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Preceptorship and Mentorship

Guest Editors: Olive Yonge, Florence Myrick, Linda Ferguson, and Florence Luhanga

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Editorial

Preceptorship and Mentorship

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Thirty years ago, there would not have been a special issue on preceptorship and mentorship. Given the rise and consequent research interest in these two practices in nursing, numerous scholarly papers are being published. This particular special edition will be highly relevant to those who participate in preceptorship or mentorship programs from those who coordinate them to the students or graduates who benefit from them.

A number of papers in this publication are the result of research projects. Informal mentoring or teaching will always exist, but when these practices are worthy of research and the research outcomes are applied, replicated in other studies, or simply critiqued, another level of critical thinking emerges. Eventually there will be a solid body of knowledge or evidence that will lead to international standards in the areas of preceptorship and mentorship. F. Myrick et al. reported on the use of evidence-based workshops to prepare preceptors for their role when teaching fourth-year baccalaureate students. Through qualitative analysis, it was established that the workshops were engaging, enriching, and promoted reflection which ultimately benefited the students who were preceptored. C. A. Blum et al. also focused their work on supporting preceptors but did so by developing web-based pod casts which focused on unsafe practice preceptorship issues. The following themes were identified to overcome unsafe practice: welcoming presence, demonstrating empathy, encouraging growth, patience and time as compassionate care, building relationships, and communicating therapeutically. Using focus groups composed of representatives from nursing practice and education, scripts were developed by the researchers and critiqued by preceptors for authenticity. Serendipitously the two groups coming from different perspectives were able to appreciate each others' contributions around the complexities of unsafe practice. S. Boblin et al. also focused on preceptor preparation but for a select population of students international ones. They found four overarching themes that needed to be addressed: culture, knowledge, expectations, and relationships. They then grouped these themes into a model of cross-cultural relationships. An outcome of their research was a manual written to assist preceptors. They noted that this manual could be used for any situation where the student's dominate language is not the one of the current culture or preceptor.

Focusing on the preceptored student experience, K. Ownby et al. compared the traditional clinical experience to a preceptorship experience during their second semester. They randomly assigned seventy one second-year students to a traditional or preceptored group for a 12-week clinical rotation. They found no difference between the two groups on measures of marks, timeliness of clinical paper work, or health education services (surgical medical knowledge) scores.

Researching both preceptors and students, V. Foley et al. examined the intergenerational context. Preceptors are typically older than the students they precept and come from a generation that holds different values. Through the use of phenomenology, she discovered a number of themes and, in this paper, explored "being affirmed." Essentially this means that there needs to be a culture of openness and respect for generational differences. Generations can learn from each other. On a more cautious note, M. Sedgwick and S. Harris identify challenges inherent in preceptorship programs ranging from issues in the clinical setting to the inadequate preparation of preceptors and faculty.

D. Jackman et al. focused on rurality. D. Jackman closely examined the literature related to rural nursing preceptorship and how preceptors in rural settings prepared nursing students. She described the opportunities and challenges for learning against a background of what it means to practice in a rural setting. She asked directly what is the impact and meaning of the context for learning. In this case, the context is a rural setting within the health care setting and external to the rural community.

Two papers focused on mentoring. S. Lennox et al. described a program whereby four experienced midwives mentored four new graduates during their first year of practice. They were surprised to find that the new graduates were as much concerned about relationships with each other and staff as they were with acquiring technical knowledge. They were pleased with the effectiveness of using group mentoring. Using groups to mentor versus a one-to-one relationship is worthy of further investigation. The second paper was authored by a cohort of the Faculty Leadership and Mentoring program sponsored by the National League for Nursing and Johnson & Johnson. They provided an overview of a model for excellence in establishing a formal mentoring program for academic nurse educators. If your faculty does not have a mentorship program, this paper is a must read. It is comprehensive and highlights the key areas to establish a successful mentorship program.

Overall, you will find this special edition invaluable for the insights and research outcomes the authors have generated. Preceptorship and mentorship programs are not static and evolve with all those who plan and participate in them, and as one author has identified, the context for their delivery is just as critical.

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Research Article

Putting the Evidence into Preceptor Preparation

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The term evidence-based practice refers to the utilization of knowledge derived from research. Nursing practice, however, is not limited to clinical practice but also encompasses nursing education. It is, therefore, equally important that teaching preparation is derived from evidence also. The purpose of this study was to examine whether an evidence-based approach to preceptor preparation influenced preceptors in a assuming that role. A qualitative method using semistructured interviews was used to collect data. A total of 29 preceptors were interviewed. Constant comparative analysis facilitated examination of the data. Findings indicate that preceptors were afforded an opportunity to participate in a preparatory process that was engaging, enriching, and critically reflective/reflexive. This study has generated empirical evidence that can (a) contribute substantively to effective preceptor preparation, (b) promote best teaching practices in the clinical setting, and (c) enhance the preceptorship experience for nursing students.

1. Introduction

Since the early nineties, a recent development in the health care system and the health professions in general is the prevailing trend towards evidence-based practice, a trend or gold standard against which current practices are being compared [1]. Its ascendancy in the field of research and practice is related to the Cochrane Collaboration in 1993 [2], and also to the efforts of Hargreaves [3] who purported that research in medicine was a model to which educational researchers should aspire. Indeed since that time evidence-based practice (EDP) has become equated with accountable, professional nursing practice [4]. Essentially, the term evidence-based practice refers to the utilization of knowledge, derived primarily from research, in practice. Nursing practice, however, is not restricted to clinical and community-practice but also encompasses the education or teaching of present and future professional nurses. Thus, it is equally important that the teaching practices of nurse educators involved in the different aspects of the educational process are to be also derived from best evidence [5]. According to Stevens and Cassidy [6], evidence-based teaching may be described as "the conscientious, explicit, and judicious use of current best evidence in making decisions about the education of professional nurses" (page 3).

2. Background

The evidence-based preparation of preceptors in this study comprised two full day conferences: (1) preparatory (Day 1); and (2) advanced (Day 2). In the preparatory conference various topics were addressed that were germane to the preceptor's role in the preceptorship experience, for example, preceptor role and responsibilities, the promotion of critical thinking, the process of evaluation, the ethics of teaching in a professional discipline, to name a few. The advanced conference served to augment the substantive content of the preparatory conference and was not merely a repeat of the same content. In the advanced conference such topics as cultural literacy, the intergenerational workplace setting and the use of Benner's model to understand the trajectory of the nurse's professional development were addressed. Additional topics such as teaching learning styles were also addressed. Both conferences were offered onsite/face-to-face

in a university setting each over an eight-hour time frame and consisted of didactic as well as interactive sessions. Case study scenarios were interspersed throughout the discussion and dialogue to encourage interaction amongst participants and to generate an environment conducive to critical reflection. In keeping with the research regarding approaches that are most conducive to effective learning, facilitative and engaging learning experiences were thus achieved in these conferences through the use of a variety of teaching and communication processes and that were clearly organized [7–9]. The conferences in this study were designed specifically to facilitate and engage the preceptor participants and to foster a climate that encouraged active engagement and dialogue throughout. The evidentiary material used to inform the discussion was derived from empirical research. As an exemplar, for instance, the session on promoting critical thinking was guided by Myrick's [10] model of enabling critical thinking in preceptorship. According to this research generated model, preceptors promote critical thinking in two ways: (1) *purposively* through their direct questioning of the student; and (2) *incidentally* through their role modelling, guiding, facilitating and prioritizing. In another session entitled "Meeting the Challenges of Precepting an Unsafe Student," the research findings of [11] were used to inform the discussion around strategies to assist preceptors in dealing with the unsafe student in the clinical setting, while the session on the different generations was derived from a research study by [12]. These empirical works were each first explored didactically with the preceptors. This process was followed immediately by interactive sessions in which the participants explored the scenarios of the different topics amongst themselves. They actively engaged with one another to explore the most appropriate approaches to be pursued to ensure for an effective preceptorship experience. All sessions were thus informed by research and critically examined in that context thereby ensuring that the substantive nature of the conferences was derived from empirical evidence.

3. State of Knowledge

While the development of the scholarship of teaching and learning in higher education is important in assisting nurse educators, research is required to evaluate teaching and learning within the context of nursing education [13]. It would be accurate to state that nursing faculty strives consistently to offer educational programs that best reflect teaching practices emanating from evidence in particular research evidence, the implication being that such practice is well informed, current and derives from knowledge that is conducive to the most effective ways to teach in the current health care climate [5]. Such a climate encompasses considerable diversity ranging from cultural to generational to technological advancements that may be described as occurring at a fast pace. In addition, configure into such a climate the academic challenges of increasing class sizes, faculty shortages, decreasing resources, and limited clinical and community teaching sites [5]. To establish a research foundation for nursing education that addresses the contemporary challenges related to nursing education, it is important to develop and evaluate research-based approaches and strategies for nursing education "by enhancing the pedagogic literacy of faculty members (including preceptors)" [13, page 73].

In any professional discipline, the acquisition of knowledge is embodied in its application to the practice setting [14]. Increasingly, nurses must contend with a growing body of knowledge, resolve complex practice issues, adapt to rapid advances in science and technology, and accommodate economic constraints that foster massive health care challenges [15–17]. Indeed, professionals of the future will need to possess, more than ever, the intellectual and emotional capacity for effectively and critically assessing and dealing with the complexity of rapidly changing situations. Consequently, nursing faculty are challenged to provide students with opportunities that will assist them to acquire the competencies necessary to manage the demands of such a dynamic practice. To meet such inexorable demands, it is important that the educators themselves be adequately prepared to teach. Such faculty/teacher/preceptor preparation must in turn derive from teaching practices that derive from the best evidence to support the teaching learning process [18] and Myrick and Yonge [14].

The effect of education on the ability of students to think critically has been the focus of many studies. Outcomes, however, reveal a lack of clarity regarding the mechanisms and operations of the critical thinking process and its applications [19–23]. Preceptorship too has been examined from a variety of perspectives including its impact on the socialization and role transition of students [24–27]; preceptor role modelling [28]; preceptor job satisfaction [29]; and clinical performance of students [30–32]. More recently, preceptorship has been examined to ascertain how it nurtures practical wisdom throughout the learning process of students in the clinical setting [33]. Despite the proliferation of research into preceptorship over the years, findings regarding its impact on clinical teaching, however, continue to remain somewhat inconclusive [34].

4. Statement of the Problem

Over the last three decades in particular, preceptorship has become the approach of choice for the clinical preparation of undergraduate nursing students. It is a teaching/learning approach, in which students are assigned to expert nurses (preceptors) in the practice setting. This particular arrangement is designed to ensure that students acquire experience on a one-to-one basis with a role model and resource person who is immediately available to them in the practice setting [10, 35] and Myrick and Yonge [14]. To date there has been little structure regarding the preparation of preceptors for the teaching and learning role in the clinical setting.

5. Purpose of the Study

The purpose of this study was to examine an evidence-based approach to prepare preceptors involved in teaching fourth year undergraduate nursing students in the preceptorship experience. The specific objectives of the study were (a) to evaluate the effectiveness of an evidence-based approach

to preceptor preparation and (b) to ascertain preceptor perceptions of this preparation in grooming them for their role in the preceptorship experience.

5.1. Research Questions. The research questions for this study were as follows: (1) how does the provision of an evidence-based approach contribute to the preparation of preceptors for their role in teaching and learning? (2) Is structured preparation using an evidence-based approach effective in preparing preceptors for their role in the preceptorship experience? (3) How do preceptors perceive their individual approach to the preceptorship experience following such preparation?

6. Research Design

6.1. Method. A qualitative method using semistructured interviews was used. Constant comparative analysis was used to examine the data. This approach was used to conduct this study because it afforded the researchers the opportunity to deal directly with what was actually going on as to how an evidence-based approach to preceptor preparation influences the teaching practices of preceptors throughout the preceptorship experience.

6.2. Procedures/Data Collection. No less than one month following completion of the workshops, the research assistant carried out data collection during tape-recorded interviews with the participants, which were then transcribed by a professional transcriber. Demographic data were obtained from all participants prior to these interviews. A purposive sample of 29 participants ($n = 29$) was interviewed. Participants were chosen for the study based on the following criteria: they must have been (a) willing to participate in the study; (b) able to speak and understand English; (c) preceptors in the fourth year of the university undergraduate nursing program in which preceptorship was the primary approach to teaching in the practice setting; (d) able to attend one of the structured preceptorship preparatory conferences (full day) provided; and (e) able to sign a consent form agreeing to participate in the study. Preceptors attending the conferences were provided information about the study. A sign-up sheet was made available which they could sign if they were interested in participating. They were also informed that they could withdraw from the study at any time once the process had begun without any fear of reprisal. Interviews were subsequently conducted at a time and place convenient to the participants. A research assistant who had not been connected to the workshops conducted the interviews. An interview guide was used which comprised open-ended questions. Sample questions included "you recently attended a preceptorship workshop, how helpful has it been for you in your preceptor role? What particular area(s) of the workshop have you found most helpful in your role as a preceptor? Has anything about the way you precept students changed following your participation in the workshop? Is there an area/topic you would like to be included in future preceptorship workshops? How would you rate your interest in the preceptorship workshop? Would you recommend this workshop to colleagues and why?" These questions were a beginning guide only and were revised as data emerged. Interviews, each lasting approximately 90 minutes, were conducted with the individual participants in a time and place deemed convenient for them. Secondary data sources included field notes, and personal reflections by the researchers throughout the study. To insure accuracy, data were confirmed by the participants.

6.3. Data Analysis. Constant comparison was used to analyse the data in this study. Intrinsic to that analysis were two levels of coding: (1) substantive and (2) theoretical. Substantive coding involves two levels of coding: open coding and selective coding. Through open coding the data were broken down into discrete components for the purpose of conceptualizing and categorizing the codes [36]. Patterns in the raw data were given conceptual labels through examination of the data line-by-line. As a result of this process, as many codes as possible were generated. The goal was to generate an emergent set of categories and their properties which fit, worked, and were relevant [37]. The second part of substantive coding is selective coding which resulted in the generation of the core variable or the major theme identified in the data. That theme was characterized by the researchers as "Shaping an Evidence-based Pathway to Preceptor Preparation." At this stage in the analysis, coding was restricted to only those categories which were related specifically to the core variable. When the substantive coding was complete, the second level, also known as theoretical coding, was commenced. At this stage in the analysis the data were put back together in a different way through a process that involved categorizing the data and making links between a category and its substantive codes. The theoretical codes thus conceptualized how the substantive codes related to each other as interrelated hypotheses which in turn accounted for resolving the core variable or theme [38].

6.4. Mechanisms to Ensure for Rigor. There are four criteria against which rigour in qualitative research is measured [39]. These include credibility, fittingness, auditability, and confirmability. Throughout this study, specific mechanisms were instituted to ensure that these criteria were achieved, thus enhancing the rigour of this investigation. As member checks is the most important mechanism to ensure for rigor in qualitative research, together with mechanisms to ensure for fittingness, auditability and confirmability, credibility was ensured by sharing the findings from the interviews with preceptors to ascertain the accuracy of researcher interpretation.

7. Findings and Discussion

Upon examination and ongoing scrutiny of the data, the core variable or theme that emerged in this study was characterized by the researchers as "Transforming Preceptorship." Integral to this transformation were three requisites: (a) engagement; (b) enrichment; and (c) critical reflection/reflexivity. For purposes of discussion and to protect the confidential nature of the study participants, pseudonyms

are used throughout the paper to reflect the preceptors' perspectives.

7.1. Engagement. According to Palmer [40, page 15] "good teaching is always and essentially communal." In other words it is important to create a space in which learners can engage in conversation with one another as well as with the subject for which they are convening. This premise was no more apparent than in the process of engagement that surfaced throughout the course of the workshops, a process that was reflected in the preceptors' sentiments. One preceptor, Joan noted:

> *"It (the workshop) has been very effective. I really enjoyed it because we got to sit down with other nurses who were experienced, but number two, we got to sit down with students and find out what their ideas have been…I think you learn very much when interacting with both sides. You see the side of the student and then you see your side…The students I was with they were fantastic in voicing what they thought they needed, their experiences and its always helpful to learn both sides."*

Another preceptor, Mary, stated "you have that flow of information like exchange of information right there, and that's really helpful, really helpful." Another preceptor, Maureen said, "it was worth hearing other people's experiences as a preceptor and just getting tips from them…I think everyone should do it (attend the workshop) if they're thinking about being a preceptor. Margaret, another preceptor, observed

> *"Sitting at the table and talking to the students and being able to hear their concerns, and they were willing to listen too…they are really very worried about the preceptorship and almost felt a bit like it's us against them and I tried to change that us against you or you against us, it is us together for the patient, then that's what our focus should be."*

Engagement can be considered to be a principle of good teaching and learning, a principle equally important for all kinds of learners [40]. Indeed, of particular importance to the participants in this study was the opportunity to be able to interact with other preceptors and to meet and engage with students in the workshop venue. The opportunity to be able to interact one-to-one and as a collective to discuss and to share experiences with other nurses who themselves were preceptors created a sense of camaraderie amongst the workshop participants that might have otherwise eluded the preceptors had they not attended the workshops.

Because the students were in attendance, these workshops were also found to provide an excellent medium for the preceptor and the student to interact outside of the clinical environment and more specifically prior to commencement of the preceptorship practicum. Such interaction served to dispel the various myths that may have previously existed about the dyad for both preceptors and students alike. In particular, it afforded preceptors the opportunity to learn firsthand what the students were thinking and feeling about their approaching preceptorship experience and their much anticipated immersion into the world of professional nursing practice. According to Brookfield [41], "having some insight into what students are thinking and feeling…is the foundational, first-order teaching knowledge we need to do good work" (page 28). Such insight in turn can further facilitate and assist the preceptor in his/her approach to the preceptorship experience through an increased understanding of the student's particular perspective. This kind of knowledge can serve to dispel any preconceived ideas on the part of the preceptor and student, diminish or confirm previous held assumptions, and contribute to enhancement of the preceptorship experience.

7.2. Enrichment. Participation in the workshop generated for the preceptors the acquisition of new knowledge that ultimately would inform and thus change their perspectives and approach to preceptorship and raise their awareness of the various challenges with which they might be confronted. The evidence-based knowledge that guided and facilitated the discussions and dialogue throughout the workshop served to (a) enhance the preceptors' understanding of the specific responsibilities intrinsic to their preceptor role; (b) increase their individual self-awareness in the preceptor role; (c) promote a greater discernment of their own and the students' expectations; and (d) engender a sense of self-confidence that the preceptor might not have otherwise acquired. As one preceptor, Alison, indicated

> *"I had no expectations when I went there (to the workshop). I really didn't know and it just was over and above what I thought it was going to be…I just thought well I'll go and see what new they can tell me after I've been doing this for so long and was wonderfully surprised."*

Alison went on to describe "the questions that were being asked at the roundtable discussions. Okay the student says this, what would your reactions be and just hearing what the students at my table thought about it."

Another preceptor, Tracey, expressed it in the following way:

> *"I'm more communicative and not afraid to show them (the students) that I have weaknesses and that I also have strengths, and that they can learn from me but they can also learn from other people on the unit that my way may not be what they feel is the best way but that I'm always also very open to new ideas that they have…Before (the workshop) I might not have communicated that so I think I'm more open about that right off the bat."*

As one preceptor, Janet, described"I think we pretty much discussed everything that we could and I don't know that there was any topic that we didn't." Patricia, another preceptor, stated

> *"It was to have some clear lines as to what the expectation is and to give you some boundaries as to where are you to go with the student and not overwhelm them with too much and to have a realistic attitude."*

In the context of this study, the preceptors were provided with the opportunity that emanated from both the knowledge and the dialogue that ensued, to engage in discussion regarding the perception that teaching and learning is a human practice and not simply a repertoire of competencies to be mastered. Teaching and learning was explored and discussed: (a) as a process that is a distinctive way of being human: Hogan [42] affirms this sentiment through the following assertion "teaching in the fullest and most enduring sense of the word, is essentially a commitment to the more worthy fruits of learning itself and a way of being human" (page 29); (b) as being comprised of more than fluency in the skills of teaching; and (c) as being contingent on the relationship that develops between the preceptor and the student which in turn affects the success or lack thereof of the preceptorship experience [14, 42]. One preceptor, Margaret, described, somewhat poignantly, "I think I've been awakened somehow."

7.3. Critically Reflective/Reflexive. "Critical reflection is a hopeful activity [43, page xiii]." According to Myrick and Tamlyn [44], conscious awareness of our own individual teaching practices is essential for establishing a more enlightening experience for both teachers/preceptors and the students alike. While there has been a concerted effort over the past several decades toward the fostering of critical thinking and reflective ability among nursing students, little attention has focused on the ability of nurse educators, including preceptors, to be critically reflective or reflexive about their own approach to teaching. Key to the critical thinking and reflexive process is the ability on the part of the teacher, in this case the preceptor, to be able to identify and scrutinize the assumptions that inform their ideas and actions [41].

An interesting finding in this study was the process of critical reflection and reflexivity that did indeed emerge as a result of the didactic and interactive process that prevailed throughout the workshop sessions. As a consequence of the topics addressed and the dialogue generated preceptors found themselves questioning their own taken-for-granted assumptions. For example, following a session on the intergenerational workplace setting, the current day context in which preceptorship occurs, one preceptor, Judy, stated:

> *"The workshop got me saying that the younger generation is all right, they just think differently. And I think that gives me a little bit more of a strength. It makes me look at my student a little bit differently. So I think that's a positive thing…It kind of made me open up a little bit more."*

As part of this reflexive process, preceptors were found to express a more open perspective toward students of a different generation. Such a process served to influence preceptors in perceiving students as individuals and as learners rather than as being emblematic of a generational cohort with particular characteristics that may or may not be congruent with the preceptor's own generational perspective.

As with the opportunity for reflexivity, the workshop also engendered a critically reflective dimension. Preceptors found, as a consequence of the discussion and their engagement with the both the topics and the dialogue emanating from them that they began to question their actions and approach to their preceptor role. In other words, they became critically reflective. For example, one preceptor, Ruth, said that as a result of her attendance at the workshop she was "going to question, to think why, why am I doing this or why don't I agree with this, what is it that I am uncomfortable about…you're going to find little questions in our mind that's going to make you dig deeper, go find out something, either from a book or from another person."

Another preceptor, Sandra, said "I thought the workshop was really, really valuable…assessing your own values and your judgments, working through things with the student rather than just debriefing after something has happened." Patricia stated, "It (the workshop) has helped me to think critically while Deborah described it in the following way, "It (the workshop) opened my eyes to how difficult it is for the student initially. I have really never thought about that much…I didn't realize that they really come with preconceived ideas."

8. Influence on Preceptors' Approach to Teaching

As a result of participating in the workshop, preceptors indicated that their approach to teaching/precepting was influenced by the knowledge and understanding derived from the didactic and interaction sessions and from the discussions in which they engaged. For example, Nicole, stated "I'm more aware of how they (students) feel…I am more reassuring to them and I value their opinion more as well. Nicole went on further to state

> *"Before I would think if I would have a student who wasn't really interested then I would say okay whatever, if you don't want to learn, it's not my problem, but now I think, I'm alone in that. They actually do want to learn and if they get the right approach they do learn and so I see more my responsibility to get them over that step so that they actually learn. I do not believe anymore that they don't want to learn."*

Insofar as influencing her approach to precepting, one preceptor, Margaret, provided a concrete example. She stated, "I make sure they (the students) are free to ask questions. I will approach them. If I think that they're confused I will introduce some information that will stimulate a question. Another preceptor, Alice, stated "I allow them (students) to think independently and not to do things for them but to say okay you can do this but come to me if you have any questions and then we'll go through it so they're working independently." Ann stated that, as a result of participating in the workshop, "I'm thinking differently

about students. . .starting really starting with what the students need."

As can be seen from the preceptors, the workshops contributed toward the way in which they subsequently approached the preceptorship experience. They indicated quite clearly that as a result of their attendance at the workshops, they assumed an informed perspective, one that was derived from the knowledge they had acquired and the discourse that had been generated in the workshop sessions. Their approach to students now emanated from a different stance. For example, rather than make assumptions about student demeanour, they instead now would use the knowledge they had acquired to view the student through a more informed and reflective lens. In other words, they were becoming critically reflective and reflexive. Their approach to the preceptorship experience now became knowledge based, derived from evidence-based teaching and grounded in best practice.

9. Summary and Conclusion

Owing to their participation in these evidence-based workshops, the preceptor participants could be said to have become somewhat transformed through a process of engagement, enrichment, and critical reflection/reflexivity. This transformation was engendered through the acquisition of knowledge and the discussion that ensued with other participants throughout these workshops. Prior to their attendance at these workshops, many of the preceptors had not participated in such a structured preparatory activity. Subsequently, they had embraced the preceptor role in a manner conducive to what they thought to be appropriate, often drawing on their own previous experiences as to how they had been taught or precepted. As a result of the knowledge acquired, the occasion to interact with other nurses who were also assuming the preceptor role and the opportunity to be able to take part in discussions with students and with faculty who facilitated the didactic and interactive sessions, the preceptor participants in this study acquired a new-found understanding of the preceptor role and a more reflective and reflexive understanding of that role.

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Research Article

Preceptorship and Affirmation in the Intergenerational World of Nursing Practice

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Research has shown that while preceptorship offers a reality-oriented learning environment and facilitates competence of students, there are inherent rewards and stressors associated with the experience. Students and preceptors can be from different generations, and as such, they may often come to the learning space with differing values and expectations. The nature of the preceptorship experience in this intergenerational context was explored in a recent phenomenological study with seven preceptors and seven nursing students in an undergraduate nursing program in Eastern Canada. Overall the experience was found to be inclusive of three main themes: *being affirmed, being challenged*, and *being on a pedagogical journey*. In this paper we explore the first of these themes, *being affirmed*. Highlighting the positive aspects of the preceptorship experience in the intergenerational context is necessary to promote a culture of openness and respect for generational differences within clinical nursing practice settings and to improving the overall quality of the educational experience.

1. Introduction

Research has shown that while preceptorship offers a reality-oriented learning environment and facilitates competence of students, there are inherent rewards and stressors associated with the experience [1]. The formation of a positive working relationship between a student and a preceptor highly influences the overall success of the preceptorship experience. In today's nursing clinical practice settings, there can be up to four generations (Silents, Baby Boomers, Gen Xers, and Millennials) present and each can be said to have its own distinct worldview [2]. The majority of today's university and college students belong to the Millennial Generation (also referred to in the literature as Generation Y), while most preceptors are either Baby Boomers or Generation Xers. Within the discipline of nursing, values and expectations are often deeply rooted in traditions and customs of nursing practice and invariably as the younger generation brings new ideas to the practice setting, clashes between the generations are occurring and these can be difficult to resolve [3]. Promoting a positive community of practice for nursing students is the shared responsibility of nurse educators and preceptors [1, 4].

In this phenomenological study, the experiences of seven nursing students and seven preceptors within the intergenerational world of nursing practice were explored. Participants were recruited from an undergraduate nursing program in Eastern Canada. The findings revealed that the overall experience was inclusive of three main themes: *being affirmed, being challenged,* and *being on a pedagogical journey.* The purpose of this paper is to undertake an in-depth exploration of the first theme, *being affirmed.* A total of five subthemes emerged from the data in relation to this theme. From the students' perspective, being affirmed related to *havinga professional role model*and *building confidence.* The preceptors' reflections related more specifically to *being respected, imparting the legacy,* and *strengthening nursing knowledge.* These five subthemes will be explored in more detail and supported with direct quotes from the participants that are believed to be particularly illuminating. In our view, highlighting the positive aspects of the preceptorship experience in the intergenerational context is necessary in order to promote a culture of openness and respect for generational differences within clinical nursing practice settings. Knowledge of the affirming aspects is also directly relevant for recruitment and retention of preceptors, as well as student

satisfaction with the clinical experience. Such knowledge can assist nurse educators as well as they prepare both students and preceptors for the preceptorship roles and responsibilities.

2. Background

At best, limited research on the intergenerational context of the teaching and learning process in higher education has been conducted and, in particular, no published studies have been carried out on preceptorship or field education in the intergenerational context [5]. A lack of research is also noted in the area of preceptorship rewards, specifically in relation to working with someone of a different generation. There is some literature available which more broadly identifies the rewards of preceptorship from the view of the preceptor [4, 6–14]. These studies reveal both intrinsic and extrinsic rewards of being a preceptor. Some examples of intrinsic rewards include seeing student growth and development, opportunities to strengthen teaching skills and influence practice, improve own knowledge base and critical thinking skills, and the opportunity to reflect on and evaluate one's own practice. Extrinsic rewards identified include pay differentials, opportunities for continuing education, journal subions, luncheons, and other similar initiatives. It is suggested in the literature that rewards must be individualized and those that are deemed to be personally/professionally meaningful contribute most to continued commitment to the preceptor role [15, 16].

The affirming nature of preceptorship from the point of view of the preceptee has not been examined specifically; however in one phenomenological study, the lived experience of student nurses in relation to learning was explored, and three main themes were identified: *directing learning, learning in practical action*, and *feeling in learning* [17]. These themes provide unique insight into the different modes of learning from the student's perspective. While no rewards were mentioned per se, the authors highlight the important responsibility of nursing faculty in providing "real life" positive situations for students. One other study (not specific to preceptorship) examined the experiences of nursing students in relation to professionalism [18]. A total of 69 baccalaureate nursing students at different educational levels participated in the study and the researchers reported that "knowing" and "belonging" were affirming for students in their professional role. Overall, a review of the literature reveals that there is limited research available on the topic of preceptorship and affirmation. Owing to this, it is difficult to ascertain whether any of the affirming aspects identified in the literature relate directly to being precepted by/precepting someone from a different generation. Findings from the current study help to fill this gap in the literature.

3. Research Methodology

Phenomenology was the methodology employed for this study. The goal in phenomenological human science research is to develop a rich, deep interpretation of lived experience that enables externalization of that which is internal and may not have been reflected upon previously [19]. Phenomenological researchers strive to make such insight available to others who have a similar interest in the phenomenon. This study was guided by van Manen's [19] approach to phenomenology. van Manen draws from the works of influential phenomenological philosophers such as Husserl, Heidegger, Gadamer, Merleau-Ponty, and others, to offer methodological guidance for researchers interested in conducting phenomenological inquiry. His particular approach is more "action sensitive" than philosophical and he promotes conducting human science research to specifically inform and improve pedagogy. van Manen notes that phenomenological reflection presents the possibility of thoughtful praxis through individual and collective self-understanding.

4. Research Questions

Two main phenomenological questions guided this research study (1) What is it like to precept a student who is of a different generation? (2) What is it like to be precepted by a nurse who is of a different generation?

4.1. Sample. To recruit participants for this study, the principal investigator worked in collaboration with the Clinical Placement Coordinator (CPC) of an undergraduate nursing program in Eastern Canada where the principal investigator was formerly employed. The principal investigator was the coordinator of the third year preceptorship course for a period of about six years and was familiar with many of the preceptors and students. The principal investigator and CPC met to purposely identify participants who would be open and willing to discuss their experiences. The goal in purposive sampling is to deliberately look for "information rich cases that capture analytically important variations in the target phenomenon" and select participants based on their knowledge and ability to communicate about their experience of the phenomenon under investigation ([20, page 181]). With this in mind, we chose students of different age ranges (i.e. Millennials and Generation X), and preceptors of different age ranges (i.e., Generation X and Baby Boomers) as well as both males and females. In order to avoid any perceived coercion, the invitations to participate in the study were distributed by the CPC via email.

Small sample sizes (e.g., 6–10) are characteristic of phenomenological studies [21] as the goal is not to make external generalizations about the population, but to attempt to gain deep insight into the meaning of the lived experience [19, 22]. In this study, there were 14 participants: seven of these were nursing students and seven were preceptors. Of the seven students, four were female, three were male, two were Gen Xers, and five were Millennials. Of the seven preceptors, six were female, one was male, and all were Gen Xers. All of the preceptors had at least five years of experience precepting students and the student participants were all in their final year of their nursing program and were reflecting upon

their preceptorship experiences in both the third and fourth years of the program. It was our goal to recruit participants from both generations of preceptors; however none of the Baby Boomers responded to the invitation. It is important to acknowledge as well that at the time of data collection, the third year preceptorship course had been completed and the principal investigator was no longer working directly with any of the participants and was not responsible for the student evaluations. None of the preceptors who participated in this study had worked directly with any of the student participants. Both groups were informed at the outset that we would not be interviewing any participant that they had been paired with previously. To further maintain confidentiality and to ensure anonymity, pseudonyms were assigned to each participant.

4.2. Data Collection. Data were collected during two unstructured interviews with each of the participants. The interviews served the dual purpose of collecting data to discover a rich, deep understanding of the preceptorship experience in the intergenerational context, as well as creating a dialogue between the researcher and the participants about the meaning of their experience. Following the first round of interviews, a number of preliminary themes became apparent and, during the second interviews, these themes were further explored in order to confirm and extend the analysis. Participants were also guided to reflect upon the meaning of their experience. Ethical permission to conduct the study was granted by the university research ethics board.

4.3. Data Analysis. van Manen [19] describes his approach to human science research as being derived from both the German tradition of human science pedagogy (the Dilthey-Nohl School), which employed an interpretive methodology, as well as the Dutch movement of phenomenological pedagogy (the Utrecht School), which was noted to be more of a descriptive methodology. In order to distinguish his particular approach to human science research, van Manen identifies an active and ongoing interplay of six distinct research activities: (1) turning to the nature of the phenomenon, (2) investigating the experience as we live it rather than as we conceptualize it, (3) reflecting on the essential themes which characterize the phenomenon, (4) describing the phenomenon through the art of writing and rewriting, (5) maintaining a strong and oriented relation to the phenomenon, and (6) balancing the research context by considering parts and whole.

As researchers, we engaged in each of these six activities and moved back and forth between them as the project unfolded. Data collection and analysis occurred simultaneously. We became immersed in the data by listening to tapes and reading/rereading the transcripts. Following the first round of interviews the research team met to discuss the emerging themes and to flesh out what gaps existed that might need to be explored during the second interviews. We prepared a summary of the emerging themes and included some direct quotations from participants that were found to be particularly revealing. This summary was sent to all participants and we then requested a second interview to explore these further. Following the second interviews, we revised the thematic analysis and began to structure the phenomenological text. We drew from van Manen's [19] suggestions when deciding how to structure our research text. He identifies five possible approaches: (1) thematically, (2) analytically, (3) exemplificatively, (4) exegetically, and (5) existentially. He adds that these are not mutually exclusive or exhaustive and that researchers may choose a combination of approaches or may invent an alternative organization.

We chose to structure our phenomenological text using a combination of the thematic and analytical approaches as outlined by van Manen [19]. In the thematic approach, the emerging themes serve as generative guides for writing the research report and the totality of the research findings are explicated under each thematic heading with the recognition that there is inherent overlap among the themes. Complex phenomena are further explored using subsuming themes as was the case in our study. The analytical approach may take several forms; however for our purposes we considered etymological sources of the key words in each of the three main themes to further explicate the meaning of the theme.

We acknowledge that juxtaposing human experience with categories or themes can be challenging in that one must be careful not to attempt to "fit" all experiences into the identified categories. Throughout the study we were mindful of the need to keep a fresh perspective on the experiences of preceptors and students through a process of constantly revisiting the tenets of phenomenology within the context of the preceptorship experience that was occurring. It was important for us to acknowledge that choosing an epistemological lens by the way of themes or categories was merely a means to organize the text and we recognize that not all experiences would necessarily fit neatly under each of the categories. The challenge for us was to treat each theme systematically while keeping in mind that one theme always has meaning dimensions in other themes. van Manen also cautions that deciding which themes are essential versus incidental is one of the greatest challenges in structuring the text. In so doing, we were ever mindful of the need to ensure that the main themes fit with each person's experience.

4.4. Rigor and Phenomenological Research. Methodological rigor is an ongoing issue in qualitative research and many authors suggest that it is inadequate to apply a quantitative concept of rigor to that of qualitative research [19, 23–28]. van Manen [19] posits that the criteria for rigor and rationality in human science research cannot be the same as that of natural science research because a much broader view of rationality is essential. Subsequently, he proposes four evaluative criteria which seem most appropriate for judging the power and convincing validity of any phenomenological human science texts. He states, "Our texts need to be oriented, strong, rich, and deep" ([19, page 151]).

In this study, we aimed for the strongest possible interpretation of the phenomenon through our awareness of the human lived experience and through the writing of a text deep in meaning. We believe that the data analysis

will enable the externalization of our participants' lived experience. Reflexivity on the part of the researchers was instrumental in maintaining a strong and oriented relation to the phenomenon. Reflexivity relates to self-awareness and the acknowledgement that the actions and decisions of the researcher invariably impact upon the meaning and context of the phenomenon under investigation and is also a means of showing honesty and transparency in the research process [27, 29]. During this study, we reflectively explored our observations, prereflections, taken for granted assumptions, critical thinking, and decision-making. In particular, we acknowledge that we have made assumptions at times that the different generations do not understand each other. In our view, a lack of awareness of generational differences can lead to tension and/or conflict in the preceptor-student relationship. Such tension can have a negative impact on student learning as well as the overall success of preceptorship. It is also our view that promoting understanding of generational diversity is an important responsibility of nursing faculty.

Husserl [30] used the term "bracketing" to describe how researchers must put aside any preexisting knowledge or assumptions they may have about the phenomenon; however van Manen [19] questions whether it is realistic for researchers to truly put aside their knowledge of the subject. He posits that it is not necessary to "bracket" the information, but rather researchers have a responsibility to make their knowledge of the phenomenon explicit. He goes further to suggest that presuppositions may resurface into the researcher's reflections when we try to forget that which we already know. Throughout this study, we sought to make our personal knowledge of the phenomenon more explicit through the use of a reflective journal.

To further ensure rigor, our participants were afforded the opportunity to confirm and extend the initial interpretations during the second interviews. Our participants not only openly shared their experiences, but also engaged in an interpretive conversation/relation with the researchers and, during the second interviews, we believe a "phenomenological nod" was evident. Munhall [31] refers to the "phenomenological nod" as participants nodding in agreement when reading or listening to the study findings, which is indicative that their experience has been captured by the researcher (page 189). One other means of ensuring rigor was to examine the study themes in the context of current nursing research literature [22] and, in so doing, we found our themes to be supported by the work of other researchers.

5. Findings and Discussion

In this study, the phenomenon of preceptorship within the intergenerational world of nursing practice was found to be inclusive of three main themes: *being affirmed, being challenged*, and *being on a pedagogical journey*. As mentioned previously, our purpose in this paper is to examine the first of these themes in depth. To begin, let us explore the meaning of the phrase *being affirmed*. From an etymological point of view, the word "affirm" derives from the French *afermer* and from the Latin *affirmare,* meaning to make steady, strengthen, and consolidate [32]. More specifically, the term "affirm" is defined as "to validate, confirm, state positively with confidence, declare as a fact, assert to be true" ([33, page 35]). In the context of this study, *being affirmed* relates directly to the participants' experiences of being validated, strengthened, and consolidated, all of which were identified as rewards of either precepting or being precepted by someone from a different generation.

After asking participants to describe their own generation and what they like about that generation, we also explored their thoughts about other generations. Inherent in the reflections of all participants was the notion that the overall experience was an *affirming* one. As one student remarked:

> *It was fantastic. I've had really good experiences... never once did I feel from them [preceptors] that they put me down or made me feel any less than what I was—which is still a student... I could always go to them with any kind of question, there was never a stupid question. So they were really open-minded and flexible when it came to that. I always ask questions... I like to seek out my own experiences, but they're always the same, looking for experiences for me to take part in... I just found it was great, I didn't have any complaints." (Christina)*

Similarly, another student commented:

> *I didn't have any encounters that were bad at all. They [preceptors and staff] were really accepting, and they were happy that I was interested and eager for learning and wherever they could help out, they helped out... a really positive experience. (Ashley)*

Another student, Kayla, also described her preceptorship in the intergenerational context as a very positive experience and felt that her preceptor's up to date knowledge base and positive attitude toward the younger generation was refreshing. She stated:

> *She was very welcoming to students. She didn't have that negative attitude that 'oh students are lazy' because I think she had really good experiences in the past. She even told me 'every student I've had in the past was really good and worked hard' so I kind of think that that worked to my benefit. She was still really up to date too...so I found that was good too...she was really knowledgeable. (Kayla)*

One of the Gen X students was afforded the unique opportunity of working with a preceptor of the same generation. He reflected on his experience as follows:

> *My first preceptor for the 3rd year course was actually my own generation—X, which was great, because we kind of had the same attitudes, I feel anyway. I think it went great... I loved the whole experience. (Mark)*

Preceptors also highlighted the *affirming* nature of their experience with precepting younger students. Patricia stated that it was "absolutely positive overall. . .I feel young, I love it, and I've gotten nothing but respect from them." Karen agreed and identified that her experience was:

> *Definitely positive overall. . .the students that I have had, for the most part, have been quite eager to learn and, you know, they're very intimidated initially, but once you make them feel comfortable and you teach them the best you can, you know, for the most part, I haven't had any issues.*

It is important to note that *being affirmed* was manifested differently for the students than the preceptors and there were six subthemes identified which illuminate this affirmation more clearly. From the students' perspective, being affirmed related to *havinga professional role model*and *building confidence.*

5.1. Having a Professional Role Model. Nursing students often look to the clinical practice setting or the "nursing world" for affirmation of their professionalism ([18, page 81]). In this study, students explained that they believed that they worked very well with experienced nurses and appreciated the practical wisdom and knowledge, as well as the sense of pride in the nursing profession that older nurses embodied. Andrew's comment suggests that students want to emulate the professional approach of experienced nurses.

> *I wanted to go to somebody older than me. I wanted someone who has a sense of the profession, and a model of professionalism which is maybe a bit more old-fashioned model perhaps than some of the younger generation. I've learned skills and knowledge from all nurses, but that issue of finding someone to model professionalism. . .for me, that's the part that I've appreciated the older generation the most for.*

Similarly, Mark stated:

> *Actually it was pretty rewarding because, I felt that I could learn a lot from the older generation. They have the skills built up from many generations, really. And she [preceptor] was willing to. . .share whatever she had, so it was great that way. I had a really positive experience overall.*

Mark added that knowing he could rely on his preceptor led to feelings of comfort and security which was *affirming* for him in his student role. He further reflected on his experience as follows:

> *I had somebody to go to if I got in trouble. . .not in trouble, I should say, there was no trouble, but if I had questions, I had that contact there, and she was more than willing to give me information and help me through whatever I had issues with.*

Christina also recognized that older nurses have a wealth of nursing knowledge and experience and, as such, represent significant role models for students. She did suggest that personality, as well as age or generation, can play a role in determining whether the preceptorship experience would be a positive one. She elaborated in this way:

> *Well, it depends on their own personality, of course. But the ones I've lucked into having, I've just been in total awe of them, to be quite honest. I just find that they're really knowledgeable and confident in their work and everything about their work, really. And the ones I've had have been really open minded to giving me as much exposure, or as much freedom, I guess, to explore my own type of experiences.*

5.2. Building Confidence. For the students in this study, *being affirmed* was also manifested in being afforded the opportunity to build their confidence. Preceptorship in the intergenerational context was seen as a direct embodied experience or, in other words, a planned immediate encounter in the here and now, that involved them physically and emotionally [34]. This direct embodied experience allowed them to build confidence in their ability to perform new roles. Students' reflections on their experiences as noted in this subtheme are consistent with the constructivist view of experiential learning, particularly Kolb's [35] cycle of learning, which involves four phases: concrete experience, reflective observation, abstract conceptualization, and active experimentation. The first two phases, concrete experience and abstract conceptualization, are considered to be "two dialectically related modes of grasping experience," while the other two phases, active experimentation and reflective observation, are viewed as "two dialectically related modes of transforming experience" ([36, pages 193-194]). During the learning cycle, immediate or concrete experiences serve as the basis for observations and reflections which are then integrated and refined into abstract concepts from which new implications for action can be drawn. These implications can then be actively tested thus serving as guides in creating new experiences and building on previous learning [36].

Kolb et al. [36] note that conflict between the "concrete" or "abstract" and between "active" or "reflective" is generally resolved in patterned ways based upon individual learning styles. Kolb [35] identifies a learning style inventory which can be used to assess four distinct learning styles known as diverging, assimilating, converging, and accommodating. We posit that all four phases of Kolb's [35] cycle of learning were evident in the students' comments. For example, Justin described how comfortable he *felt* with his Gen X preceptor's level of guidance.

> *There was never a time when she was watching me that I was uncomfortable, or that when I went on my own I was uncomfortable. (concrete experience)*

Sarah commented on the importance of *doing* and stated, "That's one of the main benefits I see. . .just getting out there and being able to put your skills in action. . .that's something

that I appreciated" (active experimentation). She added that her preceptor's level of experience working with students was a real strength and it was a key factor in allowing her to progress more easily.

> *My preceptor in third year—she's been preceptoring for ten years—so she's very experienced: a) in what the outcomes of the course are, so she was very good at helping me meet the objectives of the course, because of that was very aware of my scope of practice—what I could and couldn't do—those types of things. She was also very comfortable with students, and I think that's a factor as well. If you have a nurse that's never preceptored before, it's essentially a person doing work under your umbrella, under your name, but it's not you doing it. And I could see that nurses would be very uncomfortable with that–I would be uncomfortable with that. So if you're not used to having a student, that can be an uncomfortable thing.*

Similarly, Andrew concurred, "You do sort of learn a huge amount in your first real clinical placement with nurses and that has been really valuable for me" (reflective observation). Andrew added, "The preceptorship experience…was the beginning of feeling like a nurse" (abstract conceptualization).

Kayla identified her preceptor's strength in relation to giving feedback and recognized this as a significant contribution to developing her own confidence. She also reflected upon experiences with other nurses that were not so positive.

> *She [preceptor] was great, because in other rotations I've had other nurses who said "I'm not one to praise someone up but if you're doing something wrong I'll tell you". But she was good because if I was uncertain about a skill or it was my first time doing it I would kind of verbalize to her first, if I was nervous or really unsure, she would come in and watch me or if she thought…actually, no …she's just watch me and afterwards say "okay, you did that really good" or "make sure next time that you got the bed up higher so you're not bending over", stuff like that.*

Another student noted that her preceptor's openness and receptiveness went a long way toward building her confidence.

> *My preceptor last year, she was 45, and I found that she was excellent…if I said something, she was open to it, and I was so open to everything she said, so I thought we kind of got along really good and we could learn from one another…and I felt that I got a lot more independence and I thought that…when I finished, I felt like I was ready to be a nurse. (Ashley)*

Overall, the students' recognition of their growth toward increasing confidence led to a feeling of *being affirmed*. This affirmation as it relates to the presence of a professional role model as well as building confidence, as found in this study, is congruent with previous research [10, 18, 37–41]. Kolb's [35] learning cycle is reported to correspond well with field education experiences in professional disciplines [42] and in nursing in particular, research on experiential learning theory dates as far back as the late 1970s [43].

All seven of the preceptors in this study also agreed that precepting younger students is an *affirming* experience. In particular, they described the following aspects of the experience to be most significant and these are also considered to be subthemes of *being affirmed*: *being respected, imparting the legacy,* and *strengthening nursing knowledge.*

5.3. Being Respected. With regard to feeling respected for their knowledge and skill, one of the preceptors indicated that he felt valued when students and new nurses choose to come to him when they have questions about nursing care. He stated:

> *They come to me, and I've always had that, after I got so many years under my belt, lots of people come to me, and still do, and I like that because I'd rather for them to come to me and ask, and if I don't know, I'll get the answer rather than them go make a mistake. So I encourage that. (Dave)*

Another preceptor noted that it is "very rewarding to see a student who's just left the area and they're so impressed with the experience that they had and they thank you for passing on some of your knowledge" (Lisa). Such "tokens of gratitude" are considered to be a significant reward of precepting ([7, page 6]).

5.4. Imparting the Legacy. Being able to impart the legacy of nursing onto the younger generation was another significant reward for preceptors and led to feeling *affirmed*. One preceptor noted, "I like teaching those that are coming up, the things that I already know, that I wish I knew when I began" (Colleen). She added:

> *And I like learning the new stuff that they come to me with because there's always new stuff in nursing. They learn it and I learn it from them. "Oh we learned how to do it this way", "that's a good way, I'll remember that."*

Another preceptor elaborated on the personal responsibility she perceived for imparting the legacy and noted that she felt satisfaction when students achieved success. She stated:

> *It kind of reflects back on me when a student is finished and going to soon graduate and become a nurse and whatever type of nurse they are if they spent 8 weeks with me, obviously I've had some impact on them somehow in what they do…and how they behave…and when you find out that you know what, this is a great person, we're so happy we hired them, it's almost like a satisfaction for yourself. (Wendy)*

Likewise, Lisa stated, "hopefully you will go with them wherever they go. Like, they'll look back at it [the preceptorship experience] and say, you know, I learned a lot from this preceptor."

Students in this study also acknowledged the preceptors' innate ability to impart the legacy of nursing onto them. For example, Andrew observed, "I've seen it…they [preceptors] care about nursing…and they want to impart something onto the next generation of nurses." This genuine commitment to the profession and demonstrating value for the education of future nursing professionals could be said to exemplify what Myrick et al. [39] refer to as "engaging in authentic nursing practice," a process which the authors suggest nurtures practical wisdom in the preceptorship experience (page 82). These authors note that affirming the student role and recognizing student potential were inherent in the preceptor student interaction and were key elements of engaging in authentic practice.

5.5. Strengthening Nursing Knowledge. Several of the preceptors highlighted the benefit of feeling as though their own nursing knowledge was strengthened as a result of working with nursing students. Wendy remarked, "It keeps me on my toes and it keeps me up on my skills and reminds me of why I'm in there too. It makes me appreciate what I do." Lisa described students as "a wealth of knowledge when they're coming out of school." She added, "I am impressed with them." Colleen indicated that she appreciates it when students inform her of new ways of doing things. Patricia specified that learning these new things and keeping current made her "feel so good!" She went on to say:

> *I find that I am so on top of all my policies. I just find that I'm on top of everything, I'm so educated and I learn alongside my preceptee. They bring you new knowledge and new ideas. So you're more open, so it's good both ways, you know? You can learn.*

The preceptors described many other positive attributes of working with students of the Millennial Generation. Dave commented on the fact that he looks forward to "an influx of new blood" each time a new group of preceptees comes to his nursing unit and this keeps him from feeling "stagnant." He elaborated in this way:

> *I really have no problems working with the younger graduates. I mean, I look forward to it, it's an influx of new blood almost, because sometimes you get stagnant in areas and then the new people come in, and sometimes when they come in they're right ready to take charge and raring to go. Sometimes you need that little jolt in units … I have no problems, none whatsoever, I like new people coming in. Just change. Change is good for any area, you know.*

Sharon expressed that she enjoys working with students because "they're fun to be around and they are high energy, and I like being challenged." She added:

> *I like working with younger people because even at my age, I'm 46 years old, but at my age I don't consider myself old. Now I know a 20 year old looks at me and thinks "oh grandma" (laugher), but I don't consider myself old. I like to think that as long as your mind is active and your mind is progressive and you're open to new ideas, you're not old. So I enjoy working with the younger people because they're fun. They're fun to be around and they are high energy, and I like being challenged. I like to be in a situation where I like to know your stuff, because you've got to pass it on to someone else and you've got to teach it to somebody else. And they ARE very inquisitive.*

Lisa added, "They keep you young, keep you vibrant, keep you educated and…they're the ones we're going to be depending on."

Overall, these comments reveal a level of self-reflection that emanates from being a preceptor and such reflection in and of itself was *affirming* for preceptors. Preceptors recognized that they were strengthening their own knowledge base and awareness of themselves as professional nurses. This finding is corroborated by other researchers who have specifically examined the experiences of preceptors [9, 14, 44, 45]. Numerous other intrinsic rewards such as teaching, role modelling, contributing to the future of the profession, moulding students, and enhancing one's pedagogical skill through precepting are also identified [7, 8, 12, 13, 46–49].

6. Implications and Recommendations

Findings of this study generate new knowledge about the different generations, namely, Millennials and Gen Xers, and the influence of generational diversity in shaping the teaching/learning process in the clinical practice setting. The three themes identified serve to provide the structure and meaning of the participants' lived experience. The first theme, *being affirmed*, showed that both preceptors and students found the experience to be positive and rewarding and highlighted the fact that the rewards were manifested differently for each group. Identifying the affirming aspects is significant as it allows others to understand the nature of the rewards inherent in the experience and further research in this area would be beneficial to strengthening pedagogical nursing knowledge. It is important to acknowledge that a number of *challenges* were identified in this study as well; however it is outside the scope of this paper to address the challenges that were revealed. We acknowledge as well that developing strategies to address the challenges is crucial to the future success of the preceptorship model of clinical practice. As well, further research addressing the specific challenges that relate to preceptorship in an intergenerational context is warranted.

Overall, we believe this study provides a beginning understanding of the different generations and how they work together in preceptorship, but there is clearly a need for further research in this area. One of the topics that we suggest pursuing is a broader assessment of generational

perceptions within the nursing profession. A descriptive exploratory study with a large sample of preceptors and students across multiple nursing schools within Canada would be highly valuable in adding to this important body of nursing knowledge. We also advocate conducting other phenomenological studies to examine experiences of different dyads, such as Baby Boomers preceptors and Millennial students, or Millennial preceptors and Millennial students. Such research would help to elucidate whether the challenges identified in the current study are indeed related to the intergenerational context of the learning space. The impact of generational diversity on workplace leaning is another important area to be explored. Interprofessional studies to examine experiences of field educators and students from other disciplines would allow for valuable comparisons to be made with the findings of the current study. It is important to raise the question of whether the challenges described in this study are unique to nursing thus interprofessional studies would aid in establishing a foundation for knowledge utilization.

7. Limitations

This study describes the lived experiences of seven nursing students and seven preceptors as they negotiate the teaching/learning process in the intergenerational context. The complexities of their collective experiences have been illuminated, but that is not to say that another phenomenological study with a different group of preceptors and students would yield the same findings. The preceptors in our study were all of the Generation X and all had at least 5 years of experience with precepting students. It is likely that their experiences differ from those of less experienced preceptors and perhaps preceptors of other generations, such as Baby Boomers.

We also acknowledge the inherent limitation of any human science research that a description of one's experience, even a rich and deep description, can never truly capture the entirety of that lived experience. van Manen [19] admonishes that we must "remain aware that lived life is always more complex than any explication of meaning can reveal" (page 18). It is also worthy of mention here that we are not suggesting that generational diversity is the most important issue in nursing preceptorship today, but rather it is an emerging topic of interest and one that we believe warrants further attention. It is difficult to ascertain whether the rewards and *affirming* aspects of the preceptorship experience as described above relate specifically to working with someone of a different generation or rather preceptorship from a broader perspective. We should also add that many challenges were identified by our study participants and we recognize that a generational lens is only one way to view situations where conflicts and/or challenges are occurring. Such situations can be highly complex and the generation to which a person belongs is merely one factor in the equation. We did not explore personality conflicts or differences in learning styles in this study per se; however these topics were raised by some of our participants.

We recognize one other limitation, the difficulty in reaching all fourteen of the participants for a second interview. Following the first round of interviews a written summary of emerging themes, along with some direct quotations from the interviews, was sent to each participant and a second interview was requested to confirm, extend, or challenge the analysis. We were successful in receiving feedback from all but two of the participants (one preceptor and one student).

8. Conclusion

This study lays the foundation for pedagogical nursing knowledge development in the area of generational diversity. Through the phenomenological methodology as described by van Manen [19], we have sought to provide a rich, deep interpretation of the real-life experiences of both preceptors and students as they negotiate the teaching and learning process in the intergenerational world of nursing practice. Three essential themes were identified (*being affirmed, being challenged,* and *being on a pedagogical journey*), each consisting of a number of subthemes. Our purpose in this paper was to explore the theme, *being affirmed*, in a rich and deep way, and we believe that the findings and analysis we have presented here allow for externalization of our participants' experiences. Each of the participants in our study described their lived experience as an *affirming* experience and one that reaped many personal rewards. We believe that highlighting the *affirming* aspects of this experience is significant for the sustainability of the preceptorship model of clinical education. Generational diversity undoubtedly influences the teaching/learning process in preceptorship and developing further understanding of this phenomenon is directly relevant for nurse educators, students, and nurses in clinical practice. The findings of our study can be used to improve the preparation of students and preceptors for the intergenerational world of nursing practice. As Raines [50] notes, "We can use generational lenses to help us see things we might not otherwise notice" (page 2).

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Research Article

The Concerns of Competent Novices during a Mentoring Year

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In an innovative group mentoring approach, four experienced midwives mentored four new graduates during their first year of practice. The new graduates were in practice as case-loading registered midwives having completed a three year Bachelor of Midwifery degree. Detailed data about the new graduates' concerns were collected throughout the year of the mentoring project. A range of practice areas—administrative, working environment, professional culture, clinical issues and the mentor group itself—were prominent issues. New graduates were concerned about their own professional development and about relationships with others particularly relationships within the hospital. Technical questions focussed more on craft knowledge that develops through experience than on clinical skills or knowledge. Identifying these concerns provides a foundation for mentors, preceptors and those designing professional development support programmes for the first year of practice. It may be that new graduate midwives educated in a profession with a narrowly defined scope of practice have a different range of concerns to new graduates who have wider scopes of practice. The use of a group model of mentoring for supporting new graduate midwives proved stimulating for mentors and highly supportive of new graduates.

1. Introduction

Mentoring or preceptoring in the first year of practice in nursing and midwifery has nearly always been thought of as a one-to-one relationship in which an experienced practitioner supports a novice [1]. By contrast, this paper is derived from a naturalistic study of an innovative approach in which a group of experienced midwives worked together to mentor a group of new graduates [2]. The study was based on an assumption that the new graduates were competent novices who wanted support to develop their confidence for practice. The new graduates were responsible for seeking the support they needed and for raising concerns for discussion in regular group meetings with the mentors. Therefore, this approach to mentoring rested on adult learning principles where the learners' identified their individual concerns as they arose. This paper describes their concerns. It will be of interest to mentors and preceptors in nursing and midwifery whether they wish to work as a group or in the more usual one-to-one relationship.

2. Background: What This Paper Is about and Why It Is Important

The midwives who were mentored in this study had just graduated from a three-year Bachelor's degree in midwifery (without prior registration as a nurse) and were newly registered as midwives. Practising certificates issued annually by the Midwifery Council of New Zealand are based on competency as an entry level practitioner [3]. In New Zealand, midwives called lead maternity carers (LMCs) can provide total care to women throughout the childbearing experience from diagnosis of pregnancy, through the intrapartum experience and followup to six weeks after the birth. This primary care service is government funded, and midwives can elect to work as self-employed case-loading practitioners from the first year of registration.

In 2006, four final year midwifery students were planning their next year as autonomous practitioners and seeking one-to-one mentoring. They had chosen to become LMC

midwives case-loading as self-employed midwives. The four new graduates were planning to work together in a group practice. At this time there was a workforce shortage in midwifery, and mentor midwives were in short supply [4]. As a response to the students' practice need, four experienced mentors, who could not provide around the clock one-to-one support, agreed to share the mentoring responsibility within a group [2]. The resultant group consisted of four new graduates and four experienced midwives.

A group mentoring model was coconstructed with input from the students and the mentors, and a contract was negotiated prior to the commencement of the graduates' first year. The purpose of the group mentoring initiative was to support the development of confidence in the graduates. The starting point for the project was that new graduate midwives were competent novices who could identify what they needed to develop practice confidence. Therefore, the group mentoring approach was strongly centred on responding to new graduates' self-perceived concerns rather than imposing a professional curriculum during their transition to practice.

Concomitantly, all of the members of this group mentoring project agreed to participate in a research project designed to capture the novelty and efficacy of the approach, its strengths and weaknesses. The research involved a detailed analysis of the concerns identified by the new practitioners and how these varied over the course of the year. This paper reports on that component of the research and specifically on mentoring rather than new graduate literature. As recently identified, knowledge about how best to support midwives is sorely needed [5]. Evidence has accumulated about the transition to practice which exposes the first year in practice as challenging [6, 7]. The context in which these concerns were expressed was through group mentoring which is an unusual approach for professional support in the first year of practice. Mentoring has traditionally been thought of as a one-to-one relationship.

2.1. History and Concept of Mentoring. Historically, mentoring emerged out of antiquity from the works of Homer, and in particular the *Odyssey* [8]. When Odysseus left for war he entrusted the care of his only son, Telemarchus, to his friend, Mentor. Later when the goddess Athena visited the young adult Telemarchus dressed as a man, she did so to "embolden him." Contemporary mentorships emulate this classical tale where one adult is more experienced than another in some aspect of their career. Mentoring occurs during professional transitions such as emerging from training (new graduate) or when there are significant changes in career circumstances.

In the 1960s, mentoring emerged in the United States as a very successful career development relationship [9, 10]. Kram, a business management researcher, analysed 18 mentoring relationships and described the functions that mentoring served [11]. These were divided into two major categories: instrumental and psychosocial and nine subfunctions. This analysis has stood the test of time, and the functions have since been used as the benchmark for many studies.

Nursing soon saw the benefits of mentoring and Yoder [12], a nurse researcher, created a concept analysis of how mentoring operated across the disciplines of business, education, and nursing. Vance [13], a leader in nursing, identified mentoring as useful for women in leadership but also envisioned a time when this support could be more universally available and "evolve into some form of institutional support in many organizations" [13]. Vance's encouragement to nurses suggests that both the mentor and the mentee gain from the experience of mentoring, giving some credence to the notion that the female developmental journey "emphasize[s] connection and care" [14].

2.2. Mentoring as a Developmental Process. Models of mentoring characterise how power is expressed in the relationships. A developmental model of mentoring is characterised by the mentee taking the active role in the relationship rather than the mentor so that "empowerment and personal accountability" are emphasized [15]. Developmental mentoring is a partnership established with an end purpose in mind, such as encouraging confidence in a particular occupation or position or at a particular stage, such as the first year in practice. The plans and processes for achieving this end are purposely put in place by mutual dialogue and negotiation. Both parties are engaged in the process of achieving this end without the mentor using their influence to privilege the mentee. The purpose of the mentoring relationship is to enhance the mentee's development by inspiring the mentee to a greater understanding of the role. The learning process is shared: the mentee is learning about a role or increasing expertise, and the mentor is learning about the process of stimulating developmental changes. In New Zealand, this form of mentoring resonates with the partnership model of midwifery, where, as the primary maternity providers, midwives actively encourage women's choices and shared responsibility [16, 17].

2.3. How Group Mentoring Operated. Mentoring was defined in this study as "a voluntarily agreed professional support activity in which the person being mentored is the active partner, their needs are the focus of the mentoring, and the mentor's intention is to assist and cultivate their professional confidence" [2]. Meeting the new graduates' needs by ensuring the new graduates take the active role defined the mentoring relationship. In such a relationship, the "less experienced person (mentee) aims to gain knowledge, develop skills, and achieve insights with the help of the more experienced person (mentor)" [18]. The purpose of the relationship was to develop new graduate confidence, a purpose which is in line with the NZCOM consensus statement on mentoring and which informed the contract the group initiated and developed [19].

The terms of the group mentoring project were that the new graduates were able to contact a mentor at any time, 24 hours a day over the whole year. Group meetings were held weekly for the first eight months and then fortnightly and finally every three weeks for the remainder of the year. Attendance was voluntarily, but few meetings were missed by the new graduates, and there was only one meeting out of 31 when only one of the four mentors attended. The number of meetings and the length and the structure of the process were

all negotiated between members of the group. The meetings generally took two hours and were facilitated by each of the eight participants. The meetings followed a structure which was designed to enable the new graduates to bring up their concerns and for these to be the focus of every meeting.

3. Method: How New Graduates' Concerns Were Identified

3.1. Theoretical Underpinning and an Overview of Data Sources and Analysis. The theoretical underpinning to the research was pragmatic mixed methods, accommodating the values and limitations of quantitative and qualitative paradigms [20]. Pragmatism as a philosophy emerged in the early twentieth century and challenged the hitherto belief that knowledge could only be generated by thinking. Hume contended that matter or even the world out there was no more than a "very useful hypothesis" [21].

Therefore, Dewey's contention that knowledge was generated by action and reflection, where mind and matter were connected, was a distinctly different philosophy to the sceptical approach borne of dualism where mind existed but matter was beyond the veil of certain knowledge. Dewey himself described his new theory of knowledge as equivalent to the discoveries of Copernicus where the sun rather than the earth was the centre of the known universe [22]. Dewey's "Copernican turn" was to propose a theory of knowing which arose from interacting with the world rather than arising only from the mind. He proposed that knowledge was borne of interactions between (our) actions and (their) consequences and later described these connections between mind and matter, as transactions. Knowledge from research transactions was, he maintained, reconstructions of our experiences and had the status of warranted assertions but that did not make them certainties. Real experience should therefore not be confused with truth claims as real is contextual and temporal knowing. Pragmatism is defined as an approach "that debunks concepts such as 'truth' and 'reality' and focuses instead on 'what works' as the truth regarding the research question under investigation" [23].

The approach used in this study was naturalistic inquiry by a participant-researcher who was open to what might emerge from what was an untried practice innovation. It was therefore important that the researcher collect the data without trying to influence the process. Such an approach required that data be collected opportunistically and unobtrusively alongside the mentoring. Both qualitative and quantitative data were collected: recordings of the regular, formal meetings between the new graduates and the mentors; semistructured interviews of each of the eight participants at the beginning, middle, and end of the mentoring year (24 in total); logs of telephone, text or face-to-face contacts between the new graduates and mentors; visual analogue scales of confidence completed by the new graduates during their interviews. The birth data of women cared for by the new graduates was also collected.

The methods of analysis varied for each type of data. The 24 individual participant interviews were recorded, transcribed, and analysed for common themes [2]. A sample of 19 recordings of group meetings were transcribed and analysed using an iterative process to discover points of interest inductively and intuitively, and this resulted in two levels of thematic analysis. The 85 on-call contact logs were analysed using simple descriptive analysis of the number and type of contacts, the reasons contacts were made, and the distribution of the different categories of reasons over the course of the mentoring year.

3.2. On-Call Logs. The new graduates chose when to contact mentors for one-on-one support so these contacts reflect their self-identified needs. Therefore, the on-call logs are one source for understanding graduates' concerns. However, since these were completed by the mentors, these are not a primary source, rather they represent the mentors' understanding of the new graduates' concerns.

3.3. Weekly Meeting Transcripts. The weekly group meetings were structured around new graduates' concerns, so analyses of the transcribed recordings are the key primary source of data. All 31 of the group meetings were recorded and of these, 19 were chosen from across the year for analysis. The transcripts were the subject of many rounds of iterative thematic analysis finally settling on two levels of themes. The first level themes related to the location, within their scope of practice, of the new graduates' concerns. The second level of thematic analysis looked at 95 threads of conversations in the meetings and identified what concerns prompted each thread, resulting in three primary themes.

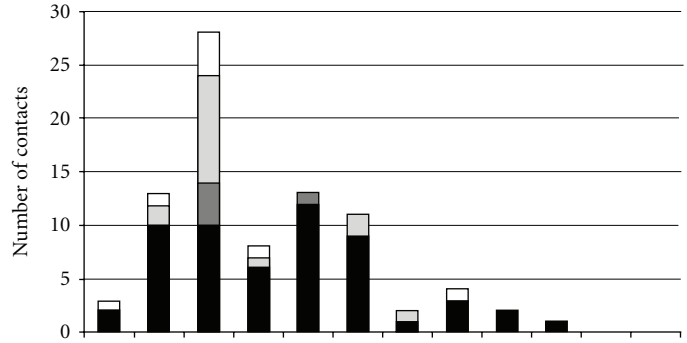
4. Results and Discussion: New Graduate Midwives' Concerns

This section presents the concerns that led new graduates to make contact with the on-call mentor and then follows with the concerns discussed in the weekly group meetings; initially identifying in which areas of practice concerns were located and then what sorts of concerns prompted discussions.

4.1. Concerns That Prompted New Graduates to Contact a Mentor. During the year (January to December), mentors recorded 85 contacts with new graduates: 56 contacts (66%) were phone calls and five (6%) were text messages, on eight occasions (9%) the mentor and midwife met without seeing the client and on 16 occasions (19%) they met together with the client.

As shown in Figure 1, most contacts occurred in the first six months with only nine contacts from July onwards. The last contact was a single call in October. Of the 16 contacts that involved the mentor being with the new graduate and her client (mostly at a birth), ten (62%) occurred in March (mid-February was the time when the first women cared for by the new graduates started to give birth). On average there were 3.1 contacts (2.6 by phone) for each of the weeks when there were contacts, with the busiest week of the year having 17 contacts recorded (including 4 texts and 5 phone calls).

Mentors recorded a brief description of the reason for each contact. As shown in Table 1, these descriptions



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Met midwife	1	1	4	1				1				
Met midwife and client		2	10	1		2	1					
Text			4		1							
Phone	2	10	10	6	12	9	1	3	2	1		

Figure 1: Number, type, and frequency of contacts between mentors and new graduates over one year.

were found to fall into one of the following categories: advice, assistance, giving information, discussion, or were initiated by a mentor. "Advice" refers to a simple request for information. "Assistance" refers to a request by the new graduate for backup from the mentor (usually to attend a birth). "Giving information" indicated that the new graduate was providing something to the mentor, often keeping her updated about a client. "Discussion" refers to times where the new graduate wanted to be able to review a situation and talk about her thoughts without needing advice or assistance. On one occasion, a mentor initiated contact by phoning a new graduate to ask about a client's progress.

In summary, mentors were contacted by new graduates several times a week in the first half of the year, but there was considerable variation between new graduates in the numbers and types of contact they initiated. Two-thirds of the contacts involved only a phone call for advice or information, while about a fifth involved the mentor meeting with the new graduate and her client (usually at a birth) and providing assistance. In the second six months, there were far fewer calls, and when they did occur, a greater proportion were contacts where the new graduate was seeking a discussion rather than asking for information, advice, or assistance.

4.2. Concerns Raised at Meetings. Five areas of concern were identified from the meeting data: administrative issues, working environment, group culture, professional culture, and clinical issues. These categories were present throughout the year with varying frequency.

Administrative issues were a varied and loose grouping of general administrative matters. The areas covered included questioning the need to document phone calls, problems with hospital access agreements, creating business cards, how to obtain letterhead stationery, and collating email addresses. Such administrative issues were mostly dealt with quickly and did not lead to much discussion. Early in the mentoring year, the new graduates asked simple information gathering questions; but after the first eight meetings, when administrative issues arose, they did so from discussions around practice issues. The change from simple information gathering to practice discussions was swift. For example, in the first meeting, there were 30 such simple information gathering questions, but by the eighth meeting there was only one.

The second area concerned the working environment, and included exchanges relating to the new graduates' work in both the community and the hospital. These concerns included their relationships with others as well as their understanding of how the systems worked in both environments. There was evidence of questioning the place of the midwife within the system, how that accorded with the regulations, and about the bases for on-going collegial relationships. For example, one new graduate reported.

> I went in with the bloods [referring to laboratory reports] and said—he said "we need to induce", I said "why?" and we talked about it. [He] rang the consultant and she said the same (NG4, 14th meeting). (to protect participant identity, new graduates are described as NG, and mentors as M with a unique number to differentiate between the participants in each group).

A conversation then developed with the mentors and new graduates around the management of negotiated conversations between the medical staff, the woman, and her LMC midwife.

The third concern was group culture and included exchanges about how the mentoring group itself worked, for example, which mentor was on call and who was facilitating the meeting. The group mentoring process unfolded naturally, enabling the new graduates to have as much decision making and facilitative power as the mentors. The new graduates and mentors took turns facilitating meetings

Table 1: Reasons new graduates contacted mentors over the year.

Month	Advice	Assistance	Giving information	Discussion	Mentor initiated
January	3	—	—	—	—
February	5	4	3	1	—
March	4	12	11	—	1
April	6	2	—	—	—
May	6	1	3	3	—
June	7	3	1	—	—
July	—	1	—	1	—
August	2	—	—	2	—
September	1	—	—	1	—
October	—	—	—	1	—
November	—	—	—	—	—
December	—	—	—	—	—
Total	34 (40%)	23 (27%)	18 (21%)	9 (11%)	1 (1%)

and directing the process. Sharing facilitation between the mentors and the new graduates enabled the new graduates to assume power within the group process from the beginning of the group mentoring meetings. The new graduates showed that they felt comfortable critiquing whether the mentoring was functioning well or not, and, therefore, how effectively supported they were by the arrangements in place. The following quote illustrates the new graduates raising an issue reasonably early on in the year about improving access to mentor support:

> Three in labour and needing support does not work; because we have no process about a second [mentor] on call (NG 4, 8th meeting).

Professional culture, which was the fourth area identified, entailed discussions about what it meant to be a midwife. This included, for example, being a professional in general, or fulfilling the regulatory bodies' requirements, such as the Midwifery Council's requirements for an Annual Practising Certificate, or attending the NZCOM local meetings, or how the national standards for practice or code of practice were played out in practice. Professional issues were frequently mentioned and discussed, as the new graduates began developing a sense of being a professional and adjusting to their new environment. The range of professional issues is vast and requires the midwife to develop a professional persona.

The clinical aspects of providing care to women did figure in the concerns of the new midwives but was not in any way the dominant focus. For example, one new graduate was talking about a woman for whom she was the lead carer whose baby was presenting by the breech in labour. She sought advice from a specialist obstetrician:

> I asked about ECV [external cephalic version] and vaginal birth and [was] told [the] risks [were] too high. If I'd known before she went into labour and she had decided to have a vaginal birth [I would have organised an ECV] (NG2, 14th meeting).

She wanted to critically reflect on the effect this had on the woman and what she and her mentors perceived as her responsibility and not particularly about the evidence about ECV.

4.3. What Sort of Situations Prompted New Graduate to Discuss Concerns at Meetings? For the second level of analysis, the threads of discussion between the new graduates and mentors were examined. The five first level categories were established using mostly isolated quotes from the new graduates, and focusing on the scope and the role of a midwife. Often the reason why an issue was raised did not become obvious immediately but was clearer in the course of the ensuing discussion. For this reason, threads of conversations were used, as exemplified in Table 2.

Each thread began with a new graduate mentioning an issue or question that they wanted to discuss. The thread of the conversation that followed formed the base of the analysis, with contributions from new graduates and mentors. Across 10 meetings, 95 such threads of conversation were identified and coded according to their content. Initially this resulted in identifying ten subthemes. Through a further reading of the material and an iterative coding process, the ten subthemes were grouped into three broad themes: self-reflection, issues to do with others, and technical issues. Of the 95 threads of conversation, 25 were coded as self-reflection, 31 as issues to do with others, and 39 as technical issues. Frequency of a theme is not necessarily indicative of its significance. Each of these three themes is discussed below with examples.

Self-reflection involved matters such as reflecting on inexperience, reviewing, and appraising one's own practice,

Table 2: Example of a thread of conversation (1st meeting).

Speaker	Speech
NG1	We want to ask a really dumb question.
M1	Good we like dumb questions.
NG1	When we are writing to hospital referring people, who do we refer the woman to? Like this woman has fibroids—who do you refer them to? We were told to refer but not who to.
M2	Do you mean who do I ring or where do I send a referral?
NG2	Where do we refer them to? Is it a particular doctor?
M1	You could ring the hospital and talk to a particular doctor. You could ring the hospital outpatients and ask what they prefer; they need to grade them anyway.
M2	When you write a referral begin the letter with "Dear Doctor, thank you for seeing. . .and then give the reason for the referral and the past and present history."
M1	There may be a more personal way of doing it by ringing and talking to the doctor.
M2	It's different if an acute thing.
M3	Is the woman term and do you want her seen within 48 hours but not urgently?
NG2	It is a 3 on the referral guidelines. I will ring outpatients.
M1	Good to get a pad to write it on and fax it so you keep a copy.
NG1	We were taught the format for writing the referrals but I just did not know about where or who to send it to so I'll ring outpatients.

sharing achievements and failures. As the year began, a comment from a new graduate that she "was trying to be confident on the phone" but that she felt "like a fraud" and thinking that the woman, "should ring someone else" preferably "a real midwife" (NG1, 1st meeting). Although the new graduates gained confidence throughout the year, each new experience such as; "I hadn't seen people under a GA [general anaesthetic]" (NG2, 20th meeting) had to be integrated into their understanding, so that the learning became part of their midwife repertoire.

Their level of comfort in this new work world was an insecure one of knowing some things, but being always aware that they would meet yet another new experience. This, one graduate said, was "really hard—[you] lose confidence constantly, feel as though you have to pick yourself up and you do—then you do learn!" (NG4, 20th meeting).

Learning to be assertive was also a constant challenge as new graduates confronted criticism or a sense of being discounted. In the next example, a registrar (a senior doctor in specialist training) wanted to induce labour in a woman late in the afternoon when it was not urgent, and when neither the midwife nor the woman had slept.

> This time I need to do what is good for us. . .I felt last time I got over-ridden and I thought "no, I have to do what is good for us" (NG1, 14th meeting).

The new graduate had met the situation before and knew now that the hospital protocol supported her resistance to a rushed induction, so she had a reasoned argument for not being "over-ridden" this time.

Issues to do with others was the second main theme. This included issues such as client emotions, new graduate peer support, observing how others practice, and negotiating the "pecking order" in the institution. There was often a tension between how the new graduates perceived themselves as autonomous practitioners and how others responded to them. Many issues arose from this tension or other aspects of their relationship with others—including other professionals and peers as well as their clients and their families. Many of these issues to do with others were related to the new graduate's autonomy and agency, such as whether they were able to have a voice, show confidence or be silenced, their concern for women, babies and the family, finding the boundaries of professional practice, establishing networks of peers, mentors, staff midwives, coordinators, and other LMCs.

New graduates sometimes found clients' emotional responses challenging because they were in the midst of managing their own emotions and therefore found emotions in others unexpectedly upsetting.

> She thought she was going to die; she was so distressed I felt I had to stay; I took the baby out to dad. They were overwhelmed and happy (NG2, 20th meeting).

The new graduates were learning about the emotional work of a midwife, whether this was during labour or during antenatal visits or over the four to six weeks of funded postnatal visits. Whilst one mother remained in hospital, her family cared for the baby at home.

> I have been doing the follow up care; baby at home, lots of paranoia, her mother is looking after baby with a mask on, they are very scared (NG3, 29th meeting).

Sometimes events happen about which the family is especially happy. In another case, a woman had a vaginal birth

where usually she would have had a caesarean section for a breech presentation, because the breech was undiagnosed and it was too late for a caesarean section.

> She said I am so glad I did not have a caesarean section and the husband said he was so pleased she wasn't cut (NG3, 22nd meeting).

The new graduates were very affected by their clients' feelings and although they often shared their observations with the group, they did not appear to need to be reassured; just telling the stories of their clients' emotions was important to them.

As well as issues to do with clients and their families, issues about peers and other professionals were commonly brought for discussion in the group. They easily shared their worries and concerns and found an enormous source of support from their peers.

> We have talked about client visits—we chat to one another and ask one another what the other one thought. It's been good (NG1, 1st meeting).

The new graduate peers were also able to provide cover and take over the work when a colleague was tired. "I went for a rest and [one of the new graduates] took over" (NG3, 29th meeting). Sometimes, however, it was only when the new graduate began to reflect on her week that her need for more support became obvious both to her and to others. "Next time hopefully we will be more supportive and you do not have to get to that point" (NG3, 20th meeting).

The experience of hearing about one another's experiences after the event was important for the peer group even if they had been present at the event. The quality of the reflection after such events changed the depth and quality of the learning. Even more frequently, new graduates talked about how experienced professionals practised—not always in a positive light. For example, after a birth, a new graduate was not sure about whether a small tear around the urethra was something she should stitch or not, and she asked for help from the hospital midwife. As the experienced midwife came in, the woman had a short rapid loss of blood, and the midwife's response was to take over.

> So I said can you come and check this out to get a second opinion. As she came in the woman had a bit of a bleed and it was flowing. The fundus was not well contracted so she started rubbing up the fundus and expressed a 100 mls clot, then she [the woman] was ok. "Jasmine" [staff midwife] put up a line, got misoprostol put in and the woman went to recovery. She was really dramatic and the woman was like "wow, what a drama". I had no idea what to do with this [staff behaviour] (NG4, 25th meeting).

The new graduate (who had been practising independently at this point for 10 months) went on to ask how one manages, not the clinical scenario, but the overly dramatic response by a more experienced and senior midwife. At the meeting she was encouraged to accept this event in the context of her inexperience and how, in asking for a second opinion, there needs to be clarity about what help you want.

The lack of negotiation and discussion, especially when the situation was not urgent, surprised and angered the new graduates, but they were unsure how to manage these experiences as revealed in this account.

> I wish I had been strong and next time I feel if it is the same circumstances I will just stand my ground. Can I do that? They weren't listening to me (NG2, 20th meeting).

The new graduates appeared affronted by being treated this way, but persisted in the behaviour they believed was appropriate, and at times this approach worked. "Got Reg [Registrar] to come in and see if we can negotiate this" (NG2, 20th meeting).

The experiences of finding themselves at the bottom of the pecking order created a good deal of discussion by the new graduates. Whilst the "issues to do with others" were varied, they were often about how individuals behaved and, as in many of the examples above, were actually about an unsupportive culture. The new graduates' autonomy and capacity to resist the worst of this unsupportive culture and to promote good professional practices was a matter that was commonly brought up and discussed at the group mentoring meetings.

Technical issues was the third main theme and covered matters such as administrative details, clinical know-how, and complexity of clinical and social issues in the community. In the first few meetings in particular, many questions were asked about administrative details, and the new graduates became aware of how much of such detail was lacking, despite their preparation for practice. This lack of awareness about the systems included what equipment was needed for practice and where to find the necessary supplies. The new graduates had all studied pharmacology, but at this point none had written a prescription. One new graduate was talking about the need to prescribe iron, but she was unsure about how much supply should be written on the prescription: "[I am] not sure about supply—like 3 months?" (NG2, 1st meeting).

They needed at this point to make clinical decisions about how long the prescription should be made out for– a decision which was not rule bound. This example reflects their world of uncertainty and complexity at the time of beginning in practice.

Sometimes issues were brought up about clinical concerns which led to a discussion of clinical matters. A baby was admitted to the neonatal unit because the mother had a positive group B streptococcal result early in pregnancy when being cared for by another practitioner; but when the new graduate repeated the screening test at 36 weeks gestation, it was a negative result.

> Baby now in NNU [Neo-Natal Unit]—thought baby had Group B strep. I took swabs at 36 weeks and they came back negative. I said "ok, I think if [group B] does not show at 36 weeks

> then [this group B strep is not a problem] ok" (NG1, 9th meeting).

This response by the new graduate showed that she was not aware of the protocol which states that any positive group B streptococcus result should have the baby treated as being "at risk." The hospital staff were very annoyed with her advice to the woman, and this left the new graduate very shaky when she arrived at the group meeting—so this issue could also be coded under issues to do with others and self-reflection. These themes are often interconnected, and it was typical for clinical issues to entail interacting with health professionals and gaining insights into those people's emotions as well as their own.

Another example shows a new graduate being skilled at identifying and managing a baby who needed assistance to breathe at birth as well as knowing how to manage a woman with a low haemoglobin measurement.

> Baby did not spontaneously breathe so needed bagging, started breathing at two minutes, she responded well and quickly and she latched like a dream, she [the mother] is home now, her haemoglobin is 76 but she declined a blood transfusion (NG2, 14th meeting).

There were times when the new graduates sought help from the hospital staff. The next extract shows a new graduate indicating her desire for respectful collaborative practice relationships with obstetrical staff.

> I really try not to get defensive inside myself; I think it is really easy just to get defensive. But I am really aware of the fact that I want these people to be on my side, you know that I can communicate with them and have them on board with me. I have been really aware about building those relationships…I have gone to some of the [antenatal obstetrical] consultations—the woman with the anencephalic baby [a cephalic malformation]—and had discussions with the obstetrician, so they know I am there…that I'm a midwife in the community and that I am proactive about things that I need to be proactive about (NG4, 2nd Interview).

This new graduate understood there was more to communicating than finding the right form or the right words to use, and she sought to collaborate and develop effective professional relationships. The next quote, taken from a group mentoring meeting late in the year, shows a new graduate openly acknowledging the limits to her experience and taking responsibility for exploring management strategies in advance.

> In terms of post-dates stuff is it different with a VBAC [vaginal birth after a prior caesarean]? I am just concerned with managing something I haven't dealt with much before. She's 39 weeks (NG 1, 27th meeting).

The confidence scales revealed that the new graduates were quite confident in their practice at this stage, so it is important to see that in this case her confidence is appropriately exercised, and she is acknowledging a lack of knowledge in a particular area.

The next quote also taken from a later meeting, illustrates the new graduates' ability to give context to questions asked during mentoring:

> How long is it ok for the head to be on view? I had this birth where all was ok, the baby was tachy [tachycardia] for a while, put the CTG on and then variable decels [decelerations of the fetal heart rate] and recovering well; ARM [artificial rupture of membranes], straw [coloured liquor], old mec [meconium], and the heart recovered, she was 7-8 [cms dilated]. We moved to theatre and I was ok with that, got to fully [dilated], [she] did not want to push. I kept showing them the [CTG] trace and getting it signed and all ok. I told reg [registrar] and [reg agreed] we should allow her to do it, so allowed her to breathe the baby down. I let her do that and I had a peep and baby's head was there, the baby came out with Apgar scores of 4, 6, and 8 (NG 1, 27th meeting).

Here the new graduate is confident and is asking for more guidance and information after reflecting on a case and questioning her clinical decision making.

In summary, this second level of analysis shows the issues that new graduates were likely to bring to the group for discussion. These sometimes involved a need for information arising from technical issues but commonly were matters that had caused them to reflect and question their own performance or the way that they interacted with their clients or other professionals. As demonstrated in the examples, these were often situations that had raised difficult questions or various emotions in the new graduates, and they valued the chance to hear the opinions of their peers and mentors.

It is of interest that within this group mentoring model the graduates' concerns reflect the mentoring functions described by Kram in 1980, even though the present study is about a profession rather than the business world and involved a group rather than one-to-one mentoring [11]. In Kram's study of one-to-one mentoring in the business world, she described two main functions of mentoring: "career or instrumental" and "psychosocial" functions [11]. In the present study the technical matters that the new graduates brought to the meetings can be seen to fit Kram's "instrumental" function, and the other two categories, "issues to do with others" and "reflections about self", can be aligned with Kram's "psychosocial" function.

5. Conclusion

The concerns of the new graduates in this study of group mentoring were as much, if not more, about their relationships both within themselves and with others. The technical

concerns, when they were presented, were about the kind of craft knowledge that develops through experience and not commonly about task-based knowledge. This group mentorship project presented an opportunity to explore new graduates' concerns in depth, and, perhaps surprisingly, finding relationships were as important as technical issues. This underlines the significance of the model of support for new graduates and that the purpose of the professional development relationship is established at the start and is clear to both parties.

New graduates need to gain confidence in practice and, therefore, to be accepted as well-educated, responsive and caring individuals capable of asking for help when they need it, that is, as competent novices is an important starting point to providing appropriate support. If the education system produces competent novices, then the professions need career development relationships, like mentoring, which speak to their sufficiency.

Understanding the concerns that competent novices are likely to have is important for mentors and preceptors and for those designing mentoring or preceptor programmes. There is little evidence in the international literature that the actual needs of graduates have been studied and the current study, based on close analysis of new graduates' discussions of their experiences, adds significantly to understanding of the topic [5].

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Review Article

Putting the (R) Ural in Preceptorship

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Rural nursing is recognized as a unique health care domain. Within that context, the preceptorship experience is purported to be an important approach to preparing safe and competent rural practitioners. Preceptorship is the one-to-one pairing of a nursing student with a professional nurse who assumes the mandate of teacher and role model in a designated clinical/contextual setting, in this case the rural setting. A research gap exists in the literature in which rural preceptorship is specifically explored. The purpose of this paper is to review preceptorship in relation to preparing nursing students specifically for the rural setting. Understanding how preceptorship as an educational model can prepare nursing students to transition to rural practice is an important endeavor. An authentic rural preceptorship may serve to influence the recruitment and retention needs for registered nurses in rural areas. A greater understanding of rural preceptorship serves to illustrate the appropriate support, socialization and contextual competence required to prepare nursing students for rural nursing practice. This paper's review may serve to highlight the research that currently exists related to rural preceptorship and where additional research can contribute to further understanding and development for authentic rural nursing preparation.

1. Introduction

Nursing as an applied practice requires its professional members to have a sound theoretical knowledge in addition to attaining proficiency in practice and skills within a diversity of clinical/contextual environments. To this end, nursing students during their undergraduate programs are exposed to theoretical teaching in classroom environments in unison with clinical experience, thus cementing their learning in relation to patient interactions and care. One of the established educational models, utilized to augment students' learning, is the preceptorship model which promotes the socialization, competence, and confidence of nursing students in the clinical/contextual setting as they transition from the role of the student to the role of newly graduated registered nurse [1].

However, the question arises that for specific environments such as the rural context, does utilization of a preceptorship model serve to provide relevant transitional learning for nursing students and what role does context play in the students' experience [2]? Therefore, the purpose of this paper is to review the literature related to "rural nursing preceptorship" and its role in preparing nursing students specifically for rural nursing practice.

2. Canadian Rural Context

Historically the term "rural" has been used primarily to refer to geographic location and distance [3, 4]. Research indicates, however, that the exclusive focus on the geographic interpretation fails to fully encapsulate the actual definition of the rural setting and what that term truly represents [5, 6]. Expressing rural context in simple geographic terms negates the complexity of "rural" where distance itself does not fully describe the term [7, 8]. Currently, the most common definition of rural has been divided into two categories, one is described as technical differentiation and the other is social differentiation [4]. Technical differentiation refers to geographic measurements in cartographic representation. Technical terminology can encompass statistical measurements such as those developed by Statistics Canada, vis-a-vis, Rural and Small Town (RST) which indicates populations living outside the commuting zones of larger urban centres,

for example, outside Census Metropolitan Areas (CMAs) containing populations of 100,000 or more and Census Agglomerations (CAs) containing populations of 10,000 or more [9].

In terms of health care services, location is measured in relation to travel distance to hospitals and acute or community health care centres. Distance is represented as kilometres away from urban tertiary centres [10]. However, Sorenson and De Peuter [11] indicate that the concept of "rural" has become more expansive in definition and interpretation to include social attributes such as income and education that impact the health of rural populations. Rural research, including nursing research, has expanded to encompass further understanding of rural health care and professional practice [3, 4, 12, 13]. Rural descriptors have attempted to allow social issues to be included with geographic issues to portray a more complete image of this environment thereby painting a picture of what community life is like, what the challenges of living in these communities mean, and what the needs and rights of these populations entail. In the past, rural health research has focused primarily on the accessibility of health care services, but there is a continued need to understand other health determinants and their implication on the health for these populations [9]. Research indicates that Canadian rural residents have a shorter life expectancy related to chronic conditions such as cardiovascular diseases, diabetes, and death due to motor vehicle accidents and suicide [14, 15]. However, rural communities also perceive a stronger sense of community than their urban counterparts as a contributor to their sense of well-being and sense of belonging [14]. Currently, rural communities have significant health challenges but face at times a lack of access to health care providers, most especially rural nurses, more than their urban counterparts. These percentages have not increased in sufficient amounts to bring health care provider-to-population ratios to the levels enjoyed by urban populations. There remains a shortage of rural nurses [16, 17]. Thus, it becomes important to appropriately prepare nurses for rural practice settings.

3. Rural Nursing Practice

Rural environments are fast paced, complex, and use an ever-increasing array of technology. These technologies include telehealth access to specialist collaboration, educational building capacities to provide interprofessional training related to emergency, cardiac, and obstetrical care [8, 18]. To that end, rural nursing practice is diverse, requiring particular foundational knowledge, practice, and skills. Rural nurses posses the specific knowledge and skills to provide expanded health care services to rural populations using a holistic approach to health care [19]. Health factors and health care services that relate to community structures, inclusive of social support, employment, education, and environmental influences are understood by rural nurses in conjunction with recognizing their fit within unique rural settings [20]. Kulig et al. [21] surveyed registered nurses practicing in Canadian rural and remote settings. They found four dominant themes. These include community characteristics, geographic location, human health and technological resources, and nursing practice characteristics. The authors suggest that these themes can contribute to a further understanding of rural settings and nursing practice.

Today, registered nurses (RNs) constitute the largest profession providing health care in a variety of rural settings [22]. Within rural communities, RNs are considered unique in their professional and personal roles [23]. There is a role blurring between the professional and personal [13]. This differs from the nursing role of their urban counterparts. Rural nurses engage in what can be described as an intertwined relationship between their personal and professional roles in the rural setting. They are community members who are living and practicing amongst their interprofessional colleagues, family, and neighbours in a closer relational proximity than occurs in the urban setting.

Nurses embody their rural practice [21]. This dual role affords nurses the opportunity to immerse themselves in the context of their practice. Kulig [5] describes this integration of the professional and the personal role as central to creating an authentic knowledge of rural practice. Rural nurses who practice within the various rural settings are patently aware of the unique needs and health care requirements. While there are challenges in rural practice, rural nurses and community members also highlight the positives of living within a rural community such as feeling a sense of open space and a feeling of connection to values, beliefs, and sense of community [24].

Historically and currently, it is rural nurses who have been providing essential care to rural populations [25–27]. Rural nurses, together with their community members, can identify specific health care and other requirements, including how these needs should be met [13], thus creating political and personal advocacy for the unique needs of rural communities. RNs have been and continue to be a linchpin in rural health care. However, recruitment and retention in rural settings remains a challenge [16, 17]. With the ongoing, critical need for RNs, demographic data indicate that the global and Canadian age of RNs is of continuing concern. Many RNs are at or near retirement [17]. Currently and in the future, this shortage implies a decreasing number of experienced RNs to fill the required vacancies. In the rural areas, there is an even greater urgency to recruit and retain RNs. In Canada, it is noted that rural RNs are older than their urban counterparts, the population ratio of patient to nurse is greater, and the shortage of these health care professionals is more acute in the rural communities who are left to cope with diminished access to health care professionals, most especially RNs [15, 16]. Rural communities face an array of complex health care needs, and with the increasing reduction of tertiary care beds available in the urban hospitals, rural patients health needs, including increased complexity of care, are provided by rural nurses and other health care professionals [17]. Rural communities indicate that they deserve equal access to health care needs including the availability of well-prepared rural RNs.

Education is key in order to prepare RNs to practice in the rural settings and should be considered for existing and future recruitment and retention strategies [28]. The specific needs of the rural settings need to be understood, and educational requirements including preceptorship need to be formulated and augmented to address rural nursing preparation to ensure both short- and long-term rural health care delivery. Thus, it becomes imperative to recognize the need to educate undergraduate students who are exposed to rural clinical environments within their nursing programs to ensure adequate preparation for practice in the rural setting [29]. Rural preceptorship may provide such an educational model to promote authentic learning. Rural nurses possess the knowledge and practice requirements necessary in the rural settings. Their experience and expertise can therefore provide relevant teaching and role modeling in preparing nursing students for all aspects of the rural setting, through the preceptorship process. The literature findings indicate that nurses who feel prepared to practice in the rural setting will be more likely to stay and practice over the long term [10, 30].

4. Rural Preceptorship

Some of the underlying principles of preceptorship date back to the teachings and writings of Florence Nightingale [1]. Nightingale posited that it was necessary for experienced nurses to teach students how to provide nursing care, through guidance and facilitation of learning. Myrick [31] indicates that nurse educators recognize that as a professional discipline nursing knowledge is embodied in its application to practice. Clinical experience is the cornerstone of socialization of novice nurses into the profession [32, 33]. The preceptorship model has emerged as central to this teaching/learning approach [34]. Preceptorship models purport to provide formal learning for the students by pairing them with an expert RN with experience in the clinical/contextual setting. The key role of the preceptor is that of teacher and role model. These knowing, showing, and doing are what nurture the nursing student in the clinical context. O'Malley et al. [35] suggest that nurturing the student to become a competent and confident practitioner in a specific setting, in this case the rural setting, allows a strong sense of connection to the environment and illuminates the required expectations of the nursing care for the particular populations being served. It is the preceptor who possesses the clinical experience, knowledge, and skills to be able to provide strong role modeling and teaching [36, 37]. Support of the nursing student's learning can allow the student to experience the benefits of preceptorship. The student who experiences a positive preceptorship is supported to facilitate successful entry to practice [38, 39]. According to Manahan and Lavioe [10], a student entering a practice environment competently and safely creates a feeling of belonging to the profession and of being a capable practitioner. This sense of belonging can contribute to recruitment and retention where a practitioner wants to apply for employment and stay over the long term. Thus, preceptorship as a model of education has been supported by many scholars [40–42].

A review of the literature confirms the well-examined role of preceptorship and its influence on learning and socialization of the novice nurse [1, 23, 31, 38, 43, 44] (Hegney, McCarthy, Rogers-Clark, and Gormann, 2002). However, a lack of research is available regarding rural preceptorship. Many studies indicate the benefits of preceptorship to educate students in the clinical setting but do not articulate or include the substantive area of rural context [1, 31, 34, 36, 45–47]. Currently, the small number of existing studies which have been conducted and related to rural preceptorship suggests particular benefits for clinical preparation of students, including nursing students, in the rural context [2, 10, 19, 23, 28, 48–50]. These studies serve to answer some of the questions related to rural preceptorship and stimulate researchers to ask additional and unique questions. The findings of these studies indicate the unique practice of rural nursing, the unique needs of rural populations, and the need to incorporate specific findings such as culture, professional boundaries, conflict management, and undergraduate and graduate education as important elements of current and future rural nursing education. Existing research related to rural preceptorship highlights the influence of preceptorship to accomplish teaching/learning components necessary for rural nursing practice. Preceptorship is an important key to preparing undergraduate nursing students who are placed in rural settings [51]. Preceptorship in this setting draws on the rural clinical/contextual expertise of the nurse preceptor to role model, teach, supervise, and evaluate to ensure preparation of the preceptee (nursing student) for the specific rural context. Altmann [36] and Letizia and Jennrich [47] note that the preceptor should be selected on criterion including clinical/contextual expertise in rural nursing practice and an ability to communicate well to provide teaching, leadership, skills, and role modeling necessary in this complex and unique practice setting.

Yonge [28] asserts that it is important to offer a relevant vehicle to support the educational and practical preparation of the rural nurse as s(he) enters the rural environment. Yonge contends it is important to examine the rural setting as it relates to and influences the experience. The rural context/setting which differs from other practice/clinical settings provides an additional component to preceptorship [52]. The author suggests that more research is required related to preceptorship and the rural setting to close the research gap and to inform rural educational preparation in undergraduate nursing programs. Yonge further suggests that rural preceptorship can combine the tenets of preceptorship with the tenets of rural nursing to elucidate an experience that speaks to both practice preparation and context. In the case of rural preceptorship, the prefix of rural is a necessary antecedent of preceptorship. Rural preceptorship needs to reflect a direct rural focus [53]. Examination of the literature indicates that rural preceptorship differs from urban preceptorship. For example, Sedgwick and Yonge [49] note that the culture in rural hospital settings has a strong community environment that presents itself

in a team approach to nursing practice that differs from urban hospital settings. Sedgwick and Yonge further state that this particular culture of team nursing influences the dynamics of rural preceptorship. Rural nurse(s), other than the preceptor, are present in the rural setting during a nursing student's preceptorship. Although their relationship is not a formal one such as exists between the members of the preceptorship triad, they will have interactions with the nursing student throughout the preceptorship experience. Rural setting creates a team or community approach to rural preceptorship that includes significant interactions with other nurses in addition to the formal relationship between the preceptor, student, and faculty member [49].

To date, researchers have conducted a number of studies examining the multiple facets and definitions of "rural" [4, 7, 8, 12, 23]. This rural research serves to facilitate understanding of the rural setting and the nursing practice required [12, 54]. Rural-oriented researchers indicate the continued need to provide well-prepared nurses for rural practice settings but do not articulate or address how to provide this preparatory education. A gap therefore exists in the literature specifically related to undergraduate nursing education for rural practice. Research related to particular aspects of rural preceptorship is necessary to ascertain how the role and influence of the rural nurse preceptor contributes to the support and preparation of nursing students for practice in the rural setting.

Research related to rural nursing indicates that it is not designated a "speciality practice." Furthermore, specific educational components related to rural practice are absent [55, 56]. Educational preparation becomes a transplantation of urban programs without inclusion of the unique needs for rural nursing practice preparation. Crooks [23] suggests that rural nursing education and practice preparation requires specific knowledge and practice skills that are ignored and remain unacknowledged. She calls for recognition of rural nursing practice as a unique domain of practice that requires thoughtful and relevant educational preparation. It is important not to negate the rural context, but to recognize it as central to informing the practice of rural nurses. As in the past, rural nursing practice is considered to be expansive in terms of the breadth and depth of knowledge and the skills required to provide the necessary nursing care [12]. Because of the contextual influence on rural nursing practice, the ability to role model and teach nursing students must be provided by practicing rural nurses. The influence of the rural context and the experience of rural nurses are thus central in the preceptorship process in contributing to the legitimate and specific preparation of nursing students entering the rural setting.

Kenny and Duckett [19] highlight the importance of educational preparation for rural nurses. The authors suggest it is this specific education for practice that supports the retention of rural nurses who are competent and confident. Because of the connection of rural nurses to their professional practice and rural communities, their ability to articulate and role model rural nursing to nursing students is strong and considered essential to rural preceptorship. It is the rural nurses who provide the expert practitioner role in the preceptorship relationship for students who are seeking to practice in the rural setting.

Many students who have an interest in rural nursing and would like to practice in a rural community have been educated in urban nursing programs, using urban clinical settings. Their curriculum does not address or include any aspects of what may be unique to rural nursing [2, 57]. Therefore, they might then be expected to practice with competence upon graduation in the rural context, but their exposure and education are from an urban undergraduate nursing program where rural experience and educational support are absent. According to Charnley [58], it is only after graduation that these novice practitioners become immersed in rural context and have to begin to learn to navigate a complex and daunting practice setting. Their learning is obtained while they are practicing. This vicarious exposure, experience, and support for novice rural nurses create an element of anxiety and stress. Concomitant, they are required to become competent and confident as they practice [11]. Thomlinson et al. [24] indicate that this lack of preparation within undergraduate nursing programs leads many to feeling overwhelmed, choosing to move away from the rural areas or out of nursing. In order to allow nurses who wish to practice in rural areas to feel educationally supported for the rural context, preceptorship can offer a sound vehicle to accomplish preparation for clinical, contextual, socialization, and competent practice.

5. Conclusion

Sedgwick and Yonge [2] suggest the importance of studies to explore how preceptorship can contribute to the preparation of nurses specifically for the rural setting. The authors conclude that understanding the cultural climate that occurs in rural preceptorship is important but note that further examination of rural preceptorship is also required. Yonge [28] posits that such research can inform rural nursing preparation and contribute to shaping the experiences of those involved. Rural preceptorship can provide a vehicle for the socialization of nursing students to the rural setting [1, 59].

Since the 1980s, preceptorship has been successfully used by nursing programs to educate and prepare students to transition into practice [31]. A cornerstone of the preceptorship model is the emphasis on clinical/contextual preparation. It is the ability of the experienced preceptor and the experienced faculty member to provide guidance for the student to be successful. The literature on the benefits of preceptorship to allow a student to feel competent, confident, and socialized as s(he) enters the practice areas is well documented [35, 59–61]. However, the unique aspects of rural preceptorship are not well documented. There is a void related to how the role of rurality impacts the preceptorship experience and a gap exists in the literature specific to rural preceptorship. The literature related to nursing and "rural preceptorship" and more specifically to "rural nursing preceptorship" in preparing undergraduate nursing students is limited. Rural preceptorship studies have focused on certain aspects of

preceptorship in the rural setting including the roles of the preceptor and the student [40, 47, 62] (Yonge, Krahn, Trojan, and Reid, 2002). Researchers have examined issues such as conflict in the preceptorship relationship [63]. Yonge et al. [63] examined preceptors and students' perceptions of the rural preceptorship experience in relation to factors that can cause challenges for the preceptor and preceptee such as geographic distance, maintaining communication with faculty members, integrating students into rural practice, weather conditions, and a lack of resources. Leipert et al. [64] concurred that weather conditions, direct communication, and access to care in rural communities pose unique challenges within rural preceptorships. Sedgwick and Yonge [2] have examined the cultural climate of the rural context and its influence on the preceptorship experience. While these studies examine aspects of rural preceptorship, additional research is needed.

Rural preceptorship can provide the necessary teaching/learning processes that combine theoretical learning and contextual/clinical learning with the required focus on rural nursing practice. Because rural nursing is unique, it is essential to prepare rural nurses educationally and formally with a rural as opposed to an urban focus. An authentic rural preceptorship can foster rural socialization and the critical thinking germane to such a context. In order to achieve this authenticity within preceptorship, it is necessary to select preceptors who not only possess communication attributes but also commitment, experience, and leadership within rural nursing [31] (Kenny and Duckett, 2005).

The authors of this review paper note that there remains a void in the literature of what constitutes a rural preceptorship. It is incumbent upon nurse researchers to conduct additional studies which examine the rural preceptorship process, thus creating evidence to support and develop educational content relevant to the preceptorship model and the rural context. These attributes will ensure the merging of the rural aspects of nursing within preceptorship. If positive and pertinent rural preceptorships can be achieved to support practicing in a rural environment, the ability to provide rural nurses, who will stay because they feel connected and safe to practice, can be a reality.

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Review Article

Best Practices in Academic Mentoring: A Model for Excellence

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Mentoring is important for the recruitment and retention of qualified nurse faculty, their ongoing career development, and leadership development. However, what are current best practices of mentoring? The purpose of this paper is to provide an overview of a model for excellence in establishing a formal mentoring program for academic nurse educators. Six themes for establishing a formal mentoring program are presented, highlighting best practices in mentoring as culled from experience and the literature. Themes reflect aims to achieve appropriately matched dyads, establish clear mentorship purpose and goals, solidify the dyad relationship, advocate for and guide the protégé, integrate the protégé into the academic culture, and mobilize institutional resources for mentoring support. Attending to the six themes will help mentors achieve important protégé outcomes, such as orientation to the educator role, integration into the academic community, development of teaching, scholarship, and service skills, as well as leadership development. The model is intended to be generalizable for faculty teaching in a variety of academic nursing institution types and sizes. Mentoring that integrates the six themes assists faculty members to better navigate the academic environment and more easily transition to new roles and responsibilities.

1. Introduction

Mentoring is important for the recruitment and retention of qualified nurse faculty, their ongoing career development, and leadership development. The functional outcomes of mentoring encompass orientation to the educator role, integration into the academic community, development of teaching, scholarship, and service skills, as well as leadership development [1]. Given the increasing shortage of experienced nurse educators, faculty may be challenged in finding a mentor and also in sustaining a mentoring relationship. In addition to the above issues, in general, questions exist around mentoring, such as the following. What are current best practices of mentoring? How can academic institutions support the mentoring process in order to develop and retain novice faculty during this time of economic hardship? How

can nursing programs mitigate the challenges of academic mentoring?

The above questions are examples of some of the inquiries that motivated the authors to conduct an integrated review to design a template for excellence in mentoring in the context of nursing education. The authors aimed to create a template addressing the "what" and "how" of mentoring that would serve as a standardized best-practice model targeting faculty across the career span. This paper reflects the yearlong work of the group project from the fourth cohort and Project Director of the National League for Nursing (NLN)/Johnson & Johnson (J&J) Faculty Leadership and Mentoring Program. The NLN, with generous support from J&J, established a faculty leadership and mentoring program in 2007 with the overall goal to prepare leaders to transform the future of nursing education [2]. Each year, program participants consisted of five experienced nurse leaders (mentors), five emerging nursing leaders (protégés), and the program leader. The mentors and protégés were matched based on experience and interest. In consultation with their mentors, protégés chose individual leadership projects to work on throughout the year; additionally, the 10 participants also worked on one group project. The fourth cohort from the program focused on how formal mentoring could transform nursing education and expanded the initial work by the NLN [1].

The word "mentor" derives from Greek mythology when Odysseus entrusted the care of his son to his friend "Mentor," to serve as guide and teacher while he went to fight the Trojan War [3]. Since then, the concept of mentoring has evolved into a multidimensional interactive process that can be formal or informal and evolves over time according to the needs and desires of the mentor and protégé [4]. Haggard et al. define mentoring as a one-to-one reciprocal relationship between a more experienced and knowledgeable faculty member (the mentor) and a less experienced one (the protégé). The relationship is characterized by regular/consistent interaction over a period of time to facilitate protégé development [5].

Research indicates many positive outcomes as a result of mentorship. For example, when a novice educator is formally mentored by a more experienced and accomplished academician, the novice educator more quickly assumes the full scope of the academic role and is more productive [6]. Across settings, mentoring has contributed to higher career satisfaction and increased departmental or organizational morale [7, 8]. Mentored faculty reported augmented professional identity and experienced a smoother bridge from practice to the academic environment [7]. In addition, mentored faculty reported increased self-confidence and professional development [9]. Not surprisingly, institutions have benefitted from sponsoring faculty mentoring programs by experiencing improved retention rates [7, 10, 11] and increased productivity in the workplace [7, 9].

Often, nurse educators enter the academic role without a clear idea of the full scope of their responsibilities, or how they can actually achieve them at a level sufficient to become productive academicians. Others labor under the misconception that teaching is the academicians' primary responsibility. Mentoring relationships can help educators understand the multifaceted roles of an academician, which facilitates achieving success in a timely manner in the areas of teaching, scholarship. and service. Research demonstrates that careers did not progress as satisfactorily when faculty did not have mentors, compared to those who did [6, 9, 12]. Unfortunately, many novice academicians cannot avail themselves of mentoring opportunities, because formal mentoring programs are not common in the nursing education organizational culture.

The purpose of this paper is to provide an overview of a model for excellence in establishing a formal mentoring program for academic nurse educators. The model is intended to be generalizable for faculty teaching in a variety of academic nursing institution types and sizes.

2. Methods

The authors participated in a formal distance mentoring program and determined to engage in a heuristic inquiry to study mentoring. Initially, the authors used an inductive process to identify mentoring themes. At a face-to-face meeting, each participant shared lived experiences (good or bad) of either being mentored or mentoring someone and described the significance of the experience. The group discussed practices of mentoring revealed in each story; a recording secretary listed practices that group members agreed upon. Through reflection and dialogue, the group clustered 25 original practices into six categories based on similar thematic content. The six categories served as the basis for six in-depth reviews of the literature; refinement of the categories occurred over several months during exploration of research literature. Databases searched included Academic Search Elite, CINAHL, ERIC, PUBMED, Google, and Google Scholar. Search terms included mentor, protégé, mentee, mentoring, faculty mentoring programs, mentorship, mentorship advocacy, collegiality, academic networking, academic socialization, matching, resources, and workload release. Only articles in English were considered for the integrated review.

3. Findings and Discussion

Six categories reflecting aims for establishing a formal mentoring program are presented, highlighting six best practices in mentoring. These practices support the four pillars of excellence (Figure 1). The discussion further describes how the best practices collectively form a model of mentoring excellence.

3.1. Achieve Appropriately Matched Dyads. Appropriate fit is an important aspect for creating a successful mentor/mentee (protégé) relationship; therefore, matching the right mentor to the right protégé is the first best practice theme. Pairing can be accomplished by a variety of methods described below. There is, however, no clear evidence as to which method is best. Fortunately, the literature does give guidance that seeking individual input from both the mentor and protégé will result in the best fit.

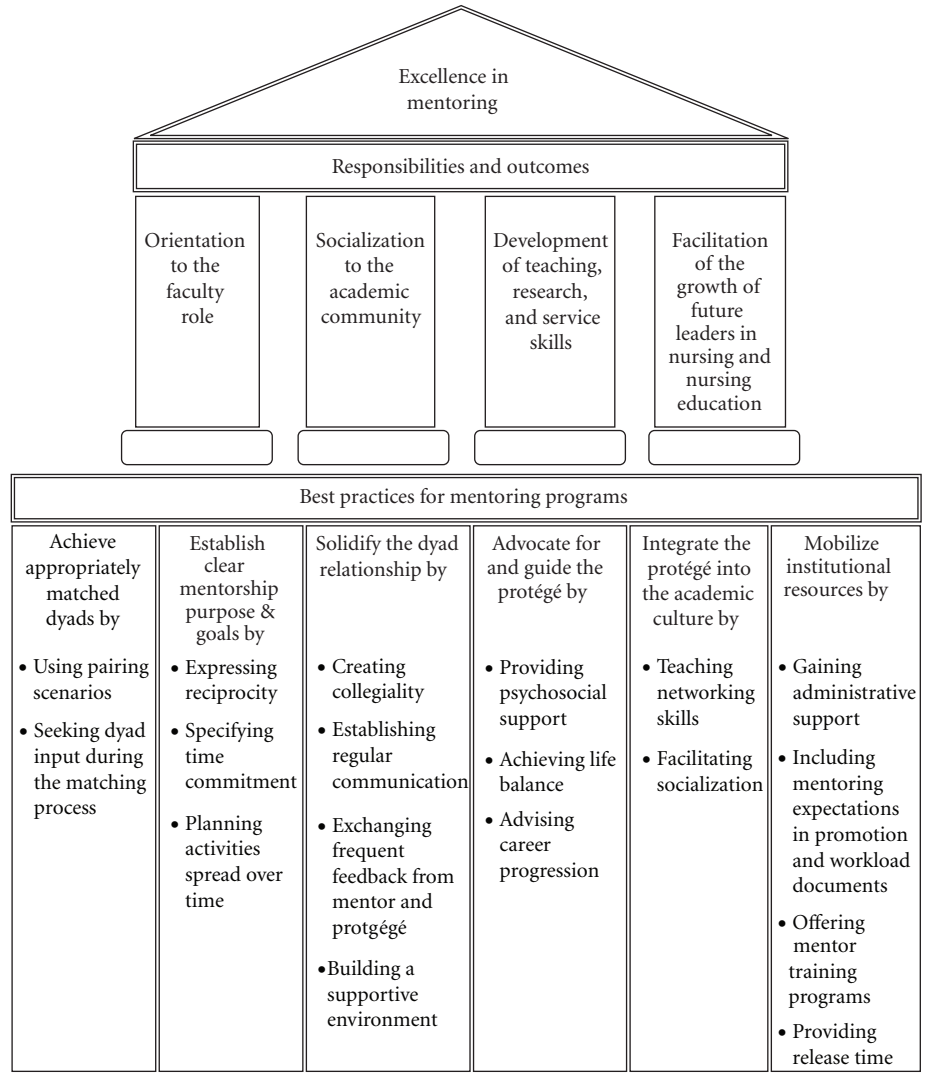

Figure 1: The model: *Best Practices in Academic Mentoring: A Model for Excellence.* Fourth Cohort, NLN/Johnson & Johnson Faculty Leadership and Mentoring Program.

3.1.1. Using Pairing Scenarios. The mentor and protégé are often referred to as a dyad or pair. There are five basic ways that mentors and protégés can come together to form a mentoring dyad: (a) paired administratively based on arbitrary criteria, (b) paired administratively based on specified criteria, (c) paired based on protégé selection of mentor, (d) paired based on mentor selection of a protégé based on recognized potential and a desire to "take under wing," and (e) paired based on finding each other and creating their own dyad relationship. Formal mentoring programs tend to use one of the first three approaches to pair mentor and protégé [13] which means that often, the protégé and mentor inputs are not taken into account in the pairing process [14].

Clearly, administrators often assign mentors based on availability: whose turn it is, who is most friendly, or who is coteaching a course. While this approach is common practice in contemporary nursing education, it may not produce the best fit. Mentor-protégé mismatch has been identified as a common problem in formal mentoring programs from both perspectives [15]. Differences in background, age, personality, and interests can lead to mismatched perceptions [16]. However, there is no clear evidence about the effectiveness of using one matching scenario over another. There is, however, evidence that having protégés and/or mentors provide input in the matching process results in better match outcomes. Therefore, obtaining input to achieve appropriate matching cannot be overemphasized.

3.1.2. Seeking Dyad Input during the Matching Process. The significance of obtaining dyad input during the matching process has been noted by many researchers [17]. Allen et al. [18] found that when mentors provide input during the matching process, mentors demonstrated stronger commitment to the relationship, and had a greater understanding of

the mentoring program. They also perceived the relationship to be of better quality and provided more career advice to the protégé. Another study by Allen et al. further reported that protégé input into the match was associated with greater mentorship quality, career mentoring, and role modeling while mentor input into the match was associated with greater mentorship quality and career mentoring [19]. Eby and Lockwood [16] showed that mentors desired more information about how matches were made—as mentors perceived the assignment as being haphazard when they were not clear how the matching process occurred.

Parise and Forret [20] studied the relationship between voluntary participation, mentor input to the matching process and training, and the benefits (or costs) perceived by mentors. Voluntary participation was positively related to rewarding experiences. Conversely, mentor input into the matching process was negatively related to what the authors called nepotism, that is: the less input given in the matching process, the more the mentor perceived favoritism occurred during the assignment. On the other hand, group interview data showed most mentors believed it was more important for protégés to have input into the selection process than mentors since it was a job expectation, and they should accept whomever they were given. Additionally, mentors felt it was up to the protégé to determine what was needed. The mentors' only concern was in their own ability to provide a good mentoring experience for a protégé. This last comment supports the concept of mentor training, discussed in a later section.

One strategy to elicit input into a matching process is to match the dyad using criteria—in this way, the potential for compatibility increases. Headlam-Wells et al. [21] tested criterion-based pairing in their research. The authors designed and used 11 criteria (age, number of years of work experience, level of qualification, marital status, children, dependent care, life/career history, personal skills, professional skills, vocational sector, and personal values) to pair up mentors and protégés. Matches were based on a majority of same responses by both mentor and protégé. Most importantly, protégés ranked their top three criteria in order of importance. The top two were having a mentor who could help with professional and personal skill development, and the third was being matched with a mentor with similar values. At the end of the mentorship, satisfaction ratings regarding the matchup showed 75% of mentors and 80% of protégés felt they were either "very well" or "quite well" matched. An example of this method, albeit on a simpler scale, is how the mentors and protégés were matched in the annual National League for Nursing/Johnson & Johnson Faculty Leadership and Mentoring program [2]. The application process required protégés to identify leadership interests, needs, and goals and ascertained mentors' experience and expertise, and then applicants were matched accordingly. Twenty dyads were successfully matched over four years using this basic approach.

Another strategy that encourages input of both mentor and protégé is a variation on speed dating. Berk [13] recommended using this concept with a novel application—speed mentoring—where several mentors and protégés meet briefly to form first impressions and then request to be matched to a specific person. When mentor requests match protégé requests, a dyad can be formed. This approach may be more useful with a large number of people.

Bozeman and Feeney [14] offered a third approach to facilitate successful matching of mentor and protégé. Their "goodness of fit" model identified three categories of factors to optimize social exchange within a dyad. When matching mentor-protégé pairs, using these factors will create the best fit. Categories include:

(a) endowments (e.g., knowledge, experience, and communication abilities);

(b) mentoring content (e.g., professional contacts and historical insider knowledge of office politics);

(c) preferences (e.g., value of modes of communicating, teaching; or learning).

The notion of goodness-to-fit generates questions for future research on how preferences affect endowments and endowments affect preferences. The fit will shape mentorship outcomes. For example, the dyad fit is good when "the mentor has the knowledge preferred by the protégé, and the ability to transmit that knowledge effectively. . .and the protégé has the ability and skill to fully [grasp] the knowledge being transmitted" [14, page 473].

Regardless of the strategy employed, the recommended best practice to achieve appropriately matched dyads is to obtain input in the matching process. Once dyads have been matched using input by both parties, the next best practice is to establish clear purposes and goals for the mentoring relationship. The following section provides direction as to what mentors should aim for when starting out in a new mentoring relationship.

3.2. Establish Clear Mentorship Purpose and Goals. Once paired, the dyad must clearly articulate the purpose of the mentorship relationship and set initial goals early on to give direction and clarity of future responsibilities. In addition to helping the protégé establish personal career goals, Chao [17] recommended mentors to take into consideration organizationally prescribed goals. When needs and desires guide the mentoring relationship, successful outcomes are more likely. The purpose and goals may be as broad as leadership development [2] or as focused as writing a research grant. Three expectations must be expressed early on in the relationship: (a) reciprocity, (b) time commitment, and (c) planning growth activities.

3.2.1. Expressing Reciprocity. The concept of reciprocity occurred frequently in the mentoring literature. Sorcinelli and Yun [22] called this concept "creating a reciprocal partnership." Wilson et al. [23] termed it "reciprocal learning"; while Carey and Weissman [3] labeled it "reciprocal relationship." All three convey the idea that each party has the experience of being the giver and the receiver. Significant to the idea of reciprocity is that mentors must also identify their purpose for being mentors and articulate personal

goals; that is, what they hope to derive from the relationship. Ideally, mentors must also perceive receiving benefits from the relationship. Benefits could be as intangible as exchange of ideas and input to more tangible as collegial work benefitting both participants. To have reciprocity identified clearly at the outset will foster the commitment to creating the relationship.

3.2.2. Specifying Time Commitment. Formal mentoring programs are characterized by a clearly stated timeframe for the dyad relationship that focuses on the protégé's development [21]. A typical duration for a dyad relationship in a formal mentoring program is one year [2, 21]. Clarifying the anticipated duration of the relationship and time commitment when the relationship is initiated is imperative so that goals can be achieved in a realistic manner [24]. In this manner, unmet expectations and disappointments are diminished.

3.2.3. Planning Activities Spread Over Time. Ideally, activities should be spread over time. While dyads have freedom to negotiate how they will communicate with one another, the key point is that both the mentor and the protégé are committed to and engaged in the mentoring relationship and participate in multiple activities over time [2, 25]. Regular interaction spread over time serves to connect and solidify the dyad relationship, another aim in the establishment of a formal mentoring program.

3.3. Solidify the Dyad Relationship. The formation of a relationship between mentor and protégé is crucial to effective mentoring. As the relationship unfolds and expectations are clarified, the dyad must strive to deepen the relationship. The relationship may be further developed through four strategies, namely, (a) creating collegiality, (b) establishing regular communication, (c) exchanging regular feedback from mentor and protégé, and (d) building a supportive environment.

3.3.1. Creating Collegiality. Once the dyad has been matched appropriately and goals set, the next step in creating successful mentoring is for the pair to establish a collegial relationship. Collegial and reciprocal relationships are the basis for effective mentoring which ultimately fosters the protégé's academic success [23]. Collegiality in academia is seen most broadly when faculty demonstrate "cooperation and collaboration in a spirit of teamwork" [26]. Fischer [27] expounds on this theme by calling for institutions to establish "codes of conduct" so this cooperation and collaborative teamwork can be everyone's responsibility to implement (paragraphs 29, 30). A prime strategy for cultivating a meaningful collegial mentor-protégé relationship is establishing mutual respect and trust; without these two, neither a collegial nor a collaborative relationship can exist [28]. This aspect alone has strong implications for departments desiring to establish mentoring programs. Without solid collegial relationships, mentoring programs will struggle. Interventions aimed at building trust and respect may need to take precedence prior to implementing a mentoring program.

Organizations have used multiple strategies for recruitment and retention of faculty. Whereas, financial incentives and promotional campaigns are effective in recruiting faculty in the short term, they do not necessarily retain faculty in the long term. Emerging evidence suggests that an environment of incivility in the workplace is often the reason for employee attrition [29, 30]. In fact, nurse educators who experience incivility are more likely to leave their employment and sometimes leave nursing altogether [31, 32]. Improving the workplace environment primarily through establishing collegial relationships has been one of the most effective strategies in faculty retention [33]. Through the development of guidelines for establishing healthy civil and supportive work environments, professional nursing education organizations are promoting mentoring as a means of faculty retention [34, 35].

3.3.2. Establishing Regular Communication. To solidify a relationship, regular "connectedness" cannot be understated. The more formalized and set the pattern of communication is the better the connection occurs between the pair. Smith and Zsohar [11] and White et al. stressed the importance of establishing negotiated times for regular communication that fits the personalities of both parties [24]. Planned activities, such as regular journaling, workshops, and off-campus activities, facilitated the development of meaningful relationships [2, 24]. What appears significant is that the method of communication is not as important as the regularity.

3.3.3. Exchanging Frequent Feedback from Mentor and Protégé. Mentors can be successful resources when dyads prepare for relationships by not only reflecting on and defining goals, but also identifying challenges and asking for feedback to evaluate relationship effectiveness [23, 36–39]. Allen et al. demonstrated that protégés who asked for and were accepting of feedback received higher quality and quantity of feedback from their mentors [19]. Receiving feedback is sound since these same authors reported that frequency of feedback from mentors was strongly associated with increased protégé productivity.

3.3.4. Building a Supportive Environment. Creating an environment where the protégé feels supported cannot be overemphasized; this action has a direct effect on solidifying the dyad relationship [11]. When protégés experience support, they feel free to exercise independent thinking, a willingness to be creative, to offer ideas for consideration, and verify lines of reasoning with their mentors. Unsupportive environments hinder the protégé's willingness to be open, take risks, and collaborate. Smith and Zsohar [11] found the ability to create collegiality was directly impacted by the presence or absence of a supportive environment.

What does a supportive environment look like? Mentors who show positive regard and genuine caring are willing

to listen, display empathy and trustworthiness, give encouragement, provide authentic feedback, and create supportive environments [6, 25, 40]. Once the dyad relationship solidifies, the mentor is ready to display confidence in his or her ability to advocate for and guide the protégé. In turn, the protégé is ready to trust the mentor's judgment and recommended actions. Advocating for the protégé is another aim in the establishment of an excellent formal mentoring program.

3.4. Advocate for and Guide the Protégé. The fourth theme of best practices is advocating for and guiding the protégé. Although much of the research in this area is less recent, it is relevant to review. Advocacy provides tangible benefits for the protégé throughout the mentoring process. An advocate is someone who supports another and acts for another's benefit or one who speaks for another's behalf. The literature provides many areas for mentor advocacy/guidance. This paper, however, focuses on three primary strategies: (a) providing psychosocial support, (b) achieving life balance, and (c) advising career progression.

3.4.1. Providing Psychosocial Support. With multifaceted academic responsibilities, faculty may easily feel pulled in many directions and become discouraged. Earlier research indicated that a major aspect of advocacy is for mentors to attend to psychosocial undertakings [9, 41, 42]. Aagaard and Hauer [41] studied activities of physician mentors; 98% of mentors identified *motivating protégés* as one of the top activities, followed by 91% providing *moral support*. Protégés who were queried about mentor activities ranked being acknowledged as a person and as a professional very highly (4.8 of 5), while having mentors who listened to their expressed concerns ranked a perfect 5 of 5 [42]. Clearly, this aspect of advocacy is highly valued by both mentors and protégés.

3.4.2. Achieving Life Balance. Achievement of life balance between personal and professional work is critical to the success of a new faculty member. Straus et al. [43] saw the mentor as advocating for the protégé and provided guided decision making so that protégés can learn time management strategies. The mentor can advise the protégé on how to work smarter, not harder; guiding the protégé to create boundaries so that professional activities do not blur into personal time is essential to achieve equilibrium. Boice [44] reiterated the importance of life balance over and over again. Providing strategies for new faculty members to be productive, yet still maintaining a reasonable work week, is of prime importance. An interesting result is that the mentor can also work to achieve life balance, an issue many seasoned faculty struggle with as well.

3.4.3. Advising Career Progression. An obvious area for protégé advocacy/guidance is advising career progression while helping the protégé achieve balance between personal and professional responsibilities. Mentors often promote progress by helping protégés set professional goals, mapping a career plan, and establishing clear career milestones [9, 43]. Mentors can also help identify career advancement opportunities the protégé may not be aware of or know how to find [41]. The literature clearly articulated the impact of no mentoring; for example, nonmentored faculty often struggle with scholarship over their entire career [9, 12, 41, 42, 44, 45]. The implication of these findings is that faculty must be cognizant of institutional alignment with scholarly productivity. If a faculty member feels strongly about establishing a productive research program, finding an institution with a mentoring program is one indicator of the institution's commitment to scholarly productivity. Conversely, trying to accomplish scholarly productivity in an institution that fails to offer a mentoring program may indicate the structure for productivity is not sufficiently established.

3.5. Integrate the Protégé into the Academic Culture. The fifth theme of best practices offers two separate but critical activities that support the program aim of integrating protégés into the academic culture: (a) teaching networking skills and (b) facilitating socialization to the academic culture. The value of integrating protégés into the academic culture is that it allows mentors to share intellectual capital and emotional intelligence. The mentor should give due diligence to this theme, since these qualities affect the protégé's ability to become a productive member of academe.

3.5.1. Teaching Networking Skills. Mentors can facilitate protégé integration into the culture of academe by helping protégés learn to network and establish professional contacts. Coleman et al. identified networking as extremely important for getting to know professional contacts in the clinical area [12]. Networking offers the potential for connecting with people in a particular field that, later in time, may assist with career advancing opportunities. Boice [44], whose research spans 30 years, stated that the "strongest predictor for early success in an academic career was that new faculty found social supports and networks" (page 220). The protégé may consider identifying internal and external mentors since the benefit obtained from each may differ. For example, the internal mentor can assist the protégé with integration into the institutional culture, while a mentor external to the institution can help the protégé identify networking opportunities on local, national, or international levels [11, 46]. Often, the mentor can invite the protégé to collaborate on projects and introduce the protégé to an expanded networking circle. These activities have been shown to promote professional development and increase scholarly productivity [23, 24].

3.5.2. Facilitating Socialization. A second way mentors can facilitate protégé integration into the culture of academe is by helping protégés navigate the social structure and culture of academics. Faculty new to academia are rarely prepared educationally or experientially for the multiple roles and expectations as well as the isolation that may present itself with academe—the reason being, academia is an unfamiliar

culture to them [1]. There is a strong correlation between organizational support during the career-entry stage and the stress novice employee's experience every day.

A smooth transition into the academic culture by a novice educator may not be realized without the assistance of a mentor since the social norms and expectations are most often not written—or easily understood [47]. Socialization, therefore, becomes crucial for new faculty to feel they are members of the academy. Importantly, Smith and Zsohar [11] showed that mentors who facilitate protégé socialization have a direct impact on the quality of nursing education provided. It is the mentor who helps socialize and prepare novice faculty in the areas of teaching, research, and service.

3.6. Mobilize Institutional Resources. The sixth theme of best practices, mobilizing institutional resources, requires institutional responsibility in order for the intended mentoring program to thrive. Four strategies are identified here that reflect administrative, collegial, or financial investments.

3.6.1. Gaining Administrative Support. When people think of the term *resources*, they often think of money. Although money is a key component, the primary resource requirement for an effective formal mentoring program is administrative support and commitment. Therefore, a critical strategy to assist mobilizing resources in mentoring is to gain administrative support at both the departmental and college level prior to initiating any formal mentoring program [10, 48, 49]. Without authentic support from departmental administration, mentoring programs are likely to struggle.

3.6.2. Including Mentoring Expectations in Promotion and Workload Documents. Another action that can be readily accomplished is the inclusion of mentoring activities into faculty expectations; these can be demonstrated in the criteria for promotion and tenure, salary merit, and workload calculation documents. Including expectations that experienced faculty mentor junior faculty in these documents sends a strong message of acceptance by both administration and faculty. Plus, faculty receive acknowledgement and credit for time spent mentoring other faculty.

The time is ripe for this action; a practice analysis conducted in 2005 by the National League for Nursing showed that, nationally, faculty and administrators identified mentoring as part of the role of nurse faculty [50]. It must be noted that protégés do not only have to be junior faculty. Cariaga et al. [51], as well as the National League for Nursing [1], showed that establishing a mentoring climate can increase productivity in faculty at the early-, mid-, and late-stage of the academic career ladder.

3.6.3. Offering Mentor Training Programs. Because effective mentorship skills do not always occur naturally, a third strategy is to train mentors. Effective mentorship extends beyond simply sharing one's knowledge or expertise; mentors can also be taught how to be effective mentors [39]. This best practice includes having a mentor-training workshop at institutions of higher learning with the purpose of increasing the number and quality of mentors. The expense for such a program can be distributed across departments since mentoring is important for all faculty.

3.6.4. Providing Release Time. This best practice requires some financial expense in the form of release time for mentor and protégé participants [49]. Release time however, pays for intangible activity at first. What administrators must remember is that although intangible at the beginning, release time has been shown to be directly associated with increased scholarly productivity and increased innovation by faculty [51]. Administrators and faculty should not be deterred over this last resource, since mobilizing financial resources can be seen as an institutional long-term return on investment.

4. A Model for Excellence in Mentoring

The model (see Figure 1) builds on the preliminary work conducted by the National League for Nursing in 2006 and includes four mentoring outcome pillars: orientation to the faculty role, socialization to the academic community, development of teaching, research, and service skills, and facilitation of the growth of future leaders in nursing and nursing education [1]. Our work introduces six themes of current evidence of best practice which underpin the four mentoring outcome pillars. The six major themes of best practices reflect the aims of establishing a formal mentoring program and include (a) achieve appropriately matched dyads, (b) establish clear mentorship purpose and goals, (c) solidify the dyad relationship, (d) advocate for and guide the protégé, (e) integrate the protégé into the academic culture, and (f) mobilize institutional resources. Attending to these six themes will help mentors achieve the four mentoring outcome pillars. The model can be used to create structure or serve as outcome measures for any mentoring program.

"Best practice" is operationally defined as those actions that produce the most desirable faculty outcomes, based on evidence and real life experiences. An underlying assumption is that relationships play a key role in any successful mentorship experience, as evidenced by the focus of the best-practice themes as it pertains to ways to initiate, build, solidify, advocate, or integrate the relationship.

5. Conclusions

Mentoring programs have many benefits and contribute to improved faculty morale, higher career satisfaction, and increased self-confidence in professional development. Mentored faculty publish more, obtain more grants, and are promoted more quickly. Institutions providing mentoring programs experience increased retention and improved sense of community and professional identity.

The model, "*Best Practices in Academic Mentoring: A Model for Excellence,*" provides a schema that can be used to create programs of mentoring and functions as a thematic basis for evaluation of program effectiveness. Mentoring assists faculty members to better navigate the academic

environment and more easily transition to new roles and responsibilities. A work environment where collaborative and reciprocal peer and co-mentoring are present results in a rich, satisfying, and rewarding career experience for both mentor and protégé. It ultimately moves the profession forward.

Imagine the impact on faculty career attainment, institutional culture, the science of nursing, and leadership development in nursing education, if all faculty were mentored. Mentoring programs are especially important at a time when academia is experiencing a shortage of nurse faculty members. A trait of a true leader then is being an excellent mentor and developing future leaders.

Conflict of Interests

The authors declare that they have no conflicts of interests.

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Research Article

Designing and Implementing an Ambulatory Oncology Nursing Peer Preceptorship Program: Using Grounded Theory Research to Guide Program Development

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Having enough staff to provide high-quality care to cancer patients will become a growing issue across Canada over the next decades. Statistical predictions indicate that both the number of new diagnoses and the prevalence of cancer will increase dramatically in the next two decades. When combining these trends with the simultaneous trend toward health human resource shortage in Canada, the urgency of assuring we have adequate staff to deliver cancer care becomes clear. This research study focuses directly on oncology nurses. Guided by the grounded theory methodology, this research study aims to formulate a strategic, proactive peer preceptorship program through a four-phased research process. The goal of this research is to develop a program that will support experienced staff members to fully implement their role as a preceptor to new staff, to facilitate effective knowledge transfer between experienced staff to the new staff members, and to assure new staff members are carefully transitioned and integrated into the complex ambulatory cancer care workplaces. In this article, the data from the first phase of the research project will be explored specifically as it relates to establishing the foundation for the development of a provincial ambulatory oncology nursing peer preceptorship program.

1. Introduction

Cancer carries a sense of urgency in our modern world. In fact, it is a worldwide problem that is growing in unprecedented dimensions [1]. Globally, cancer is the world's most deadly disease [2]. In 2009, it was estimated that over 171,000 Canadian's faced a new diagnosis of cancer and a staggering 75,300 Canadians died of cancer [3]. The growing number of individuals diagnosed with cancer is primarily related to the increasing number of aging Canadians. Based on current trends, it is estimated that 40% of Canadian women and 45% of Canadian men will develop cancer during their lifetime. Further, it is estimated that 24% of women and 29% of men, or approximately 1 out of every 4 Canadians, will die from cancer [3]. Not only are cancer rates increasing, so are the number of Canadians living with cancer. According to statistics released in 2011 by the Canadian Cancer Society, there were over 749,000 cancer survivors in Canada at the beginning of 2007 [4]. This increase in prevalence is related to increasingly successful new treatments which are able to control progression. As a result, a continually escalating number of Canadians each year will be living with cancer as an ongoing health issue [5]. Given these realities, we will begin by addressing the impact this will have on the delivery of cancer care.

2. Current State of Knowledge

Just as cancer is a global crisis, so too is the shortage of health human resources. According to the World Health

Organization (WHO), "The most critical issue facing the health care system is the shortage of people who make them work" [1]. Many significant reports in Canada have built momentum towards the prioritization of health human resources (HHRs) planning [6–8]. In 2005, a joint paper was published by the Canadian Nursing Association (CNA) and the Canadian Medical Association (CMA) titled *Towards a Pan-Canadian Planning Framework for Health Human Resources* [9]. Ten key principles and strategic directions for health human resource management were identified around three major themes: patient centered care, planning, and career life cycle. Specifically, the themes of planning and career life cycle identified strategic directions that revolved around improving the workplace environment and integrating preceptorship and mentorship across the career life cycle to support the continual professional development of staff.

Within the field of cancer care, HHR has also been identified as a priority. In 2007, the Canadian Partnership against Cancer (CPAC) was created as an arms length not-for-profit corporation to manage the implementation of a national cancer control strategy developed by a coalition of stakeholders [10]. The vision of this national group was to create a comprehensive, coordinated, high-quality person-focused cancer system that responds to the full range of needs of all Canadians and their families through all stages of the cancer experience [11]. The Institute of Medicine has defined high-quality care as care that is safe, effective, person-centred, timely, efficient, and equitable [12]. Science and medicine may make it possible to cure and, or treat cancer, but only people make cancer care a reality [13]. The issue of ensuring that there are enough well-educated healthcare professionals available to work within cancer care is fundamentally linked to providing high-quality cancer care now and in the future.

It is well understood that the oncology nurse's specialized knowledge is vital to effective care delivery across the trajectory of each individual's cancer experience [14]. As in other areas, nurses in cancer care act as a significant surveillance mechanism, identifying impending health crises, and intervening to limit the severity of the event [15]. As the number of cancer patients requiring care is expected to grow, and as the majority of cancer care is now delivered within the ambulatory setting [16], ensuring that the oncology nurses who work within the ambulatory setting are effectively supported to play their vital role in caring for and improving outcomes for these patients and their families is essential. As well, it is imperative that adequate staff are recruited and efforts are undertaken to retain staff within the ambulatory oncology setting [14]. Therefore, it has been concluded that the area of HHR planning in oncology nursing is a priority area of investment [10].

Within our provincial cancer care organization, the intersection of cancer trends and health human resource shortages moved from a theoretical level to the practice level after the development of a Provincial Nursing Council (PNC) in 2008. The PNC was created to allow oncology nurses from various roles and levels of the provincial cancer care agency to gather to discuss and provide leadership on issues that affect oncology nurses and their workplaces, and to guide the transformation and evolution of the cancer care system within our province. At the first PNC workshop, three key provincial areas of need were identified which included (1) a need to create a strategic direction for Oncology Nursing, (2) focusing purposeful attention on keeping and attracting the right people to oncology nursing, (3) and building a healthy work environment where oncology nurses are engaged in a process of continual professional growth and development. It was decided by the group that committing to and creating a provincial mentorship program was the most effective approach to address these issues.

The first step towards creating a provincial mentorship project was to explore the theoretical concepts of mentorship. Mentorship and preceptorship are key approaches that have been identified in numerous documents as holding strategic importance in ensuring adequate health human resources exists across the system [9–11, 17–26]. Although precepting and mentoring are often used interchangeably in the literature [27–29], there is some differentiation in the use of the terms in different geographical locations such as the UK and North America [29–31]. Both explain ways of using role modeling to support the professional growth of nurses, and to promote the overall quality of the practice environments, but are also unique in the focus and functions they serve [21]. Within this article, the term preceptorship is being defined as the means of transitioning new nurses into the workplace [32]. A preceptor is assigned to facilitate the new staff member's learning goals for a predetermined time, which is often short term. The focus of the relationship is the development of the new staff's clinical knowledge and skills relevant to the new work environment they are entering. Preceptorship usually occurs during regular working hours and can evolve into a mentorship relationship if both parties choose. Within the article, mentorship is being defined as a relationship that focuses on supporting continual professional development of existing staff members rather than on the transfer of skills [32]. A mentor is chosen or selected by the mentee. The relationship can span an extended period of time, sometimes years, and the focus of the relationship is to support professional growth and development. Although mentorship is also a nurturing, role modeling relationship, it is usually done away from the clinical setting [33].

Patricia Benner's "novice to expert" theory [34] and the Canadian Association of Nurses in Oncology (CANO) conceptual framework [35] were especially impactful to the group's thinking around this topic. Our group began to conceptualize mentorship as an umbrella concept that holds a trajectory of professional development over a series of distinct phases spanning the progression from novice to expert (see Figure 1). Further, the team conceptualized that within each distinct phase of professional development, forward progress needs to be supported by a specific type of constructive, nurturing relationship, with the peer preceptorship relationship between a new staff member and an experienced oncology nurse being the starting point on the continuum. As demonstrated within our conceptual framework, once the initial competency of the new staff

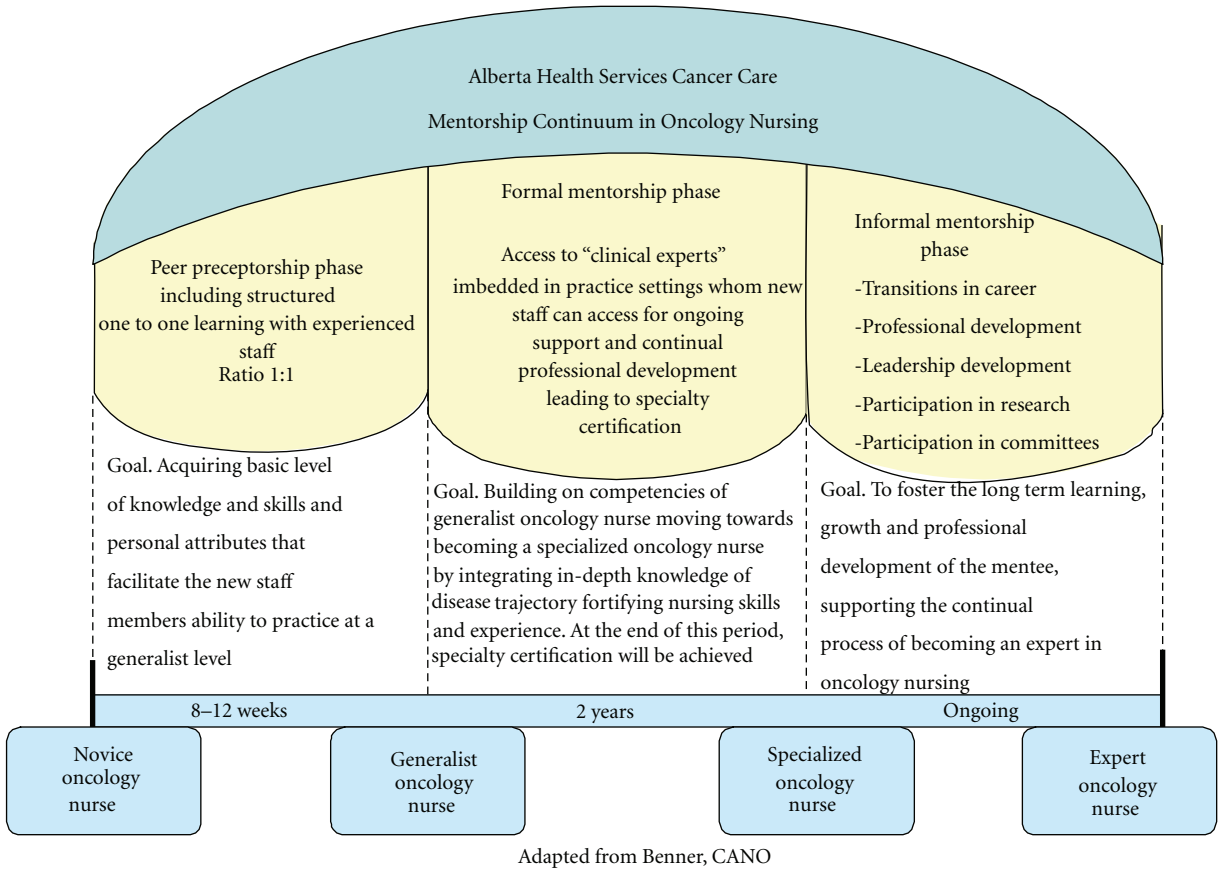

Figure 1: Conceptual model of mentorship as overarching principle.

member is achieved, the continual professional development needs to be supported by a mentoring relationship, more specifically, initially a formal mentorship relationship, in which the action of the relationship is focused on assuring the new staff member achieves oncology specialization. After specialization is achieved, the purpose of the mentoring relationship shifts to a more informal relationship that is driven by context or professional development. This framework was endorsed by PNC, and the initial area of peer preceptorship was approved as being the essential starting point for designing a change initiative, although the group indicated that the whole framework was needed. The overarching goals of continuum were established as (1) to assist the new staff member to move along the continuum from novice oncology nurse to expert oncology nurse, and (2) to offer professional development, support continued learning, personal growth, and leadership skills in existing staff.

It is important to note that the team selected the phrase "peer preceptorship" to differentiate the work of experienced staff with new staff, from the work of experienced staff with student nurses. Although there are many similarities between the work that preceptors do in both roles, the fact that work place competence drives the peer preceptor relationship is an essential core concept to this trajectory approach to mentorship. Historically in nursing, peer preceptorship has been taken for granted. Many programs exist to support staff nurses to precept students, and it is standard within our provincial nursing union that staff nurses receive additional pay for precepting students [36], but there is no such additional pay for precepting new staff to the workplace. In many workplaces, it is the same staff nurses who have received the preceptorship training to work with students who then are used to precept new staff, because they have the developed skills. However, within the ambulatory oncology nursing setting, very few student nurses do practicums due to the advanced skills and competencies necessary in this setting. Due to this limited exposure to student precepting the ambulatory oncology nurses are lacking formalized education to effectively transition new staff into the workplace. Although it is standard practice to "buddy" a new staff member with an experienced nurse until they achieve an adequate level of competency, this "buddy" relationship has received minimal formal support. An assumption has been made that if an experienced oncology nurse is good with his/her patients, he/she will be good at precepting new staff [37]. Currently within our provincial cancer care agency, no standardized program exists for supporting the preceptor in actualizing and being effective in the role of preceptor. This has resulted in differences in support and approaches to preceptorship across the province.

Staff, educators, and managers within oncology nursing settings across the province have indicated both an interest and a pressing need for additional support around the

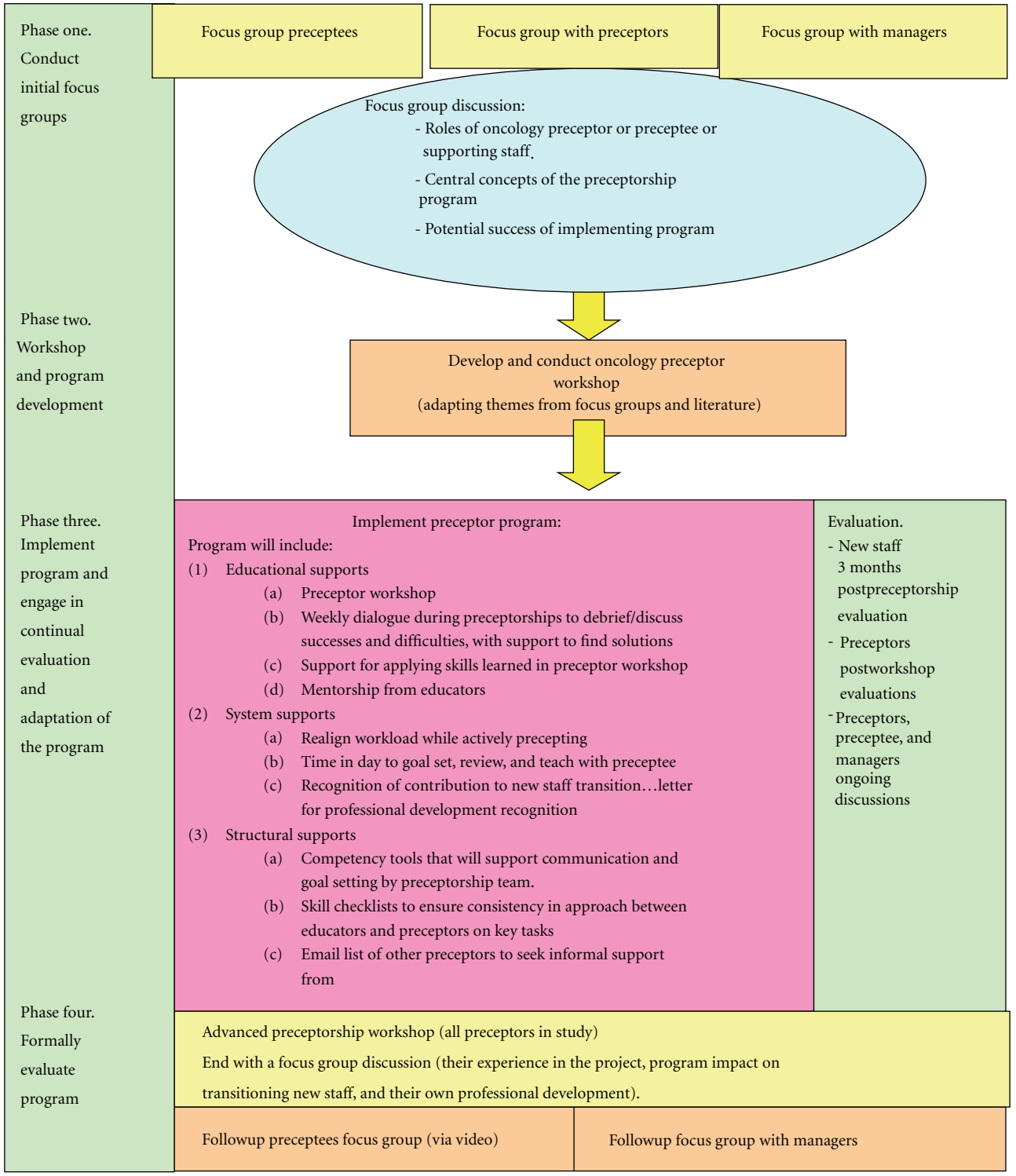

Figure 2: Schematic of ambulatory oncology peer preceptorship project.

development and standardization of preceptor skills in existing staff and improvement in how new nursing staff are transitioned into and supported in cancer care workplaces across the province. As a response to this gap, this research study was designed to contribute to the development of a provincial approach to both preparing preceptors and supporting the preceptorship phase of transitioning new staff into their ambulatory oncology nursing roles. In terms of the conceptual framework, two areas of professional development are being addressed in this initiative (1) transitioning the novice nurse into their new role as an oncology nurse, and (2) informal mentorship for the experienced staff

member to build their skills and competencies for being a preceptor. Ethical approval for this study was obtained from the local Conjoint Health Research Ethics Board.

3. Method

This study has been informed by grounded theory (GT) methodology as described by Glaser [38]. GT is defined as "the discovery of theory from data systematically obtained from research" (page 2). The goal of GT is to "generate a theory that accounts for a pattern of behavior which is relevant and problematic for those involved" [39] (page 93). This kind of qualitative inquiry facilitates the discovery of rich descriptions from which patterns of behaviors and descriptions of unique experiences can be gathered from those experienced with the phenomenon under discussion [40]. GT research differs from verification studies in that GT aims to discover theory through emergence instead of through hypothesis testing or verification. Verification studies are linear in design moving from research question, to sample selection, data collection, to analysis. GT research carries out these stages simultaneously [39]. Consequently, in the interview process, the questions are constantly evolving.

The distinguishing characteristics of GT are (1) the researchers attempt to uncover the basic social processes in the study setting instead of simply describing the behavior under study, (2) constant comparative analysis of each piece of data is underway throughout the data collection stage in order to identify emerging conceptual properties, and the relationships among the categories and their properties, (3) continual refinement of generalizations and a constant awareness of changes in the data collected as the study progresses and how that correlates to theoretical constructs that emerge, and (4) a theory results that is grounded in the data at hand [41].

The aim of GT is to understand how study participants see the world and how they define their problems as well as what would be helpful to resolve them. This method was selected to study preceptorship as it could assist the research team to uncover the processes involved in supporting existing staff and transitioning new staff across key groups. In grounded theory, a broad research question is the starting point, and through a process of discovery through individual and group dialogue, the researchers become sensitive to the questions that needed to be asked. Three broad research questions for this study were selected including: "What is the current process of nursing peer preceptorship in ambulatory oncology settings?," "What, if any, components of the process need to be modified, added, or eliminated to facilitate the effectiveness of transitioning new staff into their oncology nursing role?," and "What impact has the preceptorship program had on the preceptorship period?" This project has been designed in a phased approach (see Figure 2 for a schematic of the phased study design). At this point, only phase one is completed. In the first phase, we focused on the first two research questions in order to establish a broad understanding of preceptorship as it currently exists and to ascertain what innovations could improve this process. In phase two, this foundational knowledge will be synthesized with best evidence from the literature to develop the educational supports and peer preceptorship program that will then be implemented (phase three) and evaluated (phase four). The data from the initial focus groups (phase one) will be explored in this article.

Preceptorship is a complex phenomenon which is essentially a relational process. There are four important relationships at work in preceptorship: the learner (preceptee), the hands on teacher (peer preceptor), the instructor (clinical educator), and the manager (supporter). These relationships vary in intensity and visibility during the preceptorship phase, but preceptorship cannot be enacted without the interplay of these interrelated roles (see Figure 3 for schematic). In order for the researchers to understand more fully the process of peer preceptorship, the perspective of all participants involved in the preceptorship relationship needed to be ascertained. The best approach to collect this data was to conduct in-person interviews or focus groups, however, due to the large geographical area of our provincial cancer agency, and in an effort to be cost effective, focus groups were conducted in a large urban center with rural members joining via video conferencing.

A purposeful approach to sampling was used [42]. Participants for the focus group discussions were invited by the research team on the basis of their ability to speak to the topic and contribute to a rich discussion. The research team contacted new staff members, past preceptors, and managers to discuss the project. All clinical educators from the sites were on the research team so therefore no specific focus group was held for educators. Separate focus groups were set up for each of the three groups. Informed consent was secured from participants prior to the focus group discussions. After introductions and ground rules were established, the following open-ended question initiated the focus group discussion, "What is your experience with peer preceptorship in your institution?" Other questions included "What key factors do you think would improve the peer preceptorship experience?," "What specific skills do you think are essential for a positive experience within the peer preceptorship phase?," "What kind of additional supports would be helpful in further developing these skills?," "Can you share an example of specific challenges or frustrations that have played out for you in a past peer preceptorship experience?," and "If you could give advice to the team starting up a new peer preceptorship program, what specifically would you recommend?" The focus groups were audio recorded and transcribed verbatim. Each focus group had between 6–10 participants. A facilitator (one of the investigators) guided the focus groups, and an observer (the primary investigator) recorded field notes based on the observations of individual responses and group dynamics. All field notes were part of the data and analyzed with the focus group transcriptions. Observations will continue with the second phase of the study.

4. Data Analysis

Glaser [38] contends that in GT all data is data. As the data was collected from these focus groups, the process of analysis

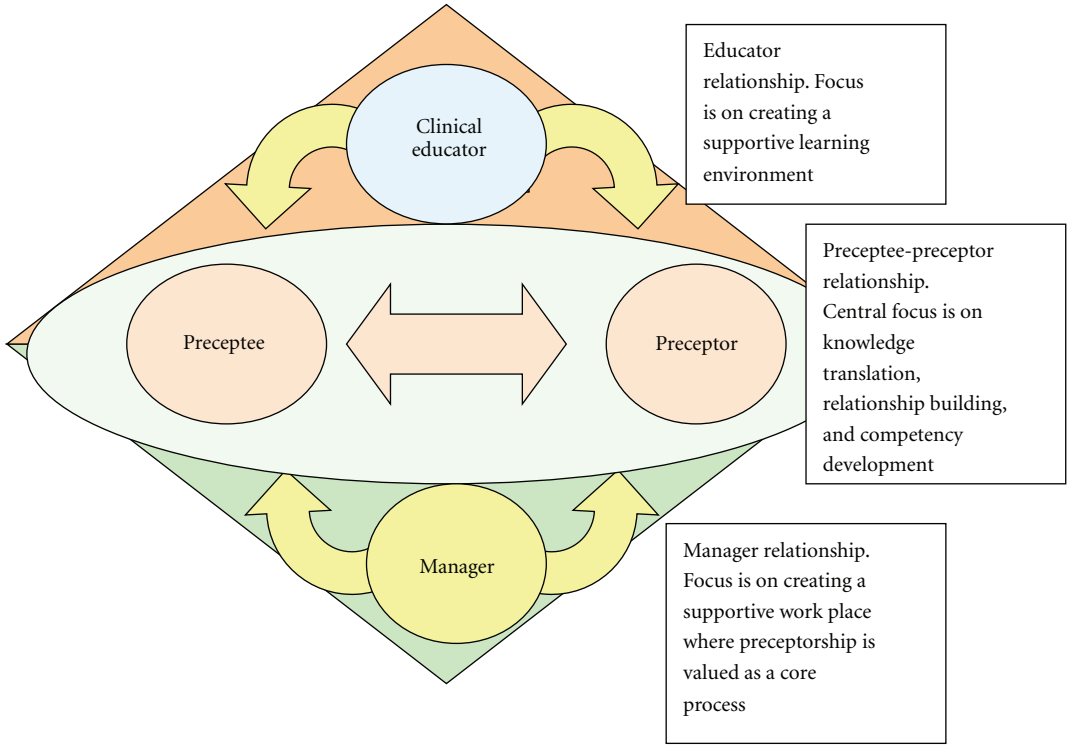

Figure 3: Schematic of relationships.

began. The synchronicity of the process of data collection and analysis is one of the hallmarks of grounded theory with new pieces of data adding depth to the inquiry [43, 44]. By using a constant comparative approach in the data gathering and coding stages, the researchers actively build towards a theory that is grounded in the data. According to Glaser [43], GT is "the generation of emergent conceptualizations into integrated patterns, which are denoted by categories and their properties" (page 1). In this process of conceptualization, each data element is compared to every other data element as data are acquired. Data analysis began with the first focus group and continued throughout the first phase of the research.

The initial steps taken to accomplish this were for two members of the research team to individually and collectively code each transcript in sequential order at multiple levels of abstraction. We began with *in vivo* (open) codes line by line of participant's words and phases, to identify possible beginning coding categories (substantive coding) moving from raw verbatim data to abstract ideas and concepts until we were able to begin theorizing. Prior to each transcript being coded, both team members read the transcript in its entirety, and memos were created to clarify concepts and hypothesize connections between ideas, in keeping with grounded theory traditions. These memos also allowed us to identify and hold our preconceptions "in abeyance" in order to let the data speak for itself. The initial process of coding resulted in 174 codes for transcript number one, 175 codes for transcript number two, and 97 codes from transcript number three, for a total of 446 codes.

These resulting codes were then broken down into data chunks (incidents) that were given labels known as categories or concepts. During open coding, the researchers broke the data down into incidents that we compared with one another for similarities and differences while asking the neutral question "what category or property does this incident indicate?" [39] (page 39). Incidents continued to be compared with other incidents until no other new incidents were found.

Once all three transcripts were independently coded and compared in terms of each transcript, the next step was to collapse similar codes and categories across all three transcripts. This is known as selective coding. These categories are tied together through relational statements known as hypotheses. During the first phase of the research, three categories emerged: "About Peer Preceptorship," "Skills Required," and "Peer Preceptorship Program Considerations" (see Figure 4). As this is only the first phase of the study, and the purpose of the data collected is to inform the development of the program, the beginning core category was *Uncovering the Foundation and Identifying Strategies for Strengthening Peer Preceptorship in Ambulatory Oncology*. The resulting basic social process will not emerge until the final phase of the research.

4.1. Addressing Rigour. An important aspect of doing qualitative research is conducting the study and analysis with rigour. Criteria for evaluating the quality of grounded theory are generally described as *fit, workability, relevance, and modifiability* of the data [38, 42]. *Fit* means the codes, categories,

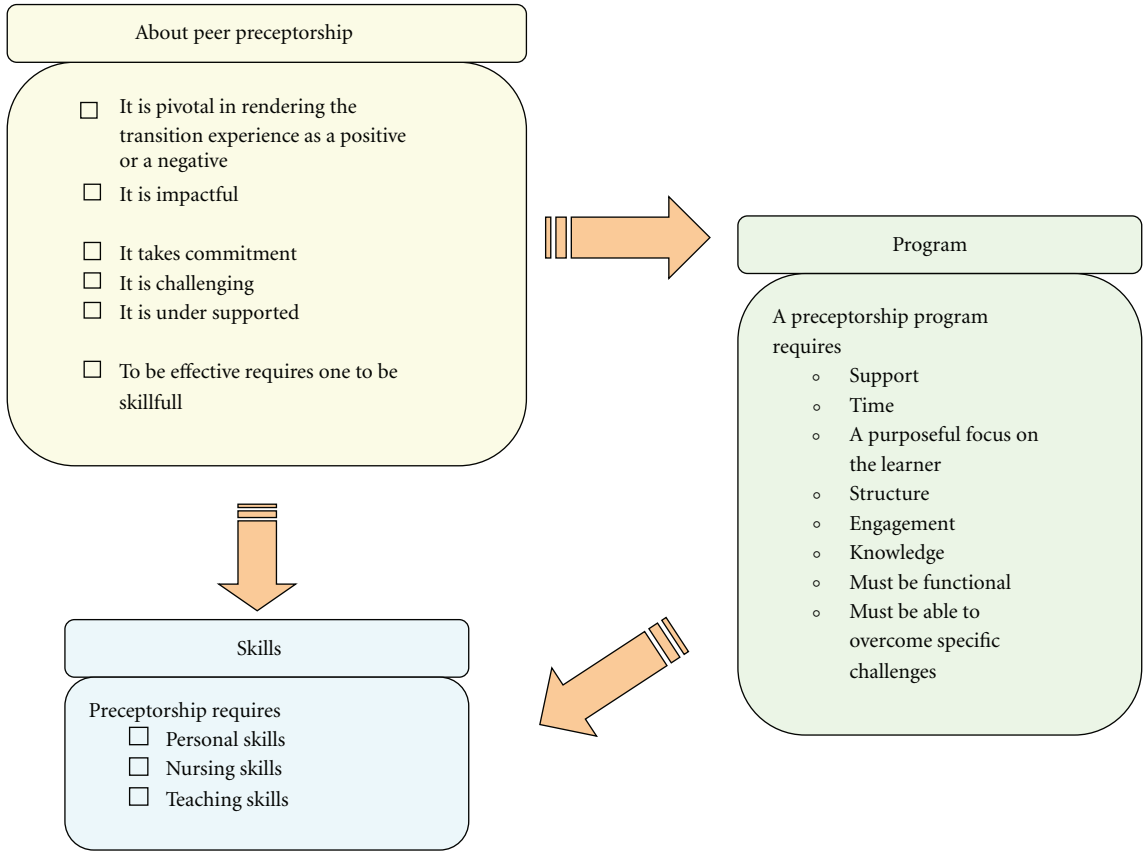

Figure 4: Three categories that emerged from the data.

and themes all fit with the data and are not forced by the researcher. In this study, fit was ensured by having two researchers code and categorize data independently, having a separate member of the research team examining the codes for appropriateness and inclusion of data, and by maintaining a clear audit trail indicating how field notes and memos were used, how data were reduced, and how decision points were reached.

Workability means that the theory is able to explain the phenomenon and to predict and interpret action under certain conditions. In other words, to determine workability is to determine if the theory works. For this study, the next phase of the research project will be where workability will be tested. The themes that were generated in the analysis will guide the formation of a peer preceptor workshop. At this workshop, the participants will be asked to review the themes and relationships identified. The workshop participants will also be asked to reflect on any areas that they feel are relevant to their ability to fulfill the role of peer preceptor that has not been covered in the workshop (member checks) to determine if the themes that emerged from the focus group discussions were reflective of the issue of peer preceptorship in its entirety.

Similarly, *relevance* of the research requires that the study deal with real concerns of the participants. This will be confirmed by the participants and others experiencing the same process. Relevance also conveys a sense of transferability; a high-quality grounded theory should hold meaning and significance for others in similar situations. The peer preceptorship workshop will be used to examine relevance of initial themes and to expand the emerging theory. The theory will continue to evolve over the next phase of the research which will consist of the implementation of a comprehensive peer preceptorship program. The question that will guide the evolution of the program will be "is this program relevant to the workplace setting and the issue of peer preceptorship." Final focus group discussions will be held in Stage 4 of this research project to determine relevance of the final product with the uses of the program including preceptees, preceptors, and managers. As the clinical educators are part of the research team, their contributions to establishing relevance will be captured through their ongoing memos. Finally, the researchers will present the findings to oncology nurses who have been preceptors and to nurses at conference meetings inviting feedback in discussion periods.

A quality theory must be flexible enough to adapt to changing environments, and as such must be *modifiable*. As new data arise, current categories must be modified to incorporate them. A modifiable theory reflects quality and attendance to the data collection/analysis process. Through the audit trail, another researcher should able to see the relevance of new data to existing data.

5. Results

5.1. About Peer Preceptorship. In the focus groups, we did not define peer preceptorship, but instead, sought participants understanding of what it meant for them. It became evident that across all transcripts there was a common understanding that peer preceptorship is a pivotal period in the transition of new staff into a new workplace. How the peer preceptorship relationship played out has a direct impact on how that experience is remembered by the new staff and directly affects their desire to stay or leave their new place of work. One participant recalled how her preceptors were centered on her learning.

> *"It was a valuable learning experience for me because they helped me with a lot of great learning experiences. We were a small center and…I had two preceptors that helped me master new learning opportunities and I also knew I had somebody else that was kind of looking out for me to help me advance in nursing and in my skills and so I found that very valuable as well."*

If the experience is positive, the new staff member is left feeling that they are in a safe learning environment that is responsive to and supportive of their learning needs, leaving the new staff member with a sense of hope that they will be able to practice and grow in their oncology nursing skills and that access to ongoing support will be available via their preceptor even when the preceptorship phase is completed. The preceptor sets the tone by providing a safe space to ask questions, and helps with integration into the team by introducing the new staff to the work place and colleagues. Participants used words such as patience, grace, and respect to describe how they made them feel safe and comfortable in their learning.

> *"I think for me it was just super positive in that they had a lot of grace for making mistakes or asking silly questions and for me that set the total tone of the entire time I was working here, so it was kind of a total positive safe place to learn and that still continues on."*

On the other hand, when the experience is remembered as negative, it directly impacts the new staff members feelings of commitment and safety in their workplace, and in some cases participants spoke of situations in the past where they had left positions directly because of a poor preceptorship experience.

> *"I had a preceptor at the hospital and I couldn't get out of there fast enough, I hated it—and part of it was that her nursing process was just horrendous—I just I felt like I wanted to be critical but the whole time I couldn't … I'm supposed to be learning um but I just was so disillusioned by what was going on—it was culture of go to coffee come back check the computer to see if the doctor had made any orders and I did one day kind of lose it and said you know I want to look at the patient—if the patient's dead we know what we're going to do and if the patient's got questions well you know and I was just- and the patient will tell us if the doctor's been. And I guess I um— just ran from that place. And they wanted me to come and work on the unit and I just said I can't—."*

Being a peer preceptor is an important role that impacts both the new staff and the preceptor individually. It facilitates a sense of satisfaction knowing that one has contributed to someone else learning and that you have helped their socialization to the team. Participants spoke of how it is gratifying to expose the learner to new opportunities within the ambulatory oncology setting.

> *"I also find it very satisfying. It's just such a different area to be a preceptor in as opposed to being on the in-patient side. I just find it very satisfying that you are giving a new staff member an opportunity that they might not necessarily have had before. You're giving them this completely different take on nursing and they get to see the out-patient side that you don't necessarily get to see elsewhere, so I really enjoy that part of it."*

Peer precepting was recalled as enjoyable, influential, and offering preceptors a sense of pride. They indicated that being a peer preceptor demanded a commitment to one's own continual growth. Each new preceptorship relationship requires the preceptor to be patient, and to recognize that peer preceptorship is a reciprocal learning experience which might mean they will not have all the answers. The peer preceptor must be open to learning with the new staff member as well as teaching them.

> *"We can go a long time without a certain protocol popping up or a certain situation so that I find I need to learn as much as the person who has not been here for very long, and if a situation comes up that doesn't happen for a few years then I need to review it as well so we can learn together … get the book or get on the computer and go over it together. It is not just about them learning it for the first time, it is me relearning it, because I have not seen it for a while."*

The participants recognized that preceptoring has some negative impacts too, such as it adds challenges and complexity to their workday. "*You're trying to give someone a really thorough orientation and you do not want it to be rushed and yet you've got your work that still needs to be done by the time you go home so that been a little bit of a challenge.*" It takes time to precept new staff, and often there is little or no modification of workload to reflect this added responsibility. The findings revealed the importance of acknowledging that the learning curve is very steep for staff nurses who are new to ambulatory oncology but even more so when the new staff member has no oncology experience or is a recent graduate. Areas of particular challenge included conflict management, adapting teaching approach to the

learner, encouraging reflective practice and critical thinking, helping the new staff set goals for learning, and balancing the new staff member's wish for more time to learn with the institutional push for completion of preceptorship on schedule.

> *"In my experience with some of the new staff and preceptors I think across the board something you consistently hear is I would have liked more training, or I would have liked more time, like everybody wants more time to learn stuff and get immersed in the environment, but the clear expectation part is huge in that we need you to be functioning by X."*

Participants acknowledged that there is currently no professional development support around being a preceptor and that often it is a trial and error approach to learning the required skills. The lack of mentorship for the preceptors contributes to the challenge of the role.

5.2. Skills Required. It was widely recognized across all three focus groups that being a preceptor requires the development of specific skills. The more one actively engages in being a preceptor, the more one's skills grow. Specifically, there was recognition among the groups that there were three distinct areas of skill development required to effectively precept a new staff. These include personal, nursing, and teaching skills. Excellent oncology nursing skills and knowledge of institutional policies and procedures are fundamental to the experienced staff's ability to precept the new staff. Currently, this domain within preceptor skill development is well developed through ongoing staff education.

Participants spoke of recognizing that effectiveness is enhanced if the preceptor has a highly developed cadre of personal skills. These include skills around communication, managing relationships, and assuming an approachable stance. "*Right away, when I started feeling welcomed it created a positive effect on my ability to learn and to know that I had support, so I think just being open and welcoming is important.*" One participant shared how her preceptor's relational skills relayed trust in her as a new learner in her initial time spent with her.

> *"My preceptor that I was paired with would introduce me to her patients that they had been working with already so right off the bat that kind of conveyed this support and trust in me as somebody that they were going to be working with and I felt because of that support my patients kind of instantly trusted me and I feel like that had a huge part to do with our patient's acceptance of my working there as well."*

The participants spoke of how important it is to be able to create a work/learning space where questions are encouraged, goals are mutually set, guidance is offered to achieve those goals, constructive feedback is delivered in a respectful manner, and where the learner is empowered to grow in skill and confidence. The notion of an approachable stance speaks to the personal approach that conveys self-confidence, while still being open to learning from the new staff member. It also speaks to being patient, encouraging, welcoming, and nonjudgmental.

> *"I think it is about being comfortable to have them ask questions … and creating an environment where they are comfortable to ask the question … it is not so much about actually wording the questions well … I think its about the back and forth talking. I think when I say being encouraged to ask questions, it is more about comfort and familiarity and not being judged about one's level of intelligence or anything like that…"*

Currently, these personal skills are not being actively nurtured within the preceptor beyond their day-to-day experiences in delivering cancer care or through their own personal development activities.

The third area of skill development is teaching skills. An example is understanding and applying adult principles of learning and knowing how to adapt teaching approaches, or understanding how to assist the learner to find their own answers instead of just giving the answers. The participants spoke of the importance of understanding how to gradually transition from being the teacher to being the resource, and how to engage in mutual learning to facilitate competence. Consensus from the participants was that currently we do not actively offer educational supports that are intended to support the staff nurses teaching abilities beyond the more familiar application of patient teaching. One manager shared her perspective.

> *"I wonder about some sort of education for preceptors so they understand what the expectations are for them and maybe some approaches to help learning for the preceptee and how to deal with issues when they come up and where to go for that sort of thing."*

5.3. Peer Preceptorship Program Considerations. A large part of the focus group dialogue centered on ideas for the development of a peer preceptorship program, as that is the core objective of this project. Six areas were identified as key issues that the program must address. These included support, time, focus on the learner, structure, engagement, and functional flexibility.

5.3.1. Support. Participants asserted that preceptorship is a unit issue, not just an individual issue. Even if someone is not precepting, there needs to be a mutual understanding of the expectation that other staff members will assume some component of the increased workload. Precepting adds workload to the preceptor, so others will need to shoulder an increased work load, even if they are not actively precepting.

> *"The peer preceptorship program has to be supported by all staff, because it affects everyone … even those who don't choose to be in it as a peer preceptor, others need to be supportive and aware*

they will be required to pick up more work so that the preceptor can focus on teaching the new staff."

The issue of workload also needs to be considered by the management team in that their involvement in active redistribution of the patient load will establish the collaborative tone of the unit. Another idea for support that the participants identified is a forum where preceptors can learn together over time. This could be through team debriefing or through advanced preceptor skill development workshops. Participants identified that mentorship for the preceptor was a current gap. They felt that ensuring the preceptor had access to a mentor in regards to their growth as a preceptor was a way to ensure continual development of their skill set.

"*When I had some people orientating, it is so helpful to have someone else around that has done a lot more preceptoring than I have. She was helpful to me because she helped me learn how to teach. Usually I don't have anyone like that whom I can go to like that, so it was very helpful to have her. It would be great to have someone like that to go to all the time for support and ideas on how to teach better.*"

The creation of a formal preceptor workshop to support the development of the various skills required for effective preceptorship was also identified as an important new support.

"*Maybe some kind of paid prep type would be helpful for preceptors I mean um—just to give them some basic suggestions or coaching in terms of what they need to know, what the goals are and just to get them to know how to be the best preceptor that they can possibly be.*"

5.3.2. Time. The need to recognize that preceptorship takes time was a dominant discourse across all groups. Importantly, it needs to be recognized that preceptorship takes time on both sides of the relationship. Participants spoke on a consistent basis of time as a barrier to effective precepting and for learning without feeling pressure.

"*For me, I think it is really more time . . . I think we have lots of teaching skills around and lots of experience in the nurses who have been here a long time, but the real problem is time, enough time to get things across to the new person, and give them your thoughts on how things are best done or whatever. . .*"

The learner needs time to acquire new knowledge, time to reflect on new knowledge and how it fits into existing experiences and knowledge, time to develop competencies in new tasks and procedures, and time to learn a new system of care delivery. On the other hand, the preceptor needs time to get to know the learner and their background, time to explain and teach, time to debrief with learner and with the clinical educator, time to reflect on their own learning and development, and time to plan how to support the new staff member's competency development. One manager voiced the following.

"*If there is a commitment to this . . . then the preceptor should be given a certain amount of protected time . . . to prepare themselves, to be able to sit with the new employee and go over some of the learning objectives they had in mind, this is what were going to do, this is what I want you to watch me do and that would be very challenging in the current environment if they were continuing their clinical assignment as it were. So protected time would be a big thing . . . that would probably encourage staff to take on this role.*"

Currently, participants felt that the various dimensions of time utilization required in preceptorship are not acknowledged by the system. The fact that workload is not routinely adjusted when a preceptor is precepting is evidence of this.

5.3.3. Focus on the Learner. The need for a purposeful focus on the learner was a strong message throughout the discussion. Learners wanted their past experiences and knowledge to be recognized, valued, and taken into account.

"*I came into this new experience with already a background in oncology . . . so for me I think maybe having that taken into consideration a little bit would have been good. There was a lot of it was information that supposedly had to be reviewed with me but a lot of information I already knew and so we spent a lot of time reviewing basic information that was very familiar to me. So maybe, in my case recognizing that I was coming with the background of oncology already, to somehow be able to take that into consideration when it came to the actual content that needed to be delivered.*"

Understanding how the new staff member learns was also recognized as important, as then the preceptor could tailor their approach to supporting competency development. This category also held the notion that the preceptor had to pay attention to the learner, not just deliver information. Participants also acknowledged that the preceptor needs to be available to the learner, which relates back to the ability to adopt an open stance.

5.3.4. Structure. Participants shared many ideas around structural components of a peer preceptorship program. Participants felt that matching the preceptor with the learner based on learning style and experience would be helpful. "*I think that matching is very important and while you may have very good preceptors for one, you may not be very good preceptors for others.*" They also indicated that clear expectations and objectives for both the learner and the preceptor for the preceptorship period would be helpful including the notion of gradually shifting the new learner's role from observing to doing while inversely shifting the preceptor's role from

doing to observing. The participants discussed formalizing the collaboration and roles of the clinical educators and managers as both roles are fundamental to supporting the process of peer preceptorship. As demonstrated in Figure 3, the clinical educators are responsible for creating a supportive learning environment, while the managers must establish a supportive work environment.

5.3.5. Engagement. Participants indicated that the only way a preceptorship program will work is if staff members want to be preceptors, and if new staff members want to become oncology nurses.

> "*First of all, we have to be sure the preceptee is interested in being an oncology nurse. I mean sometimes it's just a job that has good hours, and they don't really want to be here. So confirming that there is a sincere interest in oncology nursing is essential.*"

It was recognized that somehow the program needs to inspire staff to want to be involved in preceptorship.

> "*Currently there is low motivation and engagement among staff so this is an issue…no matter how wonderful a program you design, if you can't get your key staff to choose to participate in it or take the role of preceptor seriously it will not work.*"

Some ideas to enhance staff engagement discussed were securing financial compensation similar to working with students, letters of recognition of the preceptors contribution, backfilling shifts so preceptors can attend professional development opportunities, and ensuring a manageable workload while precepting. Even the act of being identified as someone who would make a good preceptor facilitates engagement. It was also discussed that it is essential that new staff members know what kind of nursing care they are being expected to provide. A preceptorship program will affect the whole nursing team, not just those who volunteer to precept, so it is important that broad education around this new conceptualization of preceptorship as a pivotal process is undertaken to ensure engagement of the entire team.

5.3.6. Functional Flexibility. The participants spoke of needing a peer preceptorship program that was realistic. Fiscal responsibility demands that a newly developed peer preceptorship program be functional and flexible. The program must contribute to the timely and effective transitioning of new staff members into their roles, while supporting a high degree of safety and job satisfaction among both the new and experienced staff members. The program must also alert the educational and management team of situations where new staff members are not progressing as anticipated, so that proactive interventions can be designed to mitigate stress to all involved. However, the program must be flexible enough to adapt to the constant changes in the workplace, and issues that cannot be controlled for such as sick calls, staff shortages, and personality conflicts.

6. Discussion

6.1. The Benefits of Preceptorship. Findings suggest that the process of peer preceptorship involves layers of relational engagement (see Figure 5) beginning with the recognition that peer preceptorship is enacted at the level of the individuals involved in the process including managers, educators, preceptors, and the new staff members. The next relational layer is between the institution and those involved in peer preceptorship. There must be an institutional valuing of peer preceptorship as a skillful, pivotal process in continual professional development, retention, cost savings, job satisfaction, knowledge translation, and effective transitioning of new staff into the workplace. Institutional valuing must be demonstrated by the creation of supports that enable peer preceptorship and enhance the effectiveness and experience of being involved in peer preceptorship. The final relational layer of peer preceptorship is between the entire patient care team, or unit staff with those involved in peer preceptorship. The entire team must recognize that peer preceptorship is everyone's business even if one is not directly involved at the individual level. Peer preceptorship requires support from the entire workforce (see Figure 4 for a schematic representation). In the initial phase of this study, the process of understanding peer preceptorship as layered relational engagements has been conceptualized as *Uncovering the Foundation and Identifying Strategies for Strengthening Peer Preceptorship in Ambulatory Oncology*. The process was enacted in three overlapping ways: building an understanding of what preceptorship is *(about preceptorship),* the building of a skill set *(skills required),* and building the program that fits with the organization and all individuals engaging in the program (*program consideration*).

A plethora of literature supports the positive correlation between nurse preceptorship programs and nurse retention rates [21, 33, 45–47]. Preceptorship is also correlated with effective knowledge translation [17, 18, 21]. Further to this, evidence supports that increasing retention is associated with adequate and stable staffing, which directly affects patient safety issues such as medical errors, mortality, and average length of stay in an inpatient unit [48]. As well, increased retention decreases institutional costs by minimizing the need to hire and train new staff members [21, 46, 49, 50]. These positive indicators have spurred much interest in how the potential value of effective preceptorship can be integrated into healthcare organizations across the spectrum.

Within the research literature, a *recognized skill set* has been identified as being foundational in supporting the preceptor's ability to effectively guide the transitioning of new staff into their roles [51, 52]. This skill set includes enhanced communication skills (specifically around conflict management and how to give constructive feedback), adult principles of learning, how to set goals, how to manage conflict, motivation, managing diversity, socialization of new staff, and evaluation [17, 21, 33, 51]. It is important to note that the literature did not reveal research that explored the complexity of supporting ambulatory oncology nursing across a provincial organization.

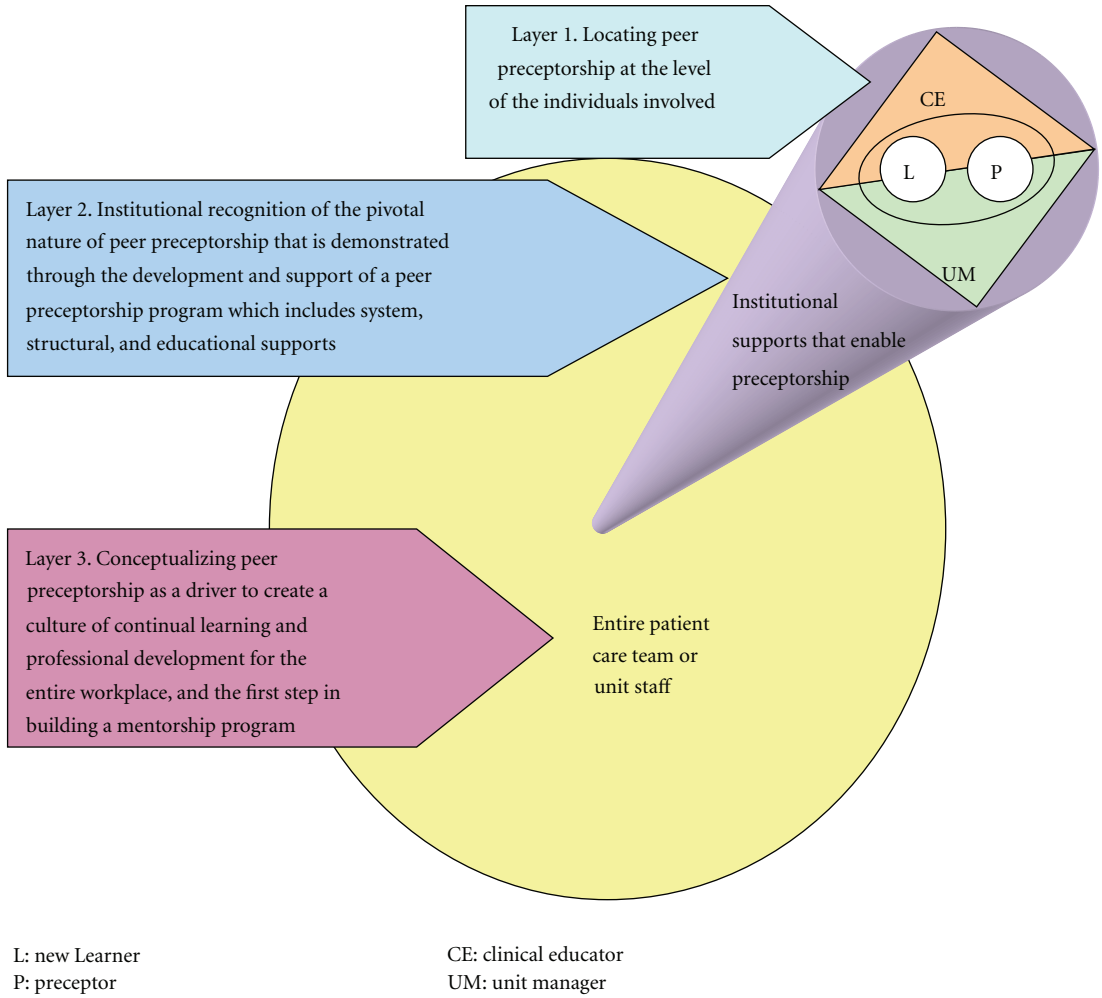

Figure 5: Conceptualizing the Relational layers of a Peer Preceptorship Program.

Effective preceptorship can enhance the knowledge transfer from the experienced oncology nursing staff to the new staff member [53] to ensure safe, competent, and compassionate cancer care is delivered. The literature and the data from our study support the use of a preceptor workshop as effective to support the knowledge and skill development within the preceptor [17, 21, 23, 27, 54], but such support is only one aspect of a preceptorship program. Additionally, it has been well documented in the literature and has emerged from our data that numerous other supports are essential to facilitate successful peer preceptorships. These include

(1) *system supports* such as managerial commitment to realign the workload/patient assignment given to a preceptor in order to free up some time and energy to actively focus on precepting the new staff member [23, 24, 55],

(2) *educational supports* such as an ongoing dialogue with the educators around issues/successes encountered in the process of enacting the preceptor role [17, 23, 24, 33, 37, 54], and assuring the preceptors have access to a mentor to facilitate the continual development of their preceptor skill set [56]; building relationships has been highlighted as being of utmost importance as it is within a mutually supportive and respectful relationship that interactions that empower, inspire, guide, advise, and model clinical behaviors can be nurtured [57],

(3) *structural supports* that facilitate continual progress toward successfully transitioning the new staff member into their specific role such as competency documents and check lists [18, 25, 33, 58].

Preceptorship is more than assigning a new staff member to "buddy" with an experienced nurse. The literature around this topic aligns well with the data that emerged from our focus group discussions. The researchers propose that approaching peer preceptorship as an integrated program that incorporates aspects noted within the literature and categories from our focus groups will maximize positive benefits to the work environment and ensure high-quality patient care outcomes.

7. Future Research

As stated earlier in this article, the three broad research questions for this study are: "What is the current process of nursing peer preceptorship in ambulatory oncology settings?," "What, if any, components of the process need to be modified, added or eliminated to facilitate the effectiveness of transitioning new staff into their oncology nursing role?," and "What impact has the preceptorship program had on the preceptorship period?" The data analysis reported here speaks to the first two research questions. The data supports a broad basic understanding of preceptorship as it currently exists within our provincial cancer care agency and clearly has identified what innovations could improve this process. This foundational knowledge will now be leveraged into the second phase of this study in which specific educational supports and preceptorship program will be developed. The data from the participants will be integrated with the best practice evidence available around how to enhance the process of peer preceptorship. Once the comprehensive program is designed, it will be implemented for 12 months and evaluated by those involved in the peer preceptorship program. The remaining stages of this research study will focus on exploring the third broad research question posed in this study, "What impact has the preceptorship program had on the preceptorship period?".

8. Conclusion

Providing adequate care for the growing number of Canadians requiring Oncology care will become a mounting issue over the next decade. As both the incidence and prevalence of cancer increase, the cancer care delivery systems will be stretched to meet the growing needs. Due to these realities, we anticipate a growing requirement for more oncology nurses within ambulatory cancer programs. The anticipated national health human resource shortage will complicate our ability to staff our ambulatory cancer care facilities adequately. The resulting reality is that our system needs to retain as many nurses as possible, recruit adequate numbers of new staff from a shrinking pool of nurses, and effectively and efficiently transition new staff members into a growingly complex ambulatory cancer work place. This research study was driven by our provincial cancer care agencies awareness of these trends and by our desire to be proactive and responsive to current and future staffing pressures. According to grounded theory methodology, theorizing is ongoing and open to continual revision. In this article, the findings of the first phase of our grounded theory study were explored. The first phase was an essential first step in the process, as it allowed the research team to understand what was currently occurring in the peer preceptorship phase and identify what our staff members believe would improve the process. The research is moving into second phase of the study, where the development of the details of the program will be grounded in our staff's experiences, ideas, and requests. This phased approach will allow the staff members involved in preceptorship to inform ongoing program development. The best available evidence will be used to build upon and strengthen areas identified by our staff and to fully develop a provincial peer preceptorship program that will help our provincial cancer care agency to be prepared to care for cancer patients across our province now and in the future.

In utilizing these findings to guide practice change, the major contribution of this research project will be established. All system redesign and program development will be grounded in the ongoing experience and ideas for improvement of our staff. Exploring and improving how the changes and new supports impact peer preceptorship will improve our understanding of how a systematic program can contribute to the effective transition of new staff into this workplace. It will also allow the research team to maximize the supports offered to experienced oncology nurses who are so essential to the process of transitioning new staff into this highly complex and rapidly evolving workplace, while still being responsible to the actual cost effectiveness and functionality of the program. Linking this research to practice change and then evaluating the effectiveness of the change will allow for the generation of a theory that will account for the patterns of peer preceptorship which is relevant and meaningful for all those involved.

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Review Article

A Critique of the Undergraduate Nursing Preceptorship Model

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The preceptorship model is a cornerstone of clinical undergraduate nursing education in Canadian nursing programs. Their extensive use means that nursing programs depend heavily on the availability and willingness of Registered Nurses to take on the preceptor role. However, both the health service and education industries are faced with challenges that seem to undermine the effectiveness of the preceptorship clinical model. Indeed, the unstable nature of the clinical setting as a learning environment in conjunction with faculty shortages and inadequate preparation for preceptors and supervising faculty calls us to question if the preceptorship model is able to meet student learning needs and program outcomes. In a critical analysis of preceptorship, we offer a deconstruction of the model to advance clinical nursing education discourse.

1. Introduction

A review of the nursing education literature reveals that clinical nursing education is considered to be a vital component of nurses' education. Indeed, Florence Nightingale, the founder of contemporary nursing practice, placed clinical education at the center of nurses' professional development. According to Nightingale, nurses' first year of training should occur in the hospital setting under the direct supervision of practicing nurses who can guide neophytes in the care of their patients [1]. While this type of clinical education model was the prototype of what would later be called preceptorship, the model remained largely dormant during hospital-based programs until it emerged once again in the 1960s in nurse practitioner programs [1]. In Canadian undergraduate nursing programs, preceptorship is typically described as a formal one-to-one relationship between a nursing student and registered nurse that extends over a pre-determined length of time [2]. Since the 1980s it has become a cornerstone of clinical nursing education. Given that the use of the preceptorship model is extensive, most Canadian programs are somewhat to very dependent on preceptors to guide their students [3]. Furthermore, because of its wide use, many nurse scholars believe that preceptorship provides the perfect medium to bridge theory and practice [1] and a way to facilitate the transition from student to graduate nurse role for the majority of nursing students [4].

However, from an education and health sector perspective there is still significant concern about the clinical learning and teaching components of undergraduate nurse education [5]. Indeed, ongoing restructuring within the Canadian health care system juxtaposed with mandated increased seats in nursing programs has taxed clinical practice settings beyond their capacity. The unstable nature of the clinical practice setting as a learning environment coupled with the challenges associated with a faculty workforce shortage illuminates the limitations of the preceptorship model of clinical instruction. These limitations ultimately create challenges for students being able to meet program objectives. Given that there continues to be a lack of criteria for determining what constitutes effective clinical education [6, 7], the purpose of this paper is to generate discussion by providing a critique of the preceptorship model of clinical undergraduate nursing education.

2. Background

In Canada and elsewhere, the need for nurses to be prepared at the baccalaureate level is well established and no longer disputed [8, 9]. The shift from hospital-based nursing

education programs to university and/or college educational settings has resulted in a giving way of educational models grounded in behaviourism to those based on interpretative pedagogies (feminism, phenomenology, postmodernism, and critical inquiry) and humanism [7, 10]. A shift in clinical nursing education has also ensued since faculty-supervised practicum is largely unsustainable [11]. Innovative approaches to clinical nursing education have been introduced into nursing programs resulting in at least ten different models of clinical education including preceptorship currently being used in entry-level nursing education programs [12]. In their overview of these clinical education models, Budgen and Gamroth [12] note key differences among them including differing ratios of students to teachers; variations in roles and responsibilities among students, faculty and nursing staff in relation to student supervision, teaching and learning, and evaluation; differences in the nature of relationships between practice and academia; variations in the implementation of these models. While these authors conclude that all models have inherent benefits and limitations that could be maximized or minimized depending on implementation, clarity of roles and responsibilities is central.

2.1. Preceptorship. While undergraduate nursing students are most often preceptored in the final semester of their program [13], sometimes they are preceptored earlier in their program [14, 15]. For this discussion, our comments will be limited to preceptorship that occurs in the final semester of Canadian nursing programs. In order to set the context for this critique, a general description of the preceptorship model in the final semester is offered.

According to the Canadian Nurses Association [2] preceptorship is intended to assist students in acquiring a basic level of knowledge, skills, and personal attributes as well as to be socialized into the profession. To facilitate being able to meet these goals as well as nursing program goals, every effort is made to have a 1 : 1 student-to-preceptor ratio. However, variations in this ratio exist. Students usually work the same hours as the preceptor with the assumption that they will progress to assuming the full nursing role and workload of the preceptor. Last, selection and preparation for the preceptor role vary across nursing programs and health regions.

For various reasons, preceptorship has become prevalent in Canadian nursing education programs as a complimentary clinical teaching model to the traditional faculty-supervised model of instruction. Economically, preceptored clinical experiences require fewer faculty members for supervision than in traditional faculty-supervised practica. This reduces expenditures and helps to contain nursing program costs [16]. Although preceptorships maximize opportunities for development of confidence and professional socialization and knowledge and skill acquisition for students and preceptors [17], they also have the potential for enhancing academic-service partnerships [18].

While an extensive body of literature pertaining to various aspects of preceptorship exists, few quantitative studies have been conducted that demonstrate the effectiveness of preceptored clinical experiences [16]. Further, within these quantitative studies there is a lack of consensus regarding the benefits or advantages of using a preceptorship model over the traditional faculty-supervised clinical model [19]. It is perhaps fitting then that we critically examine the preceptorship model of clinical instruction so that we can move toward an evidence-based clinical nursing education model [9].

3. Current Challenges for the Preceptorship Model of Clinical Instruction

Although Canadian nursing programs are faced with many challenges, some of these challenges may very well undermine the effectiveness of the preceptorship model of clinical education. Indeed many programs are faced with organizational and operational challenges. For example, inconsistent selection practices and preparation of preceptors [19] as well as pressures to conform to the curriculum and traditional academic calendar [20] might very well mean that programs have little control over the quality of the learning experience. Furthermore, because the clinical setting is characterized by high patient acuity levels, shorter patient hospital stays, staff shortages coupled with an increased casualization of the workforce, mandatory overtime, and a heavier workload, we are left to wonder if the current healthcare setting is an optimal learning environment [21]. Not only are nursing programs faced with a limited number of clinical placements, but some researchers also report that ineffective use of students' time and varying quality of learning opportunities might be offered by clinical sites [22]. Last, nursing programs are faced with a faculty shortage that may mean that faculty members do not have the breadth of expertise required to provide the clinical teaching and supervision students need and preceptors want [23]. It is a concern then that regardless of Lusted's [24] call to critically examine teaching and learning practices and, by extension, clinical nursing education models, schools of nursing are becoming increasingly dependent on the availability of preceptors as students complete their program and more experiences are sought for them in highly specialized practice areas [3].

4. Deconstructing the Preceptorship Model of Clinical Instruction

A 2004 report on nursing education in Canada [3] described models of clinical practice from a survey of 65 nursing programs. Superiority of the educational model was the most commonly occurring response for choice of the preceptorship model for clinical practice. According to Myrick and Yonge [1] there are three key players in the preceptorship model—the nursing student/preceptee, the preceptor (typically a registered nurse), and the supervising faculty member. Each member of this triad plays a critical part in the success of the preceptorship experience. While these authors also acknowledge that the clinical environment that includes everyone who interacts with students is important, we suggest the education institution and clinical environments are equally important players in the preceptorship model.

4.1. Education Institution Environment. Since the clinical learning environment is the single most important resource in the development of competent, capable, and caring nurses [25], Canadian nursing programs typically devote in excess of 50% of their program funds to clinical education [7]. The nature of preceptorship where the faculty-to-student ratio is 1 : 15–20 helps to contain financial costs associated with clinical education. However, there are some "hidden" costs that impact the effectiveness of the preceptorship model of nursing clinical education. For instance, students are frequently asked and are subsequently placed in their preferred clinical setting that may be at great geographical distances from the educational facility. Hence, supervising faculty must commute to clinical sites to perform in-person learning assessments if time and program budgets allow and/or use more "nontraditional" ways to interact with students and preceptors alike.

Historically "non-traditional" methods of interacting with students and preceptors included telephone calls. In today's environment how we communicate with others is influenced by electronic technology, and faculty members might rely more heavily on electronic messaging such as email, text messaging, and social networks to communicate with students and preceptors. Although relying on computer-assisted technology is in keeping with the Canadian Association of Schools of Nursing [26] and the Canadian Nurses Association's [27] endorsement for the use of information and communication technologies (ICTs), in undergraduate nursing programs less than 1/2 of the nursing schools in Canada have supportive policies for integration of ICT in nursing education. Given that there is evidence that faculty visits frequently do not meet student and preceptor needs [23], the lack of supportive policies regarding ICT may hamper the quality and quantity of interaction between faculty, students, and preceptors.

Last, although the need for preparation for clinical instruction is well documented [28], program expectations place considerable demands on supervising faculty and leave little time for preparation and critical reflection on the preceptorship model. While we do not presume to direct schools of nursing in determining faculty workload and teaching assignments, there are some practices that might impact the effectiveness of this model. For example, programs may lack knowledge of the clinical site and the population it serves [29]. Because programs might have little to no control over how preceptors are selected, they might also lack information about the preceptors themselves. Consequently, faculty may be unaware of the preceptors' teaching and learning needs and therefore are unable to effectively support preceptors in their teaching role. Programs might also lack information to give preceptors including how to evaluate students [30]. Further, faculty may also be responsible for arranging placements and scheduling of students' work hours [31] while concurrently needing to respond to other academic demands.

Enmeshed within the practicalities of faculty workload and school policy that impact how faculty might operationalize their supervisory role during preceptorship, most nursing programs are faced with a faculty shortage [32, 33]. Hence, despite the importance of clinical education, educational facilities are relying more and more on sessional faculty to teach their clinical programs [34–38]. Though sessional faculty might be expert clinicians, clinical expertise is not equivalent to teaching effectiveness [35, 36]. Given that sessional instructors are often "parachuted" into their clinical teaching assignment, orientation to the preceptorship model and its outcomes and strategies to support student and preceptor teaching and learning might be minimal.

4.2. Supervising Faculty. While the need for faculty involvement in the preceptorship experience has been reported in the nursing literature [23], the need to increase their involvement has also been reported [39–41]. However, the indirect supervisory nature of preceptorship where faculty are not involved in the daily teaching of the preceptored student might result in faculty role confusion [42]. If faculty are unclear as to the purpose of their clinical site visits, they may be unable to explore in depth with students and preceptors factors that influence student learning.

Indeed, the "how" to teach within the preceptored experience is dependent on supervising faculty competency in four areas: awareness of students' knowledge, skill, preferred learning style, and expectations [30]; effective use of questioning [43, 44]; ICT competencies [45]; effective communication and feedback skills [7]. Since faculty may have no formal educational preparation related to clinical nursing education, not knowing "how" to teach students in a preceptored experience would present a substantial barrier in their ability to be effective.

4.3. Clinical Environment. The primary function of the health care setting is to facilitate health and healing by meeting the preventative, curative, and palliative health needs of the population. To do this, the health sector requires an adequately prepared workforce in sufficient numbers to meet service needs. Health care consumers expect competent care from nurses and so expect that registered nurses will be properly prepared. In order to gain practical, real-life experience and to integrate knowledge and develop the clinical skills needed for successful professional practice [20], nursing students are placed within the health care setting. Hence, the health care setting serves a dual role, albeit a secondary role [46] where it also becomes an educational setting.

Although leaders in the clinical setting acknowledge the importance of clinical education, clinical placements including preceptorship are not without problems [47]. Since healthcare settings focus on workplace goals and outcomes rather than on student learning [48], they are not always ideal learning environments even though they impact teaching and learning [1]. Indeed, as noted above the scarcity of clinical placements, higher patient acuity levels, and shorter patient hospital stays are factors that increase nursing staff stress [1, 21, 48]. While a cornerstone of the preceptorship model in the final semester of the students' program is to provide them with the opportunity to consistently work alongside one preceptor, staff shortages, increased casualization of the nursing workforce, mandatory overtime, and increased workloads have the potential to impact

opportunities for students to work consecutive days with one preceptor [49]. Indeed, it is not unusual for students to be assigned multiple preceptors or to be "buddied" with other staff members during their preceptorship. While it is understandable that the presence of nursing students in the clinical setting might be perceived as a stressful burden [50], these challenges may also mean there is limited time for teaching and feedback, which could result in students lacking or missing out on learning opportunities [51] and complicate the efforts of registered nurses in supporting student learning.

4.4. Preceptor Role. According to Luhanga et al. [49], the one-to-one relationship between a student and preceptor is essential in assisting students' transition to safe, competent practice. However, they also note that multiple preceptors, higher preceptor-student ratios than the ideal 1 : 1 ratio [52], workplace and workforce stresses, and inconsistent preparation and support hamper preceptors' ability to facilitate the one-to-one relationship. Furthermore, even though preceptors might desire and be willing to teach and share their knowledge, lack of expertise in teaching and evaluation might cause them stress and create an inability to guide students especially when a student is not progressing well [12, 53].

Although all of these issues are a concern, perhaps a greater challenge is the inability of preceptors to address teaching and learning diversity issues that are related to their role as clinical teachers [54]. For example, differences in ability in cognitive, emotional, developmental, and physical domains affect how learning situations should be approached, planned, and enacted. Differences in age and age cohort can also create educational diversity between a preceptor and student. Indeed, stereotypical portrayals can diminish the unique contributions that an individual brings to the learning encounter. While generalizations cannot be made, belonging to a particular age cohort shapes beliefs, values, abilities, and skill sets that may be unappreciated by individuals from different age cohorts [55]. Last, as the number of international students admitted to nursing programs increase, preceptors and students alike are faced with a variety of challenges. Potential challenges are those of adapting to a change in sociocultural context including social integration and differences in teaching and learning approaches. Another significant issue is that of language diversity. International students may experience difficulty in clinical settings related to the use of terminology, understanding patient requests, providing explanations [56] as well as being able to engage in advocacy behaviours that are perceived as required in complex health environments. Preceptors may be ill equipped to work with these students and as a result may be unable to employ strategies that create a responsive and supportive learning environment [54].

4.5. Preceptors. Little research has been conducted on the experience of preceptoring for those registered nurses who volunteer to preceptor as opposed to those who are assigned to precept a nursing student. Of the studies conducted in this area, preceptors experienced role ambiguity accompanied by stress associated with workload issues, and self-efficacy concerns as role models and teachers in clinical interactions with nursing students [57–59].

It could be construed then that although the importance and need for the development of a strong student/preceptor relationship are necessary, current stressors within the preceptorship model inhibit this from taking place. Indeed, adequate time to mentor students in the clinical setting is apparently a key challenge for preceptors [60] and detrimental to their efficacy as role models for students and their subsequent learning [61]. Providing feedback as an evaluative strategy requires knowledge about the feedback loop; however, preceptors often receive little to no specific information on the evaluator role [59]. The ambiguity in their function as preceptors coupled with the lack of recognition by both education and service industries would seem to negate the importance of the role. This may explain the reluctance of many to step forward to take on this role.

4.6. Nursing Student. It should not be surprising that preceptorship is a stressful experience for students [62] since within the complex and fast paced environment of today's clinical practice setting, two strangers, a student and preceptor, are brought together to provide the student with the opportunity to transition from the student to graduate role. Most often the student and preceptor do not choose who they will establish the preceptor relationship with: the pairing is assigned. Students therefore might perceive they have little or no control over the experience. While Yonge et al. [62] encourage a careful assessment of students' readiness for preceptorship, Yonge [63] also acknowledges that some students might not be psychologically prepared for preceptorship. For some students needing to navigate the complex relationships that accompany being socialized into the profession especially when that experience is at a long distance from supervising faculty may be overwhelming.

Consequently, student preparation for the preceptorship experience is essential so that their learning might be optimized. While students need to take responsibility and accountability for their own learning [1, 64], preparatory course content must also be meaningful and meet student learning needs [65]. Further, it is important that students understand the purpose of the preceptorship experience, how to make the best use of their clinical time [66, 67], and that they develop social competency skills [68]. Social competency involves establishing, maintaining, and developing constructive social relationships with people not only in their personal lives but as well with people in the work setting.

5. Conclusion

A critical component in nursing education is clinical practice for student nurses. Although the concept of evidence-based nursing education has found solid footing within the nursing profession and is pervasive in nursing education literature [69], this critique leaves us to question whether it is actually being applied to the preceptorship model in clinical nursing education. The challenges to the preceptorship model described in this paper demonstrate that it is imperative

that nurse educators, nursing programs, and leaders in the practice environment engage in critical reflection of the current models of clinical practice education so that programs are able to graduate safe and competent novice registered nurses.

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Research Article

The Effect of Mentoring on Career Satisfaction of Registered Nurses and Intent to Stay in the Nursing Profession

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Mentoring is important in the career development of novice and experienced nurses. With the anticipated shortage in nursing, it is important to explore factors such as mentoring that may contribute to career satisfaction and intent to stay in the profession. This study explored the effects of mentoring on career satisfaction and intent to stay in nursing, and the relationship between career satisfaction and intent to stay in nursing. It was conducted through a mailed survey of RNs 55 years or younger currently in practice, education, administration, or research. Career satisfaction was measured through the use of the newly developed Mariani Nursing Career Satisfaction Scale. Findings revealed no statistically significant effect of mentoring on career satisfaction and intent to stay in nursing. There was a statistically significant relationship between career satisfaction and intent to stay in nursing. The majority of nurses reported participating in a mentoring relationship. Although the findings related to mentoring, career satisfaction, and intent to stay were not statistically significant, there was a prevalence of mentoring in nursing, thus suggesting the need for future research to identify outcomes of mentoring. In addition, the study contributed a newly developed instrument to measure the concept of career satisfaction in nursing.

1. Introduction

Mentoring is important in the career development of both novice and experienced nurses in the areas of clinical practice, nursing education, administration, and research, as it supports the novice's need to feel satisfaction and success as a professional nurse and offers the experienced nurse an opportunity to contribute to the profession. This study explored the effect of mentoring on career satisfaction and intent to stay in the nursing profession, two critical elements in the retention of nurses in the profession.

Despite an encouraging recent 5.7% increase in enrollments in baccalaureate nursing programs (American Association for Colleges of Nursing (AACN)) [1], it is anticipated that the nursing shortage will continue to be a major issue in nursing in the United States for years to come. According to the AACN [1, 2], there are several factors influencing the nursing shortage, including insufficient numbers of nursing faculty, an aging nursing workforce, increasing healthcare needs of an elderly patient population, and nursing job burnout and dissatisfaction that are driving nurses away from the profession. Recent economic challenges have temporarily affected the nursing shortage and the need for nurses in some regions of the United States; however, with the combination of older nurses retiring from practice, academia, and administration, and dissatisfied nurses leaving nursing, the profession of nursing must identify strategies to increase recruitment and retention to address the nursing shortage, especially in practice and academia. Mentoring may be one such strategy. Although the shortage in any one of the areas may be viewed in isolation, there is an interdependent aspect to the shortage. A shortage in the area of clinical practice affects academia, administration, and research, and a shortage in academia, in turn, affects the clinical practice arena; therefore, these four areas of the profession were studied to determine if mentoring contributed to a greater sense of career satisfaction and intent to stay in the profession.

Several factors contribute to the shortage of nurses in the profession. National data indicate that the average age of nurses nationwide continues to increase. In 2008, the average age of nurses nationwide was 48 (HRSA) [3], and it was projected that in 2012, nurses in their 50 s will account for

the largest age group of nursing workforce at about 25% of the total RN population [4]. Decreased staff satisfaction accounted for 52% of workforce shortage [5], and insufficient numbers of faculty and other factors contributed to more than 67,000 qualified applicants being turned away from baccalaureate and graduate nursing programs [1]. This along with a projected increase in demand for nursing positions calls for the profession to explore strategies to recruit and retain nurses.

The concept of mentoring is not new to nursing, as Florence Nightingale was known to have mentored many nurses in her day [6]. Stewart and Krueger [7], Yoder [8, 9], Vance and Olsen [10], Walker [11], Billings [12], Fox [13], the National League for Nursing [14], and others [15–17] have contributed to the published nursing literature on mentoring; however, further nursing research is needed related to outcomes and effectiveness of mentoring, such as career satisfaction and intent to stay in the profession.

Mentoring is a reciprocal, long-term relationship with an emotional commitment that exists between a novice (protégé) and experienced (mentor) nurse; mentoring implies a knowledge or competence gradient, in which the teaching-learning process contributes to a sharing of advice or expertise, role development, and formal and informal support to influence the career of the protégé [7, 8, 18–23]. Mentoring provides protégés and mentors with opportunities for professional growth and career satisfaction. Lack of such satisfaction with a career in nursing may contribute to nurses leaving the profession.

With the predicted shortage and anticipated need for nurses in healthcare and academia in the future, it is more important than ever to explore career satisfaction, not just job satisfaction, for nurses. Career satisfaction is defined as the contentment that a nurse feels as a nursing professional in terms of intrinsic and extrinsic rewards [24]. Career satisfaction concerns a nurse's feeling about the career choice of nursing [25]. Job satisfaction is related to the satisfaction a nurse has with a current position in nursing; career satisfaction encompasses more than just the nurses' job. It refers more broadly to satisfaction with a career in nursing and may be a critical element in retaining nurses in the profession. Nurses who have a sense of career satisfaction and feel more fulfilled may contribute to the growth of the profession. Career satisfaction was measured by total scores on the newly developed Mariani Nursing Career Satisfaction Scale (MNCSS). Mentoring may be a strategy that can contribute to career satisfaction for both the mentor and protégé.

2. Materials and Methods

2.1. Purpose of the Study. This study explored the influence of participation in a mentoring relationship on career satisfaction and on intent to stay in nursing, and the relationship between career satisfaction and intent to stay in nursing. Intent to stay in the nursing profession was defined as the nurse's plan in projected number of years to remain active in the nursing profession in practice, education, administration, or research. The following hypotheses were tested in this research study:

(1) registered nurses who participated in a mentoring relationship will have greater career satisfaction than those who did not participate in a mentoring relationship;

(2) registered nurses who participated in a mentoring relationship will report the intent to stay in the nursing profession longer than registered nurses who did not participate in a mentoring relationship;

(3) career satisfaction will be positively related to intent to stay in the nursing profession.

For purposes of this study, the mentor was a nurse who was considered experienced, competent, or expert in the novice to expert continuum and more experienced than the novice nurse in terms of knowledge, skill, and competence. The protégé was the novice nurse in the mentoring relationship, in any area of the profession who was new to the area of practice, education, administration, or research, and lacked knowledge, experience, or competence in that setting. The mentor and protégé were self-identified on the demographic questionnaire.

2.2. Theoretical Framework. The theoretical works of Patricia Benner [18, 19] on novice to expert practice and Hildegard Peplau's Theory of Interpersonal Relations [20–22] were blended to provide a framework for this study. Mentoring is frequently described as an interpersonal relationship between novice and expert nurses. Benner's model, which was introduced to the nursing community in the 1980s through her acclaimed work, entitled *Novice to expert: Excellence in clinical practice* [18, 19], supports this novice to expert relationship that occurs in a mentoring relationship, and Peplau's [20–22] Theory of Interpersonal Relations supports the interpersonal phase of the mentoring relationship. Aspects of both of these theories provided support for this study on mentoring, career satisfaction, and intent to stay in nursing.

2.3. Review of the Literature. Mentoring has been discussed in the nursing literature as early as the days of Florence Nightingale, but more recently since 1974 with the initial work of Kramer [26]. The literature is replete with theoretical and anecdotal articles related to mentoring, although the published literature revealed limited research on mentoring related to the outcomes of career satisfaction and intent to stay in the nursing profession. Kramer, in her landmark work on reality shock, suggested that a strong mentoring process could be effective in helping new nurses move through the three phases of reality shock. Vance [23] has contributed greatly to the literature on mentoring since she began her research in 1977 on mentoring in nursing, where a sample of 71 "nurse-influentials" reported that mentoring played a key role in their success, professional satisfaction, and leadership in nursing. Vance developed a paradigm illustrating the types of mentoring that were significant to the

nurse-influentials through each developmental stage of life and career, and she described the various characteristics of mentoring through the stages, including, support, guidance, teaching, counseling, advising, career support, friendship, caring, confidant, and satisfaction.

Vance and Olsen [10] and Vance [27] defined a mentoring relationship as being developmental, empowering, and nurturing, requiring commitment and self-confidence extending over a period of time, where mutual sharing, learning, and growth occur in an atmosphere of respect and collegiality. Vance [27, 28] stated the importance of strengthening mentoring in the nursing profession so that crucial aspects of the profession are retained, especially in today's healthcare environment.

Boyle and James [29] found that nurses who reported that mentors had strongly influenced their careers were significantly affected during the early years of their careers. Nurse managers ($N = 100$) were surveyed on their perceptions of mentoring experiences, expectations of mentoring relationships, organizational environment, career satisfaction, and career influence; 79% reported having a mentor at some time throughout their career, with a strong positive correlation ($r = .78$, $P < .001$) in response to a question regarding the extent to which a mentor influenced their career. The nurses who reported that mentors had a strong influence on their career believed that the most significant contributions of a mentor were offering feedback on performance, sharing expertise with the protégé, serving as a role model, and demonstrating a belief in the protégé. The findings revealed that one of the most crucial times for mentoring was early in a nurse's career and that organizational support was necessary.

Yoder's [8] concept analysis of mentoring described aspects of mentoring, such as coaching, challenging assignments, protection, sponsorship, exposure, visibility, competence, effectiveness of role acquisition, role modeling, and friendship within two dimensions: that of career functions and psychosocial functions. In her concept analysis of mentoring, Yoder identified two critical antecedents (the mentor and protégé), three critical attributes of mentoring (a structural role, an organizational phenomenon, and a career development relationship), and three outcomes (personal satisfaction, self-confidence, and empowerment) [8].

Stewart and Krueger's [7] concept analysis of mentoring was built upon Yoder's work in 1990, identifying six critical attributes of the concept: a teaching-learning process, a reciprocal role, a career development relationship, a knowledge or competence differential between participants, a duration of several years, and a resonating phenomenon; they also identified the following consequences of mentoring: career progression, development of new investigators, empowerment, expanding professional knowledge and practice base, generativity, increasing numbers of minority nurses in master's and doctoral programs, institutional stability, and professional socialization [7]. Dunham-Taylor et al. [30] cited mentoring of new faculty as the best method to influence retention and successful development of nursing faculty. Despite the literature that is available on mentoring, gaps exist in empirical evidence on outcomes of mentoring, such as career satisfaction and intent to stay in the profession.

2.4. Description of the Study. This study used a combination of a descriptive comparative and correlational design. The phenomenon of interest in this study was mentoring, the independent variable was participating versus not participating in a mentoring relationship as a protégé or mentor, and the dependent variables were career satisfaction and intent to stay in nursing.

The study was conducted through the use of a written survey. Professional nurse databases that were available for scholarly use or purchase from the State Boards of Nursing were used to access names and addresses of RNs. The target population included RNs aged 55 or below, who were currently employed in the practice, education, administration, or research setting. The age of 55 or less was selected because nurses who are over 55 may be considering retirement which could have skewed the results. Since the aging workforce in nursing is partly responsible for the predicted shortage, the aim of this study was to explore the intent of younger nurses to stay in nursing.

In addition, the intent was to study nurses who were currently employed in nursing practice, education, administration, or research; therefore, the letter of explanation describing the study included current employment as a criterion for inclusion in the study. The demographic questionnaire also addressed the current employment setting of the study participants and their educational level.

A survey was used in this study in an effort to reach a large number of nurses throughout the country; the disadvantage was that the rate of return for a survey or questionnaire is often low [31]. Colored paper and $5(3/4) \times 8(3/4)$ inch colored envelopes were used in an effort to improve the visibility of the surveys in the mail and the response rate. In addition, distribution of the surveys to a larger population increased the likelihood of an adequate sample size.

2.5. Sample Selection and Sample Size. To obtain a national random sample throughout the United States, the country was divided into the nine geographic regions (see Table 1) that were used for the national sample survey of registered nurses [3]. One state was selected from each region by clustered random sampling, and the state board of nursing was contacted to obtain the mailing lists. After the lists were obtained, random sampling was used to mail the surveys to 60 RNs from each state in the first mailing, and a second mailing was sent to 15 different RNs from each state two weeks later in an effort to increase the likelihood of more surveys being returned. In addition, after the planned sampling procedure failed to yield a sufficient subsample of nurses who did not participate in a mentoring relationship, a convenience sample from a small private university in the Middle Atlantic region was used in an attempt to obtain an adequate sample size. Although the purpose of the convenience sample was to try to increase the number of

Table 1: Descriptive statistics of categorical demographic data ($N = 173$).

Demographics	Frequency[a]	Percent
Gender ($n = 173$)		
Female	150	86.70
Male	23	13.30
Region ($n = 173$)		
New England	16	9.20
Middle Atlantic	48	27.70
South Atlantic	16	9.20
East South Central	14	8.10
West South Central	12	6.90
East North Central	15	8.70
West North Central	16	9.20
Mountain	8	4.60
Pacific	28	16.20
Highest level of nursing education ($n = 173$)		
Diploma	11	6.40
Associate's degree	61	35.30
Bachelor's degree	70	40.50
Master's degree	31	17.90
Currently enrolled in advanced degree ($n = 173$)		
Yes	48	27.70
No	125	72.30
Current area of practice ($n = 171$)[b]		
Clinical setting ($n = 154$)		
Full-time	114	65.90
Part-time	40	23.10
Education ($n = 31$)		
Full-time	16	9.20
Part-time	15	8.70
Administration ($n = 26$)		
Full-time	19	11.00
Part-time	7	4.00
Research ($n = 2$)		
Full-time	1	0.60
Part-time	1	0.60
Mentoring relationship ($n = 173$)		
Total yes	136	78.60
Formal	25	14.50
Informal	71	41.00
Both	40	23.10
None	37	21.40
Role in mentoring relationship ($n = 170$)		
Mentor	32	18.50
Protégé	24	13.90
Both	77	44.50
None	37	21.40
Choose nursing again ($n = 172$)		
Yes	145	83.80
No	27	15.60

Table 1: Continued.

Demographics	Frequency[a]	Percent
Recommend nursing ($n = 172$)		
Yes	152	87.90
No	20	11.60

[a] Totals do not include missing data.
[b] Two of the subjects did not indicate an area of current practice.

responses for the group who did not participate in a mentoring relationship, this additional sample only yielded more subjects who had participated in a mentoring relationship.

The required sample size of 102 subjects was determined based on a power analysis for both the *t*-test and the Pearson Correlation, using a power of .80 and a moderate effect size for use of *t*-tests and Pearson's correlation. For this study, the total sample was 173, but the group size for those RNs who did not participate in a mentoring relationship was only 37; therefore, the actual power in this study was .70 [32].

2.6. Instrumentation. A demographic questionnaire and a newly developed, pilot-tested research instrument, the Mariani Nursing Career Satisfaction Scale (MNCSS), was used for data collection. The MNCSS developed by this researcher measured career satisfaction. The entire survey took approximately 20 minutes for the subjects to complete. The demographic questionnaire addressed the nurse's age, gender, highest educational level, current employment status, years in practice, education, administration, or research, participation in a mentoring relationship, intent to stay in nursing (in years), whether the participant would choose nursing again and would recommend nursing as a career.

Although, there were several valid and reliable instruments, such as the Stamps and Piedmonte Index of Work Satisfaction [33], to measure job satisfaction, a review of the literature revealed no valid and reliable instrument to specifically measure nurses' career satisfaction. Therefore, a new instrument that more accurately represented the intent of this study, career satisfaction in the nursing profession, was developed.

The MNCSS is a semantic differential scale with 16-bipolar adjective pairs on which the participants rated their feelings about their nursing career that best represented their attitude toward the adjective. For the MNCSS, each adjective pair was scored on a seven-point scale using the lower number for the less positively worded adjective and the higher number for the most positively worded adjective. An example of some of the 16 adjective pairs is satisfied-dissatisfied, fulfilled-discouraged, stimulated-bored, content-discontent, rewarded-frustrated, meaningful-not meaningful, and successful-unsuccessful. The sum of the point values of responses to all 16 items yielded a total MNCSS score. The total scores could range from 16 to 112 with a midpoint of 64. The overall content validity index (CVI) of the MNCSS was .84 for the 16-bipolar adjectives that were included as part of the instrument. Cronbach's alpha internal consistency reliability of the instrument was .82 for the pilot study, and .94 for the full study.

Prior to data collection, IRB approval was obtained. The participants received the demographic questionnaire and the MNCSS with a letter of explanation including the intent of the study and the definitions of key terms. Consent was implied by the participant's return of the completed questionnaires. A stamped, return envelope was included to mail the questionnaire back to the researcher. The participants were given information as to how they could access results of the study, if desired.

Of the total 722 surveys that were mailed and distributed, 196 surveys were returned, and 173 of the surveys were usable for the research study. Of the 23 surveys that were not used 6 were not included because the respondents exceeded the age of 55 years of age, 10 were not currently employed in practice, education, administration, or research, 6 were returned after the final due date, and 1 did not complete the career satisfaction scale.

3. Results and Discussion

3.1. Results. The statistical analyses were determined by the research hypotheses. For the MNCSS, a subject with more than two missing data bits was removed from the total sample. For two subjects who were missing a response to one item on the MNCSS, the missing data were replaced with the group mean [34].

Frequency and percentage statistics were computed for the variables of gender, education level, and area of practice and are presented in Table 1. The descriptive statistics, including mean, median, standard deviation, and range, were computed for the variables of age, years of practice, and years in nursing and are presented in Table 2. The average age of participants was 41.25 years, the youngest subject was 22 years old and the oldest was 55 years old. The mean number of years of work experience was 14.07 years, with the mean numbers of years in the clinical setting of 11.28 years. Further details of these descriptive statistics are presented in Table 2.

Of the total sample ($N = 173$), 78.6% reported participating in a mentoring relationship, 41% of these mentoring relationships were informal; 21.4% of the RNs had not participated in a mentoring relationship. From the total sample, 44.5% had been in the role of both mentor and protégé at some point in their career, not just a mentor or a protégé. The majority of RNs ($n = 145$, 83.8%) responded that they would choose nursing as a career again, and 152

Table 2: Descriptive statistics of continuous demographic data.

Demographics	*n*	Mean	SD	*Md*	Range
Age	173	41.25	9.10	43.00	22 to 55
Years of RN work experience	173	14.07	9.57	14.07	0 to 34
Area and years of current practice					
Clinical practice	146	11.28	8.29	11.28	0 to 34
Education	30	5.80	5.37	5.80	1 to 27
Administration	25	6.56	5.18	6.56	1 to 20
Research	2	9.00	1.41	9.00	8 to 10

(87.9%) of these RNs responded that they would recommend nursing as a career to others (Table 1).

Hypotheses 1 and 2 were tested using independent *t*-tests to determine the differences in career satisfaction and in intent to stay in nursing between the two groups, those who participated in a mentoring relationship and those who did not. In addition, Levene's analysis was computed to test the assumption of homogeneity of variance [31, 34, 35]. Hypothesis 3 was tested using Pearson's correlation.

For the total sample of 173 RNs, the overall mean for the MNCSS was 89.05 (SD = 14.33) with a range of 46 to 112 (Table 3). For hypothesis 1, there was no statistically significant difference on the MNCSS between nurses who participated in a mentoring relationship ($n = 136$; $M = 89.79$; SD = 13.94) and nurses who did not participate in a mentoring relationship ($n = 37$; $M = 86.35$; SD = 15.56). The mean number of years for intent to stay ($n = 167$) was 18.51 years (SD = 8.38). For hypothesis 2, there was no statistically significant difference in the number of years nurses intended to stay for those who did or did not participate in a mentoring relationship. Additional details of the statistics for career satisfaction and intent to stay are presented in Tables 4 and 5. For hypothesis 3, the correlation between career satisfaction and intent to stay in the profession was positive ($r = .15$) and statistically significant ($P < .03$, 1-tailed), however it was a weak correlation.

Additional statistical analyses were computed using a one-way ANOVA to compare types of mentoring (formal, informal, both, and none) on career satisfaction and intent to stay, and a one-way ANOVA compared the types of the roles in a mentoring relationship (mentor, protégé, both, or none) on career satisfaction and intent to stay; however, there was no statistical significance found in any of the additional analyses.

3.2. Discussion. The differences in RNs' career satisfaction and intent to stay in the profession were not statistically significant for those who participated or did not participate in a mentoring relationship, regardless of whether it was a formal or informal relationship or if they were a mentor or protégé. Although 78.6% of the nurses surveyed indicated some type of participation in a mentoring relationship, the largest percentage of mentoring occurred informally. This suggests that nurses may create informal mentoring relationships whether or not there is an opportunity for a formal mentoring relationship. These findings are consistent with what has been reported for several decades in the mentoring literature in nursing, which points to the prevalence of mentoring relationships in nursing [8, 10, 12, 14–17, 23, 27, 28, 30, 36–40]. The nursing literature indicated that mentoring occurred in various settings in the profession, such as clinical practice, education, administration, and research, although there was little literature to support career satisfaction as an outcome of mentoring relationships. In this study, the phenomenon of mentoring was identified by the majority of the participants which may suggest that nurses place value in mentoring; therefore, researchers need to identify better measures of the outcomes of mentoring relationships.

Overall, the RNs in the sample reported generally moderate to high career satisfaction, regardless of whether or not they participated in a mentoring relationship. Although participation in a mentoring relationship did not have a statistically significant influence on career satisfaction, the majority of nurses surveyed participated in these relationships, which suggests that the value of mentoring may lie not in career satisfaction, but in other outcomes that were not measured in this study.

Although, there was limited literature on intent to stay in the profession, Krozek [41] indicated that 35% to 60% of nurses nationwide were leaving nursing within the first year of their career. Since the average age in the current study was 41.25 and this population intended to stay for almost another 20 years, it is likely that there are reasons other than mentoring that contributed to nurses staying in the profession longer, such as job security, the altruistic value of nursing, the caring nature of nursing, or the lack of other career options. Although participation in a mentoring relationship was not a significant factor in intent to stay, with the current shortage of nursing and the aging of the nursing workforce, it is encouraging to see that RNs intended to stay for almost 20 more years. However, since this study did not capture the younger population of nurses as was hoped, it is possible that the results may have been different if the participants were younger.

The findings of this research did not support the research hypotheses 1 and 2. It is possible that nurses who were not satisfied with their career or did not participate in a mentoring relationship or planned to leave their career in nursing may have elected not to participate in the study. In addition, the mean age plus the overall high satisfaction scores of the sample may have influenced the overall results

Table 3: Mean scores of career satisfaction and intent to stay in nursing.

Variable	n	Mean	SD	Median	Range
MNCSS total	173	89.05	14.33	92.00	46 to 112
Mentoring	136	89.79	13.94	93.00	46 to 111
No mentoring	37	86.35	15.56	86.00	53 to 112
Intent to stay total	167	18.51	8.38	20.00	0 to 40
Mentoring	132	18.44	7.93	20.00	2 to 40
No mentoring	35	18.80	10.02	20.00	0 to 35

Table 4: Mean scores of career satisfaction and t-test comparing mentoring relationship and career satisfaction.

MNCSS score	n	Mean	SD	t	df	P
Mentoring Relationship	136	89.79	13.94	1.30	171	.098
No mentoring Relationship	37	86.35	15.56			

Table 5: Mean scores of intent to stay and t-test comparing mentoring relationship with intent to stay.

Intent to stay	n	Mean	SD	t	df	P
Mentoring Relationship	132	18.44	7.93	−.20	45.91	.42
No mentoring Relationship	35	18.80	10.02			

of the study, and the MNCSS may not have been sensitive enough to detect a difference between the groups. The sample of nurses in this study, although consistent with the age reported in the literature at the time of the study, represented nurses who may be more than halfway through their career; therefore, the results of this study may not be representative of the younger population of nurses. For hypothesis 3, the correlation of career satisfaction to intent to stay in nursing was weak ($r = .15$).

A large number of participants in this study indicated that they had participated in an informal mentoring relationship; although the definitions were provided to the participants in the letter of explanation, the possibility exists that the participating nurses may not have differentiated role modeling, coaching, and precepting as concepts different from informal mentoring.

There were several limitations noted in this study. A modified Total Dillman Method (TDM) was used to distribute the surveys; however, there was only a 27% overall return rate. While this was not extremely low, the rate of return did not reach the projected 60% that Dillman [42–44] suggested could be achievable by multiple contacts with the intended study population. Due to the cost of multiple mailings, it was not possible to send out four mailings, as suggested by the TDM. In addition, Dillman recommended a short letter of explanation. This was not possible for this study due to the nature of the definitions that were necessary to include for the intended study population.

Another limitation may have been attributable to the overall population that received the survey. The database lists for RN names and addresses were not as accessible as expected, and since the names were randomly selected from the lists, it was not possible to know in advance if those who received the survey actually met the inclusion criteria for the study of being currently employed in clinical practice, education, administration, or research despite having an active RN license and meeting the age criterion. In addition, the random search for names nationwide was a time intensive and financially expensive process.

Another limitation pertained to the unevenness of the survey response rate from those who had participated in a mentoring relationship ($n = 136$) and those who had not participated in a mentoring relationship ($n = 37$). It was difficult to achieve an adequate sample size for RNs who had not participated in a mentoring relationship. From the 722 surveys that were mailed, there was only a 5.12% rate of return for the group that had not participated in a mentoring relationship. This may have been attributable to the following reasons: RNs who were not in a mentoring relationship did not participate because they thought the survey pertained only to RNs who had been in a mentoring relationship; RNs who had not participated in a mentoring relationship are no longer in nursing; or there is more mentoring occurring in the profession than is typically thought. Although a mentoring relationship at any point in a nurse's career may have significance, the question on the survey pertaining to participation in a mentoring relationship did not ask when the mentoring relationship occurred; therefore, the mentoring relationship may have occurred recently or 20 or more years ago.

In addition, the survey question that asked the study participant about participation in a mentoring relationship was a self-assessment of their participation and role in a mentoring relationship. Although the distinctive definitions of a preceptor, a mentor, and a protégé were included in the letter of explanation, participants who responded positively to participating in an informal mentoring relationship may have been referring to a precepting relationship or role modeling, not necessarily a mentoring relationship in the truest form of the definition. And lastly, RNs who were dissatisfied with nursing as a career may not have been interested in participating in a research survey.

There are implications for nursing related to this study's findings. With the predicted shortage of nurses, the implications of this study and the recommendations for future

studies may have an effect on nursing practice, education, administration, research, and science. Although the results of this study were not statistically significant related to the outcomes of career satisfaction and intent to stay, 136 of the 173 participants indicated that they had participated in a mentoring relationship either formally or informally as a mentor or protégé at some point in their career. Nurses should continue to encourage mentoring relationships within the profession to foster some of the other positive outcomes of mentoring such as personal satisfaction, self-confidence and empowerment [8], and professional development [45, 46]. Mentoring may help bridge the gap between novice and expert practice and help new nurses feel satisfied with nursing as a profession, increase retention and, hopefully, decrease the impact of the nursing shortage. Kalagher [47] wrote that nurse leaders were in a position to positively influence the careers of novice and expert nurses. Mentoring and career satisfaction could contribute to retention of registered nurses in the profession, while providing an opportunity to groom future nurse leaders. Mentoring programs may be costly, but orientation and turnover in the profession are also costly; therefore, retention of nurses in the profession through mentoring programs may be a cost reducing measure for administrators. Leaders are in a position to influence the development of more formal mentoring programs by validating the effectiveness and financial impact of such programs.

Although, this study did not yield statistically significant results supporting the outcomes of career satisfaction and intent to stay in the profession with a mentoring relationship, the presence of the phenomenon of mentoring was very apparent. Through this study, future research initiatives can be identified to explore the outcomes of mentoring. In addition, this study contributed to nursing science and research through the development of a new valid and reliable nursing research instrument, the MNCSS, to measure the concept of career satisfaction in nursing.

This study demonstrates that mentoring is a prevalent phenomenon in nursing. Mentoring is a concept that is well-supported in the literature; research that continues to explore mentoring relationships in nursing can help demonstrate the positive outcomes of mentoring in nursing.

4. Conclusions

This study explored whether participation in a mentoring relationship had a positive effect on career satisfaction and intent to stay in the nursing profession. Based on recent statistics in the literature, despite increasing nursing school enrollment, it is predicted that the nursing shortage will continue. This study did not demonstrate a statistically significant difference in career satisfaction and intent to stay between nurses who participated in a mentoring relationship and nurses who did not participate in a mentoring relationship. However, there was a statistically significant positive relationship between career satisfaction and intent to stay in the nursing profession.

Despite the findings, this study contributes to the body of knowledge for the nursing profession related to mentoring relationships, nurses' career satisfaction, and intent to stay in the nursing profession. Nurses responded favorably about their careers in nursing and the importance of mentoring relationships which is promising for the profession of nursing. Further theory development and research are needed to add to the body of knowledge about the outcomes of mentoring related to career satisfaction and intent to stay in nursing.

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Research Article

Stakeholder Focus Groups to Inform a Technology-Based Strategy of Preceptor Support

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While preceptors are a vital link in student nurse practice education, ongoing support beyond an initial orientation is often lacking. It has been reported in the literature that preceptors experience stress related to difficulties in handling preceptee situations. They are frustrated by negative experiences centered on preceptor-identified hallmarks of unsafe practice including the inability to demonstrate knowledge and skills; attitude problems; unprofessional behavior; and poor communication skills. Their unrealized expectations for novices threaten their commitment to their preceptor role. As part of a larger study testing the effectiveness of podcasts as an ongoing method of preceptor support, this paper addresses the developmental stage of the podcasts. A team of academic and acute care nurse educators developed scripts for eventual filming of four podcasts focusing on unsafe practice issues, designed to provide continual support through web-based availability. The use of podcast technology is consistent with the learning styles of digital natives and is a demonstrated and valuable educational resource to review, reinforce, and clarify difficult concepts. These podcasts were informed through preceptor focus groups to address situational and environmental realism for student behaviors and preceptor responses.

1. Introduction

A preceptor serves as an expert in his or her field and provides practical experience and training to a student or novice. The central role nurse preceptors play in supporting the transition of student nurses and new nurses into professional practice is well recognized. Yet, ongoing support for nurse preceptors is too often lacking in clinical settings [1–4]. Staff nurse preceptors expect support from their practice site [5, 6]. Although support is initially provided, it frequently diminishes or ends after orientation [1–4, 7]. Preceptors view support as recognition from the institution, authorization to share from their personal experiences, and the opportunity to create environments for safe practice through mentoring students and novice nurses [8]. Realizing these layers of preceptor support, a model has been proposed that guides precepting and mentoring of students and novice nurses by infusing caring behaviors to address areas of unsafe practice noted by preceptors. Podcasts created to address unsafe practices are expected to serve as an innovative educational mechanism for providing support consistent with the usual learning practices for staff nurse preceptors, most of whom are digitally competent. This podcast approach to ongoing support provides an opportunity to strengthen and build the preceptor workforce, concurrently reinforcing caring connections between staff and students or novices. The findings of this research have the potential to provide guidance to nurse leaders regarding innovative ways to prepare and support nurse preceptors.

1.1. Background. Since 2002, Palm Healthcare Foundation, Inc., a grantmaking philanthropy serving Palm Beach County, Florida, has been convening the Healthcare Workforce Partnership (HWP) to advance professional nursing

practice. Today, the HWP is a volunteer community collaboration of nurse leaders and nursing stakeholders from a variety of healthcare settings and academe that serves as a catalyst for positive change; a resource to ensure an adequate supply of highly educated and trained nursing practitioners and faculty; and fosters innovation in the study and practice of nursing. The success of the HWP is grounded in the diversity of its members; a spirit of openness and collegiality by all the partners; and the ability to leverage and share resources and expertise across the community.

Over the years, the members of the HWP have identified specific strategies for, and implemented a number of programs and initiatives designed to address shared nursing challenges, including the nursing shortage; nursing leadership development; and the transition to professional practice for new nurses. Formal strategic planning sessions and a committee structure—including an education-practice gap (EPG) committee—facilitate this work.

Recognizing the critical role preceptors play in developing nurse professionals and the bridge they provide between the academic and clinical settings, the EPG committee has focused its work on efforts to strengthen the skill-set and role commitment of these key educators. This work builds on earlier initiatives of the HWP, including a *Preceptor of Excellence* training and recognition program that the partnership conducted from 2004 to 2008 for approximately 450 nurse preceptors throughout Palm Beach County. In addition, a series of focus groups and surveys conducted by the EPG committee in 2008 and 2009 with nurse preceptors and preceptees identified the need to expand involvement and cultivate the preceptor-student relationship.

Strengthening the preceptorship experience for students and preceptors supports needed realignment and change in nursing education, as detailed in the recent Institute of Medicine [9] report, "*The Future of Nursing: Leading Change, Advancing Health*", and The Carnegie Foundation for the Advancement of Teaching study, "*Educating Nurses: A Call for Radical Transformation*" [10]. The velocity of healthcare system and practice change and the growing knowledge demands for nurses are challenging academia to keep pace [11]. As nursing education is redesigned to produce an adequate number of well-prepared nurses to meet current and future health care demands [9], preceptor support and lifelong learning opportunities are critical because preceptors not only are an immediate link to student, but also represent potential future nurse faculty.

1.2. Literature Review. Nursing knowledge learned in the classroom comes alive when experienced staff nurse preceptors share their current practice-based knowledge with novice nurses [12, 13]. Preceptors have honed their teaching skills through patient teaching and can be expected to transfer this ability into teaching others in the clinical setting [13]. In a comprehensive literature review, Billay and Yonge [14] identify common defining preceptor attributes as role modeling, facilitating, communicating, sharing knowledge, and using adult education principles. Preceptors are accountable for providing bedside teaching and competency evaluation of novice nurses [15], ideally in a one-to-one relationship [13, 16] designed to facilitate novice nurse role development. The relationships between the nurse and novice epitomize caring, as an expression of the humanness of other [17].

According to Carper, "Caring is not readily, if at all, learned in a classroom or a formal course of study" [18, page 18]. Rather, "Caring is developed within the practitioner while practicing nursing, by modeling others and learning by doing, and may be demonstrated without intention, and without the language to express the actions that follow" [19, page 29]. The relationship between the staff nurse and novice thrives in the context of caring where each honors the other's gifts [17], but infusion of caring demands structural guidance for staff nurse preceptors engaged with novice nurses.

Preceptors expect support from their place of employment [5, 6], as well as from affiliated academic institutions [20–22]. Most frequently, support is provided as a formal, face-to-face preceptor orientation in preparation for coaching novice nurses [5, 23], although web-based preceptor courses have also been successful [24]. After orientation, updates in preceptor knowledge may be provided, but ongoing preceptor support is less likely to occur [1–4]. Once a preceptor is "established," that person is considered the resident resource for novices within the organization. Preceptors often report stress related to the difficulties in handling preceptee situations [7, 25, 26]; they are frustrated by negative experiences centered on preceptor-identified hallmarks of unsafe practice including: the inability to demonstrate knowledge and skills; attitude problems; unprofessional behavior; and poor communication skills [27]. Their unrealized expectations for novices threaten their commitment to their preceptor role [28].

The *expectation gap* between the preceptor and novice can make the difference in retaining practicing nurses, new hires, and the potential employee that a novice represents [7, 21]. The frustrated and overworked staff nurse of today may be hesitant to take on the responsibility of educating a novice nurse unless he or she recognizes available support systems and resources [20, 29]. Podcasts can be a supportive resource to address preceptor frustrations. The use of podcasts is a novel way to incorporate technology [30], consistent with the learning styles of digital natives. Podcasts serve as a demonstrated and valuable educational resource to review, reinforce, and clarify difficult concepts [31, 32]. Convenience and accessibility enable the preceptor to utilize this resource immediately when support and knowledge are needed most (reactively), or at any time when learning is sought (proactively).

2. Materials and Methods

This study was designed to develop and test educational podcasts that infuse caring principles into situations of unsafe practice that concern staff nurse preceptors. For the purpose of this study, preceptees were presented as student nurses, although the researchers acknowledge the larger role

that preceptors assume with all novice nurses. Consistency of student nurses as preceptees was chosen to avoid confusion during initial development and testing of the podcasts.

The podcasts provide an opportunity for the preceptor to learn effective ways of dealing with challenging situations, serving as a mechanism of ongoing support with potential to increase commitment to the preceptor role. This paper addresses the development of the podcasts as informed by qualitative focus groups. Resultant podcast scenarios will serve as a tool to assist the preceptor to use a caring approach when dealing with situations identified as unsafe [27].

Podcast scripts were written by the EPG committee based on the four hallmarks of unsafe practice [27]. Caring attributes of preceptors as identified through thematic analysis of BSN student interviews were incorporated in the scripts including; welcoming presence, demonstrating empathy, encouraging growth, patience and time as compassionate care, building relationships, and communicating therapeutically [19]. Small subgroups of two to three committee members were responsible for initial script development within a scenario, each addressing one of these hallmarks. The scripts were further refined through email exchange of ideas and a committee meeting. Preceptor caring responses were purposively embedded in the detailed scripted scenarios. The scenarios were then reviewed by Dr. Anne Boykin, an expert on caring theory, who agreed to be a consultant for this work. Dr. Boykin worked with the committee to assure the infusion of caring principles in the developed podcast prior to review by the focus group participants.

The intent of the qualitative focus groups was to have a range of informants provide feedback on the realism and credibility of each of the four podcast scripts. The committee felt it was important to include the stakeholders in review of the final podcast scripts, prior to filming taking place. Two small focus groups were held; this strategy is consistent with the recommendation of Morgan [33] to employ a smaller group when the participants are experts or well acquainted with the topic.

Initially, the researchers specified a central location to hold the focus groups, but the limited response prompted them to hold the focus groups at two designated locations that were convenient to the participants—one of which was a hospital and the other a college of nursing. Nurses responded voluntarily to e-mails, announcements from instructors and committee members, and/or conversations with one of the researchers to discuss their inclusion. No additional points or grades were attached to these activities and nonparticipation was not penalized. Participants were given a $20 gift card in appreciation of their time and expertise that was shared.

Two focus groups with different participants were held one week apart; each of the focus groups reviewed all four podcasts scripts. The first focus group lasted for 60 minutes and the second lasted for 70 minutes, including completion of the associated university IRB approved informed consent and demographic information. All focus groups were recorded and transcribed; field notes were written, and content was analyzed consistent with recommendations by Krueger [34, 35].

2.1. Participants. Each focus group consisted of five or six participants. The final sample size of 11 provided a purposive convenience sample of practicing nurses; a total of ten females and one male with an average age of 33 years (range = 20–59 years). Participants reported from less than one year to 26 years of nursing experience (mean = 4.821), and zero to six years preceptor experience (mean = 0.95). The participants' experience with various types of preceptees was reported as zero to five occasions precepting newly hired nurses; zero to two occasions precepting nurses transferring from another department; zero to 15 occasions precepting nursing students; and no experience precepting but self-described recent experience as a preceptee. The mean total number of precepting experiences was 3.27, with a range from zero to ten. Only 18% of the sample reported engaging in preceptor training of any kind. An Associate of Arts or Associate of Science was the highest educational degree earned for 55% of the participants, 36% were Baccalaureate of Science or Baccalaureate of Science in Nursing graduates, and 9% were Master of Science or Master of Science in Nursing degree graduates.

2.2. Focus Group Procedures. After explaining the purpose of the focus group research and obtaining informed consent from the participants, the principal investigator (PI) guided the focus group interview. First, the PI asked the participants to read each script (Table 1 summarizes the final content of the podcast scripts).

After each script was read, the PI asked three questions designed to direct the focus group discussion: Is this script true to nurse preceptor experiences? Are the nursing responses appropriate? and What would you add or remove from the scenario to enhance realism?

3. Results

The focus group interviews were recorded and transcribed. Field notes were written and used in the analysis process. Focus group content analysis was consistent with the Krueger method [35]. Inductive processes were used to identify themes, culminating in both generalized and specific guidance to enhance podcast realism and meaning for practice. Field notes were also considered which allowed the researchers to note key points, notable quotes, and observe body language and inflection, providing valuable insight. No identifying information was used in the analysis of transcriptions. The researchers read transcripts and field observations independently. Using descriptive analysis, six themes emerged in response to the key questions, which guided revision of the podcast scripts.

The first key question the PI asked the focus group participants was whether the scripts were true to nurse preceptor experiences. Transcript analysis and field note consideration identified the following themes.

Modeling and Learning Professionalism. Professionalism is a key concern of nurse preceptors, which was thought to be best learned through modeling of professional behaviors.

Table 1: Educational podcast design.

Preceptor identified hallmarks of unsafe practice [27]	Summary of podcasts
Attitude problems	The nursing student seems unprepared, unfocused, and overwhelmed, and just wants to "put in her hours" as opposed to seeking a quality experience. The nurse preceptor creates a supportive atmosphere as she helps the nursing student identify and work through her difficulties.
Poor communication skills	This podcast focuses on professional communication between student and patient, centering on the delivery of discharge instructions. The nurse preceptor has an opportunity to observe the student's approach and create a supportive atmosphere as she reviews critical aspects of this responsibility with the nursing student.
Inability to demonstrate knowledge and skills	A senior level nursing student is preparing to administer medication to two patients. The nursing student mixes up the medications for the two patients. The nurse preceptor gently stops the student and corrects the mistake before the patient takes the medication. Together the preceptor and student discuss what occurred (outside of the patient's room) and how to prevent a reoccurrence.
Unprofessional behavior	While interacting with a patient during medication administration, the nursing student is texting on her personal cell phone. The nurse preceptor politely excuses both himself and the student and discusses the situation privately with the student in a supportive and constructive manner.

The participants felt that within the scripts, the preceptor's tolerance of a student's actions and attitudes was not always consistent with nursing practice. Furthermore, they felt that in some scripted situations, the preceptors were too permissive and allowed students to inappropriately take control. They did not feel that those behaviors would help the student learn professionalism, and they commented that the preceptor should be a model for appropriate behaviors. An example of these behaviors was stated as follows:

> "To me, I think the preceptor is awfully friendly, a lot friendlier than I have ever encountered ever, and a lot more time is spent understanding the student. I mean it's awfully nice, but it's not realistic."

Some participants expressed differences between past personal experiences as preceptee conflicting with the preceptor caring behaviors represented in the scripts. The PI informed the participants that although the scripted interactions may not reflect their own precepting experiences, the purpose of the podcasts was to model caring behaviors critical to successful precepting.

Defining reality is a theme that identified truthfulness to nurse preceptor experiences in actual practice situations, a commonly identified division between nursing education idealism and nursing practice realities. When reviewing the scripts, there was some controversy about the reality of practice versus academic instruction. For example, in a script in which medications were administered there was discussion regarding whether the practicing nurse would ask patients the purpose of their medications (potentially preventing an error), or whether the nurse would inform the patient of the purpose of the medications while administering them. Students are taught to first ask the patient in order to assess knowledge but the preceptors were divided on this point; some stating that instruction while giving medications is more time efficient and others feeling it best to clarify what patients state they have learned about the medications. Overall, it was felt that either method is a variant of practice that is equally acceptable. Moreover, utilizing either method would not detract from the fact that the preceptor handled the prevention of the potential error professionally, as stated below:

> "She didn't, you know, like correct the student like right in front of the patient, let the patient know that there was an error going to happen, embarrass the student you know, none of that, she handled it very professionally."

Several participants thought that with the advent of medication administration software, many medication errors would be prevented in the future. But, the reality of nurse preceptor experiences may be in conflict with how students are taught.

The second key question the PI asked the preceptor focus groups was whether the nursing responses were appropriate. From the raw data, descriptive themes emerged.

Finding Solutions. Nurse preceptors feel caught between their responsibility as preceptors, and knowing how to handle uncomfortable student situations. At times, academe lacks clear guidance on the preceptor's role. The participants felt that the preceptor should consistently demand professional behaviors from the student, who needed to set aside personal problems and focus on the patient. They felt that there should be repercussions if a student is not prepared for an assignment, such as a drop in grade, allowing the student to observe without hands-on nursing care, or getting a third party involved, such as the manager of the unit or the instructor. Most of the participants agreed that, the majority of the time, the student should not be sent home because it would be punitive and counter-productive. Instead, they suggested that if the preceptor stated the expectations for the student's performance ahead of time, it might keep the student focused.

In addition the group suggested other potential solutions:

> "...Maybe not being able to pass meds at all for the day or just observation, because as students

> we really want to get the hands-on practice unless her goals are not in the right place. But, usually, we really want to get involved and get some hands-on knowledge. So maybe by telling her, "well, since you're not prepared you cannot pass any medications today"; and usually as a student she will be very upset. Like, oh man, so I better make sure I am prepared next time."

Preceptors and preceptees learn from each other. The theme *Working and learning together* describes how focus group participants felt the scripts could be enhanced, by showing the student performing patient care and demonstrating how scripted interactions between the preceptor and student enhanced the student's ability. After the demonstration, the preceptor and student could have a dialogue to demonstrate confidence in the student's ability, the value of teamwork, and a reminder that the preceptor will always be available for student support as stated here:

> "When the student nurse mentioned like, I just hope I don't forget anything,... I would give them like a reaffirming statement like, "you're not in this on your own", or, ..., Yes, I do trust you enough to do this on your own; if you need my help or support I am still here for you."

More specifically, the focus group participants felt that the scripts should not present intentionally conflicting situations; such as both patients' medications being pulled at the same time, particularly with sound-alike/look-alike medications. However, the participants said it is realistic that you would pick more than one patient's medication from the PYXIS at one time. Some participants in this group thought that the student should be given more independence while having the support of the preceptor as a safety net, which provided an excellent learning opportunity as stated here:

> "And that was good she let her go through the motions up until the point you know, but it's good. I think she was kind of waiting to see if maybe she would catch her own mistake. I think it was handled well."

In this example the nurse preceptor and student were *working and learning together* and the nursing responses were deemed appropriate.

The final key focus group question "What would you add or remove from the scenario to enhance realism?" triggered specific suggestions from the focus group participants to "fine-tune" each of the podcast scripts. The participants shared the importance of *setting realistic expectations*, an overarching theme throughout this work. In one script, the participants felt that the preceptor should have reviewed the discharge instructions with the student before going to the patient's room, to be sure that the student was prepared and knew the important points to review with the patient. Since there are too many things at stake, including core measures and patient satisfaction, the participants said that the preceptor would never let the student give discharge instructions alone:

> "But if we teach them and we set the tone, "this is what we expect from you" instead of let them do whichever way they come from, this way we will first prevent and make sure that they do the right thing. ..."

Reproducing reality is the final theme related to the appropriateness of nursing responses as identified by the focus group participants. This theme differs from *defining reality* in that "defining" identifies education versus practice realities, where "reproducing" refers to the realities of contemporary society. For example, in one script the student was talking on a cell phone while in a patient room. While the participants agreed that the preceptor handled the cell phone situation very professionally (explaining not only that the behavior was unprofessional, but also that it was against the rules, unsafe, and why), the participants suggested that the scripted unprofessional behavior change from a phone call to texting, to reflect contemporary concerns as stated below:

> "I can see how they would, the student here would think, oh, it's you know, because we pick up our *Spectralinks* ®in the room. ... But, I think texting would be better."

4. Discussion

The focus group participants identified many different concerns to guide revision of the podcast scripts, thereby allowing the potential stakeholders to inform this technology-based intervention of ongoing preceptor support. Each of the podcast scripts was revised to reflect the suggestions gleaned through thematic analysis of focus group content. Podcast (1) *attitude problems*—was made less wordy, but struck a better balance between the intolerance for the student's lack of preparedness and the preceptor's sensitivity to the student's attitude. Indeed, this scenario provoked the most discussion between reviewers of this podcast. The focus groups' feedback served to enhance the dialogue and the intended outcome. Podcast (2) *communication*—was revised to include the student providing the discharge instructions to the patient a second time, after the preceptor and student had the opportunity to discuss discrepancies with the student's method and content. The student performance expectations were emphasized in the revised script, as well as preceptor support and confidence in the student's ability. Minor revisions were made to Podcast (3) *inability to demonstrate knowledge*—since the focus group participants agreed to the realism of the situation, particularly with senior level students. In addition, the focus group participants concurred that, although software may mitigate medication errors, they still might occur and near misses proved an invaluable learning tool. The script was revised to emphasize that the preceptor brought the look-alike sound-alike phenomena to the student's attention before an error could be made. In the script for Podcast (4) *unprofessional behavior*—the phone call was changed to a texting scenario, in keeping with the unanimous suggestion from both focus groups. The focus group feedback aided the researchers in creating a final

product with enriched content authenticity and authority, which was the overall intent of the focus group approach.

Although the intent of the study was to include only experienced preceptors in the focus groups, three of the participants recruited by an EPG committee member were novice nurses who had not served as preceptors, but had recently been preceptees. Initially, it was considered that this might limit the development of the scripted scenarios. In actuality, these participants brought personal insights to the student role, which created lively discussion within this group. These recent preceptees shared that, although the situations may be realistic, the scripted preceptor's actions were not consistent with some of their personal experiences. Surprising to the researchers, the recent preceptee participants were more likely to suggest sending the student preceptee home or to take punitive actions. However, they also appreciated the kinder, gentler approach to potentially unsafe preceptee behaviors suggested in the scripts. They discussed how reviewing these scripted podcast scenarios would make them less likely to repeat inappropriate preceptor behaviors that were experienced in their personal student development.

The focus group participants were enthusiastic about the availability of the podcasts to serve as an ongoing resource for nurse preceptors. In addition to responding to the focus group questions for the podcast scripts addressing previously identified hallmarks of unsafe practice [25], the participants offered the following suggestions for future podcast themes:

(i) teamwork, interacting with coworkers;

(ii) communicating with physicians;

(iii) computerized physician order entry;

(iv) incorporation of core measures into the scenarios.

5. Conclusions

Involving the stakeholders when designing a technology-based strategy of preceptor support has enhanced this project and conjoined nursing education and nursing practice. The focus group participants supported the infusion of technology-based podcasts as a method of ongoing preceptor support. Finally, the participants, representing a range from recent preceptees to experienced preceptors, brought practical experience to the design of the podcast scripts by answering the questions; Is this script true to nurse preceptor experiences? Are the nursing responses appropriate? and What would you add or remove from the scenario to enhance realism?

5.1. Limitations. A possible limitation of this study may have arisen when novices and experienced preceptors were comingled within one focus group. Krueger [35] warns that focus group participants may influence each other, sometimes seeking to convert an individual's point of view. While intimidation from either group was not observed in body language or discussions, this does not preclude a member's reluctance to share an opinion regarding one of the scripted scenarios. However, having gained the unexpected insight from the novice nurses regarding their experience with preceptorships, perhaps another stakeholder group, that of students, will be added to elicit feedback on future podcasts from their perspective. An important lesson learned from our unintentional inclusion of novice nurses in the focus groups is that all stakeholders need to inform the podcasts, which emerges from their unique vantage point as to the realism of the situations.

5.2. Future Directions. Content saturation occurred quickly with the focus groups and the participants supported further development of this project. The podcasts have been filmed and are currently being edited. The next step of this funded study is to make the podcasts available to a selected group of preceptors during their experience with students and evaluate their perception of support using this technology-based intervention. Those research results will direct the further development of a *library* of podcasts that would be continuously available and without cost to all preceptors via a publically accessible website. While student nurses have served as the preceptee within the initial scripted scenario, further podcasts might represent preceptor engagement with novice nurses.

Future directions of this work are to research the effectiveness of podcasts as teaching tools to improve preceptor skills, facilitate knowledge transfer to preceptees, and improve the quality of patient care. As nurse residency programs continue to emerge and the central role that preceptors inhabit is acknowledged, podcast technology has the potential to develop and support preceptors in a cost-effective and contemporary manner.

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Research Article

A Comparison of a Traditional Clinical Experience to a Precepted Clinical Experience for Baccalaureate-Seeking Nursing Students in Their Second Semester

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The shortage of nursing faculty has contributed greatly to the nursing workforce shortage, with many schools turning away qualified applicants because there are not enough faculty to teach. Despite the faculty shortage, schools are required to admit more students to alleviate the nursing shortage. Clinical groups in which preceptors are responsible for student learning extend faculty resources. *Purpose.* To determine the effectiveness of an alternative clinical experience (preceptorship). *Methods.* quasi-experimental, randomized, longitudinal design. Students were randomized to either the traditional or precepted clinical group. The clinical experience was a total of 12 weeks. Groups were compared according to several variables including second semester exam scores, HESI scores, and quality and timeliness of clinical paperwork. *Sample.* Over a two-year period, seventy-one undergraduate nursing students in the second semester medical-surgical nursing course participated. 36 were randomized to the experimental group. The preceptors were baccalaureate-prepared nurses who have been practicing for at least one year. *Setting.* Two hospitals located in the Texas Medical Center. *Statistical Analysis.* Descriptive statistics and independent t-test. *Results.* There was no difference between the groups on the variables of interest. *Conclusion.* Students in the precepted clinical group perform as well as those in a traditional clinical group.

1. Introduction

A recent report published by the American Association of Colleges of Nursing (AACN) noted that over 67,000 qualified applicants were not accepted into baccalaureate and graduate nursing programs in the USA in 2010. The report also noted that almost two-thirds of the nursing schools participating in the survey noted that faculty shortage is the primary reason for not accepting all qualified applicants into baccalaureate programs [1]. The consequence of a nursing shortage is nurses work longer hours under stressful conditions, which leads to nurses being more prone to making mistakes and medical errors. Subsequently, patient care suffers.

Schools of nursing are increasingly using hospital-based nurses to precept students during clinical rotations. These nurse preceptors extend the faculty at a time when a shortage of nursing faculty limits nursing school enrollment. Combined with initiatives already in place, such as using master's prepared nurses at the hospital as loaned faculty, compressing students' clinical rotations and assigning clinical rotations to off-shifts or, in less popular nursing units, using nurse preceptors as clinical faculty helps in two ways: it increases the number of available clinical nursing slots and it provides qualified clinical instructors. As little quantitative research on the effectiveness of using preceptors as clinical instructors early in a nursing program has been reported, this study looks at the question "Given baccalaureate students in their second medical-surgical class, do precepted students perform as academically well as traditionally prepared students?"

Clinical groups in Texas traditionally have a ratio of one master's prepared instructor to 10 students. The instructor's

role is to monitor students in the clinical setting and instruct them in meeting their educational learning objectives. When class size is extended to increase enrollment, procuring a sufficient number of qualified clinical instructors is often difficult. That nurses qualified for teaching can make higher salaries working as a nurse in a hospital than as faculty in a university exacerbates the faculty shortage problem. Additionally, as the number of clinical slots dedicated to nursing students is limited, schools in the region compete with each other.

Nursing students today differ from students of past generations [2]. Students often demand accessible and timely information, and they want flexibility to meet their needs of working, studying, and raising a family. The younger students rely heavily on technology for learning, entertainment, and life scheduling. Learning experiences must be not only timely, but also relevant [3]. Students precepted one-on-one with registered nurses (RN) in hospital settings are more likely to find their needs met than is possible under a traditional group model, which permits less interaction between faculty and student, limits student opportunities for learning and skills practice, and provides an inaccurate view of the profession [4, 5].

According to the Texas Board of Nurse Examiners [6], master's prepared faculty can oversee the teaching activities of 12 RN preceptors, each of whom can supervise two undergraduate students. Using preceptors as clinical faculty alternatives more than doubles the number of students ($N = 12 \times 2 = 24$) than can be placed in traditional clinical rotations ($N = 10$). The policy established by the Texas Board of Nursing states that a precepted student must be visited by a faculty member at least once a month. Faculty conducting the study rounded on precepted students at least twice a month since the students were early in their nursing program.

Hospital-based clinical preceptors, as alternatives to clinical faculty, expect adequate support to function within the educator role [7]. According to Yonge and Myrick [8], preparation of preceptors includes teaching educational principles that help prepare the preceptors beyond their usual staff nurse orientation. Wilkes et al. [9] identified that continued support materials, beyond orientation, were essential to success. This support can be online and extended to faculty and students [10]. Using hand-held computers allows preceptors to obtain support at the bedside when time is at a premium and desktop services are not available [11]. The use of hand-held computers with internet access is an effective way for preceptors to obtain information, such as faculty contact information, school policies, and student clinical schedules, prepare anecdotal notes, and search for useful clinical information [12, 13].

Use of the precepting alternative also frees up additional nurses and hospital units for clinical training; nurses on smaller units not able to support a traditional group of 10 students could precept one-on-one and nurses working off-shifts can serve as preceptors [14]. Students participating in precepted groups find that they have more scheduling flexibility, greater opportunities for learning and practicing skills, and more relevant learning experiences [15].

Table 1: Online Modules Available to Nurse Preceptors.

Module No.	Module title
1	Nurses and the educational process
2	Preceptorship and nursing education
3	Applying learning theories to teaching
4	Assessing learning styles
5	Learning contracts
6	Motivation to learn
7	Critical thinking
8	Communicating with students
9	The impact of technology on education
10	Ethical and legal issues in clinical nursing education
11	Clinical evaluation of students
12	Evidence-based practice
13	Cultural competency and health care
14	Educating students with special needs

To prepare the nurses for the preceptor role, the researchers developed a 14-module online preceptor education course. The module units, listed in Table 1, were designed to provide direction on teaching students as adult learners and to promote critical thinking in nursing students. The online training was offered through Blackboard. The project team, including faculty and hospital educators, attended the preceptors' presentations to offer technical training and support. Upon completion of the preceptor training, nurses received 9.6 continuing education units.

Having Blackboard access also gave the RN preceptors access to the students' course materials, including syllabi and lecture notes, which permitted the RN preceptors to provide clinical experiences that met the learning objectives and to keep pace with the students learning progression. As nurses traditionally work with new hire graduates and not students in their second semester of nursing education, it was important that preceptors knew that these students would not perform at the same level as a new graduate nurse.

Technology assisted in permitting continuous availability of faculty and in forming a communication net for students, preceptors, and faculty. Communication was via a dedicated web page, E-mail, cellular phones, traditional pagers, and handheld computers. Preceptors working at the bedside could communicate with nursing faculty in the office. Using the handheld computers, preceptors had a rapid means of access to relevant nursing and drug information while they were working with the students.

In addition, the research faculty and project staff developed a project-specific website to provide quick access to contact information, school policies, performance issue information, tips and topics, and links for emergencies and needle sticks. The website was a resource for preceptors and students whether the students were precepted during school hours or on off-shifts. Both preceptors and students could rapidly locate faculty contact information or receive technical support 24 hours a day. This was necessary as

the precepted students worked the schedule their preceptor worked, whether this was a day, night, or weekend shift. E-mail group links permitted communication to the project staff and the control and experimental student groups. The availability of student performance information and school policies assisted preceptors to take appropriate action in addressing student attendance, dress and appearance, safety, and professionalism issues.

Using Blackboard to deliver the education course online permitted the RN preceptors to complete the training at their convenience; it also gave them access to additional learning resources. Since the students worked all shifts, discussion boards were set up to support communication and submission of assignments. Nursing faculty moderated the discussion postings and responded accordingly. Additionally, faculty and hospital educators periodically made rounds when students were scheduled to be with their preceptors to stay in contact, answer questions, and provide support. This also permitted faculty to assess student progress and preceptor effectiveness. The use of technology helped to decrease preceptor resistance in precepting students without the instructor being present and increased faculty assurance in the quality and relevance of the preceptors teaching.

The students had to complete a total of 96 hours in the clinical setting and were permitted to work between 8 and 24 hours per week. For faculty to keep track of student schedule and hours, students posted their clinical schedule at least 48 hours prior to working with their preceptor. Faculty held weekly post-clinical conferences with students at the school to answer questions and reinforce learning objectives. However, faculty were available to the students and preceptors by cellular phone twenty-four hours a day.

2. Methodology

The study used a quasi-experimental design where students ($N = 69$) were randomly assigned to a control group (traditional clinical group) or experimental group (precepted group). The subjects were in the second semester of their nursing education, and instruction that semester included pharmacology, gerontology, pathophysiology, and the second medical-surgical nursing course. Both experimental and control students volunteering to participate in the study submitted an informed consent form in accordance with the university's Institutional Review Board policy.

For experimental and control groups, the student's accumulative numerical course grade in medical-surgical course 1 (taken in the first semester) was used as an independent variable. The dependent variables were students' numerical grades on unit examinations given throughout the semester, comprehensive final examination grades, and accumulative numerical course grades in both the medical-surgical course 2 and the corequisite pharmacology course. Both experimental and control students took a standardized medical-surgical exam. Although scores earned on exams administered to measure what the student learned in the classroom does not have established reliability and validity for measuring clinical performance, issues surrounding clinical evaluation exist. Some of the identified issues pertinent to this study include the subjectivity of the evaluation especially when using "novice" clinical faculty. Novice faculty (bedside nurses serving as preceptors) may have limited formal education and experience in evaluation of students and often lack confidence in their ability to fairly evaluate students [16, 17].

Using a grading rubric, two faculty members on the research team reviewed the precepted student's nursing process papers at weeks 4, 8, and 12 and recorded these grades. To increase interrater reliability, the two researchers critiqued one student's paper prior to week 4 to standardize scoring.

A clinical evaluation form was developed for preceptor use (Table 1 in supplementary material available online at doi:10.1155/2012/276506). After each 12-hour shift, the preceptor evaluated the student's clinical performance and faxed the form to the research team. Content covering the process of clinical evaluation was included within the online preceptor course. Faculty reviewed clinical evaluations after each shift worked by the student. If a student is consistently scoring 2 or less on the evaluation, the faculty meets with the preceptor to discuss the weaknesses of the student. Faculty would meet with the student as well to discuss strategies for improving their clinical performance. The final clinical evaluation was completed by the faculty and was based on data from the preceptor evaluations, the nursing process paper grades, and the faculty's impressions when rounding on the student in the hospital.

2.1. Sample and Setting. The students were randomized into two groups, experimental or precepted group ($N = 37$) and control or traditional group ($N = 32$). The sample consisted of 6 male and 63 female students. The precepted students were assigned clinical rotations at two tertiary-level hospitals, where they worked one-on-one with a baccalaureate-prepared registered nurse (RN) on a medical or surgical unit or a surgical intermediate care unit. As per the request of the two hospitals, precepted students could not work on the days other school of nursing held their traditional clinical. This meant that there was one day a week in which the precepted students could not schedule a clinical day. Precepted students were not exposed to the traditional students or their faculty when working. The control students were mixed within the traditional training groups of 10 students, and these groups were assigned to medical-surgical floors at various local hospitals.

Hospital educators recruited the preceptors. The criteria for eligibility were that the RNs (1) have at least one year experience as a registered nurse; (2) have a recent satisfactory annual evaluation by their nurse manager; (3) have a current BCLS and nursing license; (4) completed the online preceptor education course; (5) graduated from a baccalaureate nursing program. Inclusion criteria for students were that they were in their second semester of nursing school and had not previously withdrawn from or failed a class.

2.2. Data Analysis. The students' final numerical course grade from the first semester medical-surgical course was analyzed using an independent sample t-test to determine

whether the first semester grade needed to be used as a covariant. However, this test showed no significant difference between the experimental and control designated groups. Student 2nd semester medical-surgical examination scores (4 units and 1 comprehensive final) were analyzed using a mixed model approach for repeated measures ANOVA. Final numerical grades from their pharmacology course and a standardized specialty medical-surgical examination (HESI) were analyzed using independent sample t-tests.

3. Results

No significant differences between the experimental and control groups on any measurement were found. For discussion purposes, an implication is that precepted students did as academically well as students in the control group. Likewise, this could be stated, as precepted students do no better than traditional students academically despite the one-on-one clinical treatment. Given this, the study supports using hospital-based RN nurses as clinical preceptors. Using RNs as preceptors not only provides much needed clinical faculty but also frees up clinical slots that previously have not been available.

3.1. Analysis of the Medical-Surgical Course Grades. The four unit examination grades and the final examination grade were analyzed using a mix model approach for repeated measures ANOVA. There was no statistically significant difference between the precepted and control groups ($F = .936$, df = 63, $P = .449$). Mean grade scores for the examinations are presented in Table 2.

An independent sample t test was computed to determine if there was a significant difference between precepted and control groups in academic performance as demonstrated by the final course grade students received in their second semester medical-surgical course. Students in the traditional clinical group had a mean of 83.7 (SD = 5.9), and the precepted students had a mean of 83.5 (SD = 4.6). There was no statistical difference between the two groups ($t = .118$, df = 67, $P = .906$).

3.2. HESI Medical-Surgical Specialty Exam. As second semester students take the Health Education Services Inc. (HESI, now owned by Elsevier) medical-surgical specialty exam at the end of the semester, this mean score was considered in the analysis. The mean standard score for the traditional students was 784.19 (SD = 182.5) as compared to a mean standard score of 807.76 (SD = 136.7) for the precepted students. However, there was no statistical difference between the two groups ($t = -.612$, df = 67, $P = .543$).

3.3. Pharmacology Final Course Grade. Students in the traditional clinical groups usually prepared medication cards the day before each clinical session. As students in the precepted group did not know which patients their preceptor would have until report, they had to take a different approach. They reviewed each medication and presented the information to their preceptor before administering the medication. In analyzing pharmacology final course grades, there was no statistical difference between the two groups ($t = -.786$, df = 67, $P = 434$). The students in the control group had a mean grade of 89.1 (SD = 3.8), and the precepted group had a mean of 88.3 (SD = 4.8).

Table 2: Mean Scores for 2nd semester BSN student medical-surgical course.

Examination	Group	Mean	SD
1	Control	88.7	6.3
	Experimental	88.4	5.5
2	Control	87.3	7.9
	Experimental	87.6	7.3
3	Control	84.9	5.5
	Experimental	86.1	5.5
4	Control	83.0	8.5
	Experimental	81.1	9.0
Comprehensive	Control	78.1	8.1
	Experimental	77.9	6.8

3.4. Clinical Evaluations. On average, the students in the precepted group received ratings of 3–5 for the clinical competencies listed on the clinical evaluation form. As expected, some preceptors were more confident in their role as clinical evaluator. Confident preceptors not only rated the clinical performance, but also provided anecdotal information to justify the given ratings. Preceptors did note that the clinical evaluation process was an added responsibility to their busy clinical day.

3.5. Nursing Process Papers. Unlike students in the traditional group, precepted students arrived for their shift with no preparatory work in place. The student and their preceptor selected one patient as the student's primary patient for that shift. Although the precepted student was responsible for obtaining the same information as that of a traditional student, the precepted students did this on shift and completed the nursing process papers retrospectively. The faculty found that the quality of the nursing process papers were similar between the precepted and the traditional groups. Students in both groups struggled with parts of the nursing diagnosis ("related to" statement) and setting measurable expected outcomes. Precepted students demonstrated a better comprehension of the importance of replanning. Another difference between the two groups was timeliness. The precepted students, instructed to turn in their paperwork within a week of completing the shift, tended to fall behind, allowing the paperwork to accumulate.

3.6. Challenges. The research team confronted several challenges during the two-year study. One major challenge was merging the technology of two different institutions via Internet. The information technology (IT) member of the research team worked closely with the two hospitals that participated in the study. The IT personnel from the two

hospitals and the university had to breech the "firewall" that existed between institutions. IT teams on both sides were involved and were able to accomplish this task. Once the two systems were connected, the IT member of the research team met with preceptors one-on-one to help them navigate the Blackboard site within the university. The IT personnel discovered that many nurses were not technologically perceptive. The IT member held mini tutorials to help the preceptors learn how to use their institution's intranet, access the university's Blackboard site, and navigate the preceptor course. This challenge was not anticipated by the research team and did require additional time not planned in the original proposal.

Overall, the experiences with the preceptors were positive. Most preceptors had served in the role in the past, orienting new hires on their respective units. One occasion arose where a preceptor placed the student in a dangerous situation (administering medications without being present). The student reported the incident, and working with the institution, the preceptor was replaced with another nurse.

Another challenge was the evaluation process by the preceptors. Although many of the preceptors have mentored new nurses on their units, they had not participated in a formal evaluation process. Some preceptors would circle all the same number on the Likert scale clinical performance evaluation and would not provide any commentary. The members of the research team would meet with preceptors and ask for a verbal evaluation of the student's performance. Questions asked included an assessment of the student's ability to perform a focused review of systems and physical exam, knowledge of medications and their administration, and the potential to use the nursing process to plan appropriate care for the patient, for example. Meeting with preceptors frequently provided more insights into the clinical performance of the student. Reviewing the nursing process papers also provided insights as to how the student was performing in the clinical setting.

4. Discussion

In the last decade, we have seen an increase in the number of applicants to nursing programs, a decline in the number of nurses in the workforce, and a decline in the number of nurses who pursue a career in academia. With the nursing shortage, demands are made on schools to increase enrollment; however, with the shortage of nursing faculty, this demand has been difficult to meet. As a barrier to increasing enrollment has been clinical availability [5], a solution is using nurse preceptors to extend faculty in the clinical setting.

This project examined the use of preceptors, supported by training and technology, to facilitate the clinical experience of students in their second semester medical-surgical course. Precepting students are not a new concept within nursing; however, a preceptor support model for students early in their nursing education has not been fully studied [14]. The purpose of the study was to determine whether students who were precepted performed as well as those in a traditional clinical group. As there was no significant difference in performance on grades and HESI scores, the premise is upheld. The results suggest that from an academic perspective, providing clinical education when using qualified and trained preceptors did not interfere with the student's ability to master the course content.

The quality of the nursing process papers produced by students was deemed to be equal between the two groups. Students in both groups were provided feedback on their papers and were asked in equal proportion to resubmit work. The quality of the medication information sheets was found to be equivalent. As the main problem encountered was the timeliness of the submission of the paperwork, a solution would be to design a mechanism within the computer-scheduling program that locked out students from posting their schedule until all nursing process paperwork was completed.

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