NURSES' EXPERIENCES OF THE TRADITIONAL CLINICAL LEARNING ENVIRONMENT FOR NURSING STUDENTS

by

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Abstract

Nursing education is unique in its integration of theoretical and experiential learning and yet this integrated approach presents a number of challenges. One nuanced challenge in nursing education is the overlap of the students' clinical learning environment (CLE) with the clinical nurses' work environment. It is believed that the clinical nurse plays an important role in clinical learning, but it is not well understood how the clinical nurse understands and contributes to the CLE. The framework for this study was based on Benner's (1982) Novice to Expert model, transformative learning theory, and the AACN (2005) Healthy Work Environment framework. The purpose of this basic qualitative research was to explore how non-preceptor nurses who work with nursing students described the CLE, teaching nursing students, working with nursing faculty, and their role within the CLE. Participants were recruited from a professional nursing organization and social media and completed individual semi-structured interviews. Data were analyzed using thematic analysis. Several themes emerged including how teaching a student affected time and workload, how the nurse approached teaching and learning, and benefits and challenges nurses noted in planning and implementing clinical learning. Participants described significant challenges to the integrated clinical learning and work environment and simultaneously found value in the learning opportunities for student nurses. Participants explained how explicit communication and effective relationships with student and faculty helped to support a positive learning environment, as well as expressing a desire for support from faculty, colleagues, and hospital leadership to fulfill the teaching role well. Understanding the benefits, challenges, and needs of the nurse,

serving in a dual role as bedside caregiver and clinical teacher, can help to inform best practices in clinical learning. Finally, further research may be directed at understanding how novice through expert nurses implement teaching practices within and experience the CLE.

Dedication

I dedicate this work to the educators who inspired in me a love for learning, first and foremost, my parents. You instilled in me a desire to understand, strive, and achieve. Without the guidance and support of many formal teachers along the way, I never would have been inspired to seek a combined path of nursing and education. I dedicate this work to my academic and practice colleagues and the students we serve. I value our collaboration and wish to continue striving for improved working and learning conditions. Finally, I wish to thank my family for their patient and loving support. The distractions in the form hugs and cuddles and encouraging "Dr. Rowe Neal" statements meant so much more than you will ever know.

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CHAPTER 1. INTRODUCTION

Within nursing education, the clinical learning environment (CLE) is well recognized for its importance in curricula, as it provides real-life context for nursing practice and supports important learning, socialization, and professional development opportunities for nursing students (Charleston & Happell, 2005). The student perspective of the CLE is well documented both qualitatively and quantitatively and students indicate that a supportive learning environment, especially support from staff, is essential (Chan, 2002; Levett-Jones, Lathlean, Higgins, & McMillan, 2009; Newton, Jolly, Ockerby, & Cross, 2010; Sand-Jecklin, 2009; White, 2003). Though housed in the academic setting, clinical nursing education is dependent upon practice partners and clinical nurses to support the clinical learning for nursing students.

The literature is less developed regarding the nurses' experience working with nursing students. Multiple authors describe the experience of preceptors (Altmann, 2006; Charleston & Happell, 2005; Burns & Northcutt, 2009), though not all curricula follow a preceptor model for clinical education. An experienced nurse who may have specific qualifications, training, or educational preparation typically fills the preceptor role (Altmann, 2006; Callaghan et al., 2008). This role includes the development of a one-to-one working relationship with the student nurse over a period of time, with the aim to achieve the student's course and personal learning goals (Bourbonnais & Kerr, 2007;

Burns & Northcutt, 2009). Additionally, the nurse may volunteer for the preceptor role, which is added to the clinical workload (Altmann; Burns & Northcutt). This preceptor model contrasts with the traditional clinical model, where a student is assigned a patient and is incidentally taught by the nurse also caring for that patient (Stokes & Kost, 2012). Under the traditional model, the nurse may or may not be trained as a preceptor and is perhaps not provided a choice in teaching the student. Additionally, the nurse working and teaching within a traditional clinical learning model is likely not provided relief from patient care responsibilities to enable role modeling and teaching. Given the student perception of the influence of clinical nurses in the CLE, it is worthwhile to investigate the clinical nurses' experience in order to fully understand the components of the CLE. The purpose of this chapter is to explore the background and describe how this study addressed the experience of non-preceptor nurses within the CLE.

Background, Context, and Theoretical Framework

A particular challenge inherent to clinical learning is that it occurs both in the learning environment for students and the work environment for nurses. Within the traditional clinical learning model, the nurse's work responsibilities include that of clinical teacher and role model to the student nurse. According to the American Association of Critical Care Nurses (AACN, 2005), "Work environments that tolerate ineffective interpersonal relationships and do not support education to acquire necessary skills perpetuate unacceptable conditions" (p. 11). Students indicate that relationships with clinical nurses play a significant role in clinical education (Baxter & Rideout, 2006; Levett-Jones et al., 2009; Levett-Jones & Lathlean, 2009; Papathanasiou, Tsaras, & Sarafis, 2014; Reutter, Field, Campbell, & Day, 1997) so theoretically the work

environment for the nurse extends to the learning environment for the student. AACN's standards for a healthy work environment include skilled communication, true collaboration, effective decision-making, appropriate staffing, meaningful recognition, and authentic leadership. These standards are meant to support clinical excellence and optimal patient outcomes (AACN, 2005). A supportive work environment for the nurse helps to create a supportive learning environment for nursing students.

The literature reveals a number of themes regarding the components of the clinical learning environment, especially related to communication and relationships. First, students perceive that clinical nurses significantly affect the outcome of clinical nursing education and seek the guidance of clinical nurses for support in clinical decision-making (Baxter & Rideout, 2006; Saarikoski et al., 2012; White, 2003). Saarikoski and colleagues (2012) found that a small majority (59%) of European nursing students surveyed perceived the nurse as more important in their development than the nurse teacher. Baxter and Rideout found students relied heavily on nurses for support in clinical decision-making, even with the clinical instructor readily available. White's research resulted in a model of student clinical decision making that excluded the clinical instructor. Despite having support of clinical faculty, students rely on clinical nurses to support their clinical learning and development.

The relationships among nursing staff, students, and faculty are also an essential component of the clinical learning environment (Gillespie, 2002; Stemmans & Gangstead, 2002). Students indicated that clinical nurses can have a positive and supportive or negative and impeding impact on clinical learning (Baxter & Rideout,

2006). The development of supportive relationships in the clinical learning environment increases learning opportunities by easing anxiety and increasing motivation (Levett-Jones et al., 2009). The clinical nurse has the potential to impact clinical learning directly through teaching and relationship building with students.

Clinical nurses also recognize the importance of developing working relationships that support student learning. Mental health nurse preceptors described a desire to connect with and create a supportive learning environment for students (Charleston & Happell, 2006). Preceptors also noted a desire for additional preparation and support for the teaching role (Andrews, et al., 2006; Charleston & Happell, 2006; Shakespeare & Webb, 2008; Wilkes, 2006). A survey of United States nursing schools indicated 61.6% provided some form of preceptor preparation, ranging from 45 minutes to 10 hours (Altmann, 2006). While the literature does demonstrate that preceptor preparation can be beneficial (Smedley, Morey, & Race, 2010) not all professional development supports nurse preceptors (McCarthy & Murphy, 2010). Despite a desire to learn more about the teaching role, the evidence and current practice are inconsistent in providing this support for preceptors. Additional challenges in this dual working-teaching relationship include recognition and value for the teaching role, as well understanding productivity for nurses both caring for patients and teaching nursing students (Wilkes, 2006). These ambiguities could lead to burnout among clinical nurses or create negative feelings within the clinical learning environment.

Despite the volume of data regarding the experience of preceptors and the preceptor model of clinical nursing education, the traditional model of clinical learning continues to be used (Benner, Sutphen, Leonard, & Day, 2010). The traditional model of

clinical learning involves *total patient care* with students assigned to a clinical agency or site and tasked with completing nursing responsibilities (Nielsen, Noone, Voss, & Mathews, 2013). This model emphasizes skill performance to the detriment of integrating theory into practice, or applying critical thinking and clinical decision making processes (Stokes & Kost, 2012). Given these concerns, the ongoing calls to reform this traditional model of clinical learning are logical (Benner et al., 2010; Forbes & Hickey, 2009; Institute of Medicine [IOM], 2011; National League for Nursing [NLN], 2002). In order to best understand the need for clinical reform in nursing education, it is prudent to first understand the perspectives of all stakeholders, including those of non-preceptor clinical nurses.

Learning and nursing theoretical perspectives informed this study. Andragogy, or adult learning, and transformative learning theory both describe the different factors involved in learning and change in behavior. The main assumptions of andragogy are that adults are self-directed, problem-centered, experiential learners (Pew, 2007). Transformational learning is a conceptual framework that extends learning beyond the acquisition of knowledge to a change in the learner (Merriam, Cafferella, & Baumgartner, 2007). There are several different lenses that clarify transformational learning, but all share the same basic tenets: that people must make meaning from their *experiences*, *reflection* supports the transformation, and as a result *development* takes place. Mezirow provides a psychoanalytical approach to transformational learning (Merriam et al., 2007). This psychoanalytical approach holds that an individual uses prior experience to inform his or her interpretation of current experience, which guides

behavior. Finally, the learner takes action, with a transformed perspective to guide decisions or action (Merriam et al.). Benner (1982) created the Novice-Expert model of nurse development where a nurse transforms with added knowledge and experience from the rules-based novice to the intuition-guided expert. The difference in skills base between the novice and more experienced nurses can be compared and aligned to match the novice's learning needs to the advanced nurse's abilities (Altmann, 2006). Within the clinical learning environment and with support and instruction from clinical nurses, the student is able to develop through the novice stage.

Statement of the Problem

Calls to reform nursing education have increased over the last fifteen years, yet the traditional clinical model remains common (Benner et al., 2010; Forbes & Hickey, 2009; IOM, 2011; NLN, 2002). Student and preceptor experiences are well documented, yet that of the clinical non-preceptor nurse who intermittently teaches is not. Students indicate a heavy reliance on clinical nurses, despite availability of clinical instructors, to support clinical learning (Dunn & Hansford, 1997; White, 2003). Skills, qualities, and attitude of the preceptor are perceived by students to be of greater importance than the actual clinical learning environment (Wilkes, 2006). Additionally, students indicate supportive relationships and clear communication with staff as supporting a positive learning environment (Sand-Jecklin, 2009). The impact of the clinical nurse on the quality of the clinical learning environment is an essential component to an overall understanding of clinical learning. There is an abundance of literature describing the student experience within the clinical learning environment and the student perception of the importance of the nurse in clinical learning, yet it is unknown how the clinical nurse

describes the experience of working with and teaching nursing students. The problem addressed in this study was how the clinical, non-preceptor, nurse experiences the clinical learning environment.

Purpose of the Study

The purpose of this basic qualitative study was to explore how non-preceptor nurses who work with nursing students in the traditional clinical learning model experience the clinical learning environment. Understanding how nurses experience the clinical learning environment will help to inform necessary changes to clinical nursing education.

Research Questions

For inpatient non-preceptor clinical nurses working with nursing students in the traditional clinical learning model on medical-surgical units, how do nurses describe their experiences within the clinical learning environment?

Additional subquestions for this study included:

1. How do nurses describe their experience teaching nursing students?
2. How do nurses describe their experience working with nursing faculty?
3. How do nurses perceive their role within the CLE?

Rationale, Relevance, and Significance

In research, several factors must be evaluated to assure the worth of the evidence found in the existing literature. Relevant qualitative research addresses appropriate research questions and is situated in the literature (Merriam & Associates, 2002). Additionally, quality is measured by the contributions to the given field's knowledge

base as well as its practical application within the field (Merriam & Associates). Rationale for this study, as well as its relevance and significance to the state of nursing education will be discussed in this section.

Rationale for the Study

The current evidence demonstrates the student perspective that the clinical nurse plays an integral role within the clinical learning environment (Baxter & Rideout, 2006; Saarikoski, et al., 2012; White, 2003; Wilkes, 2006). While there is evidence to describe the preceptor experience (Andrews et al., 2006; Charleston & Happell, 2005; Shakespeare & Webb, 2008; Wilkes, 2006), there is a dearth of literature relating to the nurse working in the traditional clinical learning environment. MacIntyre, Murray, Teel, and Karshmer (2009) recommended ongoing research in nursing education best practices so that benefits are maximized while risks are minimized, including both traditional and innovative clinical learning models. The National Council of State Boards of Nursing (NCSBN) (2005) and Lillibridge (2007) also recommended ongoing research related to the CLE, especially perspectives of all stakeholders to understand how to recruit and support nurse teachers. In order to holistically understand the clinical learning environment it is essential to understand how the clinical nurse describes this experience. This understanding can better inform leaders in academic and practice settings how best to plan and implement needed reforms to clinical nursing education that will meet the needs of learners and the nurses who support clinical learning.

Relevance of this Study

For the nursing education specialization, there are a number of practical implications related to this research. First, the data gathered could be used to inform academic and practice partners how to collaborate to improve the combined work and clinical learning environment through support of clinical nurses. Vallant and Neville (2006) found that positive relationships between clinical nurses and nursing students enhanced student learning. Optimizing the CLE through support of clinical nurses may have a positive impact on student learning. This may also lead to further research related to other ways to maximize the clinical learning environment, including staff development and staffing procedures.

The clinical learning environment is an essential component of nursing curricula (Hickey, 2009). One of the challenges inherent in clinical learning is the unpredictability of learning opportunities, which may depend on expertise of clinical faculty, number of staff and availability of skilled preceptors, skill mix of staff, patient acuity, and workflow of the unit. While student perceptions of the clinical learning environment are well documented (Chan, 2002; Levett-Jones et al., 2009; Newton et al., 2010; Sand-Jecklin, 2009; White, 2003), the experience of clinical nurses is less developed. Exploring how nurses experience the clinical learning environment provides further information regarding the nature of clinical learning. It was anticipated this information could contribute to the field of nursing education by providing evidence to support future practices that will create a supportive work environment for nurses and supportive clinical learning environment.

Significance of this Study

The CLE is well recognized for its value in providing opportunity to bridge nursing theory and practice, providing nursing students the opportunity to learn to think like a nurse. Nursing educators' understanding of the CLE and its various elements continues to evolve. Student nurse perceptions of the CLE were that relationships between clinical nurses and students impact learning, having both a positive and negative effect (Baxter & Rideout, 2006; Grealish & Ranse, 2009; Hickey, 2010; Vallant & Neville, 2006; White, 2003). Preceptors indicated an understanding of the importance of relationship-building and creating a supportive learning environment (Charleston & Happell, 2005), but also a need for further development to support this role (Lillibridge, 2007; McCarthy & Murphy, 2010). The evidence demonstrated a gap in how clinical nurses teaching within the traditional, as opposed to preceptor, model experience the CLE. The research questions for this study explored these topics from the perspective of the clinical nurse.

There is evidence related to nurses' experience in the CLE and much of it is qualitative in nature and relates mostly to the experience of nurses operating within the preceptor model of clinical learning (Brown, Douglas, Garrity, & Shepherd, 2012; Charleston & Happell, 2005; Dibert & Goldenberg, 1995; McCarthy & Murphy, 2010; Usher, Nolan, Reser, Owens, & Tollefson, 1999). Not all nurses who work with students in the clinical learning environment function within the preceptor model. There is a paucity of evidence concerning the clinical nurse working with students in the traditional clinical model. Peters, Halcomb, and McInnes (2012) noted in an Australian study that clinical nurses working in primary care desired strengthened relationships between the

academic and practice institutions, with increased communication and opportunity for influence in the model of clinical placements. Clinical nurses have a desire to contribute to the clinical learning environment in a meaningful way. This study contributes to the scientific knowledge by developing a holistic view of the clinical learning environment; one that includes the clinical nurses' experience teaching student nurses while providing patient care.

Nature of the Study

To answer the research questions, a qualitative methodology and basic qualitative research design were used. The basic qualitative approach allows for detailed data collection and a deeper understanding (Trochim, 2006) of how nurses who work with students perceive their role within the clinical learning environment. Frankel and Devers (2000) noted that qualitative methods work well to provide insight and direction regarding education, especially when research questions are difficult to answer by conventional approaches. Given the paucity of evidence regarding the experience of non-preceptor nurses, the use of the basic qualitative approach allows for exploration of the non-preceptor nurse's experience teaching nursing students.

The process of data collection and analysis occurred simultaneously, as is typical of qualitative research (Frankel & Devers, 2000). Data collection occurred via semi-structured one-on-one interviews to allow participants to describe their individual experiences working with nursing students. Interviews were audiotaped for data retrieval. Data were transcribed for analysis, which occurred via thematic analysis.

Thematic analysis is noted as a common method of qualitative analysis, which requires survey across data to identify patterns and themes (Bricki & Green, 2007).

Definition of Terms

Common terms used within this study are defined for increased clarity. These terms include *academic partner, clinical learning environment, clinical nurse, practice partner, preceptor,* and *traditional clinical learning environment*. Definitions are explored in the following section.

Academic Partner

The academic partner is an institution of higher education that delivers a nursing curriculum.

Clinical Learning Environment

The clinical learning environment refers to learning within a healthcare setting and excludes classroom and laboratory environments.

Clinical Nurse

The term clinical nurse describes the bedside nurse whose primary job assignment is to provide direct patient care.

Practice Partner

A practice partner is an institution that collaborates with academic institutions to provide a clinical learning environment.

Preceptor

The preceptor is a clinical nurse who is designated to teach new staff or student nurses. The preceptor is typically an experienced nurse who may have specific

qualifications, training, or educational preparation (Altmann, 2006; Callaghan et al., 2008).

Traditional Clinical Learning Environment

The traditional clinical learning environment refers to a model of clinical learning where students are assigned to a particular institution or clinical unit. Students are typically responsible for "total patient care" (Nielsen et al., 2013). Academic faculty serve as the primary teacher and supervisor to students learning in the traditional clinical model. The clinical nurse, student, and faculty share accountability for providing patient care.

Assumptions, Limitations, and Delimitations

Devers (1999) noted that one criterion for evaluating qualitative research is the inclusion of the researcher's perceptions and assumptions. Description of these perceptions and assumptions provide some of the context for the study, given the researcher's role in collecting and analyzing data (Merriam & Associates, 2002). Considering a philosophical perspective, the researcher's role as clinical faculty may have influenced data collection and analysis. As a clinical faculty, the researcher assumed that clinical nurses desired to have a voice regarding the process of the CLE. From a methods perspective, it was assumed that the sampling procedures would provide access to participants who could provide rich descriptions to answer the research questions. Additionally, it was assumed that nurses engaged in a professional organization would be more likely to participate in the research process. It was additionally assumed that participants would answer truthfully, providing reliable data.

Limitations must be addressed as part of rigor within research. One weakness inherent in this study included the sampling method. A convenient and purposive approach was used in this research, as this allowed the researcher access to key informants and stakeholders within clinical nursing education, non-preceptor clinical nurses. Recruiting nurses through a professional organization provided for a convenient and "information rich" sample (Devers & Frankel, 2000, p. 264) but may have also created bias in the sample. It is logical to assume that nurses participating in a professional organization, and those nurses contacted through snowball sampling, may have a skewed view that was not representative of the total population of non-preceptor clinical nurses. Participants were recruited from one geographic region, so culture differences may also limit the generalizability of these findings. Finally, the researcher as instrument may challenge validity of findings (Merriam & Associates, 2002). The use of member checks following interviews helped to address this limitation.

Delimiting factors are used to create a study that is feasible. A delimitation within this study was the recruitment of medical/surgical nurses. This population was chosen due to the more general nature of clinical learning on medical/surgical units. Nurses who work on specialty units such as labor and delivery, critical care, or mental health may have a different experience teaching and working with nursing students. A second delimiting factor is the use of non-preceptor clinical nurses. The literature demonstrates wide variability and growing use of preceptor nurses (Altmann, 2006; Brehaut, Turik, & Wade, 1998; Croxon & Maginnis, 2009; Omer, Suliman, Thomas, & Joseph, 2013; Weiland, Altmiller, Dorr, & Wolf, 2007), yet non-preceptor nurses continue to have student contact within the traditional clinical model (Croxon &

Maginnis; McNelis, Ironside, Ebright, Dreifeurst, Zvonar, & Conner, 2014; Nielsen et al., 2013). This study was necessarily limited to the non-preceptor nurse to address a gap in the literature.

Organization of the Remainder of the Study

The importance of clinical learning within nursing curricula is well recognized and valued. At the same time, multiple bodies have called for reform to clinical nursing education to better support student learning within the rapidly changing healthcare environment (Benner et al., 2010; Forbes & Hickey, 2009; IOM, 2011; NLN, 2002). The traditional clinical model continues in existence, despite these calls for reform. While the literature reveals that students perceive clinical nurses to have a considerable impact on learning, the experience of clinical nurses teaching nursing students is not widely known. This basic qualitative study used semi-structured interviews to discover the nurse's experience working with and teaching nursing students, with the aim to better inform future reforms to clinical nursing education.

The remainder of this dissertation will be organized in a standard approach. Chapter 2 will include a description of theoretical framework for the study, including a number of learning and nursing theories that inform this work. The literature review will also describe, analyze, synthesize, and critique the literature related to the clinical learning environment and the role of clinical nurses in clinical nursing education. Chapter 3 includes the rationale and explanation of the selection of the basic qualitative approach and design of this study, including sampling, data collection, and analysis procedures. Chapter 4 will present an analysis of the data. This paper will conclude with

chapter 5, which will include a summary of the findings, as well as conclusions explicated from the data. Chapter 5 will additionally discuss the data in regards to the implications for practice, relationship to the literature review, and report recommendations for practice and future research within clinical nursing education.

CHAPTER 2. LITERATURE REVIEW

A review of the literature was conducted to understand the background and scope of the clinical learning environment (CLE) and relevant gaps in the evidence. A systematic review of the literature was conducted via the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Education Research Complete, Ovid Nursing Full Text PLUS, and Google Scholar. Search terms included *clinical nursing education, clinical learning environment, faculty-student relations, professional-student relations, clinical model, traditional clinical model, clinical placement, student supervision, clinical supervision,* and *clinical nursing teacher.* References were reviewed as well for additional sources. While a variety of qualitative and quantitative evidence described the clinical learning environment from the perspective of nursing students, there was considerably less evidence describing the faculty and staff perspective. Much of the evidence pertaining to the staff experience described the experience of preceptors and originated outside of the United States. Of the articles describing staff nurses' perspectives, six reported on the non-preceptor nurse and only three were based in the United States. The U.S. studies included were replications of survey research by Grindel, Patsdaughter, Medici, and Babington (2003).

Both nursing and learning theories guided the literature search and provided framework for the research. These theories are explored further, including transformative learning theory, Benner's novice-to-expert model, and the AACN Health Work Environment framework. The research literature revealed a number of themes, to be

explored in depth. These themes included the benefits and challenges or complexities inherent to the CLE as well as the various clinical models and student, faculty, and staff perspectives of the CLE.

Theoretical Framework

From a theoretical perspective, there is an intersection between the clinical nurse's work environment and the student's clinical learning environment. According to AACN (2005), ineffective work relationships impede professional development and delivery of safe patient care. Duddle and Boughton (2007) reported that a negative work environment may increase patient errors and impact patient safety. The AACN standards for a healthy work environment (HWE), including skilled communication, true collaboration, effective decision-making, appropriate staffing, meaningful recognition, and authentic leadership, are elements that may also be applied to an effective clinical learning environment. Though academic and practice priorities may diverge, ultimately all stakeholders are accountable for patient safety and the education of safe, competent practitioners (Henderson, Briggs, Schoonbeek, & Paterson, 2011). Within the CLE, it is challenging to separate student learning from the work of nurses.

There appears to be significant overlap between the student CLE and the nurse's work environment. Papp, Markkanen, and von Bonsdorff (2003) reported that students recognized unit culture as having a significant impact on learning. A culture that was welcoming to students, including quality mentoring and quality patient care, facilitated clinical learning (Papp et al.). A HWE, where nurses are skilled communicators, decision-makers, and willing to collaborate with students, may then also have a positive impact on clinical learning. A variety of literature described how relationships have an

impact on student learning in the CLE (Brammer, 2006; Charleston & Happell, 2005; Datillo, Brewer, & Streit, 2009; Gillespie, 2002; Hartigan-Rogers, Cobbett, Amirault, & Muise-Davis, 2007; Hovland, 2011; Kristofferzon, Martensson, Mambidir, & Lofmark, 2013; Landmark, Hansen, Bjones, & Bohler, 2003; Lee, Cholowski, & Williams, 2002; Levett-Jones & Lathlean, 2009; Levett-Jones et al., 2009; Newton, Cross, White, Ockerby, & Billett, 2011; Peters et al., 2013). However, it is also known that time barriers and workload may have a negative impact on clinical learning (Atack, Comacu, Kenny, LaBelle, & Miller, 2000; Charlston & Happell, 2005; Dibert & Goldenberg, 1995; Henderson, Fox, & Malko-Nyhan, 2006; Landmark et al., 2003; Lillibridge, 2007; Madhavanpraphakaran, Shukri, & Balachandran, 2013; McCarthy & Murphy, 2010). A healthy work environment for the nurse may be required in order for clinical learning to be effective.

Within this combined work and learning environment, student and nurse interact. Transformative learning theory and Benner's novice to expert model of professional development relate to the student transformation under the supervision of and within the work environment of the nurse. Transformative learning, based on the work of Mezirow, described how learners link prior experience to inform current experiences, which then guides behavior (Merriam et al., 2007). Transformation is not always the result, but often occurs due to a "disorienting dilemma" that encourages the learner to critically reflect and synthesize current events with prior knowledge, values, or beliefs to make meaning (Merriam et al., p. 132). Mezirow (1997) contended that learners are best able to make

meaning when free from coercion, are well informed, and have support in analyzing situations.

Contextual awareness was an essential component of transformative learning (Dirkx, Mezirow, & Cranton, 2006). For student nurses, the ability to distinguish between relevant and irrelevant data within the clinical context can prove challenging (Benner et al., 2010). White (2003) noted that students specifically sought the support of the clinical nurse, over that of the instructor, in making clinically based decisions. White asserted, "when students understood their patient's conditions, the clinical decisions students made positively influenced patient outcomes" (p. 119). The clinical nurse plays an important role in the transformative learning that occurs in the CLE.

Transformative learning theory relates well with Benner's novice to expert theory. Benner's model holds that nurses with various levels of experience literally live in different worlds, experiencing and perceiving situations differently based upon the integration of knowledge, skills, and past experience (Benner, Tanner, & Chesla, 1992). Nurses with these various levels of experience vary in their ability to focus on salient information, as well as their understanding of their involvement and responsibility for the patient (Waldner & Olson, 2007). The experienced nurse can provide guidance and support, as the novice experiences clinical learning. Waldner and Olson described how Benner's model could be used to guide simulation experiences, scaffolding for the novice, advanced beginner, and competent student. This approach facilitates the needs of the novice learner, and may conceivably be applied also within the CLE.

Benner's model allows flexibility in pedagogical approaches, encouraging a learner-centered approach, given the emphasis on the characteristics and needs based on

the experience level of the nurse. Edgecombe and Bowden (2009) identified similarities between their model of student evolution to novice nurse and Benner's model, including integration of prior learning and experience, as the student develops into a competent novice. Within the CLE, the novice and rules-based (Benner, 1982) student is guided by expert faculty and staff nurses. Lyneham, Parkinson, and Denholm (2009) asserted that a supportive CLE was essential for a novice to develop appropriately. While the novice to expert model described how the novice develops, there is a gap in understanding how the experienced nurse or faculty provides support for maturation from the novice stage. Exploring experienced nurses' understanding of working with students in the traditional clinical learning environment may illuminate how the nurse functions and teaches the novice within the combined work and learning environment.

Review of the Research Literature and Methodological Literature

The literature revealed an abundance of evidence related to the benefits, challenges, and perspectives of the student nurse. A variety of quantitative and qualitative studies demonstrated that students value the CLE (Dunn & Burnett, 1995; Dunn & Hansford, 1997; Kristofferzon et al., 2013; Newton et al., 2010; Newton, Jolly, Ockerby, & Cross, 2012; Papp et al., 2003). The evidence also suggested that student relationships with staff and faculty are paramount to successful learning (Dunn & Hansford; Gillespie, 2002; Hartigan-Rogers et al., 2007; Hovland, 2011; Levett-Jones & Lathlean, 2009; Levett-Jones et al., 2009; O'Mara, McDonald, Gillespie, Brown, & Miles, 2014; Papathanasiou et al., 2014; Steven, Magnusson, Smith, & Pearson, 2014; Vallant & Neville, 2006). The staff nurse perspective is described mostly by qualitative

research that focused on the preceptor experience (Bourbonnais & Kerr, 2007; Carr & Gidman, 2012; Charleston & Happell, 2005; Dibert & Goldenberg, 1995; Henderson et al., 2006; Lillibridge, 2007; Madhavanpraphakaran et al., 2013; McCarthy & Murphy, 2010; Usher et al., 1999; Yonge & Myrick, 2004). Not all nurses working with students are trained or recognized as preceptors and there is little research describing the perspective of the non-preceptor staff nurse. The evidence regarding these various concepts within the context of CLE are explored in depth in the remainder of this chapter.

Review of Research Regarding Clinical Nurses and the CLE

The CLE is an essential component to learning the practice of nursing (Chan, 2002; Hartigan-Roger et al., 2007; Newton et al., 2010). The CLE provides opportunities to integrate theory into practice, build clinical decision-making abilities, and develop a professional identity (O'Mara et al., 2014). In one study, graduate nurses recalled an appreciation for the CLE, as it served to develop skills and knowledge, such as psychomotor, communication, time management, and organization skills (Hartigan-Rogers et al., 2007). There was also an appreciation that practice of these skills helped to prepare graduates for the work environment. Students, faculty, and staff noted experiences afforded on the clinical unit; attitudes of students, faculty, and staff; and role and responsibility expectations contributed to the CLE (Young, Simpson, McComb, Kirkpatrick, LaLopa, & Bullard, 2014). Preceptors described elements creating a positive CLE as those that facilitated learning, including adequate and protected time and good communication with the student, as well as a correlation between theory and practice (Madhavanpraphakaran et al., 2014). Graduates also noted that placement within a specialty area mattered less to meaningful learning than did feeling supported in their

practice (Hartigan-Rogers et al., 2007). This evidence indicated that relationships with others, including clinical faculty and nurses, play a significant role in clinical learning. While valuable to the development of student nurses, the CLE involves a complex interaction of people and experiences.

Attempts have been made to quantitatively measure the CLE. Dunn and Burnett (1995) developed a Clinical Learning Environment Scale (CLES) including the subscales of staff-student relationships, nurse manager commitment, patient relationships, interpersonal relationships, and student satisfaction. The authors reported strong validity by confirmatory factor analysis and reasonable reliability reported by a range of reliability coefficients (r = 0.7-0.85) of the instrument (Dunn & Burnett, 1995). Dunn and Hansford (1997) reported qualitative data that supported the constructs (staff-student relationships, nurse manager commitment, patient relationships, interpersonal relationships, and student satisfaction) within the CLES. Chan (2002) noted that the multidimensional CLE, including student preparation, characteristics of faculty and staff, peer support, and clinical learning opportunities, directly impacted students' ability to achieve clinical learning outcomes and developed the Clinical Learning Environment Inventory (CLEI) to quantify these measures. Both inventories addressed the significance of relationships within the CLE from the student perspective. The question remains if either truly addresses the significant complexities inherent in this learning environment.

Complexities and challenges within the CLE. The CLE is accepted for the opportunities to integrate theory and practice, yet some research challenges the idea that

the CLE supports this integration (Landmark et al., 2003; McNelis et al., 2014). Landmark and colleagues noted that nurses were aware of theory-practice gap and yet nurses also felt unable to help students bridge that gap. Likewise, McNelis and associates observed no discussions relating theory to practice in field observations monitoring students, faculty, and preceptors. Researchers also found that preceptors reported that a weak link between practice and theory hindered student learning (Madhavanpraphakaran et al., 2014). This evidence suggests that one of the major goals of CLE, integration of theory and practice, may not always be achieved.

It is also commonly accepted that the CLE is fraught with a variety of complexities. For example, the clinical learning environment physically occurs within the healthcare institution, but is typically coordinated by a separate academic institution. The context of this learning environment includes nursing program, curriculum, and nursing unit (O'Mara et al., 2014), where the academic institution provides for the program and curriculum and a separate healthcare institution provides the nursing unit for clinical learning. The separate institutions may have divergent priorities. Young and colleagues (2014) noted competing priorities between patient care and student learning through focus groups including faculty, staff, and students reflecting on clinical learning experiences. These competing priorities may contribute to the difficulties in achieving learning goals in the CLE. Preceptors described elements of the CLE that hindered learning, including a busy unit and heavy workload, lack of interest by students, and communication gaps (Madhavanpraphakaran et al., 2014). These complexities challenge a holistic understanding of the CLE, as well as solutions that may contribute to the quality of the CLE.

Certain processes and standards of practice also add to the complexity of clinical learning. The CLE is challenging due to the transitory nature of clinical placements. When students transition to different facilities and different staff, this can have a negative impact on learning as students focus on finding their way and fitting in within the new facility (Newton et al., 2012). From a staffing perspective, nurses may work with students from several different schools, with differing learning objectives and differing abilities (Slaughter-Smith, Helms, & Burris, 2012). Practice partners typically train preceptors for new hires, but some nurses were recruited to precept students with minimal training (Altmann, 2006). Additionally, availability of nurses within these different facilities who are qualified and willing to teach, as well as placing academic scheduling constraints onto the practice environment further complicate the ability to create a high quality CLE (MacIntyre et al., 2009; Seldomridege & Walsh, 2006). The differing processes between the academic and practice sectors create significant challenges when planning for clinical learning.

An additional complexity within the CLE is the hospital unit as a combined work and learning environment. Researchers noted that nurses appreciate when students demonstrate an eagerness to learn and willingness to help on the unit (Slaughter-Smith et al., 2012). This demonstrates a tension noted in others' work. Grealish, Bail, and Ranse (2010) found that clinical nurses may depend on student work, as nurses noted an expectation that students be "of use" (p. 2296). Students may be aware of this tension, as well, as students reported feeling guilt for distracting staff from patient care (Steven et al., 2014). Eaton, Henderson, and Winch (2007) noted, "appropriate clinical learning

environments are difficult to establish when staff prioritize patient care over quality undergraduate education" (p. 316). However, others suggested that defining the student solely as learner within the CLE may limit learning within a busy unit (Allan, Smith, & O'Driscoll, 2011). In the presence of calls for increased safety and quality in patient care (Benner et al., 2010; IOM, 2011; The Joint Commission, 2008), it is difficult to distinguish a single priority between patient care and student learning.

The tension between academic and practice priorities may be evidenced in other ways. Steven and colleagues (2014) found that students learned from observing clinical nurses' practice, but with the combined pressures of fitting in and concerns over evaluation, students did not question potentially unsafe practice. MacIntyre and colleagues (2009) also asserted that nursing students and faculty function as guests in the CLE, hampering efforts to create and sustain a culture of safety. Allan and others (2011) noted differing expectations between academic and practice stakeholders, with unit-based nurses expecting students to work, while academic institutions placed a priority on student learning in practice, though not providing explicit direction for this student role. Competing or unclear expectations add to the complexity of learning in practice, with the added concern for patient safety.

Safe, high quality healthcare is dependent in part on the effective education of nurses. Creating a positive CLE contributes to this education. Henderson and others (2011) suggested a framework with the key constructs of a positive CLE including leadership, management, and partnership and recommended several tools to measure these constructs. However, the focus of this framework was on the role of nursing management and administration to create a positive CLE and was not inclusive of the

collaborative relationship with academic faculty that is required to create a positive and holistic approach to the CLE. In contrast, Mannix, Wilkes, and Luck (2009) recommended that faculty take a leading role to establish positive working relationships with the healthcare industry to set a firm foundation for a positive and effective CLE. MacIntyre and colleagues (2009) suggested that strengthened relationships between academic and practice partners as the ideal to address the many challenges inherent in clinical nursing education and improve the quality of the CLE. Synthesizing the perspectives of all stakeholders may be helpful in addressing the quality of nursing education within the healthcare environment.

Ongoing innovation is aimed at strengthening the CLE. A variety of clinical learning models are apparent in the literature including academic-service partnerships, preceptorships, and dedicated education units (Callaghan et al., 2008; Croxon & Maginnis, 2008; Moscato, Miller, Logsdon, Weinberg, & Chorpenning, 2007; Myrick, 2002; Myrick & Yonge, 2002; Nabavi, Vanaki, & Mohammadi, 2011; Newton et al., 2011; Niederhauser, Schoessler, Gubrud-Howe, Magnussen, & Codier, 2012; Nielson, Noone, Voss, & Mathews, 2013; Preheim, Casey, & Krugman, 2006). While innovation is helpful in addressing the known complexities of the CLE, there is little evidence to demonstrate how these models directly contribute to student learning outcomes, graduate readiness for practice, or practice competencies (MacIntyre, et al., 2009; McNelis et al., 2014; Tanda & Denham, 2009). The various clinical learning models evidenced in the literature will be described in depth at a later point in this chapter.

Types of clinical models. The traditional model of clinical nursing education involves *total patient care* with students assigned to a clinical agency or site and tasked with completing nursing responsibilities (Nielsen et al., 2013). This model emphasizes skill performance at the detriment to integrating theory into practice, or applying critical thinking and clinical decision making processes (Stokes & Kost, 2012). In field observations of students and faculty, both groups were found to be focused on completion of tasks, with students forgoing learning opportunities to accomplish tasks (McNelis et al., 2014). Faculty directed conversations focused on completion of basic patient care and student assignments. The researchers concluded that the workload of staff and faculty encouraged task orientation, impeding the development of effective relationships and in-depth conversations regarding the complexity of care (McNelis et al.).

Another significant challenge to the traditional model of clinical nursing education is that of isolation. Typically, students connect with faculty and the assigned patient, but not necessarily with the nurse providing care (MacIntyre et al., 2009). The nurse's primary concern is patient care, not student learning, which contrasts with the student focus on individual student actions with an individual patient (MacIntyre, et al., 2009). Edgecombe and Bowden (2009) also noted that students practicing in a traditional CLE noted a sense of isolation. This isolation is not reflective of the real life practice the CLE is meant to provide, challenging students' understanding of the context of providing nursing care within a complex healthcare system.

Despite challenges inherent to the traditional clinical model, there is conflicting evidence when compared to other models. Croxon and Maginnis (2009) found that students rated the traditional model higher than a preceptorship model. Students reported

the traditional CLE was better for achieving clinical objectives and providing opportunities to practice skills. Students additionally appreciated being able to work with and problem solve with peers and having support from a clinical instructor when the clinical nurse may not always be available or willing to teach (Croxon & Maginnis, 2009). Though challenges are inherent within the traditional CLE, it does possess some strengths that must be considered in planning reform.

Preceptor model of CLE. The preceptorship model has seen significant use in recent years. Altmann (2006) reported that 85.9% of US nursing schools surveyed used some preceptorship experiences. The preceptor experience is characterized by a one-to-one experience between the preceptor, a clinical nurse employed by the practice agency, and the student nurse, with some degree of support and evaluation provided by academic nursing faculty (Callaghan et al., 2009). In contrast to the traditional clinical model where the clinical nurses interacts with the student for one shift, the preceptor relationship typically develops over a period of time (Altmann). This time-intense relationship supports student socialization into the nursing profession (Sedgwick, 2011). Preceptorship offers opportunities to build independence and confidence, especially for quieter students who might "slip through" (Croxon & Maginnis, 2009, p. 240). Students reported increased knowledge, skill, competence, independence, and time management ability during a 9-day precepted experience, while faculty and preceptors observed increased accountability, confidence, organization, and prioritization ability on the part of the students (Weiland et al., 2007). Providing for a safe relationship within the preceptor model encouraged and promoted critical thinking (Myrick, 2002). In a clinical learning

model that included learning facilitated by preceptors, head preceptors, and clinical lecturers, students reported achieving required learning objectives, except applying research in practice (Kristofferzon et al., 2013). The repeated exposure to a similar CLE with support from a single preceptor may provide for a teaching-learning relationship that promotes student development.

Communication seems to also play a significant role within the preceptor model. Yonge, Hagler, Cox, and Drefs (2011) reported that certain elements provided for a decreased student anxiety and a positive preceptor experience: open communication among faculty, staff, and student and understanding of realistic expectations prior to the experience. Open communication and sharing of expectations helps support the learning environment. Myrick and Yonge (2002) found that effective and open communication facilitated critical thinking and effective role modeling. Multidisciplinary team members reported communication and attitude of the preceptor had a direct effect on the student's ability to interact with and learn from the multidisciplinary team (Sedgwick, 2011). Effective communication is essential not only to develop the teaching-learning relationship between preceptor and student, but also to facilitate other learning opportunities for the student.

Relationships seem to play a significant role in student perceptions of the CLE. Students identified appreciation for trusting relationships with preceptors, consistent feedback, and the ability to consolidate practice as advantages within a preceptor model (Callaghan et al., 2009). Sedgwick (2011) reported that clinical nurses felt that trusting relationships developed over time and that a longer clinical experience provided additional multidisciplinary learning opportunities. Preceptored public health students

reported increased competence related to influencing other healthcare providers to impact patient's healthcare (Brehaut et al., 1998). Comparisons between preceptored and non-preceptored students found no significant differences between perceived competency and both groups reported similar number and target of learning activities (Brehaut et al.). Preceptorships provide meaningful learning opportunities and support competency development, in part due to relationship development inherent in this model of clinical learning.

There are also a variety of challenges inherent within the preceptor model of clinical learning. Student learning is dependent in part on the ability to receive guidance and feedback (Croxon & Maginnis, 2009). Students noted this could be limited in a preceptor model, due to the workload and time constraints for the nurse (Croxon & Maginnis, 2009), as well as preparation of the preceptor. Altmann (2006) noted a wide range of preceptor preparation, from 45 minutes to 10 hours, with 26% of surveyed schools providing no orientation. Altmann additionally noted that the majority of orientation materials focused on student evaluation and few materials focused on pedagogical approaches. Yonge and Myrick (2004) reported that staff had negative reactions to preceptor manuals meant as preceptor preparation. In a Saudi context, students preferred a preceptorship model that included a faculty-appointed clinical teaching assistant (Omer et al., 2013). Students noted the teaching assistant was well equipped to role model and provide feedback, while preceptors alone were found to be less able to advocate for students and facilitate learning (Omer et al., 2013). The

preparation and support for preceptors may contribute to the learning outcomes for students learning in this model.

Evaluation is needed for learning to occur, but this also presents a challenge in the preceptor model. Staff noted inadequacies with the evaluation process in one study (Yonge & Myrick, 2004). Evaluation can also be threatened in a preceptor model due to reliability and validity. Seldomridge and Walsh (2006) found that evaluation was challenged due to faculty not observing student performance over time, inexperienced preceptor unfamiliar with academic jargon and summative evaluations, and inflated student self reports. There were concerns for grade inflation with 95% of grades reflecting A or B status and 5% at a C level over a 5-year period at a public, comprehensive university (Seldomridge & Walsh, 2006). Students similarly noted concerns about evaluation processes, as preceptors had input but faculty, with minimal contact, would provide the final grade (Sedgwick & Yonge, 2009). Finally, the National Council of State Boards of Nursing (NCSBN) (2005) recommended in a position paper that clinical learning should be supervised by "qualified faculty who provide feedback and facilitate reflection" (p. 9). Coordinating teaching and evaluating responsibilities between preceptor and clinical faculty presents a significant impediment to the preceptor model.

Other challenges inherent in the preceptor model include coordinating across many sites, selecting and preparing preceptors, supporting students and staff with challenging placements, and additional stressors to students (Luhanga, Billay, Grundy, Myrick, & Yonge, 2010; Yonge et al., 2011; Yonge & Myrick, 2004; Yonge, Ferguson, Myrick, & Haase, 2003). Students noted increased stress with coordinating travel,

accommodations, and finances, as well as dissatisfaction with curricular and faculty preparation for preceptorships. Some noted concerns that the emphasis may be on professional socialization and acquisition of psychomotor skills and not on critical thinking (Myrick, 2002). Staffing inadequacies also challenge clinical learning, as there was less time for student supervision and learning (Croxon & Maginnis, 2009). Finally, students may feel pulled between learning and patient care needs (Croxon & Maginnis). This tension echoes a concern noted within the literature regarding the traditional CLE (Grealish et al., 2010; Slaughter-Smith et al., 2012; Young et al., 2014) and may demonstrate a concern that extends beyond a particular clinical model. Newton and colleagues (2012) found that preceptorship is not automatically student-centered, which additionally challenges the CLE.

Dedicated education unit model of CLE. Another clinical model emerging is the dedicated education unit (DEU), informed by a community of practice framework (Grealish et al., 2010). Moscato and colleagues (2007) defined the dedicated education unit as a collaborative partnership among administrators, nurse-clinicians, and faculty meant to optimize and increase efficiency for student learning in the clinical learning environment. Clinical nurses serve as students' clinical instructors, helping to bridge theoretical knowledge gained in the classroom to outcomes in the clinical practice environment. Faculty serve to support the professional development and comfort of the clinical nurse in the teaching role. Clinical nurses and faculty collaborate to assure student progress towards meeting clinical learning objectives and competencies. Tuohy (2011) identified a number of benefits related to DEU adoption, including relationship

development, enhanced student learning, and efficient use of resources. Australian researchers concluded that staff benefited from the DEU model given that nurses noted appreciation for student work, as well as how students' learning provided for stimulation of thinking among staff and sharing ideas (Grealish et al., 2010).

Like the preceptor model, the DEU model of clinical learning supports the development of relationships. Students developed strong relationships with clinical nurses in the DEU (Hannon et al., 2012; Ranse & Grealish, 2007), with students being integrated as members of the healthcare team (Edgecombe & Bowden, 2009; Mulready-Schick, Kafel, Banister, & Mylott, 2009). Additionally, working in a one-on-one relationship with the staff nurse/clinical instructor, students noted increased knowledge related to medications and decreased potential for errors, as well as increased critical thinking and clinical decision making (Hannon et al., 2012). Students on DEUs reported increased accountability, in tandem with increased confidence (Callaghan et al., 2012; Hannon et al., 2012; Ranse & Grealish, 2007; Mulready-Shick et al., 2009). Moscato and colleagues (2007) also found students felt more in command of their own learning goals. Teaching accountability in nursing education can be challenging, so the opportunity for students to achieve this professional standard is important. There is little research to describe the challenges inherent in this model, though it is a newer model than the traditional and preceptor models of clinical learning.

Academic-practice partnership model of CLE. Similar to the DEU, academic-practice partnerships are a recent innovation in clinical learning and are loosely defined as a relationship among multiple partners to attain common objectives (Nabavi et al., 2012). The Oregon clinical education model is one such example, where statewide

practice and education leaders created a clinical model based on specific course and student needs (Nielsen et al., 2013). The elements of case-based, concept-based, focused direct client care, integrative experience, and intervention skill based were considered to promote deep understanding of knowledge and skills required of professional nurse (Nielsen et al.). Formal outcome evaluation of this model is underway, but Nielsen and colleagues provided anecdotal evidence that student thinking increased in complexity and faculty reported a more student-centered approach to teaching.

Academic-practice partnerships seem to be an innovative way to increase efficiency for stakeholders. A partnership based in Hawaii resulted in decreased demand for acute care clinical sites and number of students in clinical units (Niederhauser et al., 2012). Another academic-practice partnership resulted in increased student integration to patient care unit, useful coordination of clinical placements, increased flexibility to manage additional student clinical requests, coordinated clinical learning experiences, evidence based practice in clinical and teaching practices (Preheim et al., 2006). Evidence suggested that partnerships have potential mutual benefits, offer opportunities for collaboration and joint practice, and support partners reaching mutually beneficial outcomes (Nabavi et al., 2012). Students reported that an Australian partnership model increased their familiarity with the practice organization, facilitating increased confidence and work preparation (Newton et al., 2011). Similar to the DEU, academic-practice partnerships seem to support a more efficient use of clinical units and provide for consistency in teaching-learning relationships.

There are challenges related to academic-practice partnerships. The flexible definition makes it difficult to evaluate and compare models that may include different constructs and assumptions. There is also a dearth of literature actually analyzing outcomes (Nabavi et al., 2012). For example, a clinical scholar model developed in Colorado was believed to be successful, there was no specific data regarding student outcomes (Preheim et al., 2006). Niederhauser and colleagues (2012) found no difference in HESI scores between pilot partnership students and students participating in traditional CLE. Though these researchers made an attempt to connect clinical learning to specific learning outcomes, HESI does not directly measure clinical learning.

Student perspective of the CLE. Students perceive that staff nurses affect the outcome of clinical nursing education. Students indicated a heavy reliance on staff nurses for clarification and direction in the clinical setting (Baxter & Rideout, 2006). White (2003) explained a minimal influence of the clinical instructor on student learning, even with the instructor readily available. Students who participated in a Finnish study described a positive CLE through cooperative attitudes among staff and staff regarding students as young colleagues, as well as feeling appreciated for and supported in their work (Papp et al., 2003). Skills, qualities, and attitude of the preceptor were perceived by students to be of greater importance than the actual CLE (Wilkes, 2006). Stemmans and Gangstead (2002) found that students working with inexperienced instructors contributed far less than those working with more experienced instructors. Expanding the understanding of how staff impact the CLE, students noted fear when approaching staff nurses, not wanting staff to be aware of their deficiencies or not wanting to upset or bother the nurse with questions (Baxter & Rideout, 2006; Hovland, 2011). Furthering

this idea, students reported decreased confidence and commitment to learning in response to nurses' impatience or frustration with the students (Levett-Jones et al., 2009). Students require a safe environment for learning to occur and nurses contribute to a safe and positive CLE.

The evidence is less clear in regards to how students understand the different roles of the practice-based clinical nurse or preceptor and academic-based clinical instructors. Saarikoski and colleagues (2013) found a wide variability in student preference for professional role modeling between the unit-based mentor and the clinical teacher, though a small majority did indicate a preference for the unit-based mentor. In contrast, Hovland (2011) found students had no clear preference for supervision by nurse or teacher. A similar Swedish study found that students were satisfied with all clinical facilitators, including clinical lecturers, preceptors, and head preceptors (Kristofferzon et al., 2013). All demonstrated supportive behaviors, but lecturers exhibited more challenging behaviors such as making students describe thinking process and promoting reflection (Kristofferzon et al.). In a Canadian study, students viewed faculty role minimally within a rural preceptorship model and indicated a need to have more in-depth conversations with faculty regarding learning goals and outcomes (Sedgwick & Yonge, 2009). Hovland (2011) found that Norwegian nursing students were able to compare and contrast the supervising styles of clinical nurse and clinical teacher, noting that the teacher asked more questions and required more student reflection. Students also desired faculty to coordinate placements that paralleled theory (Papp et al., 2003). This evidence suggests that students may appreciate the practicing nurse for clinical expertise, while

recognizing the academic clinical teacher or instructor for pedagogical expertise and yet role clarification appears to be needed.

Students recognize nurse expectations for student performance, which increases student anxiety. Students navigated a combined role of worker and learner, trying to adhere to expectations of nursing faculty and norms of the clinical unit (Reutter et al., 1997). Vallant and Neville (2006) found that students worked to balance addressing their learning needs while not drawing attention to themselves, so as to not upset staff. Reutter and colleagues (1997) noted, "the relationship between the students and staff nurses clearly points out that the professional school, practitioners, and students do not necessarily constitute a system bound together by mutual interest and shared outlooks" (p. 152). Students were aware of mentors' busyness (Vallant & Neville) and expressed difficulties communicating and prioritizing their learning needs in relation to the clinical unit needs (Shakespeare & Webb, 2008). Allan and colleagues (2011) suggested that mentoring relationships required sponsorship in order to be effective. In order to function effectively within the CLE, student-staff dyad may require additional support and preparation to understand and navigate their role within the combined work and learning environment.

Relationships within the CLE may create challenges also. All students participating in focus groups noted relationships presented a challenge to clinical learning, including faculty communication and expectations and nurses being rude, ignoring or gossiping about students (O'Mara et al., 2014). These challenges inhibited students from asking questions and seeking learning opportunities, as well as causing loss of initiative and confidence (O'Mara et al.). Baxter and Rideout (2006) reported that due

to feelings of intimidation by nursing staff, students then avoided discussing their clinical decision making process with the nurse. In another study, students reported "being invisible in the relationship" with clinical nurses, which limited their ability to learn (Vallant & Neville, 2006, p. 26). Levett-Jones and Lathlean (2009) found that students' willingness to question or conform to practice is dependent on belonging; students failed to question due to a sense that they would not be accepted. Students perceive that negative relationships with staff and faculty impede clinical learning.

In contrast, supportive relationships seem to facilitate clinical learning. Students noted that supportive relationships with others, including peers, could help overcome other challenges within the CLE (O'Mara et al., 2014). Interpersonal relationships among participants in the CLE greatly contributed to a positive CLE (Dunn & Hansford, 1997). Gillespie also (2002) found that student nurse-nurse teacher relationships had a significant impact on the CLE, in that students who described a non-connected relationship with their teacher were more likely to focus on the teacher in lieu of learning. Lee and colleauges (2002) reported survey data that indicated both students and clinical educators (term not defined) rated educators' interpersonal relationships highest, over teaching ability and clinical competence, in being effective.

Relationships between nurses and students are also described in the literature. Students perceived that staff relationships were foundational for a positive CLE, based on collegial relations and open communication (Atack et al., 2000). Papathanasiou and colleagues (2014) noted that students placed a significant premium on supportive relationships in the CLE. Birx and Baldwin (2002) reported that efforts to promote staff-

student relationships resulted in a more caring CLE from the student perspective. Levett-Jones and Lathlean (2009) explained that caring and supportive relationships may help students feel a sense of belonging within the clinical unit.

There is also evidence to describe how positive relationships impact the CLE. Levett-Jones and colleagues (2009) found that a receptive and welcoming staff helped to ease anxiety and improve students' motivation to learn. This positive learning environment allowed students to feel safe and secure, allowing them to ask questions and take on challenges (Levett-Jones et al., 2009). "When students are assured that the nursing staff they work with are supportive of their learning and committed to their professional development, they focus on learning rather than being preoccupied with interpersonal relationships" (Levett-Jones et al., 2009, p. 322). Gillespie (2002) noted how students who were well connected with the nurse teacher described a focus on their learning needs, as well as increased ability to respond to patient care needs. Vallant and Neville (2006) also described that nurturing relationships with staff contributed to a positive CLE for students by helping students feel more confident, enabling skill development and student learning. Students who felt a sense of belonging expressed increased motivation and capacity learn: they noted increased self-esteem, resilience, feelings of connectedness, confidence, self-efficacy, and ability to learn (Levett-Jones & Lathlean, 2009). Supportive relationships within the CLE alleviate student anxiety and enable learning to occur.

One element of effective relationships in the CLE may relate to consistency. Students indicated a preference for the same clinical teacher across different facilities in the same organization; this consistency likely contributed to students' rating this model of

clinical learning higher on student-centeredness on CLEI (Newton et al., 2012). Student nurses indicated that supernumerary status may have limited their ability to connect consistently with assigned mentors and discuss and meet their specific learning needs (Allan et al., 2011). Students and staff who work together over time have a relational foundation, enabling students to move past establishing relationships to focusing on learning. Trusting relationships also contribute as the foundation for successful clinical learning. Researchers found that without trust, students do not feel safe to question and learn and staff do not feel safe to enable students to care for patients (Steven et al., 2014). Consistency in relationships may help to contribute to trusting relationships that enable student learning.

Nurse perspective of the CLE. Mannix and associates (2009) asserted that all nurses must be interested in the condition of the CLE, as well as contribute to the overall effectiveness of the CLE. Being licensed as an RN automatically signifies qualification for a nurse to guide nursing students (Landmark et al., 2003). Though the nurse serves as a practice expert, within the CLE the nurse also serves as an educator to the student nurse. Brammer (2006) additionally suggested that the way in which nurses understand their role in the CLE influences student learning and ability to develop. Eaton and colleagues (2007) found that staff recognized the importance of undergraduate education and how the clinical unit, including knowledge and skills of the nurse, contributed to overall education of student nurses. Yet nurses also considered work with a student as a burden, adding work rather than value to the clinical environment (Eaton et al., 2007).

Understanding the complexities of the CLE may be challenging for nurses as they navigate the dual role of nurse and teacher.

Nurses seem to be well aware of their role within the CLE. Researchers in Norway indicated clinical supervisors had an awareness of their role and status as a role model when working with nursing students, but indicated a lack of time and need to be relieved from some patient care responsibilities as challenges to effective teaching (Landmark et al., 2003). Bourbonnais and Kerr (2007) reported that preceptors described their role as teacher and protector, while others report the role as educator, coach, and role model (Atack et al., 2000). Similarly, Lillibridge (2007) reported that preceptors viewed their role as teacher, engaging in processes that protected the student from harm or situations that might erode confidence and facilitated learning opportunities. Preceptors reported being stimulated and rewarded, but also stressed by the role (Hallin & Danielson, 2009). Preceptors indicated desire to work with and enjoyment in working with nursing students (McCarthy & Murphy, 2010). Preceptors indicated personal and professional rewards inherent in precepting: mental stimulation, ongoing learning, satisfaction in teaching role and growth of students, but downplayed extrinsic rewards (Usher et al., 1999). The role of nurse teacher may provide some professional fulfillment to nurses.

Despite a reported awareness of the role of the nurse within the CLE, nurses may fulfill a variety of roles within the CLE. Brammer (2006) interviewed and observed nurses fulfilling the informal teaching role of the buddy nurse, a non-preceptor. Nurses filled a breadth of roles as a buddy to students from a positive facilitator or coaching role, to a negative dissenter or resistor role (Brammer, 2006). Nurses who described their role

as facilitator and coach were more likely to see students as future colleagues, creating a positive CLE. Other roles were challenged in providing a consistent CLE, perhaps because of a focus on controlling patient care and student learning, workload allocation concerns, or the desire to avoid students (Brammer, 2006).

A gap exists between the expectations for the nurse to have an active and meaningful role within the CLE and the preparation of nurses to contribute positively to the CLE. Nurses indicated significant ambiguity regarding the accountability for student learning and evaluation (Atack et al., 2000) as well as being unaware of how to bridge the theory-practice gap for students (Landmark et al, 2003). Evaluation is also a considerable concern. Atack and others found that staff were uneasy with student evaluations. Andrews and colleagues (2006) found that 18% instructors who passed failing students doubted the validity of their concerns and did pass a failing student, felt pressured by the university to pass a failing student, or had lack of confidence, concern about lack of support from lecturer or manager, unclear about process, and concerns for student emotions. McCarthy and Murphy (2010) also found that a majority of preceptors never failed a student and many would find it difficult to do so. Qualitative findings indicated that preceptors felt unsupported in the assessment process and anticipated a lack of managerial support in failing a student (McCarthy & Murphy, 2010). Being unfamiliar with academic processes for assessment and evaluation may limit the impact the nurse can have within the CLE.

Practice teachers and mentors indicated a lack of support from the clinical organization in their dual role as practitioner and educator, including need for support

from colleagues and workload adjustments when working with students (Carr & Gidman, 2012). Interestingly, many indicated feeling well supported by the university and faculty, though other comments indicated a need for better understanding of clinical teacher workload and responsibilities (Carr & Gidman, 2012). Preceptors also desired support from their peers. "Senior staff may give 'lip service' to supporting the preceptor role, but in many instances the only compensation is the intrinsic reward from the professional relationship and the growth observed in the preceptee" (Henderson et al., 2006, p. 135). Additionally, nurses with varying levels of experience may have different needs for support. Nurses with less experience precepting (1-5 years) ranked setting priorities and organization of workload higher than nurses with more experience (>6 years) (Rogan, 2009). The difference in priorities for nurse preceptors with more or less experience indicates some individualized preparation or support may be necessary.

Significant challenges are present with the nurse fulfilling the role of teacher and nurse. Preceptors reported being stressed by the role (Hallin & Danielson, 2009), perhaps due to the significant mental energy required when concurrently caring for patients and teaching students (Lillibridge, 2007). Preceptors described not feeling appreciated or recognized by management and indicated that a lack of quality time with students due to busy ward, understaffing, increased workload, and lack resources contributed to these feelings (McCarthy & Murphy, 2010). Given this evidence, it can be considered that preceptors feel committed to their role but feel divided between responsibilities to teach students and provide patient care. Clinical supervisors indicated awareness that the relationship between nurses and student impacts learning, as well as nurse confidence (Landmark et al., 2003). Preceptors felt unsupported by leadership, especially related to

workload and time involvement with students and desired feedback to guide future growth (McCarthy & Murphy, 2010). Only 29% of preceptors indicated satisfaction with feedback (Hallin & Danielson, 2009). As part of their commitment to the role, preceptors desire feedback to direct their ability to contribute to the CLE and well as their professional identity.

Workload and time barriers present as a significant challenge for nurses in the CLE. The workload of clinical teaching and mentoring was not well recognized, valued by organizations, or demonstrably productive (Bourbonnais & Kerr, 2007; Charleston & Happell, 2005; Wilkes, 2006). Madhavanpraphakaran and others (2014) reported that while 54% of surveyed preceptors positively rated teaching and learning experiences, qualitative data revealed that time constraints and conflicts between patient care and student learning as concerns. Henderson and colleagues (2006) found that preceptors also noted lack of time as a significant barrier to teaching well. Lack of time limited the ability to perform the preceptor role as preceptors were unable to review progress with the preceptee or were pulled from teaching duties secondary to unit/patient care needs (Atack et al., 2000; Henderson et al., 2006). Lillibridge (2007) also noted time and patient load as barriers to preceptors doing the job well, with some preceptors describing hurrying students to get out on time. Other studies also validated time as a barrier to effectively teaching and connecting with students (Atack et al., 2000; Charlston & Happell, 2005).

Preparation for the role of nurse teacher may impact the CLE. One study found that mentors based many judgments regarding student readiness for practice on ability to

communicate (Shakespeare & Webb, 2008). This evidence suggests that preparation and support for the role of nurse teacher may impact the nurse's ability to fulfill that role. Lillibridge (2007) noted preceptors desired orientation to the role, especially related to expectations of the role and experience of previous preceptors. Nurse preparation may help delineate the nurse's role working with and teaching nursing students. Smedley and colleagues (2010) surveyed Australian nurses following a professional development course. Nurses indicated that following the course, their knowledge and skills related to teaching and learning methods had increased. Most nurses also indicated their generic preceptor skill increased. Additionally, there was a positive relationship between preceptor self-efficacy and his or her attitude toward student nurses (Smedley et al.). In the Swedish setting, a preceptor preparation course was associated with increased awareness of role demands and role security, lending to the perception of preceptor preparedness (Hallin & Danielson, 2009). Staff appreciated internal networking, were better able to understand the program of study and clinical requirements following a professional development course jointly offered by academic and practice partners (Mackay, Brown, Joyce-McCoach, & Smith, 2014). Burns and Northcutt (2009) described positive evaluations following the creation of a preceptor program aimed at preparing and supporting preceptors; however, no specific evaluation data was presented.

Clear communication may help to address some concerns related to expectations. Duddle and Boughton (2007) noted that within the work environment, clinical nurses reported negotiating relationships as part of their workload. Preceptors indicated that a structured student assessment form was useful; researchers reported that of these preceptors, almost ⅔ had no formal preparation for their role (Lofmark & Thorell-

Ekstrand, 2014). Usher and colleagues (1999) found that nurses had a desire for preparation and support from peers and hospital administrators. RNs desired a clear structure and expectations from faculty, as well as support in delineating the theory-practice gap (Landmark et al., 2003). Nurses desire support and structure to assure meaningful contributions to the CLE. Faculty, staff, and students may need to explore roles and responsibilities to facilitate ease in relationship development and thus workload.

There is also evidence that describes how nurses perceive students within the CLE. Three studies in the US used the Nursing Students' Contributions to Clinical Agencies (NSCCA) tool. In one study, all staff noted student clinical is a useful source of recruiting (Grindel et al., 2003), demonstrating that nurses may recognize value for the organization to invest in student clinical. All three studies indicated that nurses perceived that students contribute mostly in a positive way, allowing for mentoring and reciprocal learning opportunities and exposure to other perspectives (Grindel et al., 2003; Matsumura, Callister, Palmer, Cox, & Larsen, 2004; Slaughter-Smith et al., 2012). Grindel and colleagues found that staff with less than 10 years of experience were more positive regarding the contributions of students than nurses with more than 10 years experience, an interesting finding given that clinical instructors may seek out more experienced, expert staff when assigning students. Matsumura and colleagues also noted that master's-prepared nurses were more positive of their view of student contributions, indicating that educational level may impact nurse perceptions. With additional education, staff may have a higher value for mentoring (Matsumura et al.) or be more aware of the work involved in the professional development of others.

The evidence from the NSCCA surveys indicated a mix of positive and negative elements. Staff noted level of students differed in communication ability, learning objectives, and ability to assist with care on the unit (Matsumura et al., 2004). This may be a source of frustration for nurses who work with multiple levels of students during a workweek. Slaughter-Smith and colleagues (2012) noted that problem students were a significant source of frustration. One theme noted in qualitative questions revealed that teaching students takes too much time (Matsumura et al., 2004). The combination of working with problem students and trying to adapt to different levels of students' learning needs may add to an already heavy workload for nurses. In response to a qualitative question, nurses noted that students seemed eager to learn and willing to help with patient care, though some students appeared unmotivated and nurses thus chose not to invest in these students (Slaughter-Smith et al., 2012). The role of the instructor was also noted to impact the quality of the CLE, due to knowledge of unit practices and procedures, role modeling, absence, and relationships with staff (Matsumura et al., 2004). The contributions of students and faculty alike impact how the nurse views the CLE.

Faculty perspective. Academic nursing faculty experience significant challenges in facilitating a quality CLE. "One of the challenges for nurse educators is to find appropriate practice experiences for increasing numbers of nursing students in an already stressed health care system" (Callaghan et al., 2008, p. 245). Faculty must find a balance between number and quality of placements for growing numbers of students. Additionally, roles and expectations must be defined. Faculty viewed their role as liaison and support for student and viewed preceptors as teacher and evaluator (Yonge et al., 2003).

Faculty also noted the importance of relationships. In an Australian study, clinical facilitators noted the need to develop alliances with staff to assure student learning occured seamlessly (Dickson, Walker, & Bourgeois, 2006). With faculty teaching in agencies where they may not practice, this helps to transition the students into the practicum. Also, faculty identified a need to find appropriate staff to partner with students. Faculty evaluated staff professional and personal qualities in determining if a clinical nurse would develop a meaningful relationship with students (Dickson et al., 2006).

Additional challenges relate to the academic structures surrounding the CLE. Faculty reported large clinical groups (more than 8-10 students), which limits faculty availability to teach each student, as well as provide guidance or support to clinical nurses (Schuster, Fitzgerald, McCarthy, & McDougal, 1997). This may contribute to faculty dissatisfaction and burnout. Additionally, 70% of nurse faculty surveyed indicated that clinical workloads receive less credit than teaching in the classroom, which was associated with fewer hours spent in service and scholarly pursuits (Schuster et al., 1997). This potentially limits the nurse teacher's ability to develop nursing practice, further limiting teaching effectiveness (Schuster et al.). Faculty were also unlikely to pursue clinical roles if it was not included as part of academic workload (Nabavi et al., 2012). The academic structure may impede nurse faculty's ability to create a positive CLE through the development of their own clinical competence and their ability to support students and clinical nurses in a meaningful way.

Faculty also have significant needs for preparation within the CLE. Faculty indicated a need for mentoring to navigate academia's spoken/unspoken rules, as well as intense orientation to course and role responsibilities to support successful transition from a practice to academic role (Dattilo, Brewer, & Streit, 2009). In one study, faculty described a desire for clear expectations for the faculty role and preparation to support a positive learning experience within the preceptor model (Yonge et al., 2003). Other evidence suggests that preparation and expectations may support the faculty role. Higher educational levels and more experience were found to be associated with higher self efficacy (Yang, Kao, & Huang, 2006).

Review of Methodological Issues

When considering the complexity and importance of the clinical learning environment, the perspectives of each stakeholder is useful in considering needed reforms. Multiple authors used surveys and questionnaires to understand the staff and preceptor experience with students within the CLE (Altmann, 2006; Carr & Gidman, 2012; Dibert & Goldenberg, 1995; Grindel et al. 2003; Hallin & Danielson, 2009; Madhavanpraphakaran et al., 2013; Matsumura et al., 2004; McCarthy & Murphy, 2010; Slaughter-Smith et al., 2012; Usher et al., 1999; Yonge & Myrick, 2004), as well as the student perspective (Chan, 2002; Dunn & Burnett; 1995; Dunn & Hansford, 1997; Kristofferzon et al., 2013; Livsey, 2009; Newton et al., 2010; Newton et al., 2012; Omer et al., 2013; Papathanasiou et al., 2014; Salamonson, Bourgeois, Everett, Weaver, Peters, & Jackson, 2011; Sand-Jecklin, 2009; Yonge et al., 2011). Some authors included qualitative questions within the tools (Matsumura et al., 2004; Slaughter-Smith et al., 2012) but Matsumura et al. also noted that further exploration through focus group

interviews may help to explore the survey findings. This trend regarding the use of surveys was not noted in regards to the faculty perspective of the CLE. Only two surveys were noted (Schuster et al., 1997; Yang et al., 2006) though the body of faculty evidence is also less extensive than that of the student and staff perspective. The various staff and student surveys described a wide variety of findings to an admittedly complex issue. The use of surveys limited the ability to explore themes with more depth. Jinks (2007) noted a predominance of survey research and that mentor experiences and perceptions required description from a qualitative perspective. The complexity of the CLE warrants breadth and depth of evidence to inform best practices.

An additional challenge related to research methods relates to terminology. It is difficult to understand the evidence in a larger context and how to apply findings, as there are varying terms to describe the nurse who facilitates or teaches clinically including preceptor, mentor, buddy, practice teacher, and tutor. Likewise, a variety of terms were used for academic faculty, as well. When exploring different models of clinical learning, there is also a wide variety of terms used such as DEU, clinical learning unit, mentorship, and preceptorship. These terms are not always defined in the literature, making it difficult to understand how to best use the evidence to guide practice within the CLE.

Synthesis of Research Findings

A variety of themes are evident in the literature. The complexity of the CLE is made clear by the evidence, given the recognition of the CLE as an essential component of nursing education as well as the numerous challenges inherent in clinical learning. A complex challenge that was common across the literature related to the combined work

and learning environment. Competing priorities between student learning and patient care and unclear expectations contribute to an ambiguous and challenging clinical environment for all stakeholders. While there was some evidence to support that preparation for the teaching role has a positive effect for nurses (Hallin & Danielson, 2009; Mackay et al., 2014; Smedley et al., 2010), there was no literature to describe how these interventions impacted the overall CLE or student outcomes. There is also no literature that addresses how to overcome the challenge related to competing priorities.

Building effective relationships seems to be one theme across the evidence related to clinical models, staff, students, and faculty (Atack et al., 2000; Brammer, 2006; Charleston & Happell, 2005; Datillo et al., 2009; Gillespie, 2002; Hartigan-Rogers et al., 2007; Hovland, 2011; Kristofferzon et al., 2013; Landmark et al., 2003; Lee et al., 2002; Levett-Jones & Lathlean, 2009; Levett-Jones et al., 2009; Newton et al., 2012; Peters et al., 2013). Effective relationships support a positive CLE where learning is facilitated, where learning is hindered when relations among students, staff, and faculty are ineffective. Time and workload may be the most significant barriers to creating a positive CLE. The evidence indicates that nurses' heavy workload impedes their ability to effectively work with and teach students (Atack et al., 2000; Charlston & Happell, 2005; Dibert & Goldenberg, 1995; Henderson et al., 2006; Landmark et al., 2003; Lillibridge, 2007; Madhavanpraphakaran et al., 2013; McCarthy & Murphy, 2010). Students who may be ill-prepared for clinical or require additional coaching or support may intensify this issue. The creation of innovative clinical models such as the DEU and preceptor programs begin to address the concern for building relationships, but not the

attainment of student learning outcomes or the concern for nurse workload and time constraints.

Critique of Previous Research

There is an abundance of information regarding the CLE from the student perspective. Considering a learner-centered approach to learning, where the emphasis shifts from the teacher's perspective to the needs of the learner (Candela, Dalley, & Benzel-Lindley, 2006) it is logical to be well informed regarding the perspective of the student. However, the CLE is incredibly complex. Reform cannot be well informed without understanding the perspectives of all stakeholders. While much of the literature regarding the nurse's experience within the CLE is from the perspective of a preceptor (Bourbonnais & Kerr, 2006; Burns & Northcutt, 2009; Carr & Gidman, 2012; Charleston & Happell, 2005; Dibert & Goldenberg, 1995; Henderson et al., 2006; Landmark et al., 2003; Lillibridge, 2007; Mackay et al., 2014; Madhavanpraphakaran et al., 2014; McCarthy & Murphy, 2010; Peters et al., 2013; Sedgwick, 2011; Usher et al., 1999; Yonge & Myrick, 2004), there is a lack of evidence regarding the staff nurse experience. The evidence describing the staff nurse perspective involves survey research using the same NSCCA tool (Grindel et al., 2003; Matsumura et al., 2004; Slaughter-Smith et al., 2012). The limited qualitative data emerged from other countries, which may limit usefulness in the US due to cultural differences (Atack et al., 2000; Brammer, 2011; Grealish et al., 2010) or is the result of action research (Eaton et al., 2007). The evidence also reveals that much of the research regarding the CLE originated from outside the US, despite nursing authorities in the US being well aware of the need for reform in the CLE

(Benner et al., 2010; Forbes & Hickey, 2009; IOM, 2011; MacIntyre et al., 2009; NLN, 2003). There is additionally a lack of research related to the faculty perspective. This limited understanding of the staff nurse and faculty perspectives challenges a holistic understanding of the CLE.

There is growing evidence regarding the use of alternative clinical learning models, such as preceptorship and DEU. However, effectiveness of alternative models is still in question, with specific evidence regarding learning outcomes, practice competencies, and readiness for practice lacking (Mackay et al., 2014; McNelis et al., 2014). Studies are few and typically have small sample sizes (Tanda & Denham, 2009). There are also very few theoretical models directly pertaining to the CLE. Some theoretical models focus on discrete parts of the CLE, such as student development (Edgecombe & Bowden, 2009). Other models neglect important stakeholders, such as Henderson et al.'s (2011) and White's (2003) models which exclude nursing faculty. These models also require testing to further understand their accuracy and applicability. Developing the faculty and staff perspective of the CLE may help inform future research that can better link specific models and interventions to learning outcomes.

Chapter 2 Summary

To consider the experience of the nurse who works and teaches the student nurse within the CLE, a combination of learning and nursing theory informed this study. Transformative learning theory (Merriam et al., 2007; Mezirow, 1997) and Benner's novice to expert model of professional development (Benner et al., 1992) provided a framework that describes how the novice interacts with the learning environment, as well as expert nurses and faculty, to develop new knowledge and ability as a nurse. It is

difficult to fully separate the student learning environment from the nurse work environment. The AACN (2005) framework for HWE integrates a number of issues also key to creating a positive CLE, such as appropriate staffing, skilled communication, and collaboration. The interplay of these models and frameworks provided the theoretical lens for this study.

The role of the CLE in nursing education is appreciated for the opportunities it affords students to learn nursing practice in a real-life context (Hartigan-Rogers et al., 2007; O'Mara et al., 2014). However, these learning opportunities occur within a fast-paced work environment where the need to provide patient care may compete with student learning needs (Dickson et al., 2006; Eaton et al. 2007; Grealish et al., 2010; Reutter et al., 1997; Schuster et al., 1997; Steven et al., 2014; Slaughter-Smith et al., 2012). While there are common themes of time barriers, workload, and effective relationships hampering the CLE among three major stakeholders in the CLE (Baxter & Rideout, 2006; Charleston & Happell, 2005; Hovland, 2011; Landmark et al., 2003; Levett-Jones et al., 2009; O'Mara et al., 2014; White, 2003; Wilkes, 2006), there is much yet to learn regarding the experiences of faculty and non-preceptor nurses.

CHAPTER 3. METHODOLOGY

This study explored the experiences of non-preceptor nurses teaching and working with nursing students in a traditional clinical learning environment (CLE). The intersection of student learning with the nurses' work environment requires investigation so as to best maximize student learning while minimizing burdens to the nurses balancing both patient care and teaching responsibilities. Transformative learning theory, Benner's novice to expert model of professional development, and the American Association of Critical Care Nurses Healthy Work Environment framework guided the literature review, data collection, and interpretation. This chapter comprises the rationale and explanation for the use of the basic qualitative approach and design of this study, including sampling, data collection, and analysis procedures.

Purpose of the Study

The purpose of the qualitative study was to explore how nurses who work with nursing students in the traditional clinical learning model describe the CLE.

Research Questions

For inpatient non-preceptor clinical nurses working with nursing students in the traditional clinical learning model on medical-surgical units, how do nurses describe their experiences within the clinical learning environment?

Subquestions:

1. How do nurses describe their experience teaching nursing students?

2. How do nurses describe their experience working with nursing faculty?

3. How do nurses perceive their role within the CLE?

Research Design

The basic qualitative approach supports detailed data collection and a deeper understanding of a particular experience (Trochim, 2006). Non-preceptor nurses who work with students in the clinical learning environment, through the traditional clinical model, were recruited to participate in one-on-one interviews. The use of conversational individual interviews allows the researcher to obtain rich, detailed data, which inform the research question (Merriam & Associates, 2002). A semi-structured process was used to enable the collection of specific data related to the research question, but the flexibility to engage participants in constructing meaning of their individual experience (Merriam, 2009). A one-hour interview was conducted per participant. Interviews were audiotaped, with use of field notes to assure accuracy and context during the interviews (Merriam & Associates). Data were transcribed verbatim by the transcriptionist and stored. Data were secured in an encrypted hard drive, located in a fire safe in a locked office.

Target Population, Sampling Method, and Related Procedures

According to Seidman (2013), the open-ended nature of qualitative research requires strict attention to preparation, planning, and structure. This attention must include details related to the participants of a study. Describing the target population and sampling methods allows the researcher to be transparent about the process, enabling replication and effective evaluation of the process (Jones & Kottler, 2006).

Target Population

The target population was registered nurses (RNs) who work on inpatient medical-surgical units and work directly with nursing students participating in traditional clinical experiences. This population was selected because of the known gap in the research literature. It was assumed that other populations of nurses, such as those working in outpatient or specialty units, may have a different experience than those of medical-surgical nurses.

Sampling Method

The sampling design was a non-probability, purposive sample of inpatient nurses who work with nursing students. This approach permitted access to participants who were most able to provide rich data to answer the research questions (Merriam & Associates, 2002). A convenience sampling procedure was used to recruit inpatient medical-surgical nurses through a nursing organization in the Midwestern United States. The convenience approach was used in contacting a group that was easily accessible. Using a purposive procedure also allowed access to participants who could provide data needed to answer the research questions (Jones & Kottler, 2006). Recruiting nurses through a medical/surgical nursing association allowed contact with a sample that was similar to the target population of study. One disadvantage to the convenience and purposive procedures was a risk of researcher selection bias and a lack of representation of the target population (Jones & Kottler, 2006). Limiting the sample to only nurses in a professional organization, while providing the expert participants needed for data collection, could have created bias. To help alleviate this bias, two area hospitals, the researcher's social media, and snowball sampling was also used. Snowball sampling

allowed for discovery of key participants who met criteria (Merriam, 2009) and also served to increase the sample size and achieve additional diversity within the required medical-surgical nursing practice.

Sample Size

Marshall (1996) noted that sample size in qualitative research is guided by the research question; when the question is answered the sample size is then defined. In similar qualitative studies exploring nursing students or preceptors sample sizes ranged from 10-18 (Koontz, 2010; Levett-Jones et al., 2009; Shakespeare & Webb, 2008; White, 2003). A target sample size was anticipated to be within this range; however, data saturation occurred with six participants.

Setting

The research occurred in the Midwestern United States in an urban area with a variety of medical centers, including tertiary care, teaching hospitals, and community hospitals. The research participants determined the setting for this study. Interviews were completed at a location convenient to the participant. All interviews allowed for a quiet and uninterrupted environment. Some interviews occurred in the participant's work or home space, while other interviews occurred in the researcher's work location or via telephone.

Recruitment

Volunteers were recruited through an electronic messaging distribution list maintained by the professional nursing organization. Three electronic messages were sent through the professional organization's e-mail list, sent by the organization's

president and the researcher. Additionally, social media was used, as the organization had an established Facebook site. Recruitment materials were posted to the organization's Facebook page. Two regional hospitals were used, with a nurse administrator sending two recruitment e-mails to medical-surgical nurses. Finally, recruitment messages were also posted to the researcher's LinkedIn and Nurse's Lounge profiles.

Nurses who were interested initiated further contact with the researcher through e-mail or phone. Volunteers were contacted by phone or e-mail to confirm interest in participation and determine a time and location for interviews. Interviews were scheduled at a time and location convenient to both the researcher and participant. E-mail attachments of the informed consent were sent to volunteers for review prior to the interview. A paper copy of the consent form was presented for review at the scheduled interview with participants and participants were then given opportunity to seek clarification or ask questions. Informed consent for the interview, as well as for audiotaping and transcribing of interviews, was obtained immediately prior to the interview. Consent forms were then stored in a locked file cabinet in a secured office. Transcripts and field notes were kept anonymous through the provision of an identifying number to each participant.

Instrumentation

Instrumentation included a researcher-developed interview protocol, which was created based on the review of the literature and revised based on feedback from expert review. McNelis and colleagues (2014) suggested that clinical nurses required development to support change within the CLE, yet the literature mainly described the

preceptor experience, which included both positive and negative perspectives (Atack et al., 2000; Bourbonnais & Kerr, 2007; Charleston & Happell, 2005; Dibert & Goldenberg, 1995; Henderson et al., 2006; Hallin & Danielson, 2009; Lillibridge; 2007; Madhavanpraphakaran et al., 2013; McCarthty & Murphy, 2009; Usher et al., 1999). An additional concern noted by Altmann (2006) was that many nursing schools using the preceptor model provided minimal professional development for preceptors (average 2.5 hours). The student perspective was that the staff nurse played a significant role within the clinical learning environment (CLE) (Dunn & Hansford, 1997; Edgecombe & Bowden, 2008; Gillespie, 2002; Hartigan-Rogers et al., 2007; Hovland, 2011; Levett-Jones & Lathlean, 2009; Levett-Jones et al., 2009; Livsey, 2009; O'Mara et al., 2014; Papathanasiou et al., 2014; Papp et al., 2003; Steven et al., 2014; Tanda & Denham, 2009; Vallant & Neville, 2006) and yet little research is devoted to how the nurse understands their role within the CLE. The interview questions were developed to address these knowledge gaps.

The interview protocol provided structure for the interview process. According to Maxwell (2013), using a structured approach allows for comparing data across individuals, while a less structured approach supports contextual understanding of individual differences. In an attempt to find balance between comparability and validity (Merriam, 2009), a semi-structured approach was used. An interview protocol was developed based on the research question and field tested to assure that questions were appropriate for the population being studied. The interview protocol included the following questions:

1. How often do you have nursing students participating in clinicals on your unit? What level of students do you encounter (program type, program level)?

2. Recall a time when you were working on your unit with a nursing student. In your own words, can you tell me about your experience working with a nursing student in your work area?

a. Describe your approach to teaching nursing students.

b. How do you approach teaching the student and managing patient care?

3. How would you describe your experience working with nursing faculty or clinical instructors within the CLE?

4. Based on your overall experience, describe the quality of the clinical learning environment.

a. How would you describe the current reality?

b. How would you describe a high quality CLE?

c. How would you describe a poor quality CLE?

5. How would you describe your role teaching students?

a. How do you feel you are supported for this role?

b. How do you feel you are prepared for this role?

c. How do you feel unsupported for this role?

d. How do you feel unprepared for this role?

e. Describe any benefits or drawbacks you see to your role.

Data Collection

For this basic qualitative research regarding the experience of nurses teaching and working with nursing students, data collection occurred through one 45-60 minute one-on-one, semi-structured interview per participant. Interviews occurred immediately after informed consent was obtained. The semi-structured approach allowed for specific data collection from all participants as well as the flexibility to explore ideas of specific

interest of individual participants (Merriam, 2009). The semi-structured interviews were guided by an interview protocol that included the open-ended questions listed in the previous section. Additional probing questions were asked to clarify meaning from the participants or to further explore ideas presented by the participants (Maxwell, 2013). Each interview was also audiotaped to enable accurate, verbatim transcription of data (Gill, Stewart, Treasure, & Chadwick, 2008). Field notes, including the researcher's reactions and thoughts as well as conversational context, were recorded during and after interviews. Field notes also served to guide probing questions.

Field Test

Field-testing, or expert review, helps to assure credibility of qualitative research (Radhakrishna, 2007). Three experienced nurses with a variety of academic and hospital-based leadership experience completed field-testing of the interview protocol. All three experts had experience as staff nurse educators and in undergraduate nursing education, providing useful perspective in understanding both the CLE and how staff nurses function within the CLE. These content experts were contacted via electronic messaging to seek permission for field-testing. A cover letter explained the purpose of the field test and a separate document included the problem statement, purpose, research question for context and the proposed interview protocol for review. Each expert reviewer was asked the following questions: Are the interview questions appropriate for the population; will the interview questions make sense to the population and do they represent the perspectives of the field; do you think the interview questions will provide enough data that the research question would be answered; do you think the interview questions

thoroughly address the problem identified in the problem statement? Experts then replied via electronic messaging with comments or provided hard copies of feedback.

Feedback from each reviewer was reviewed in relationship to the meaning in context of the research study. All reviewers agreed that the interview questions were appropriate for the population. All reviewers also agreed that interview questions would provide sufficient data to answer the research questions, as well as addressing the research problem. The reviewers also made recommendations to clarify some of the interview questions and revisions were made based on these recommendations. Additional feedback helped to inform some of the probing questions the researcher used during interviews.

Data Analysis Procedures

Roulston (2014) described qualitative data analysis as a constructive and contextualized approach, dependent on the researcher to conceptualize and categorize effectively. For this reason, Roulston recommended thorough description of data analysis, to enable adequate evaluation of the analysis. Transcriptions were compared against audiotapes for ongoing verification of accuracy (Merriam, 2002). Data collection and analysis also occurred simultaneously (Merriam, 2009). During interviews, the researcher, documenting the context of the interview as well as thoughts regarding data and developing themes, recorded field notes. Data were transcribed verbatim for analysis; the researcher transcribed the first two interviews and a paid transcriptionist transcribed the remaining interviews. Transcriptions were compared to audiotapes to verify accuracy.

Thematic analysis was used to examine the data. Patton and Cochran (2007)

noted that thematic analysis is a common method of qualitative analysis, which looks across the data to identify patterns and themes. Patton and Cochran also described thematic analysis as starting with reading and annotating transcripts, while also reviewing the audiotapes (Maxwell, 2013), to get a feel for the data. During subsequent readings, abstract themes were identified and noted within the transcript as categories (Merriam, 2009). Data analysis began immediately after the first interview and continued through data saturation (Maxwell, 2013). Additionally, memos were produced during data analysis to document emerging themes, ideas, and issues (Merriam).

After initial themes and categories were recognized, codes began to emerge which allowed coding of all data gathered from the interviews. Codes were revised as the analysis evolved (Bricki & Green, 2007; Merriam, 2009). Bricki and Green also noted that validity is increased through use of member checking. As data were analyzed for meaning, member checking was used to monitor the assumptions and assure internal validity. Merriam (2009) also suggested that validity is achieved through data saturation, which was a goal of this research. Member checking was included as part of the informed consent and occurred via electronic messaging with the participant's approval. Read receipt was requested to assure participant receipt; agreement was assumed with non-response within one week. Corrections or revisions were made as directed by participants.

Limitations of the Research Design

Evaluation of research methods can uncover limitations inherent in the particular design (Jones & Kottler, 2006). Limits inherent in this particular study include the

sampling plan. The purposive sampling plan aimed to recruit participants who would be best able to provide insight related to the research question (Merriam, 2009). The selection of nurses from a particular organization enabled the researcher to access information-rich cases (Devers & Frankel, 2000). However, it can also be assumed that nurses in a professional organization may have a different set of values and experiences than that of the larger population, lending to a potential selection bias. While use of snowball sampling was used in an attempt to build diversity in the sample, it could also be assumed that professional contacts of participants may share similar values and experiences. This may limit transferability of the findings, though discussion of the decision-making and sample selection supports transparency and understanding of the researcher's process (Devers & Frankel).

An additional limitation relates in part to generalizability. Maxwell (2013) noted that qualitative research and the typically small sample size limit the ability to generalize findings. Patton (1999) noted that this limitation is inherent in qualitative research, especially given the typical purposive sampling procedure. Devers (1999) noted that generalizability is not a goal of qualitative research, but is transferability. Transferability is supported by detailed descriptions of the context of the research (Devers) which this study attempted.

Credibility

Credibility in qualitative research requires establishing believability of the findings (Trochim, 2006). Believability is established through the data, which in this case was through the use of participants' own words to support conclusions (Merriam, 2002). The detailed descriptions establish that the findings reflect reality (Merriam).

Data collection methods that recorded participants' responses accurately included audiotape recordings with transcription. Transcriptions were verified for accuracy against the recordings. Additionally, the use of field notes helped to describe the context for the interviews and provided additional data to assure credibility in the interpretation of data. Finally, in presenting this research, describing the process as well as using participants' words to support the researcher's interpretation and assertions helped to support credibility.

Dependability

Dependability refers to the consistency of the findings (Merriam, 2002). Merriam stated that dependability is established through the instrument, or researcher, in qualitative research. Through course work, practice interviews, and reflective practice, expertise was developed and will continue to develop in qualitative research. Peer examination through mentor and dissertation committee review helped to support validity and dependability (Merriam, 2002). An audit trail was also used to describe the data collection, the thought process in discovering and creating categories, and decision-making to also assist in supporting dependability (Merriam, 2002). Results from field testing were included in the audit trail to demonstrate evolution of the interview questions and the decision making process used (Merriam, 2009).

Transferability

Transferability, or external validity, refers to how findings might be used in another situation (Merriam, 2009). Transferability is a challenge in qualitative research, but can be obtained through clear descriptions of the guiding assumptions and context of

the research (Trochim, 2006). A detailed description of the CLE, including what is evidenced in the literature and as well as expected interview data, was included to support transferability. Thick, rich descriptions of collected data support transferability (Merriam, 2009). The sample used for this study included medical-surgical nurses from a local nursing organization, with snowball sampling to provide additional diversity and avoid the bias implied by professional organization membership. Merriam (2009) suggested that maximum variation also supports transferability due to a greater opportunity for application. Though resources limited the researcher's ability to seek greater variation, the use of purposive and snowball sampling techniques supported variation in the sample so as to mimic the target population.

Expected Findings

Given the researcher's experience as clinical faculty, clinical nurse, and nursing student, the researcher had certain expectations regarding data collection. It was expected that data would reveal that nurses experienced both frustrations with the added responsibility of teaching students, as well as some degree of satisfaction in the teaching role. It was also expected that nurses who felt well supported by clinical faculty and hospital administration would be more positive in their perspective of the CLE and the work of teaching students, in accordance with the AACN (2005) Healthy Work Environment (HWE) framework. Also expected was that nurses might describe how teaching students and working with nursing faculty might impact the work environment. Benner and others (1992) noted that practitioners of different experience levels lived in different "clinical worlds" (p. 27). It was expected that participants might experience the

work of teaching students differently, based on the amount of experience as a nurse and as a teacher.

The researcher desired to better understand what contributed to the frustrations and satisfaction with the dual role of clinical nurse and teacher, as well as understand from the nurse's perspective how a quality CLE might be defined. Given potential bias, reflexivity was used during data collection and analysis. Reflexivity supports researchers in understanding their role in stimulating and limiting data collection and analysis (Watts, 2007). The use of bracketing during interviews, journaling, and writing memos during data analysis were used to support researcher insight into the data, analysis, and the researcher's role as instrument (Maxwell, 2013; Watts, 2007).

Ethical Issues

Ethical issues were considered in the planning and implementation of this research. The researcher's academic institution, Capella University, granted Institutional Review Board (IRB) approval. Permission to recruit nurses from the professional nurses organization was obtained from the national organization and the local chapter's leadership. Permission to recruit nurses from the area hospitals was also obtained from hospital administration and institution IRB. According to Seidman (2013), the essential principle in human subjects research is respect for persons and allowing participants to volunteer freely and without coercion. Participants were provided with an electronic and paper copy of the informed consent form, which was also reviewed with the researcher. Volunteers were provided opportunity to ask questions, clarify meaning, and provided

consent. The researcher also informed participants verbally that voluntary withdrawal from the study was allowed at any time.

An additional ethical consideration for research related to confidentiality (Seidman, 2013). Confidentiality was maintained through locked storage of the participant's informed consent forms in the researcher's locked office. Additional measures to protect confidentiality included the numbering of participant audiotapes and transcripts. Electronic copies were stored on an encrypted flash drive and maintained in a locked cabinet in the researcher's place of employment. During transcription, any identifying data shared during the interview was removed and replaced by bracketed generic terms.

Researcher's Position Statement

The role of the researcher as a clinical faculty, with former experience as a clinical nurse and nursing student, provided a unique understanding of the clinical learning environment. The researcher's lived experience in these roles validated much of the evidence outlined in the literature review. Given the experience of the researcher as clinical faculty, anecdotal reports and observations of nurses' experience working with students have been previously noted. It was expected that interviews would show a wide variety of responses from clinical nurses, including negative and positive experiences, with potential data revealing the burden involved with teaching students. The researcher was mindful of verbal and nonverbal communication to assure unbiased communication that would not influence the participants, as well as assuring participants of privacy and confidentiality. Additionally, attention was given to reactions to data that may highlight students or faculty in a negative light. Maxwell (2013) suggested bracketing personal

assumptions and framework to increase validity. Maxwell also recommended that the interview protocol and guiding questions be open-ended to allow for the participant's experience, rather than use of closed or short-answer questions. Gill and colleagues (2008) suggested use of field notes during and immediately after an interview to support unbiased data analysis. Additionally, member checks can be used following each interview to assure that the researcher interprets the meaning the participant intended to share (Maxwell, 2013).

Conflict of interest assessment. The researcher had minimal conflict of interest in this study. There were no financial interests associated with the research. There was a potential conflict of interest regarding personal relationships, as volunteers may have potentially had working relationships with the researcher. The researcher was a member of the professional nursing organization but was not in a position of leadership. The researcher also worked as a clinical instructor, facilitating clinical learning at a local hospital where many nurses involved in the professional nursing organization were employed. Recruitment was completed through electronic messaging and social media, so as to minimize potential risk for coercion. Member checking was also used to help assure that bias was not apparent in the data analysis.

Position statement. The researcher desired to contribute to a body of knowledge that would inform practices related to the CLE, so as to maximize benefits to student nurses and minimize any potential burden to clinical nurses. In planning and implementing the study, the researcher was mindful of potential bias to assure that data collection and analysis revealed reality as experienced by the participants, and not the

researcher. Use of bracketing and field notes, reflexivity in journaling, and use of memos and audit trail help to provide transparency in the research process (Gill et al., 2008; Maxwell, 2013; Watts, 2007).

Ethical Issues in the Study

In reviewing the Belmont Principles of justice, beneficence, and respect for persons, there are some ethical challenges noted (United States Department of Health and Human Services [USDHHS], 1979). First, the non-probability sampling plan violates the principle of justice. Because the research is centered on the experience of medical-surgical nurses, the sampling plan is necessarily limited to those nurses. From a feasibility perspective, recruiting through a professional organization offered easy access to volunteers. Selection bias may be a concern and an attempt to address this concern included the use of snowball sampling. A local hospital declined to allow recruitment. There is a potential for violation to respect for persons related to the use of electronic mail. Use of the blind-carbon copy option may help alleviate this risk. Another risk is that the researcher may have had previous contact with the sample due to previous employment and current contact through clinical instruction. There were no risks to the principle of beneficence.

Chapter 3 Summary

Chapter 3 included a description of the basic qualitative approach in relation to understanding the clinical nurse's experience teaching nursing students in the CLE. The chapter began with a description of the purpose and research question and then more fully described the research design and rationale. The basic qualitative approach was found to be best suited for the exploratory nature of the topic and research questions (Trochim,

2006). The target population included registered nurses working on in-patient medical-surgical units who also worked directly with nursing students partaking in traditional clinical learning. Sampling procedures were purposive and convenient and included recruitment through a professional nursing organization in the Midwestern United States. Snowball sampling was also employed to help minimize selection bias and increase diversity within the sample (Jones & Kottler, 2006). The sample size was anticipated to be within a range of 10-18 participants. Recruitment occurred through electronic mail and social media.

Data collection occurred through semi-structured interviews that occurred either in person or via phone. The semi-structured approach was supported by a researcher-developed interview protocol, which was created based on the literature and revised based on field testing by three expert reviewers. Interviews were audiotaped and transcribed by the transcriptionist and researcher, and supplemented by field notes. Data analysis was an iterative process, guided by a thematic approach. Chapter 3 also included a discussion of study limitations, credibility, dependability, and transferability. Expected findings were described in relation to the theoretical background and researcher experience. Finally, Chapter 3 concluded with an examination of ethical issues and strategies to support an ethical approach to this study.

CHAPTER 4. DATA ANALYSIS AND FINDINGS

The purpose of this basic qualitative study was to explore the experiences of nurses who work with nursing students on the clinical unit in order to more holistically understand the clinical learning environment. Chapter 4 begins with a description of the sample and methods used to collect data. An account of data analysis is also included in Chapter 4, outlining the use of thematic analysis, which was used throughout data collection. Bricki and Green (2007) noted that thematic analysis is useful in identification of themes and in summarizing the views collected, which helped to provide a coherent account of nurses' experience teaching nursing students. The data resulting from thematic analysis is also included in Chapter 4.

Description of the Sample

The targeted population for this study included non-preceptor medical-surgical nurses who work on in-patient hospital units that provide an environment for nursing student clinical learning. Medical-surgical nurses were sampled through a professional medical-surgical nursing organization, two area hospitals, and through social media, including the professional organization's Facebook page, and the researcher's LinkedIn and Nurse's Lounge profiles. Additional participants were recruited through snowball sampling. Participants made contact through e-mail, which enabled the researcher to arrange a meeting to review inclusion criteria and complete a single interview.

Interviews lasted 45-60 minutes. Following the interview, participants were contacted through e-mail to verify the accuracy of transcript and interview notes.

A total of six participants were included in the study. The proposed sample size was 10-12 participants, based on similar research (Koontz, 2010; Levett-Jones et al., 2009; Shakespeare & Webb, 2008; White, 2003); however, data saturation occurred with six interviews. Table 1 presents the demographic data for the six participants. When discussing data specific to participants, including quotations, participants will be referred to as Participant 1, Participant 2, and so forth.

Table 1. *Demographic Features of Study Participants*

Participant	Age	Years of experience
1	56 years old	31 years
2	28 years old	5 years, 6 months
3	27 years old	3 years, 2 months
4	22 years old	2 years
5	24 years old	11 months
6	28 years old	5 years

Research Design and Introduction to the Analysis

The basic qualitative approach was used in order to best understand the experiences of staff nurses teaching nursing students in the clinical setting (Lodico et al., 2010). Data were collected using a semi-structured approach, including an interview

protocol reviewed by three content experts. Data were analyzed using the thematic approach to identify common issues and themes (Bricki & Green, 2007).

Participants were recruited through a professional nursing organization, two area hospitals, and social media. Interested participants e-mailed their desire to participate and the researcher arranged for phone or in-person interviews at a date, time, and location convenient to each participant. At the time of the interview, inclusion and exclusion criteria were reviewed. For those who met criteria, informed consent was provided, with time allowed for questions. Each participant provided demographic data that was recorded at the beginning of each interview. Interview notes, transcripts, and memos associated with each participant were coded with a pseudonym to help protect confidentiality. Additional identifiers, such as organization or unit names, were removed from transcripts, notes, and memos.

Interviews were digitally recorded and transcribed verbatim with support from a transcriptionist. Transcriptions were reviewed for accuracy prior to analysis. After verifying the accuracy of a transcript, it was then read to gain a sense for the data (Lodico et al., 2010). Data analysis, through constant comparison, occurred after each interview, with the researcher recording memos outlining observations, thoughts, and concerns after each interview. Transcripts and memos were combined into one document for ongoing analysis, with each transcript read multiple times. Transcripts were managed within Microsoft Word, in table format to enable line-by-line navigation, with numbered lines in the left column, codes and themes identified in the center column, and data in the right column. Additional annotations were added as comments. A list of developing codes, categories, and themes was maintained separately.

Coding was initially based on specific words of participants and continued within the context of previous analysis (Gibbs & Taylor, 2010). Codes were created with an attempt to use action words used by the participants in order to most accurately represent participants' experiences (Lodico et al., 2010). As analysis continued, codes were compared and contrasted to assist in ongoing analysis and formation of categories. Memos were recorded during data analysis as codes and categories were created and refined to track the process and rationale (Bricki & Green, 2007).

Summary of the Findings

The research question central to this study was how non-preceptor medical-surgical nurses who work with nursing students described the clinical learning environment (CLE). Interview questions were constructed to understand how nurses described their experience teaching nursing students and working with nursing faculty, as well as how nurses perceived their role within the CLE. Three main themes emerged from the data including those related to time and workload, approaches to teaching and learning, and benefits and challenges inherent in planning and implementing clinical learning. These themes and associated subthemes are noted in Table 2. The following discussion provides supporting details related to each theme and subtheme.

Table 2. *Themes and Associated Subthemes*

Theme	Associated Subtheme
Time and workload	
Approaches to teaching and learning	Finding balance
	Teaching role
Benefits and challenges inherent in planning and implementing clinical learning	Benefits
	Challenges

Time and Workload

The intersection of the student's clinical learning environment with the nurse's work environment impacts the nurse's workload and flow and this requires the nurse to find balance. Participants noted that students had both a positive and negative impact on workload. Sometimes students provided relief from workload with nurses delegating some of their work to students. In other cases, students added to the work through the students' slower speed and questions. Participant 5 described how, "sometimes, it can feel like just another thing on my to-do list. Oh, now I have to check in with the student before they leave at 1 o'clock. I need to look over their assessments and get all that done." Participant 3 shared a similar experience, describing the pull she felt when teaching students:

> And sometimes to have that student, as much as I enjoy having the student and teaching them and showing them interesting things and new things, it can be frustrating at times because I have 4700 things I'm doing and 8 phone calls and it's

> hard to follow me around like a little puppy and, you know, that nursing out loud thing is sometimes really hard for me because I get, I just want to do it, I don't want to have to explain why I'm doing it.

Participant 2 also noted that increased workload could be detrimental to clinical learning, the same participant noted instructors impact workload when making assignments.

Multiple participants noted time as an issue within the combined CLE and work environment. All participants noted being busy while working to both teach students and care for patients. Staffing was cited as an issue by all six participants. Participants shared how short staffing challenged the CLE. Participant 1 stated, "We've been more short staffed . . . recently, so that definitely has [affected] how much time that staff nurse has to spend with the student to do those follow up things such as checking their charting, checking for accuracy with I/Os and those kinds of things." Participant 5 noted how staffing limited her time with students. Participant 5 said, "I just wish we had better staffing so that we could really have more one-on-one time with the student to sit down with them." Participant 6 explained that more instructors were needed to allow better timing of tasks (such as medication administration) and flexibility in completing tasks, as some tasks required instructor supervision. Participants related that increased staffing, both for clinical faculty and bedside nurses, would be helpful in the context of the CLE.

Approaches to Teaching and Learning

Participants explained a variety of approaches to teaching and learning. The participants shared that finding balance between the work of patient care and teaching students was challenging but essential to a successful learning and work environment.

Prioritization sometimes meant that the clinical nurse had to focus on patient care instead of student learning. Participants approached teaching by accommodating students into their work routines and including students in unit processes. Participants described an approach to teaching and working, termed *nursing out loud*, a colloquial term used by Participant 3. *Nursing out loud* was a process also used by several other participants, who described simultaneously talking through a process while completing it. Past experiences as a student or new nurse also helped inform participants in their role as teacher.

Finding Balance. Participants described working to find balance while teaching student nurses. Participants noted retaining accountability for patient care and safety while students were involved in clinical learning. To accommodate students, nurses worked to balance the roles of bedside nurse and bedside teacher. Participant 2 provided an example of working with the charge nurse to balance learning opportunities for the student nurse with the workload of the clinical nurse. Having a routine seemed to support the balance of working and teaching. Participant 6 described how having a routine that included the student had an impact on this balance. Participant 6 said,

> If I can just become comfortable with them being there, and just kind of place them within my perception of the day, then I'm fine and I'm feeling more, excited is too strong of a word but more apt to say, 'Hey, we need to give SQ heparin, let's show you how to z-track.'

Several participants described this balance as challenging to achieve. Others described not being able to achieve this balance and thus feeling limited as a teacher.

To address challenges related to finding balance, some participants described finding balance through prioritization. Four participants noted the need to prioritize patient care over student learning, sharing that patient needs and overall busyness limited teaching. Participant 4 exemplified this need to prioritize, describing,

> I had quite the caseload that day. I had one going to the cath [catheterization] lab, one coming back, one was unstable, so I wasn't really a good teacher that day because my patient[s] needed their nurse, rather than the student nurse needed the teacher. And that was one of those days where I just kind of looked at her and said 'We'll talk later' but unfortunately this is how nursing can be sometimes.

Nurses had to focus on essential patient-centered tasks, such as assessment and documentation, rather than developing the critical thinking skills of students. If the work environment was too busy, nurses delegated tasks to students. Participant 5 noted short staffing of nurses made it difficult to balance both patient care and student learning.

Teaching Role. Participants used a variety of approaches when describing their role as teacher, finding value in fulfilling this role, but felt largely unprepared to fulfill it. Building relationships, like mentoring, was a consistent theme related to nurses' approach to teaching students. Four participants described their role as a mentor, aiming to make positive contributions to the students' clinical learning. Building relationships with both students and faculty was seen as essential in "working together," according to Participant 6. Participant 3 noted relationship building among faculty and staff as essential for student learning. This participant stated,

> I feel like this instructor, being that she's been on this floor for so long, and she's gotten used to all the staff and we've gotten used to her, I feel like she's developed a good relationship and we've all developed a relationship with her, so it's more of a positive experience for the students, as well.

Building relationships with faculty and students contributed to a positive learning environment.

Accommodating students into the nurse's plan for the day was another way that participants described their teaching role. All participants described being accommodating, sometimes with a student-centered approach and other times with a patient-centered approach. Participants described being purposefully non-intimidating in their approach to help students feel comfortable approaching nurses and asking questions. Participants 3 and 6 also noted a more patient-centered approach to being accommodating, to assure that the patient was also comfortable being cared for by a student. Another way to accommodate was through game planning. Four participants described a conversation with students or faculty to determine the plan for patient care and student learning during the shift. Sometimes, this included a brief assessment of the student, including their academic level, comfort or confidence level, ability, or learning needs.

Five of the participants used their own experiences as a student or new nurse in planning their approach to teaching student nurses. Participant 3 shared,

> And I guess for me what it boils down to is my own personal experience and the times that I've really felt supported by my nurse instructor and by the nurses I was working with as a student, like when I was personally a student, I just try to think

> back to those times and the positives and the negatives and what I liked and what I didn't like and I try to remember that.

Personal experiences and preferences provided guidance in how nurses taught nursing students. Participant 2 also noted that relating similar experiences helped to build relationships between nurses and students, especially for nurses with less experience. Participant 2 shared,

> I think they [new nurses] just have a different level of connection [to nursing students] and I think it's somewhat easier for them to communicate or they're more willing to share their experiences as a new nurse because, 'Oh I just went through this a couple years ago, this is what happened when I had my first code situation.'

Relating personal experiences allowed the nurse to connect with and know how to teach student nurses.

Another teaching approach common among participants was getting students involved in unit processes. All participants noted that getting students involved in unit processes was a positive way to impact the CLE. Sometimes this meant simply involving students in the full nursing assignment, pulling students to observe procedures, or including students in unit-wide processes like huddle and multi-disciplinary rounding. Participant 1 described her approach as such, "Just involve them [student nurses] in the care of the patient, the plan of care for the patient, but then also involve them in the real world type things. Such as those bedside rounds and that interdisciplinary communication." To contrast, Participants 2 and 6 also noted that excluding students

from unit routines was detrimental to students. Participant 6 explained, "I guess I've never had a nurse pawn off a student before but I've had them [nurse] ignore them [student nurses]." These participants related feeling protective of students in these situations, working to involve students to compensate for the student being excluded.

Five of the participants described an approach to including and teaching students simultaneously. Participant 3 used the words "nursing out loud" to describe what she was doing and why, while she was completing the tasks, to make clear to the student the internal processes the nurse used. Participant 2 described the importance of this approach, saying,

> Basically, just going and doing what I normally do but at the same time talking through what I'm doing. A lot of times you get so into your routine and you continue to go over with the student and it's important to take the time to explain, okay, this is why I'm doing it, what I'm going to do next, just that thought process.

Five participants also described this talking and doing approach. Participants 4, 5, and 6 noted that this approach can be challenging to integrate into their daily routine and that it adds another layer of difficulty to their work.

Benefits and Challenges Inherent in Planning and Implementing Clinical Learning

The CLE is a valuable component of nursing education with inherent benefits and challenges that require careful planning and clear communication. Participants described benefits of the CLE, both for clinical nurses and the students attending clinical. Having support from colleagues, faculty, and leadership as well as a varied patient population were elements of the CLE participants described as beneficial. Participants also reflected

on challenges within the CLE. Participants described feeling unprepared for teaching students, as well as needing explicit communication and support from others.

Benefits. Participants described a variety of benefits, both for themselves and for students, as a result of clinical learning. Participants described joy in filling their role of teacher, as student excitement was contagious. Participant 3 verbalized how excitement spread, stating,

> [I]t's fun to teach and it's fun to see the excitement . . . I had a student not too long ago who gave a suppository . . . and it was like the kind of excitement that they had with it was like, oh wow, and then the patient was able to have a bowel movement afterwards. It's kind of like, hey I did that and that's what I think is the really positive experience.

Participant 2 also noted benefits in teaching students well. Participant 2 shared,

> having students in general, it's a lot of work, but . . . [when] you have like an 'ah-ha' moment or they really valued you and you feel, that feeling valued makes me, personally, feel really good, like, oh, I made a difference.

Participants found value in developing their future colleagues. Nurses also described other benefits of teaching nursing students. Staying up to date as a major benefit of working with students, who helped to keep nurses up to date on new approaches to learning, as well as accountability for policies, procedures, treatments. To describe how teaching students was a benefit, Participant 5 noted, "it keeps me on my toes, critically thinking, constantly thinking about why I'm doing what I'm doing for the patients."

Participant 1 called this a "reverse benefit," noting how student presence is a benefit to the clinical nurse.

The participants seemed to have a deep appreciation for the value of clinical learning and recognized the need for careful planning and clear communication. Participants all understood and supported the value of the CLE, noting the "hands-on" (Participants 3 and 6) and rich, contextual learning opportunities the clinical units provide. According to Participant 6, "My role as a nurse for them is to show them what it's like to be a nurse. What real nursing is and not NCLEX nursing." Participant 4 also noted a difference between text book learning and clinical reality. Participant 4 stated,

> I would say I am the real life teacher . . . no offense to the teachers in the schools, but they teach things by the book and . . . nursing isn't always by the book. It always changes. We're always learning new things or there's a trick to doing a skill a little bit easier. And so I feel like we, med/surg nurses on the floor, are kind of like, 'This is how it really works more efficiently on the floor' rather than by the book.

The real life context of clinical education was seen as essential.

Another advantageous element of the clinical learning environment cited by participants was the patient population. Four participants viewed their work areas as providing rich learning opportunities due to the complex and varied patient populations. The variety and complexity of patients provided multiple opportunities to practice skills in a real life context. Participant 2 described how patients contribute to the CLE, saying,

> We have a lot of patients that usually have a lot of complex things going on. We get overflow on our floor, so not only is it colorectal patients but we're primary

> overflow for ortho [orthopedics] and then we're getting a lot of med [medical] patients now, too. So some of those med patients have a lot of comorbidities, so they're getting a lot of that, lots of drains, tube skills, we have a lot of skills on our floor.

Participant 4 noted that there was a balance in acuity of patients when working with students, stating,

> . . . you have a decent patient load . . . not normally a couple patients to where they're not learning anything, but not where patient census is so high that you're more worried about patient safety and getting the cares done rather than teaching them. I feel that there's a balance between patients and diagnoses and how many student nurses you have.

The nurse's workload should be light enough to allow teaching to occur, but heavy enough to offer learning to the student. Having multiple opportunities was also seen as beneficial to the learning environment. Participant 3 described how she facilitated multiple opportunities, noting, "I try to really include the students and even if say I have three patients and they're only with one or two of mine, I try to get them involved in that third patient . . . And that's an extra learning experience for that student."

Challenges. Participants described a number of challenges in planning and implementing their dual role as clinical nurse and bedside teacher. Most participants described being unprepared for their role, however most did feel supported in their role. Five participants described being prepared for their role by virtue of their own experiences, either in developing competence as a nurse or in relating successful teaching

and learning strategies from their own student experience. Participant 4 described her experience as a student and how that guided her current approach to teaching, "I know when I was a student I liked the nurses who were helpful and hands-on and they don't just tell you what to do, they explain why." Four of the participants described overall feeling unprepared. Participant 6 shared, "I guess I never truly feel prepared, because I never know what they're going to throw at me, but I guess just comfortable in, when I become comfortable in my own knowledge, then I'm comfortable explaining it to them." Participant 6 went on to describe concerns related to her lack of preparation, "we're not taught what to do if something were to go wrong, or if we did notice that they [student nurses] gave a wrong medication or there was some sort of a safety issue or a person fell." Also feeling unprepared, Participant 5 noted her relative inexperience as a nurse (11 months) as a contributing factor. Some participants described teaching as a rite of passage, meaning that the assignment of a student conveyed that the nurse was competent and prepared for teaching a student.

Despite feeling generally unprepared to teach nursing students, participants reflected feeling supported in their role as teacher. Instructor visibility and involvement contributed to feeling of support. If faculty were not readily available on the unit, participants related feeling unsupported. Other participants described feeling supported by faculty presence. Participant 3 noted feeling supported by the instructor, "I think just with the instructor being there is a big support and having the instructor talk to us about . . . what is expected of the student and what she's expecting out of this clinical situation which is really beneficial for us." Participant 5 also described using clinical faculty as a resource and that faculty were helpful as a "second pair of eyes" in patient care.

Some participants also noted feeling unsupported in their role. Participant 2 noted that co-workers not assisting with her workload made her feel unsupported in her teaching role. This participant explained how she had no relief from her regular workload, despite having additional work in teaching a student nurse. Participant 6 shared being unsupported by unit leadership, stating, "She [unit leadership] never actually talked to me directly beyond thanking me for volunteering to take a [summer intern] and this what her name is and these are the dates . . . I can't say I've had a lot of support for it, I guess." Unclear expectations seemed to also play a role in participants feeling unsupported. For example, Participant 2 described how an instructor's inability or lack of desire to supervise a student performing central line cap change made her feel additional burden to complete the task and teach the student. An additional concern shared by five of the participants related to responsibilities for student learning, evaluation, and patient care. Participant 5 described how discrepancies between clinical faculty or groups of students left her feeling unsure of what students should be expected to accomplish. Several participants also shared feeling uneasy about evaluating students. Participant 6 articulated,

> I also feel bad because sometimes the students really didn't do everything that they were supposed to, but I know some of the other nurses are just gonna give them 5 out of 5 [through an evaluation form] and just send them away regardless of what they did. So I don't want them to be academically, you know, like hampered by this when their colleagues did the exact same thing.

Participants had concerns that their evaluation would contribute to a poor grade for the student and that evaluations may not be fair.

Clear communication was noted by all participants as an essential component for successful and seamless clinical learning. Participants all described requiring clear communication to support an ideal learning environment. Examples of clear communication desired or observed by participants included explicit guidelines regarding student assignments, clear learning goals, and division of responsibilities. Participant 1 described the instructor's responsibility for this, stating, "Clear cut clinical assignments . . . very clear cut from the instructor's perspective to the staff nurses." Outlining student expectations was seen as the responsibility of the instructor. Expectations needed to be clear among all parties, as noted by Participant 2, who stated, "I think communication is big between the nurses, knowing the expectations between the student, the nurse, and the instructor. I don't think always nurses realize the expectations, setting goals I think is big, too." Participant 2 also contrasted this idea, stating, "Obviously a poor situation would be not having good communication, not knowing the expectations. I think sometimes it's hard for students if they don't feel like they know the expectations just from what's expected from them from their instructors." Having adequate communication contributed to a positive learning experience, while not having clear communication contributed to a poor learning environment.

The student's ability to communicate commitment to learning the nursing profession also made an impact for participants. Several participants described that when students were visible and active on the unit and showed interest in learning, the nurse felt motivated to actively involve the student in both care planning and patient care.

Participant 2 also noted concerns for students "doing paperwork and not nursing." When students were focused on patient charts to complete academic assignments, students appeared disengaged from patient care, which was disheartening to the nurse who also had concerns for lost learning opportunities.

Chapter 4 Summary

Chapter 4 included an explanation of the qualitative methods implemented to explore the non-preceptor nurse's experience teaching nursing students. Methods used to select participants, as well as processes used to complete interviews and data analysis were reviewed. Additionally, Chapter 4 detailed the data and themes that emerged from interviews, including how student learning impacts workload and flow for the nurse, how nurses see their role as teachers, and how nurses perceive the CLE. In Chapter 5, study findings will be discussed in relation to Benner's (1982) Novice to Expert model and the AACN (2005) Health Work Environment framework, and within the context of what is known about the CLE, while also exploring implications for practice and research.

CHAPTER 5. CONCLUSIONS AND DISCUSSION

The purpose of this basic qualitative study was to describe the non-preceptor nurses' experience working with nursing students in the clinical learning environment (CLE). Data was collected through semi-structured interviews in order to obtain thick description of participants' experiences (Merriam, 2009). Data analysis occurred through thematic analysis with constant comparison across data to support a coherent view of the themes within the data (Lodico et al., 2010). Several themes were discerned and will be examined within Chapter 5. These themes will be discussed in relation to the research questions and within the context of the American Association of Critical Care Nurses (AACN, 2005) Healthy Work Environment framework and Benner's (1982) Novice to Expert model. There will be additional discussion relating the current findings to evidence reflected in the literature. Finally, limitations will be outlined and implications for practice and research will be considered.

Summary of the Findings

The central research question for this study considered how non-preceptor clinical nurses working on inpatient medical-surgical units, hosting nursing students participating in a traditional clinical learning environment, described the CLE. Subquestions explored how nurses described their experiences teaching nursing students, working with nursing faculty, and nurse perception of their role within the CLE. The themes identified included how student learning affected the workload and time for the clinical nurse, how nurses approached teaching and learning, and the benefits and challenges inherent to the CLE. The discussion that follows will explore these themes in depth in relation to the literature.

Discussion of the Findings

In nursing, evidence-based practice is an essential component in the provision of quality patient care. Likewise, the evidence base for nursing education must also inform curricular praxis. Nursing educators are called upon to reform clinical nursing education (Benner et al., 2010) and while evidence to support reform is apparent, it does not always address the needs of all stakeholders. One of the challenges to be considered for clinical learning is the intersection of student learning with the clinical nurse's work environment. In this study, nurses described the challenge of fulfilling the dual roles of teacher and caregiver. It is important to consider how the presence of students impacts the nurse's work environment, especially as related to staffing, effective communication, and true collaboration (AACN, 2005). The AACN Healthy Work Environment standards are meant to support the provision of safe, quality patient care through effective relationships among providers. When considering innovative approaches to the CLE, the nurse's work environment must be considered.

Participants also informed how they, as more experienced practitioners, guided and supported the novice student to understand the realities of clinical practice (Benner, 1982). This study adds what strategies clinical nurses use to guide, support, and teach nursing students. In planning this research, it was expected that there could be differences between how novice and experienced nurses described their experiences working with and teaching nursing students (Benner et al., 1992). This study did not support this premise, potentially because the sample size and demographics were such

that this premise was not realized. These study findings provided additional awareness to the CLE, considering the necessary perspective of the clinical nurse.

Discussion of the Findings in Relation to the Literature

Following is a discussion of participant experiences within the CLE within the context of the literature. Participants described their experiences working with nursing faculty and teaching nursing students, as well as how they perceived their role as a bedside teacher. The three major themes of workload and time, approaches to teaching and learning, and benefits and challenges inherent to planning and implementing clinical learning are each discussed.

Workload and Time

The combined CLE and work environment impact the nurse's workload and workflow, changing the dynamics in an acute care environment. Participants in this study described a significant impact to their workload and workflow when working with nursing students. While it was noted that students were capable of completing tasks and providing some relief from workload, the addition of teaching made an impact to the overall workload. All participants also cited staffing as a concern for implementing the dual role of clinical nurse and bedside teacher. These findings are concerning in light of the AACN (2005) Health Work Environment standards. Appropriate staffing is defined as a match between patient needs and nurse competency (AACN). The additional assignment of a student to patient care may test a nurse's ability to provide care effectively. Participants in this study acknowledged the additional tasks and energy required when teaching a nursing student.

All of the participants also cited being busy while teaching students and providing patient care. Being busy limited the participants in taking time to review the plan of care, stimulate critical thinking, or review student documentation or learning needs. This busyness can create a significant tension within the combined work and learning environment. Students may consider themselves guests within the work environment (MacIntyre et al., 2009) and be reluctant to pull the nurse away from patient care to address student learning needs (Steven et al., 2014). Preceptors also described how the busyness of the unit and heavy workload hindered learning (Madhavanpraphakaran et al., 2014). McNelis et al. (2014) also noted that staff and faculty workloads limit the development of effective relationships and in-depth conversations that support critical thinking. The busy workload of the nurse has an impact on clinical learning, across both traditional and precepted clinical models. It may be useful to address the workload of the nurse as part of planning and implementing various clinical models.

Approaches to Teaching and Learning

Participants in this study described a variety of approaches to teaching and learning. Participants worked to find balance between the work of patient care and student learning. Participants described their role as a teacher and mentor, explaining significance in building relationships with faculty and students. To this end, participants related their own experiences as novices to help students learn, as well as accommodating into the nurse's workflow, and including students in unit routines.

Finding balance. Participants in this study described the challenges and their approaches to finding a balance between working with patients and teaching nursing

students. Sometimes, finding balance meant prioritizing patient care over student learning or focusing on task-orientation rather than critical thinking, which included delegating to students. These findings are not unique. Competing practice and academic priorities were cited as challenges in the literature, as well (Croxon & Maginnis, 2009; McNelis et al., 2014; Young et al., 2014). Some participants described working with the charge nurse to balance patient care with student learning, or how having an established routine was helpful to finding balance. Some participants explained feeling limited as a teacher when this balance was not achieved. Other research did not describe approaches nurses used to address competing priorities. Considering how participants understood the impact these conflicts had on teaching and learning, this may be an area for additional study.

Teaching role. Participants in this study found value in their role as teacher, describing the necessity of building relationships and the enjoyment in mentoring. Other studies (Hallin & Danielson, 2009; McCarthy & Murphy, 2010; Usher et al., 1999) supported these findings. Developing relationships and mentoring future colleagues may contribute to these feelings of satisfaction. MacIntyre and colleagues (2009) asserted that strong, structured relationships between the clinical nurse and student nurse might increase capacity in clinical learning. Gillespie's findings (2002) explained how students who related poorly with their clinical teacher focused on the teacher, rather than learning. Participants in this study also recognized how relationships contributed to a more positive learning environment. Making considerations for how best to support relationship building among clinical nurses, nursing faculty, and students may be overlooked in

planning clinical learning, but participants recognized its importance in implementation of clinical learning.

Findings from this study expand on other literature by describing processes nurses use when teaching. A number of studies described how nurses viewed their role as role model, mentor, coach, or teacher (Atack et al., 2000; Bourbonnais & Kerr, 2007; Landmark et al., 2003; Lillibridge, 2007). Lillibridge discussed processes nurses used to protect students or facilitated learning experiences. Nurses in this study also described wanting to protect students, especially when other staff excluded students. Participants in this study described using a student-centered, sometimes integrated with a patient-centered approach, to accommodate students. Participants also discussed how game planning drew students and faculty actively into the plan for the shift. Nurses worked to collaborate with faculty and students (AACN, 2005) to establish an approach to learning about patient care. These approaches served to provide support to students (Mezirow, 1997), allowing students to feel comfortable in their environment and focus on learning the nurse's role. Finally, most of the participants described drawing from their own experience to inform these teaching practices. Prior personal experiences and learning preferences guided these participants in their teaching practices, as would be expected of an expert clinician (Benner, 1982).

Benefits and Challenges Inherent to Planning and Implementing Clinical Learning

Benefits and challenges were both described by participants in this study. Participants were asked to describe the quality of the CLE, as well as contrast the reality

of the CLE with poor and ideal conditions. Ideally, the *hands-on* experiences amongst a wide variety of complex patients, with adequate staffing, provided the best learning environment. This experience helps the rule-based novice develop competency as a nurse (Benner, 1982), while being supported in their learning and development (Merriam et al., 2007). Challenges were apparent, including communication among faculty, staff, and students; and nurses desiring preparation and support for their role.

Benefits. Even with the increased workload in teaching a student, participants appreciated the opportunity to contribute the CLE. Participants in this study described finding joy from students having *ah-ha moments,* where student excitement related to learning is shared with clinical nurses. Participants also noted how it was a *reverse benefit* to have students on the unit, as they were held accountable for best practice, current policy, and new practices related to learning. These findings are mimicked from the literature, where inherent rewards were well recognized (McCarthy & Murphy, 2010; Usher et al., 1999). Interestingly, Usher and colleagues noted how nurses downplayed any extrinsic reward. Meaningful recognition, as defined by AACN (2005) posits that recognition is meaningful when it is relevant to the nurse, but also that the nurse must recognize the value others bring. Perhaps the reciprocal nature of the student-clinical nurse relationship provides the meaningful recognition required. Given the context of busy and potentially understaffed units, it may be that students provide the recognition for the value of nurses' work.

All of the participants expressed an appreciation for how clinical learning provided students with the realities of practice. Participants noted the *real-life* and *hands-on* opportunities afforded in the clinical unit and described how the right mix of

patient acuity, complexity, and time for the nurse to teach were ideal for the CLE. While the literature is replete with similar such benefits of the CLE (Chan, 2002; Hartigan-Rogers et al., 2007; Newton et al., 2010), it is interesting that the student perspective is in stark contrast. Wilkes (2006) discovered that students felt preceptor qualifications and attitudes were of greater importance than the actual CLE (Wilkes). Participants in this study described a desire to support students as their future colleagues, which may describe the diverging CLE priorities between students and clinical nurses. Clinical nurses likely place priority on learning the reality of practice, despite recognition that effective relationships play a role as well.

Challenges. It seemed that the addition of students in the work environment contributed to significant challenges, especially related to nurse preparation, support for the dual role as care provider and teacher, and communication. Being inexperienced as a nurse, not knowing what to do if something went wrong, as well as how to provide feedback were concerns these participants had regarding their preparation as a teacher of nursing students. Most of these participants related being unprepared, likening to Altmann's (2007) findings that some preceptors received no preparation. Concern for these findings is that an expert clinician does not necessarily equate to an expert teacher. Clinical nurses may be challenged in effective decision-making (AACN, 2005) given their lack of preparation, which may affect both student learning and patient care outcomes.

Nurses participating in this study desired support from a variety of sources. Some participants related feeling supported by faculty, while others shared that faculty

invisibility or inability to perform lent nurses to feeling unsupported. Matsumura and colleagues (2004) also noted how the instructor might have a positive or negative influence on the CLE. Participants in this study described how feeling supported by faculty, along with students who communicated a desire to learn, encouraged motivation for the nurse to contribute positively to the CLE. Since nurses may enter the teaching relationship with little preparation, it may be more important that faculty provide support and coaching for the clinical nurse approaching the teaching role. The provision of structure to the teaching role was found useful, especially for nurses without formal preparation in teaching (Lofmark & Thorell-Ekstrand, 2014). Participants also described feeling unsupported by organizational leadership and colleagues on the unit. These findings are echoed from the literature, where issues related to workload, time, and desire for professional development were described (Duddle & Boughton; 2007; McCarthy & Murphy, 2010). Nurses desire meaningful recognition for their work with students and it may be that adequate preparation, time, and relief from workload could fill this need.

Communication was an additional challenge within the CLE. Participants described how the ability of the student to communicate learning needs or commitment to the unit helped to motivate the clinical nurse to support learning. Communication gaps and feelings of isolation were also described in the literature (Edgecombe & Bowden, 2009; Madhavanpraphakaran et al, 2014), as well as a lack of clarity in general for learning and specifically for evaluation (Atack et al., 2000; McCarthy & Murphy, 2010). In this study, participants also described a need for explicit instruction and expectations. Having this structure may help support the clinician who could lack experience as a teacher of students (Benner, 1982). Structure also likely lends support to the nurse in

guiding the student in connecting past and current learning experiences (Merriam et al., 2007).

Limitations

There were a number of limitations, which provide context for this study. The study used a small sample of medical/surgical nurses who practiced on in-patient clinical units and was limited to the geographic location within the Midwest. Nurses in other specialty areas, including ambulatory care, may have a different experience working with students. Additionally, regional or organizational cultural differences related to staffing and clinical learning practices may provide different findings. The sample was drawn from a professional organization, which likely contributed to a rather homogenous sample, where participants shared values regarding clinical learning.

Implication of the Findings for Practice

Findings from this study replicate findings from previous studies. Time, workload, and workflow were considered to be limiting factors in other research (Croxon & Maginnis, 2009; Madhavanpraphakaran et al., 2014; McCarthy & Murphy, 2010; Vallant & Neville, 2006). These concerns were described by the participants in this study, where the traditional clinical model was used, as well as other studies describing the experiences of preceptors (Madhavanpraphakaran et al; McCarthy & Murphy). While the preceptor model has been touted for its ability to support relationships and critical thinking (Croxon & Maginnis), similar challenges present between a traditional and precepted clinical learning model. It seems that time, workload, and workflow considerations should be made when planning the CLE. This would require true

collaboration (AACN, 2005) between academic and practice partners to assure that the foundational needs of both patient care and student learning can be met simultaneously, rather than remaining in conflict. Findings from this study support practice and academic partners working together to consider how to minimize the impact of teaching students on nurses while optimizing learning outcomes for students.

Participants in this study described a variety of approaches to teaching and learning. Participants described their role as a mentor, emphasizing the need to develop strong relationships with students and faculty. Diverging from previous research, participants in this study also described various techniques when teaching students, such as accommodating students into the workflow, prioritization and delegation, using a non-intimidating or student-centered approach to communication, involving students in unit processes, *nursing out loud*. Interestingly, none of the participants described adult learning principles when explaining how they taught students or in describing their role. Participants also shared feeling unprepared. Altmann (2006) reported preceptor orientation materials contained little information on pedagogical approaches. These findings indicate a gap in knowledge for clinical nurses. It would be prudent to provide clinical nurses with professional development opportunities related to adult learning principles and support the integration of evidence-based practice into the clinical nurses' approach to teaching at the bedside. Addressing both the structure of the combined CLE and work environment and the teaching competency of clinical nurses is essential in planning for a high-quality learning environment.

Recommendations for Further Research

Several recommendations for ongoing research emerged from this study. First, ongoing exploration of non-preceptor nurses' experiences within the CLE should be considered outside the Midwest and with a more diverse sample. Four of the participants in this study had between 2 to 6 years of experience as a nurse, likely representing competent and proficient nurses, as designated through the Novice to Expert model (Benner et al., 1992). Given findings from Benner and colleagues' work that nurses with different levels of experience live in the same clinical world differently, it may also be useful to take a purposeful approach to comparing and contrasting how the various levels experience the CLE and implement teaching practices. Participants in this study were also limited to medical-surgical nurses. Additional study that includes specialty areas would be useful in defining how specialty practice areas experience the CLE. Participants in this study described their role as *real life teachers.* A more detailed investigation into teaching strategies used by clinical nurses might provide additional insight into how nurses implement this teaching role. Finally, use of the AACN (2005) Healthy Work Environment Assessment tool prior to and after implementation of new clinical models or interventions to support or prepare nurses would also provide additional information about how clinical learning affects the work environment.

Conclusion

The purpose of this basic qualitative study was to explore how non-preceptor clinical nurses described working with and teaching nursing students in the traditional clinical learning model on medical-surgical units. The intent of this study was to explore

nurses' view of the CLE, as well as how nurses described teaching nursing students, working with nursing faculty, and viewed the nurses' role within the CLE. Three major themes emerged from interviews. The first theme identified how student presence in the work environment influenced workload and workflow, adding tension to an already busy work environment. Another theme explained how nurses approached teaching and learning, including how participants found balance, approached their teaching role through accommodating and including students while building relationships with faculty and students, as well as drawing from their own student experiences. The final theme related to benefits and challenges. Participants described finding joy in teaching students, while also learning from students. Participants additionally identified the *real life* learning opportunities afforded in their work environment as a must for clinical learning, including a varied and complex patient population that affords students multiple learning opportunities. Challenges were also present, such as feeling unprepared for teaching and evaluating, needing support from nursing faculty, as well as support from colleagues and organizational leadership. Communication was an additional challenge, especially related to expectations for task completion, student learning needs, and student evaluation.

Participants indicated an understanding of and value for clinical learning, even with the challenges that present within their work environment. Participants identified significant challenges within their work environment that limit their ability to teach and for students to learn. Skilled communication and appropriate staffing (AACN, 2005) were features seen as essential and yet were largely missing within the combined work and learning environments, potentially placing patient safety at risk. Participants also

emphasized relationship building with students and faculty, including relating their personal experiences for the benefit of student learning. Given that the novice student lacks contextual awareness (Dirkx et al., 2006) necessary to make effective clinical decisions (Benner, 1982), it is helpful to understand how more expert nurses guide the novice to find new meaning and develop competency. Within the combined work and learning environment, the nurse can find joy in and be effective in teaching through meaningful relationships with faculty and students, while receiving necessary support through effective communication and preparation, as well as support from colleagues and organizational leaders.

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