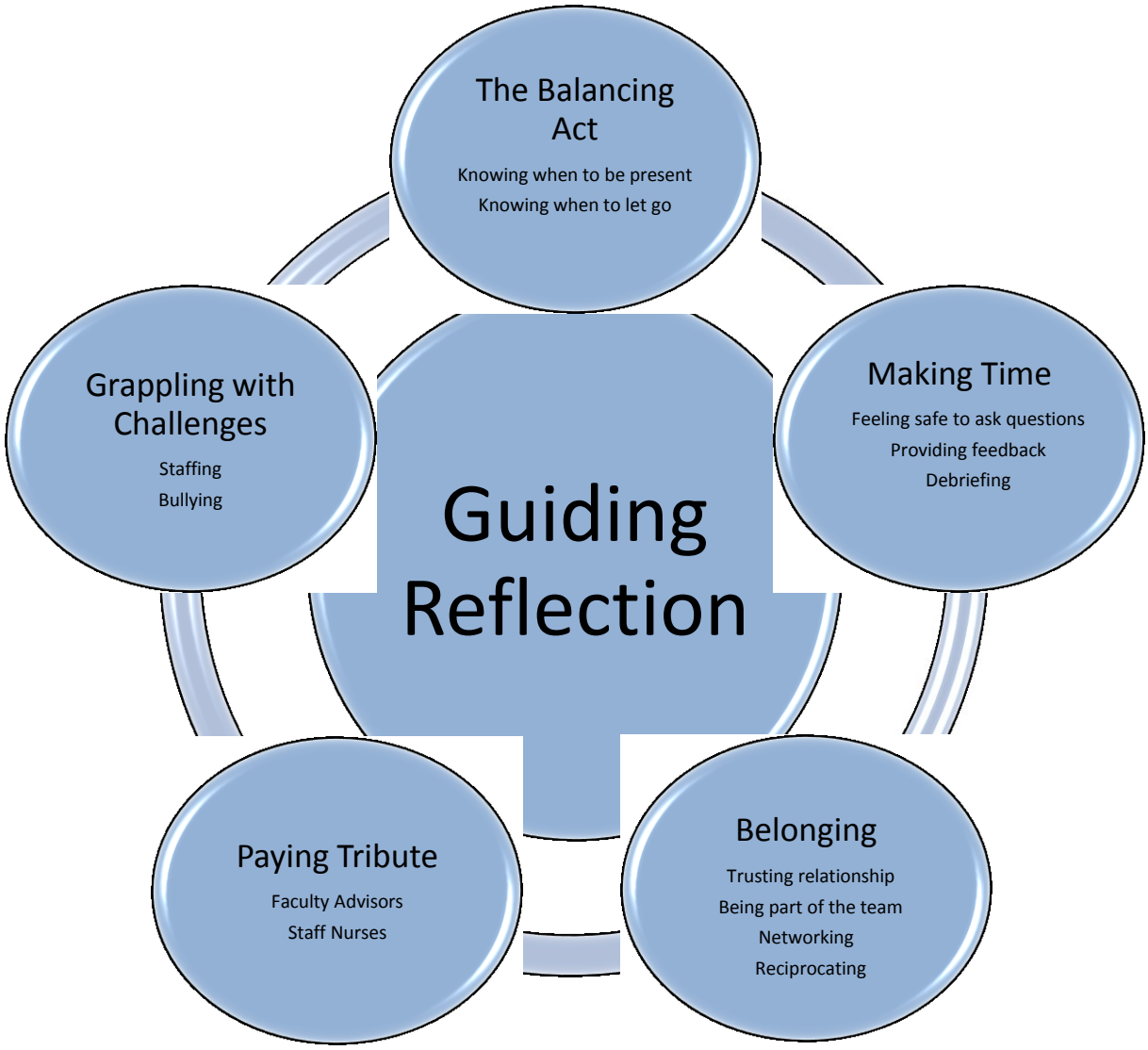
Figure 1.0: Preceptorship: Guiding Reflection in Clinical Teaching and Learning



This model is a visual representation of the findings of this research study. The core variable, the process of guiding reflection, is situated in the centre and is connected to all five key ambient conditions of the social psychological process that emerged from data analysis. Within each of the conditions are elements that were found to be essential to the process of guiding reflection. Although, each of the conditions are important, one is no more important than the other inasmuch as all five influence and support one another, are interconnected and connect with the core variable.

Appendix A: Information Poster

UNIVERSITY OF ALBERTA
FACULTY OF NURSING

Participants needed for a Nursing Research Study

I am looking for volunteers to take part in a study called Preceptorship: Creating an Environment Conducive to Student Learning. I am asking nurse preceptors, staff nurses, faculty advisors and fourth year nursing students to participate.

As a participant of this study, you would be asked to take part in 2 to 3 interviews lasting 60 to 90 minutes each.

For more information or to volunteer for this study, please contact:

Vicki Zeran, Nursing,
University College of the North
(204) 627-8583 or
vzeran@ucn.ca

This study has been reviewed by, and received ethical approval through the Research Ethics Boards of the University of Alberta and the University College of the North

Appendix B: Information Letter

UNIVERSITY OF ALBERTA
FACULTY OF NURSING

Research Project: Preceptorship: Creating an Environment Conducive to Student Learning

Investigator:	Co-Investigator:
Vicki Zeran, RN, BScN, MS, PhD Candidate	Florence Myrick, RN, BN, MScN, PhD
Faculty of Nursing Room B76 University College of the North The Pas, MB R9A 1M7 Email: vzeran@ucn.ca Phone: (204) 627-8583	Professor and Associate Dean, Teaching & Learning Faculty of Nursing 3rd Floor Clinical Sciences Building University of Alberta Edmonton, AB T6G 2G3 flo.myrick@ualberta.ca Phone: (780) 492-0251

Invitation to Participate and Study Purpose

As a graduate nursing student or faculty member, we are inviting you to participate in a qualitative research study that aims to examine the process involved in creating an environment conducive to student learning in the preceptorship experience. It is envisioned that the findings from this study will be used to advance nursing knowledge in the clinical context and enhance preceptorship as an approach to clinical teaching and learning.

Voluntary Participation

If you choose to participate, your participation in this study is completely voluntary and confidential. Should you decide to take part and at any time during the study wish to withdraw, it is entirely within your right to do so. Until such time as we, the researchers, begin to disseminate the study findings, we will delete any information that you have passed on to us if requested, and it will no longer be included in the study. You may refuse to answer any question or refuse to discuss any topic, and you can request to have the digital voice recorder turned off at any time during an interview. Your wishes will be respected at all times.

Please feel free to contact the University of Alberta's Health Research Ethics Board (HREB) at 780-492-0302 if you have further questions regarding your rights as a potential participant in this research study.

Participating in the Study

If you decide to participate, you will be interviewed approximately two to three times over a period of 6 weeks. The interviews may take about 60 to 90 minutes each. You will be interviewed at a time and place that are suitable to you and the investigator. These interviews will be digitally-recorded and, to protect your identity, will be coded with a number. Only the investigator will know your name.

After the initial interview we might need to contact you briefly to clarify or expound on a topic that we have already discussed. This will also ensure that we are correctly capturing your feedback. This part of the study, if needed, is also completely voluntary, and you do not have to take part in this follow-up to be able to participate in the initial interview.

Confidentiality

Your participation is completely voluntary and confidential. All information that you provide will be kept confidential, and only Dr. Myrick and I as the two principal investigators will share this information for the purpose of analyzing the findings. All digital recordings, transcriptions of your comments, and written notes that we collect from you will be locked in a safe that will be accessible only to Dr. Myrick and me as the investigators in this study.

Upon completion of the study, we will hold all digital recordings and documents with regard to your specific comments in the aforementioned safe for a minimum of five years in compliance with University of Alberta Research Policy. After five years, we will shred all documents or destroy those that have been saved electronically (e.g., compact disc). Because we also intend to publish and distribute the findings, the results of this study may include some of your words and actions but your name will at no time be used. The results may be published in nursing journals and presented at professional conferences. At no time will you be identified in any way.

Benefits and Risks

There will likely be no direct or immediate benefit to you for taking part in this study nor are there any risks involved. However, because of your participation you will be contributing to faculty, preceptor, staff nurse and student understanding of the preceptorship experience that in turn may help to improve the preceptorship experience for future students, preceptors, and faculty.

Based on the literature regarding this type of research, there are no foreseeable risks to you from participating in this study. We are conducting this study for the purpose of advancing nursing knowledge and to enhance preceptorship as an approach to clinical teaching and learning. For students, your participation will in no way impact your academic progress in the nursing program; and for preceptors, nurses and faculty advisors, your participation will in no way affect your employment. Conversely, if you choose not to participate in this study or to withdraw your consent to participate at any time during the study, your academic standing and/or employment will not be affected. We anticipate that there will be no financial cost to you as a result of participating in this study.

Please contact either Dr. Myrick or me for any questions or concerns that you may have about participation in this study. Thank you for your time and consideration.

Sincerely,

Vicki Zeran RN, BScN, MS, PhD Candidate

Appendix C: Consent Form

UNIVERSITY OF ALBERTA
FACULTY OF NURSING

Title of Project: Preceptorship: Creating an Environment Conducive to Student Learning

Investigator:
Vicki Zeran RN, BScN, MS, PhD Candidate
Phone: (204) 627-8583
Email: vzeran@ucn.ca

Co-Investigator:
Florence Myrick, RN, BN, MScN, PhD
Phone: (780) 492-0251
Email: flo.myrick@ualberta.ca

The following is to be completed by the study participants:

Do you understand that you have been asked to be in a research study?	Yes	No
Have you received 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 without giving a reason?	Yes	No
Has the issue of confidentiality been explained to you?	Yes	No
Do you understand the benefits and risks involved in taking part in this research study?	Yes	No
Do you consent to being digitally recorded during the interview?	Yes	No
Do you agree to have your data reviewed at a later date for secondary analysis?	Yes	No
Do you understand who will have access to your information and comments made during your interview(s)	Yes	No
This study was explained to me by:_____ Date:_____		

I agree to participate in this study.

_____ _____ _____
Signature of participant Printed Name Date

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

_____	_____	_____
Signature of investigator	Printed Name	Date

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

Appendix D: Preceptor Interview Guide

1. Tell me about your role as a preceptor.
2. What makes this role challenging and why?
3. What does a learning environment favourable/supportive to student learning mean to you? Why?
4. Tell me about the process in which you engage to create a learning environment supportive to student learning.
5. What resources are available to help you to provide such a learning environment?
6. What hinders you from providing such a learning environment?
7. Can you describe some to the hindrances you might encounter in such an environment?

Appendix E: Student Interview Guide

1. Tell me about your role as a student in the preceptorship experience.
2. What does a learning environment favourable/supportive to student learning mean to you?
3. Tell me about how your preceptor/faculty advisor/staff nurse creates a learning environment supportive to student learning.
4. Tell me about what resources are available to help your preceptor and faculty advisor to provide such a learning environment?
5. How do you think your preceptor and faculty advisor are hindered to provide such a learning environment?
6. Can you describe some to the hindrances you might encounter in such an environment?

Appendix F: Faculty Advisor Interview Guide

1. Tell me about your role as a faculty advisor.
2. What makes this role challenging and why?
3. What does a learning environment supportive/favourable to student learning mean to you? Why?
4. Tell me about the process in which you engage to create a learning environment supportive to student learning.
5. What resources are available to help you to provide such a learning environment?
6. What hinders you from providing such a learning environment?
7. Can you describe some of the hindrances you might encounter in such an environment?

Appendix G: Staff Nurse Interview Guide

1. Tell me about your role as a nurse working on a unit where preceptorship takes place.
2. What does a learning environment supportive/favourable to student learning mean to you?
3. Tell me about the process in which you engage to create a learning environment supportive to student learning.
4. Tell me about how preceptors and faculty advisors create a learning environment supportive to student learning.
5. What resources are available to help you to provide such a learning environment?
6. What hinders you from providing such a learning environment?
7. Can you describe some of the hindrances you might encounter in such an environment?

Appendix H: Preceptor Demographic Data

1. Code: _____
2. Age: please check one of the below

   □ 20 to 30

   □ 31 to 40

   □ 41 to 50

   □ 51 to 60

   □ over 60
3. Gender: _____
4. Nursing education: _____
5. Continuing education: _____
6. Total years of nursing practice: _____
7. Current practice area (Nursing Unit) and how long have you been working there:

   _____
8. Brief description of work experience and major responsibilities:

   _____

   _____

   _____
9. How many times you have acted in a preceptor capacity with students: _____
10. Briefly describe how you have been prepared for the preceptor role:

    _____

    _____

    _____

Appendix I: Student Demographic Data

1. Code: _____
2. Age: please check one of the below

   □ 20 to 30

   □ 31 to 40

   □ 41 to 50

   □ 51 to 60

   □ over 60
3. Gender: _____
4. Which nursing unit did your senior practicum take place? _____
5. Was this unit the area you chose for your senior practicum? _____
6. Briefly describe how you have been prepared for the preceptorship experience:

   _____

   _____

   _____

Appendix J: Faculty Advisor Demographic Data

1. Code: _____
2. Age: please check one of the below

   □ 20 to 30

   □ 31 to 40

   □ 41 to 50

   □ 51 to 60

   □ over 60
3. Gender: _____
4. Nursing education: _____
5. Continuing education: _____
6. Total years of nursing: _____
7. Total years of teaching: _____
8. Nursing Unit current preceptorship is taking place: _____
9. Brief description of work experience and major responsibilities:

   _____

   _____

   _____
10. How many times you have acted in a faculty advisor capacity: _____
11. Briefly describe how you have been prepared for the faculty advisor role:

    _____

    _____

    _____

Appendix K: Staff Nurse Demographic Data

1. Code: _____
2. Age: please check one of the below

   □ 20 to 30

   □ 31 to 40

   □ 41 to 50

   □ 51 to 60

   □ over 60
3. Gender: _____
4. Nursing education: _____
5. Continuing education: _____
6. Total years of nursing: _____
7. Brief description of work experience and major responsibilities:

   _____

   _____

   _____
8. How many times you have you worked on a unit where preceptorship has taken place:

   _____
9. Briefly describe how you have been prepared for the preceptorship experienced:

   _____

   _____

   _____

Appendix L: Research Budget

Item	Rationale	Cost
Room booking	For interviews	$0 (no charge)
Digital voice recorder	For interviews	$200
Transcriptionist	For transcribing digital recordings	$2200
Assorted memory devices (USB drives)	For backing up interviews and research documents	$50
Microsoft Office	For dissemination of findings	$0 (owned)
Safe	To store all documents and recordings	$350
Filing cabinet	To store linking document	$0 (owned)
Computer	For field notes, transcription and document preparation	$0 (owned)
Photocopying, printing, ink	Document preparation and dissemination of findings	$200
Travel costs	For dissemination of findings to national and international conferences	$5000
		Total: $8000.00