IT'S COMPLICATED: STAFF NURSE PERCEPTIONS OF THEIR INFLUENCE ON NURSING STUDENTS' LEARNING

by

Sarah Hanson

B.A., Trinity Western University, 1994

THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF SCIENCE IN NURSING

UNIVERSITY OF NORTHERN BRITISH COLUMBIA

April 2016

© Sarah Hanson, 2016
Abstract

The focus of this study is to extend our knowledge of teacher-led clinical practica from the perspective of the staff nurse. Nurses’ self-appraisal of their contributions to nursing students’ learning is an important element in enhancing our understanding of clinical education. This is particularly important in nursing education, in which much of the integrated learning takes place within the context of complex hospital environments and is often rooted in the informal interactions that occur between students and staff nurses. The student–staff nurse relationship not only impacts students’ learning outcomes, but also students’ desire to remain in the program, and ultimately, the profession. Given the importance of these interactions to student learning outcomes and the fact that the staff nurses may not even perceive that these interactions are part of the learning cycle, it is time to examine this phenomenon more closely.

This study used a qualitative descriptive approach to answer the question: How do staff nurses perceive their contributions to nursing students’ learning during teacher-led practica? Interview transcripts of nine staff nurses’ interviews within a Northern British Columbia regional hospital were analyzed. The findings show that nurses’ interactions with nursing students is complicated. Nurses wanted to train up their future colleagues but felt a significant burden of responsibility when having students on the wards. The sense of burden for the staff nurses was influenced by several factors: nurses’ experience of the practice environment, their experience of the clinical instructor, their experiences of the students themselves, and their understanding of their own contributions to nursing students’ learning. Despite the multiple factors that contributed to the staff nurses’ sense of burden, they
remained willing to support student learning. Implications for nursing education, nursing practice, and future research are discussed.
# Table of Contents

Abstract ........................................................................................................................................... ii  
List of Abbreviations ....................................................................................................................... vii  
Acknowledgements ........................................................................................................................ viii  

Chapter 1: Overview ....................................................................................................................... 1  
  Purpose and Research Questions ................................................................................................. 2  
  Study Context ............................................................................................................................... 3  
  Background ................................................................................................................................ 6  
  Researcher Context ...................................................................................................................... 7  
  Overview of the Thesis ................................................................................................................ 8  
  Definition of Terms ..................................................................................................................... 9  

Chapter 2: Literature Review ......................................................................................................... 10  
  Search Methods and Criteria ....................................................................................................... 10  
    Key search terms ....................................................................................................................... 11  
    Inclusion criteria ...................................................................................................................... 11  
    Exclusion criteria ..................................................................................................................... 11  
  Clinical Practice Environment .................................................................................................... 11  
  Clinical Learning Environments ................................................................................................. 12  
  Clinical Practice Models ............................................................................................................ 14  
    Teacher-led model .................................................................................................................... 15  
    Preceptorship model ............................................................................................................... 16  
    Dedicated education unit model .............................................................................................. 17  
  Professional Socialization and Role Modelling ....................................................................... 19  
  Staff and Student Nurse Relationships ..................................................................................... 21  
    Role of the preceptor ................................................................................................................. 23  
    Benefits and challenges in preceptoring ................................................................................ 23  
    Student nurse contributions .................................................................................................... 25  
  Summary ..................................................................................................................................... 28  

Chapter 3: Design and Methodology ............................................................................................ 30  
  Qualitative Research Methodology ............................................................................................ 30  
  Qualitative Description ................................................................................................................. 31  
  Study Location ............................................................................................................................. 32  
  Participants .................................................................................................................................. 33  
    Participant recruitment ........................................................................................................... 33  
    Inclusion criteria ..................................................................................................................... 34  
  Data Collection ............................................................................................................................ 34  
  Data Analysis ............................................................................................................................... 36  
  Evaluative Criteria ....................................................................................................................... 39  
  Ethical Considerations ................................................................................................................ 43  
    Confidentiality and anonymity ................................................................................................. 43
List of Abbreviations

DEUs....... Dedicated education (or teaching) units
NCBNP ... Northern Collaborative Baccalaureate Nursing Program
NHA ...... Northern Health Authority
NSCCA .. Nursing Students’ Contributions to Clinical Agencies
RN .......... Registered nurse
RPN......... Registered psychiatric nurse
UHNBC... University Hospital of Northern British Columbia
UNBC ..... University of Northern British Columbia
Acknowledgements

A learning journey of this magnitude is never accomplished alone. I would like to express my deep gratitude to Dr. MacLeod, Dr. O’Neill, and Catharine Schiller, my research supervisors, for their valuable and constructive suggestions during this thesis process. Your generous sharing of knowledge, skills, and encouragement have enhanced this learning experience. I would also like to offer my special thanks to Dr. Lela Zimmer for your unwavering belief in my scholarship and this project.

I wish to acknowledge assistance provided by the Research Project Award (RPA) grant from the UNBC Graduate studies department. This funding enabled the professional transcription so capably provided by DaVerne Wood.

Finally, I wish to thank my husband, children, along with my family and friends. Their ongoing love and support has been foundational in my success.
Chapter 1: Overview

The successful, effective, and efficient operation of the health care system in Canada is heavily reliant upon a highly functional team of health care professionals, predominantly nurses. Not only does the health care system require a large number of nurses, but also, to be part of highly functioning teams, these nurses need to be well educated, clinically competent, and properly socialized within their profession (MacMillan, 2013). The availability of such nurses is dependent upon a successful education process that effectively balances academic preparation and real-life practice experiences (Budgen & Gamroth, 2008; MacMillan, 2013). In the case of nursing students, real-life practice preparation takes place within a clinical learning environment.

Researchers widely agree that the opportunity to learn and interact in one’s future career setting can be transformative and can shape the way that nursing students make decisions in their nursing practice (Benner, Sutphen, Leonard, & Day, 2009). Learning to be a nurse is most effective in an environment in which students feel safe and welcome. Clinical learning can be best accomplished through positive experiences with nursing staff who provide support, supervision, teaching, and modelling (Bahn, 2001; Levett-Jones, Lathlean, McMillan, & Higgins, 2007). Atack, Comacu, Kenny, LaBelle, and Miller (2000) affirmed that experienced nurses make valuable contributions to student learning by sharing their critical thinking and clinical reasoning skills. However, nurses care for complex patients in settings that are increasingly underresourced, resulting in both a high patient–nurse ratio and limited time to support nursing students (Grindel, Bateman, Patsdaughter, Babington, & Medici, 2001). These competing demands on staff nurses can negatively influence the clinical placement of students and create a breaking point for the staff nurse (Omansky,
Nevertheless, both educators and health care leaders hold an expectation that staff nurses will create a nurturing learning environment for students while coping with a myriad of stressors. It is therefore not surprising that nurses can harbour attitudes that may damage students' learning (Stagg, 1992), or that there remains ambiguity and confusion for staff nurses regarding how to best support clinical education (Henderson & Tyler, 2011). These tensions pose a significant problem because nursing students say that their interactions with staff nurses influence them more than their interactions with clinical instructors (Dunn & Hansford, 1997). The student–staff nurse relationship not only impacts students' learning outcomes, but also students' desire to remain in the program and, ultimately, the profession (Coudret, Fuchs, Roberts, Suhrheinrich, & White, 1994; Dunn & Hansford, 1997).

The informal interactions between staff and nursing students during teacher-led practica have been largely overlooked in the nursing literature. Due to the importance of these interactions to students' learning outcomes, it is important that this phenomenon is examined more closely. Increased understanding of staff nurses' perceptions of their contributions to nursing students' learning, allows nursing educators and administrators to better support both the staff nurses' practice and nursing students' educational environments.

**Purpose and Research Questions**

The purpose of this study was to understand teacher-led clinical nursing education from the staff nurse’s perspective. The research focused on the complex, and largely previously unexamined, informal relationship between staff and nursing students in teacher-led practica. The study sought to understand how staff nurses perceive their contributions to the education of nursing students.
Both health service and postsecondary education sectors are challenged to provide effective clinical education (Sedgwick & Harris, 2012). Given the recent call for radical review and revision of the education of nurses at both the national and provincial level, understanding staff nurses’ perceptions of their contributions to student learning is both necessary and timely (Canadian Nurses Association, 2012; MacMillan, 2013). The outcomes of this study may assist nursing educators and nursing administrators to better support staff nurses in their teaching and professional socialization functions with nursing students. The following question guides this thesis: How do staff nurses perceive their contributions to nursing students’ learning during teacher-led practica?

Study Context

There is currently a call for radical transformation of nursing education in Canada (MacMillan, 2013). The recent document prepared by the National Expert Commission and mandated by the Canadian Nurses Association (2012) asserted, “Nothing is more fundamental to transforming health care than the way professionals are educated” (p. 45). Additionally, a small gathering of educational leaders from Canada, the United Kingdom, and United States have responded to the National Expert Commission’s recommendations, concluding that any transformative change will require collaboration with students, unions, nursing regulators, and nursing administrators (Canadian Nurses Association, 2012; MacMillan, 2013). The complex and ever-changing health care terrain requires a significant alteration in approaches to nursing education in order to match the competencies required of new graduates as they attempt to meet shifting patient care and population-based needs (Benner et al., 2009; Jeffs, 2013; MacMillan, 2013).
A major change in Canadian undergraduate nursing education occurred during the 1960s and 1970s, when education moved from apprenticeship models in hospital settings to universities and colleges. Following this change, the increasing demands and complexities of the practice environment have resulted in all Canadian provinces (with the exception of Quebec) making the entry-to-practice requirement at the baccalaureate level (Budgen & Gamroth, 2008; MacMillan, 2013). The move to postsecondary institutions was intended to improve nursing education and to allow for greater recognition of nursing as a discipline with both practice and academic elements (Budgen & Gamroth, 2008). There is some evidence that nursing’s academic legitimacy has been established with the creation of degree preparation as the entry-to-practice standard and the addition of graduate programs. However, some nurse leaders also expressed concern that, in trying to gain such academic recognition, schools of nursing have favoured research and publishing over practice and now need to refocus their pedagogy on the fundamentals of nursing care (MacMillan, 2013). Teaching and learning these fundamentals of care requires refocusing on the practice setting rather than classroom and clinical practice labs.

The need to integrate theory and practice keeps the clinical learning experience at the core of professional nursing education; throughout their education, nursing students are typically provided with opportunities to consolidate their knowledge and skills while socializing into the profession and gaining professional values (Chan, 2001; Levett-Jones, Lathlean, Higgins, & McMillan, 2009). Rafferty (2013) asserted that the calibre of nursing education is highly dependent on the quality of the nursing practice environment. Clinical placements are intended to provide positive experiential learning opportunities (Levett-Jones et al., 2007); however, existing stressors within both education and health care settings have
created challenges in obtaining and providing positive clinical experiences (Henderson & Tyler, 2011; Levett-Jones et al., 2007; Slaughter-Smith, Helms, & Burris, 2012). Sedgwick and Harris (2012) concluded that continual restructuring within the Canadian health care system, together with an increased number of seats in nursing programs, have strained clinical practice settings beyond their capacity. Key stakeholders, including government, industry, health, and education providers, as well as researchers, continue to raise concerns about the nature, quality, and amount of clinical learning opportunities that can realistically be made available to students (Mannix, Faga, Beale, & Jackson, 2006). The unstable environment of the clinical setting, a higher acuity of patients, and frequent shortages of staff and faculty can all contribute to a less-than-ideal clinical learning environment in which supervising students is difficult (Brammer, 2006; Matsumura, Callister, Palmer, Cox, & Larsen, 2004; Sedgwick & Harris, 2012).

In addition to the national discussions regarding the state of nursing education, there is significant work being done at the provincial level in British Columbia to address some of the concerns noted above. The Northern Health Authority (NHA), along with other British Columbia health authorities, is moving forward with implementation of the provincial Practice Education Guidelines (HSPnet, n.d.) in order to support both students and staff during the learning process. Nurse leaders and educators have recognized that student cohorts have grown in numbers (A. Starck, personal communication, October 5, 2015). With this growth comes a need to move to a more standardized approach to clinical education. Nursing administrators expect that the provincial Practice Education Guidelines will "provide a clear pathway for student practice in the health authority, clearly articulate the roles of each group involved and provide a clear view of the expectations around the role of student, clinical
instructor, school and health authority” (A. Starck, personal communication, October 5, 2015). This attention to clinical education at the local level is judicious. Research has shown that, central to a positive learning environment, are the interactions that students have with faculty, clinical instructors, and the staff nurses (Brammer, 2006). In fact, some research goes even further to conclude that “nursing staff were the most influential factor, besides the students themselves, within the learning environment” (Papp, Markkanen, & von Bonsdorff, 2003, p. 263). There is little published literature concerning the informal relationships between staff nurses and students from staff nurses’ perspectives (Brammer, 2006; Rebeiro, Edward, Chapman, & Evans, 2016). The challenges in the clinical learning environment described previously require that nurse researchers examine the informal relationships between staff nurses and nursing students. The focus on gaining the staff nurse’s perspectives on clinical education coupled with the call for reform made this research timely.

**Background**

My interest in the interactive relationships between staff and nursing students began as a response to reports raised with me as clinical instructor for third-year undergraduate nursing students. During clinical rotations at the local regional hospital, I was disturbed by student stories of hiding in closets to avoid certain staff members in some clinical settings. Students described feeling afraid of some staff members, and some students vowed never to practise in that particular setting in the future. These same students expressed both surprise and delight when staff nurses in other settings welcomed and appreciated students’ questions and contributions. Subsequent observations of, and discussions with both students and teaching colleagues made me aware that these reports did not reflect isolated incidents and were, in fact, indicative of a more widespread phenomenon.
Although these stories led me to question the behaviours of those nursing colleagues who provided the clinical experiences to these students, they also made me wonder about a clinical milieu in which staff nurses would respond so negatively to nursing students—and about the dynamics that might have contributed to such behaviour. Curiosity about staff nurses’ perceptions of, and experiences with nursing students during their practica led me to ponder how these staff nurses understood their informal relationships with students and how they perceived their contributions (if any) to educating students during teacher-led practica.

**Researcher Context**

With 30 years of psychiatric nursing experience, I have worked as a front-line clinician, a clinical educator, a team leader, a director, and a theory and clinical instructor in nursing. My roles have led me to work with those who are marginalized within the health care system. I have sought ways to support and advocate for users of the system so that they might have a voice in improving it. This study was a logical extension of my passion for quality improvement and my belief that nurse educators can learn much about the ways in which they may be able to improve systems by asking questions of those most closely connected to those systems.

Taking a pragmatic approach similar to O’Leary (2004), I did not merely seek to research an issue. Instead, I wanted my research to make a practical difference. To this end, I sought the participation of staff nurses, to share their experiences, insights, frustrations, and suggestions about the education of nursing students.

As a researcher interested in the views of staff nurses as they relate to and influence students’ learning as part of their day-to-day practice, I found qualitative description to be a suitable approach. While I respect the apparent clarity that can result from quantitative
research, I think that solutions to some of the more complex human and systems issues can be found in the nuances that are possible to glean through qualitative methods. I value the power of voice and believe that educators can learn much by attuning themselves to other people’s stories.

Lipson (1990) noted that many of the skills associated with effective nursing practice are congruent with those of qualitative research, such as the intentional use of self to elicit information, the ability to listen carefully when interviewing, and the capacity to observe and interpret on several levels simultaneously. By using these skills to interview staff nurses, nurse educators can gain insight into the experiences and perspectives of nurses who carry out healing work on a daily basis while working alongside nursing students and influencing their learning. I believe that nurse administrators and educators can use the insights gained from this study to help improve the nursing education system and, ultimately, the quality of patient care.

Overview of the Thesis

This thesis is organized into five chapters. This chapter provided an introduction and overview of the research. Chapter 2 is a review of the literature related to nursing clinical education. Chapter 3 provides an overview of the qualitative descriptive methodology that influenced the study design as well as the methods employed for data collection and analysis. Chapter 4 presents the research findings, including themes and a metatheme. Chapter 5 reflects upon and discusses the key findings and includes implications for nursing service, education, and limitations of the findings and potential future research.
Definition of Terms

For the purpose of this study, the following terms are defined:

*Staff nurse*: A full-time, part-time, or casual Registered Nurse (RN) or Registered Psychiatric Nurse (RPN) employed in a hospital. A nurse who provides direct patient care and works with students in an informal manner (not as a preceptor, nor necessarily employed by the educational institution) during teacher-led clinical practica.

*Student nurse*: An undergraduate student in a baccalaureate nursing program enrolled in a clinical practicum course under the supervision of a clinical instructor and/or faculty member.

*Acute care clinical practicum*: A hospital setting, such as the medical/surgical, psychiatric/geriatric, operating room/recovery, or pediatric ward/unit that provides clinical placements for groups of nursing students. (Since the nurses in this study referred to both unit/ward interchangeably, the term ward will be used synonymously for unit.) Exceptions will be made for direct quotes by participants or when used as a proper noun.

*Professional socialization*: The process by which students learn, internalize, and come to embrace the skills, knowledge, values, and norms associated with their professional identity.

*Clinical instructor*: A RN or RPN employed by the University of Northern British Columbia (UNBC) to instruct students in a clinical practicum. The clinical instructor provides orientation for eight to 10 undergraduate students, arranges learning opportunities, instructs them in the clinical setting, and monitors their progress, while assessing competencies.
Chapter 2: Literature Review

In this literature review, five main concepts are examined as they pertain to the relationships between staff nurses and nursing students. First considered are clinical practice and learning environments in which nurses and students interact. Second, key clinical teaching models are examined to situate the study within a practice frame of reference. Third, an introduction of the concepts of professional socialization and role modelling provides an understanding of the ways in which nursing students begin to adapt to and adopt the role of a nurse. Fourth, a review of the ways in which relationships between staff and nursing students have been considered in both historic and contemporary literature provides an overview of the work that preceded this study and establishes a framework for the research method. Last, a summary of the findings identifies the gaps that I perceive in the existing body of research and establishes the need to hear from staff nurses about both their experiences with nursing students during teacher-led practica and their perceptions of their contributions to nursing students’ education.

Search Methods and Criteria

An initial review of nursing literature was conducted using the following computerized databases: Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline, Psycinfo, Academic Search Premier, Science Direct, Google Scholar, and Education Resource Information Center (ERIC). The search strategy was adapted and tailored for each database, based on their use of medical subject headings or differences in headings used.

The topic of interest, staff nurses’ perceptions of or attitudes toward nursing students, guided the initial search and yielded few articles. Subsequent searches of articles (using the
snowball method) from bibliographies were used to trace key authors and other promising studies not evident in the initial database results, including relevant theses and dissertations.

**Key search terms.** The following terms were used in database searches for literature: staff nurs*, student nurs*, attitudes, clinical placements, clinical learning environment, staff perceptions, practic*. The asterisk indicates that all terms of the root word were searched.

**Inclusion criteria.** Literature reviewed was limited to English language articles, including grey literature and theses, published between 1980 and 2015. It was necessary to include some of the foundational research into clinical nursing education to set the foundation and background for the current study. Articles included research studies and meta-analyses, as well as review and critique articles that focused on clinical practice. The search yielded studies from Australia, Canada, Ireland, Sweden, the United Kingdom, and the United States of America, which was helpful in allowing for comparison and to gain a global perspective. Studies that focused on staff and student attitudes toward, or perceptions of one another, in the clinical practice setting were included.

**Exclusion criteria.** In order to maintain the focus on staff nurse and undergraduate student nurse perspectives, articles that focused solely on faculty perspectives, incivility, and patient safety, without reference to practicum placements or staff-nurse and student-nurse relations, were excluded from consideration. Most of the articles that related to newly graduated nurses tended to focus on transition into the practice role and incivility and were thus excluded.

**Clinical Practice Environment**

Critical to nurses’ performance is the presence of a positive clinical practice environment (Storch et al., 2009). The term “clinical practice environment” is often used
synonymously with the terms "organizational culture" or "climate." Although there has been significant debate over the differences between the terms climate and culture, Sleutel (2000) argued that significant similarities exist between culture and climate; both pertain to the ways in which individuals within an organization make sense of their environment and determine shared meanings. Olson (1998) stated that climate can be understood as the personality of an organization. As such, climate "encompasses and influences employee attitudes, beliefs, and behaviours and is composed of the physical environment, the interprofessional relationships, and the structure of the organization" (Sleutel, 2000, p. 54). Sleutel (2000) purported that, in nursing, the most commonly used term to describe both organizational culture and climate is 'clinical practice environment.' For the purposes of this research, the term practice environment will be used to refer to both the physical space in which nurses work as well as the nature of nurses' relationships with other hospital staff; the practice environment includes nurses' perceptions of procedures, practices, and behaviours within the work setting. It is important to note that the practice environment in which nurses work is the same environment within which students engage in clinical practica and in which they are learning.

Clinical Learning Environments

The clinical learning environment for students takes place within the practice environment of practising nurses. The clinical learning environment is a complex social entity in which patients, staff nurses, nursing students, and clinical teachers coexist, each with their own (sometimes competing) objectives (Chan, 2001). Positive clinical learning environments, imperative for the success of clinical education, are largely dependent upon such factors as nursing students feeling safe, a positive ward atmosphere, cooperation amongst staff members on the ward, and students being treated as younger colleagues (Papp
et al., 2003). The work conducted in the United Kingdom by Fretwell (1983a, 1983b), Ogier and Barnett (1986), and Orton (1981) established that positive learning environments are those in which the communication is effective, the staff work as a team, and the ward sister (head nurse) is cognizant of the emotional and physical needs of both staff and students.

Callaghan and McLafferty (1997) and Chan (2002) both developed evaluation tools to measure clinical learning environments. They focused on obtaining students’ opinions about what makes a positive learning environment, since learning in the clinical setting tends to be more anxiety provoking to students than learning in the classroom. Chan’s (2002) Clinical Learning Environment Inventory is a tool based on the acknowledgement that clinical learning takes place in a dynamic context in which patient care is the staff nurse’s core business. Both Callaghan and McLafferty’s (1997) and Chan’s (2002) studies concurred that the quality of the clinical learning environment can be measured, and that the calibre of learning is associated with, communication and collaboration between the practice site and the nursing school.

Saarikoski and Leino-Kilpi (1999) of Finland developed the Clinical Learning Environment and Supervision instrument, a 50-item questionnaire to evaluate clinical teaching and supervision. In Saarikoski and Leino-Kilpi’s study, second- and third-year nursing students ($n = 162$) completed the questionnaire that measured ward atmosphere, ward manager’s leadership style, premises of nursing care on the ward, premises of learning on the ward, and supervisory relationship. Results showed that the supervisory relationship and the ward manager’s leadership style were significant factors in students’ assessment of the ward as a learning environment (Saarikoski & Leino-Kilpi, 1999). Similarly, those wards
characterised as having a positive atmosphere exhibited good team spirit and high quality care (Saarikoski & Leino-Kilpi, 1999).

Hart and Rotem (1994) utilized a qualitative research approach with a convenience sample of 30 senior-level Australian students to understand, from students’ perspectives, attributes that support learning opportunities in the clinical setting. Students noted that staff who were friendly and approachable, understood students’ roles, and acted as positive role models were able to shape the clinical setting in a positive way (Hart & Rotem, 1994). Conversely, staff who treated students’ questions as annoying or inconvenient were impatient, and either ignored students or hovered over them contributed to a negative learning experience (Hart & Rotem, 1994).

All of the aforementioned studies examined the clinical learning environment solely from students’ perspectives (Callaghan & McLafferty, 1997; Chan, 2002; Hart & Rotem, 1994; Saarikoski & Leino-Kilpi, 1999). Students revealed that nursing staff, including nurse leaders, are crucial in setting the tone of the clinical working and learning environment. These findings underscore the importance of the culture of the workplace in determining the success of the learning experience from the student perspective.

**Clinical Practice Models**

Budgen and Gamroth (2008) identified at least 10 different models of clinical education used in undergraduate nursing education. For the purposes of this study, I examined the three most commonly used clinical practice models in Canadian nursing education: teacher led (sometimes known as facilitated), preceptorship, and dedicated education (or teaching) units (DEUs; Budgen & Gamroth, 2008).
**Teacher-led model.** Teacher-led practica are those in which a clinical instructor (faculty member) with clinical or teaching expertise is assigned to work with groups of six to 10 students on one or more wards for a limited time each week. Ideally, this clinical instructor is available to advocate for student learning and is responsible for evaluating students’ progress. However, the clinical instructor may have to travel between units to supervise students. This leaves students to seek guidance from staff nurses in an informal way and requires staff nurses to give both guidance and evaluative feedback to students and the clinical instructor (Brammer, 2006; Walker, Cooke, & McAllister, 2008). Brammer (2006) noted that there are tacit assumptions that RNs are willing and able to buddy up with students in the absence of the clinical instructor and that students will benefit from these interactions. Staff nurses in teacher-led practica are not typically asked if they actually wish to support nursing students nor are they usually formally prepared to assess students, but they may be required to do so regardless. Consequently, staff nurses’ understanding of their role in nursing students learning is variable and may contribute to some students have positive learning experiences while others do not (Brammer, 2006).

Despite the evidence that interactions between staff nurses and nursing students significantly impact the learning environment, little is known about the ways in which staff nurses understand their contributions to nursing students’ learning within the teacher-led model (Brammer, 2006, 2008; Walker et al., 2008). This study addressed this gap in the literature by focusing specifically on those nurses who have informal interactions with nursing students during teacher-led practica. By interviewing staff nurses specifically about their informal interactions with students, I sought to gain insights into the ways in which staff nurses perceive their contributions to student learning.
**Preceptorship model.** The preceptorship model is one of the most enduring and researched clinical education models and is considered by many to be a cornerstone of clinical education (Billay & Yonge, 2004; Budgen & Gamroth, 2008; Rebeiro et al., 2016; Sedgwick & Harris, 2012). Furthermore, preceptorship is a well-established educational model in Canadian nursing curricula. It is defined by the Canadian Nurses Association (1995) as a frequently employed teaching and learning method using nurses as clinical role models. It is a formal, one to one relationship of predetermined length, between an experienced nurse (preceptor) and a novice (preceptee) designed to assist the novice in successfully adjusting to and performing a new role. (p. 3)

International terminology describing the concept of preceptorship tends to vary; Australia, New Zealand, North America, and Sweden use the term “preceptor,” while the United Kingdom uses “mentor.” However, with the emergence of the European Union, there is a strong impetus to gain clarity amongst the terms “supervisor,” “mentor,” and “preceptor,” and most of Europe continues to favour the latter (Jokelainen, Turunen, Tossavainen, Jamookeeah, & Coco, 2011).

In practice, the student works directly with an experienced staff nurse during a preceptorship, and this nurse supports the student’s learning goals and provides evaluative feedback on the student’s progress to both the student and the clinical teacher. Being a preceptor can be both rewarding and stressful; nurses need to navigate students’ and patients’ needs in workplaces rampant with complex technology, high staff turnover, and demands for cost effectiveness (Hallin & Danielson, 2009). In response to these identified pressures in the practice setting, Sedgwick and Harris (2012) questioned whether the preceptorship model is sustainable or even able to meet students’ learning needs or nursing program outcomes.
Dedicated education unit model. One model that has been introduced to meet the demand for more clinical practice in nursing education is the DEU or collaborative learning unit (Budgen & Gamroth, 2008; Edgecombe & Bowden, 2009; Edmond, 2001). DEUs are designated nursing units in which multiple clinicians share the responsibility of teaching all students assigned to the ward and where education as well as patient care are deemed to be the primary functions of such clinicians (Budgen & Gamroth, 2008). Students develop their own learning goals and are responsible for articulating these goals to the nursing staff and faculty. Clinical faculty are assigned to the entire ward and are on site several hours each week to support student learning. Several staff nurses share responsibility for a student; as such, the student's learning is enhanced by time spent with multiple nurses (Budgen & Gamroth, 2008). However, this model can make obtaining feedback from multiple nurses challenging for the faculty. Furthermore, there remain concerns about monitoring student progress when no single nurse is responsible for a particular student (Budgen & Gamroth, 2008). Staff on DEUs understand that, by virtue of working on the ward, they are required to assist nursing students with their clinical learning; nevertheless, staff nurses still report uncertainty about the specifics of their role (Budgen & Gamroth, 2008).

Each of these three teaching models contributes to and influences clinical learning for nursing students. Henderson, Twentyman, Heel, and Lloyd (2006) used Chan's (2002) Clinical Learning Environment Inventory to survey and measure Australian undergraduate nurses' perceptions of these three different models of clinical learning: the facilitation model, teacher-led (n = 269), the preceptor model (n = 16), and the clinical education unit model or DEU (n = 114). Their findings suggested that, in the Australian context and regardless of the specific model used, two key components stand out as important to a successful practicum:
the consistency of staff and the establishment of relationships (Henderson et al., 2006). While the preceptorship model remains desirable because it provides one-to-one psychosocial support for students, the DEUs may be more sustainable because they are able to accommodate greater numbers of students at times when there is a shortage of clinical staff and faculty (Budgen & Gamroth, 2008).

Regardless of the clinical practice model employed, staff nurses play a crucial role in the clinical education process. Since clinical education is under increasing scrutiny, it seems appropriate that staff nurses play a pivotal role in assessing its efficacy (Budgen & Gamroth, 2008; Dunn & Hansford, 1997; Levett-Jones et al., 2007; Papp et al., 2003).

By focusing on the unexamined informal relationships between staff nurses and students in teacher-led practica, it is possible to gain important insight into staff nurses’ perceptions as they interact with students and influence student learning. These insights can be beneficial for both education and practice, since the current practice models (especially teacher-led) are under increased scrutiny and are deemed by some scholars to have significant limitations, to the point of being unsustainable in some situations (Budgen & Gamroth, 2008; Tanner, 2006). Tanner (2006) noted multiple issues associated with the current teacher-led model. Hospital clinical placement positions have become saturated, leaving a limited number of acute care placements available and requiring an increased use of community placements (Tanner, 2006). The current shortage of nurses combined with increased patient acuity means that staff nurses do not always have the time to provide close levels of supervision; additionally, the dispersal of students across several sites also leaves clinical faculty little time for direct supervision (Tanner, 2006). To accommodate an increased numbers of students, clinical settings often require that students work 12-hour
shifts in which they spend most of their time repeating routine tasks; however, this does not contribute to the development of critical thinking or clinical judgement (Tanner, 2006). Tanner also noted that it can be difficult within the confines of this model for students to gain experience with a variety of patients and for clinical faculty to plan for learning opportunities through which students can acquire essential clinical reasoning skills. Similarly, Edmond (2001) maintained that the success of any of the clinical practice models depends on wrestling with the problems of availability of staff nurses or clinical educators and on ensuring these clinical teachers have the time, tools, and training to provide nursing students with effective clinical learning opportunities.

**Professional Socialization and Role Modelling**

Jacox (1973) argued that nursing education can and should contribute to the professional socialization of nursing students. The literature was clear that students not only become more proficient at technical nursing skills during clinical rotations, but that they also observe practising RNs and incorporate (or reject) demonstrated attitudes and behaviours associated with being a nurse (Bahn, 2001). The concepts of professional socialization and role modelling create a lens through which to understand how nursing students begin to adapt to and adopt the role of being a nurse. Cohen (1981), building on the work of Jacox (1973) and Merton, Reader, and Kendall (1957), provided a comprehensive definition of professional socialization in nursing, stating,

> [It] is the complex process by which a person acquires the knowledge, skills, and sense of occupational identity that are characteristic of a member of that profession. It involves the internalization of the values and norms of the group into the person’s own behaviour and self-conception. In the process a person gives up the societal and media stereotypes prevalent in our culture and adopts those held by members of that profession. (p. 14)
Benner et al. (2009) argued that, although the notion of socialization is useful in practice disciplines, they prefer the term “formation” (p. 166), which “denotes development of perceptual abilities, the ability to draw on knowledge and skilled know-how, and a way of being and acting in practice and in the world” (p. 166). A nurse’s formation is relational and strongly connected with embracing the persona of being a nurse, not merely doing nursing tasks. Benner et al. also asserted that formation best articulates the process of becoming a nurse “because it points to being constituted by the meanings, content, intents, and practice of nursing rather than merely learning or being socialized into a nursing role in an external way” (p. 86). However, the concept of formation does not differ fundamentally from the earlier concept of socialization. Both of these concepts are relational in nature, both involve the internalization of values, and both involve growth and movement toward becoming a nursing professional rather than merely performing nursing tasks. Since the term socialization is more widely used in nursing and other practice professions (medicine, physiotherapy, social work), I have chosen to employ this term throughout my study.

Du Toit (1995) noted that although nursing students may enter their training with a set of values akin to the general public, such values can change as students are introduced to differing theories and principles within their education process and begin to adapt through the professional socialization process. As these values shift, behaviours will change accordingly, and a change might even occur in the student’s self-concept as the student gradually adopts a nursing identity. Clinical education is a time when nursing students move through developmental stages that shape their personal and professional formation and concept of self and deepens their understanding of the types of roles nurses undertake in various settings (Jarvis-Selinger, Pratt, & Regehr, 2012). One way in which socialization
occurs for students is through interaction with more experienced nurses in the clinical setting. The experienced nurse models not only technical skills but also comportment and other unwritten expectations of what it means to think and behave as a nurse. In clinical settings, much of the informal teaching takes place as a function of modelling and imitation. Iwasiw and Goldenberg (1993) described modelling as the process by which individuals observe the behaviours of others, form impressions of the actions and consequences of these behaviours, and then use those impressions to guide their own future behaviours. In nursing, the student can and does learn through observation and imitation, allowing for an efficient and safe way of acquiring complex patterns of behaviour. Since nursing students learn by both doing and observing, the quality of the role model will contribute to the quality of the learning and, ultimately, to the quality of the nurse. Nursing students develop their professional identity from several sources throughout their education, but the staff nurse is one of the most influential (Hathorn, 2006). Nursing students discern quickly if they are not welcomed into the profession by staff nurses, and these negative interactions may result in the student rejecting specific clinical settings and even the profession altogether (Coudret et al., 1994; Dunn & Hansford, 1997). Understanding how staff nurses perceive students in the clinical setting and inviting staff nurses to reflect upon ways in which they contribute to students’ learning can help educators and administrators to cocreate learning environments that are most conducive to students’ learning needs.

**Staff and Student Nurse Relationships**

For over 30 years, the discipline of nursing has been interested in the relationship between nursing students and staff nurses as it relates to clinical learning. The foci of this
interest have shifted over the years to reflect the changing demands of the profession and trends in nursing education.

Much of the early research regarding the relationship between nursing students and staff was completed in the United Kingdom during the 1980s and focused on the role of the ward sister, a position roughly equivalent to the head nurse role in North America (Ogier, 1981). Ogier and Barnett (1986) surveyed 24 ward sisters, 42 staff nurses, and 62 learners, concluding that the role of ward sister was pivotal in creating positive climates conducive to student learning and that students found the staff nurses more helpful and easier to talk to than the ward sister. Orton (1981) used questionnaires (n = 395) to show that the learning climate is a measurable reality for students, and, along with Ogier and Barnett (1986) and Fretwell (1983a, 1983b), determined that the ward sister was in the most crucial position to establish the ward’s learning climate. The most successful ward sisters demonstrated behaviours that were highly structured, relational, and goal oriented (Fretwell, 1983b). Furthermore, specific aspects of ward sisters’ leadership styles—including being warm and welcoming, demonstrating respect for others’ ideas and awareness of subordinates’ needs, and valuing trust and teamwork—were associated with positive learning environments (Fretwell, 1983a, 1983b; Ogier, 1981; Ogier & Barnett, 1986; Orton, 1981). These early works identified the importance of nursing leaders in setting a positive tone in the clinical learning environment. After recognizing the importance of the ward sister (head nurse) in creating a positive clinical learning environment, the focus of nursing literature turned to the relationships between students and staff nurses, and, specifically, to the role of the preceptor/mentor.
Role of the preceptor. Canadian and international evidence suggest that preceptorship is one of the quintessential methods of clinical teaching within nursing education (Billay & Yonge, 2004; Myrick & Yonge, 2003). Preceptors play an important role in nursing students’ education prior to graduation by providing guidance, supervision, and role modelling in order to facilitate students’ development of clinical reasoning skills, knowledge, and professional attitudes (Billay & Yonge, 2004; Budgen & Gamroth, 2008; Myrick & Yonge, 2003; Sedgwick & Harris, 2012; Yonge, Ferguson, & Myrick, 2006).

Benefits and challenges in preceptoring. Canadian researchers Dibert and Goldenberg (1995) were among the first to study the intrinsic and extrinsic rewards and benefits of preceptorship in nursing. They used a descriptive correlational design to explore the relationship between a preceptor’s perceptions of the benefits, rewards, and supports offered by the role and a preceptor’s willingness to commit to the role. Using the four-part Preceptor’s Perceptions of Benefits and Rewards questionnaire, which examined 59 preceptors, 90% of whom had attended preceptorship training, Dibert and Goldenberg found that preceptors are more likely to be committed to their role when there are worthwhile benefits, rewards, and supports. The benefits and rewards most highly associated with choosing to preceptor were opportunities to improve teaching skills, to help preceptees integrate into the ward, to share knowledge, and to gain personal satisfaction. There were no correlations found between age, educational background, or years of nursing with either the perceived benefits or commitment to the preceptor role. Usher, Nolan, Reser, Owens, and Tollefson (1999) in Australia and Hyrkäš and Shoemaker (2007) in Canada have since replicated this study and confirmed that, to remain committed to the role of preceptor, nurses require a clear sense of the benefits, rewards, and supports for the role. Usher et al. found that...
preceptors identified benefits of preceptoring as both intrinsic—the opportunity for their own professional development—as well as extrinsic—formal recognition of the importance of the role. More recently, Hyrkäs and Shoemaker found that the preceptors who felt most supported in the role had ongoing support from clinical faculty rather than only a one-off preceptorship workshop.

McCarthy and Murphy (2010) of Ireland conducted a mixed-methods study (24 self-administered surveys with two open-ended questions) involving 470 nurses to explore preceptors’ experiences of educating and assessing nursing students. Their findings were consistent with those of Carlson, Pilhammar, and Wann-Hansson (2010) of Sweden, who used an ethnographic approach with 29 preceptors to describe conditions for preceptoring. Both studies found that preceptoring is a complex function for nurses that is influenced by conditions that can be both supportive and hindering in nature. It is noteworthy that both studies also identified the importance of organizational and collegial support for the role, and both studies listed time as a limiting condition (Carlson et al., 2010; McCarthy & Murphy, 2010). The lack of dedicated time for instruction and the need to prioritize patient care over teaching made the role of preceptor very challenging. Although Carlson et al.’s and McCarthy and Murphy’s studies were not solely designed to capture benefits, rewards, and commitment to the preceptor role, as in the studies by Usher et al. (1999) and Hyrkäs and Shoemaker (2007), the findings corroborated the notion that preceptors appreciate benefits such as personal satisfaction, personal development, and an increased sense of competence.

Bourbonnais and Kerr (2007), in a small qualitative study, interviewed Canadian nurses who had experience as preceptors (n = 8). Nurse preceptors in the study identified their roles as helping students to grow, providing guidance and protection in critical
situations, and advocating for learning opportunities (Bourbonnais & Kerr, 2007). Preceptors received support for the role from educational materials, preceptorship workshops, and, when available, the faculty advisor (Bourbonnais & Kerr, 2007). Challenges experienced by the preceptors included a lack of recognition by peers and administration, as well as a lack of support from some faculty (Bourbonnais & Kerr, 2007).

Given the increasing patient acuity and workloads in the clinical setting, it is becoming more difficult for nurses to take on the preceptorship role in addition to their already demanding assignments. Consequently, clinical demands may overtake the student–preceptor relationship and compromise efforts to meet students’ learning needs (Henderson et al., 2006).

**Student nurse contributions.** Grindel et al. (2001) surveyed 108 mental health and medical-surgical nurses across the United States and devised a 54-item Nursing Students’ Contributions to Clinical Agencies (NSCCA) survey to measure nursing students’ contributions to clinical agencies. The NSCCA measures the perceived effects that undergraduate nursing students have on staff time, staff development, quality of care, staff’s personal satisfaction, and ward standards and practices. Grindel et al. found that students make positive contributions to staff members’ professional and personal development, as well as to patient care. In contrast, Matsumura et al. (2004) used the NSCCA to survey 165 nurses and found that staff nurses actually experience a great deal of ambivalence towards students. In a more recent replication of Grindel et al.’s (2001) work, Slaughter-Smith et al. (2012) added a free textbox to the NSCCA survey to capture some qualitative comments from staff nurses, who characterized students as eager to learn, willing to help, or merely serving their time. Responding nurses identified numerous benefits and challenges associated
with having students in their practice settings (Slaughter-Smith et al., 2012). However, the type of relationship captured by the surveys remains unclear, as none of the reports explain if the nurses surveyed were in a formal preceptored relationship or were instead working casually alongside nursing students in teacher-led placements.

Many of the benefits that staff nurses identify concerning working with students involve professional development and personal growth. Staff nurses have enjoyed the intellectual stimulation they experienced when working with students (Grindel et al., 2001; Matsumura et al., 2004). Staff nurses also noted appreciating the opportunities for mentoring, reciprocal learning, and personal growth and development (Grindel et al., 2001; Matsumura et al., 2004; Slaughter-Smith et al., 2012). Zisberg, Bar-Tai, and Krulik (2003) examined the influence of nursing students on staff nurses and concluded that nurses provide higher quality care when students are present on the ward. When nursing students were present, staff nurses gave enhanced attention to their role as caregiver. Despite these positive contributions, staff nurses also described feeling unsure about their role with students, feeling threatened or insecure about their own skills in the presence of students, and feeling uncertain about evaluating nursing students (Atack et al., 2000; Matsumura et al., 2004).

It may be precisely these competing priorities that make it difficult for staff nurses to move away from the instrumental view of students as helpers toward a perspective in which students are seen as future colleagues to be guided and nurtured. When nurses are working in hectic conditions with staff shortages and highly acute patients, the use (or misuse) of time becomes a significant issue (Slaughter-Smith et al., 2012). If students arrive unprepared and require extra time to give or receive report and extra guidance to administer medications, or if students appear to be merely killing time, staff nurses note both an increase in workload
and stress (Atack et al., 2000; Grindel et al., 2001; Matsumura et al., 2004; Slaughter-Smith et al., 2012). In order to mitigate this stress on staff nurses, Matsumura et al. (2004) suggested that it may be helpful to orientate students to the workflow of a ward to decrease unwarranted interruptions during peak times.

One area of significant agreement in the literature was that staff nurses appreciate having clear role expectations and support as they assist students’ learning (Atack et al., 2000; Grindel et al., 2001; Jackson & Neighbors, 1988; Matsumura et al., 2004; Ogier & Barnett, 1986; Slaughter-Smith et al., 2012). Although RNs are expected to support students, staff nurses are not always clear about their role and, furthermore, do not always view their role as an informal educator of students in a positive manner (Atack et al., 2000; Jackson & Neighbors, 1988; Matsumura et al., 2004; Ogier & Barnett, 1986; Saarikoski & Leino-Kilpi, 1999; Slaughter-Smith et al., 2012). Levett-Jones et al. (2009) noted that some nurses found the responsibility of supporting students in practice to be burdensome and they seemed to ignore students’ feelings, making little attempt to hide their own irritation and impatience.

These attitudes impact nursing students’ learning significantly. While attempting to navigating the dynamic and often competing demands of the clinical setting, nursing students reported that if positive staff–student relationships are not established, students feel that they are “just in the way” (Levett-Jones et al., 2009, p. 321) and a burden to the staff.

Nurse leaders from both education and service must be actively engaged in supporting staff nurses as they take on the task of helping students learn in clinical settings (Atack et al., 2000; Grindel et al., 2001; Jackson & Neighbors, 1988; Matsumura et al., 2004; Slaughter-Smith et al., 2012). The need for communication and collaboration at the staff nurse, clinical educator, and systems levels was consistent throughout several studies (Atack
et al., 2000; Grindel et al., 2001; Jackson & Neighbors, 1988; Matsumura et al., 2004; Slaughter-Smith et al., 2012).

Educators play a key role in maintaining communication between staff nurses and students by providing clear instructions to students and clarifying the expectations of staff nurses (Jackson & Neighbors, 1988; Slaughter-Smith et al., 2012). This process includes ensuring that students arrive prepared and motivated and troubleshooting with staff when students are not performing well (Matsumura et al., 2004). The position of the clinical instructor is vital in helping staff nurses become comfortable with and gain clarity around their role of informal teacher (Atack et al., 2000). The ability of the clinical instructor to create positive relationships with staff is important, but can be challenging when the students under their tutelage are spread out across various units and settings (Jackson & Neighbors, 1988).

Summary

After reviewing the literature, it became evident that clinical education is an essential component of university nursing programs. Furthermore, clinical education presents an opportunity for educators, and staff nurses to collaboratively support students while they gain competence in fundamental nursing skills and begin to be positively socialized into the profession. It is worth noting that clinical learning environments are also working environments and, as such, are complex and highly stressful. Nurse leaders in the workplace play a key role in setting the tone in the clinical learning environment. Positive and open relationships between staff nurses and students are essential in enabling student learning (Atack et al., 2000; Jackson & Neighbors, 1988; Matsumura et al., 2004; Slaughter-Smith et al., 2012). Nursing students are aware that, in order to learn effectively, they need to be
treated with respect, welcomed by staff nurses, and viewed as future colleagues. The relationship between students and staff nurses is significant and influences students' clinical learning as well as their decisions to choose a particular specialty area or even to stay in the profession at all (Levett-Jones et al., 2009). Jackson and Neighbors (1988) insisted that staff nurses' attitudes towards students are extremely important and influence the clinical learning environment; as such, staff nurses working with students need to examine their own attitudes and their willingness to work with students if their hospital is offered as a clinical practica setting. Largely overlooked in the literature are staff nurses perceptions of their own contributions to nursing students' learning.
Chapter 3: Design and Methodology

In order to build upon previous research showing the importance of the interactions of staff nurses and nursing students and the impact these interactions can have on the student’s learning from the student’s perspective, this study asked staff nurses to speak about their own experiences of students in the clinical practice setting. This chapter describes the qualitative research methodology used to help address the research question: How do staff nurses perceive their contributions to nursing students’ learning during teacher-led practica? The first section explains the selection of a qualitative research methodology, specifically qualitative description, followed by discussions of study context and site selection, participant recruitment sampling strategy, data collection, analysis, and research rigour (including ethical considerations).

Qualitative Research Methodology

Qualitative research investigates and describes phenomena that take place in human experiences outside of controlled conditions: it examines culture, relationships, and values (Speziale, Streubert, & Carpenter, 2011). Qualitative methodology recognizes and values multiple ways of knowing and being in the world, and merit is given to both individual experience and context (Lopez & Willis, 2004; Patton, 2002). Qualitative research is often used when little is known about a phenomenon, as it allows the researcher to gain insight and understanding from an insider’s perspective (Morse & Field, 1995). Given little that has been published regarding clinical education from the staff nurses’ perspective used quantitative methodology, I felt it was appropriate to use my experience as a clinical instructor to design a study that allowed for staff nurses to tell their story in an interview setting.
Qualitative Description

This study employed a qualitative description approach (Sandelowski, 2000, 2010) to study the complex, informal relationship between staff and nursing students in teacher-led practica, a relationship that has been largely unexamined in the research literature to date. I had initially considered a quantitative survey to pursue my research question. However, after completing the literature review, it became clear that the little that is known about clinical education from the staff nurses' perspective has been derived primarily from exploratory quantitative surveys. As I immersed myself in the available literature, I became increasingly convinced that utilizing another exploratory quantitative survey would not increase nurse educators' and administrators' understanding of the meaning that nurses assign to their experiences of having students on the ward. I became even more reluctant to use a survey method when nursing colleagues in the practice setting shared with me that they had been "surveyed to death" and would not be enthusiastic about participating in that type of research initiative. Qualitative description enables the answering of questions that are of relevance to clinical disciplines and policymakers, in which the researcher aims to gain firsthand knowledge of the experiences of a patient, a relative, or a professional regarding a particular topic (Brink & Wood, 1998; Neergaard, Oleson, Andersen, & Sondergaard, 2009; Sandelowski, 2000). Although less interpretive than phenomenological or grounded theory approaches, qualitative description allows for more interpretation than a purely quantitative survey approach and therefore was well-suited to both the purpose of the study and to my novice research experience (Sandelowski, 2000). By employing a qualitative descriptive approach, I was able to connect with and build upon existing knowledge, make attentive
linkages to the work of others in the field, and make use of my own experience with the research topic (Neergaard et al., 2009).

**Study Location**

This study took place in Prince George, British Columbia. Several factors combined to make the chosen site suitable. The Northern Collaborative Baccalaureate Nursing Program (NCBNP) of UNBC works closely with the NHA within which the University Hospital of Northern British Columbia (UHNBC) resides. Over the past several years, this hospital has formally changed from being identified as a regional hospital to being identified as a teaching hospital and has undergone an official name change to signify this. Additionally, nursing student practica have taken place there for the 17 years of the NCBNP’s existence, and NHA is currently reviewing their clinical education practices to create a more standardized approach to support the clinical cohorts. Clinical nursing practica within UHNBC occur in three ways: clinical instructor-led group placements, preceptored (one-on-one) placements, and placements in clinical teaching units (also known as DEUs) in which students have the opportunity to work with a variety of health care team members. Nursing students begin their group clinical rotations as early as first year, and over 300 NCBNP nursing students attend clinical placements at UHNBC over the course of any given academic year. The majority of these clinical placements are teacher-led.

Despite the fact that UHNBC is the largest acute care hospital in the region, the increase in student numbers, as well as the complexity of the practice units, has made it difficult for practice settings to accommodate the various student groups all at once. This often requires dispersing students across several sites. Some students remain on hospital units while others are placed in community settings. This dispersion separates groups of students
geographically and reduces the clinical instructor’s ability to supervise, which, in turn, has led to an increased dependence on nursing staff to provide supervision and to “buddy” with students during teacher-led practica. The above factors as impetus for this research were discussed through a series of meetings with nursing leaders at UHNBC, who agreed that this was a topic of relevance and interest to the larger health care system; they, therefore, and assented to support the research. All of these factors combined to make UHNBC a suitable site for this particular study.

**Participants**

Participants in this study were staff nurses purposefully recruited based on their firsthand experience and considerable knowledge of the issues that were central to the research (Patton, 2002; Streubert, Speziale, & Carpenter, 2003). The participants consisted of nine RNs who self-identified as having a practice focus in the acute or rehabilitation wards of UHNBC and who had experience with managing groups of students on their wards during teacher-led practica on their wards. Seven female and two male RNs took part in the study. The participants ranged from 25 to 63 years of age. On average, these participants had been employed as RNs for 12 years, with years of experience ranging from 1.5 to 40 years. In terms of participants’ level of education, two of the nine participants possessed a diploma in nursing, six had baccalaureate nursing degrees, one had a master’s degree in nursing, and one was currently enrolled in a Master of Nursing program.

**Participant recruitment.** RNs or RPNs were invited to participate through posted announcements within hospital ward clinical sites where baccalaureate-nursing students were assigned throughout the academic year, as well as on poster boards near the cafeteria (see Appendix A). Nurse leaders also sent the invitation out to the staff through email via the
clinical nurse educators in each area. Nurses who chose to participate stated that they had learned about the study not only through the posters, but also through word of mouth, social media posts, and emails received from their colleagues.

**Inclusion criteria.** Initially, the eligibility criteria limited participation to staff nurses who were (a) practising for at least 1 year as an RN or an RPN, and (b) not currently in a clinical nurse educator role. All of the participants met these criteria with the exception of one nurse who was currently in a clinical nurse educator role. After consultation with my thesis advisor, I elected to keep this participant’s data. My advisor and I felt that, given the small sample size, and because this RN has practised for many years, had exposure to both nursing students (as a staff nurse), and held frequent dialogues with staff nurses, that her insight would act as a useful comparator.

**Data Collection**

The data collection phase was lengthy with eight one-time, face-to-face, semistructured interviews taking place between December 2014 and February 2015, and the last interview taking place in July 2015. The interviews for this research followed a semistructured guide that was designed with open-ended questions (see Appendix B). This interview guide provided me with a starting point and focused the conversations, while still allowing for the flow of the interviews to go where the participants’ responses led (Marshall & Rossman, 1995). Some of the interviews lasted 60–75 minutes, which allowed for a conversational style and the flexibility, while still maintaining enough consistency for comparison of data across multiple interviews (Marshall & Rossman, 1995).

Prior to beginning each interview, the nurses were given ample time to read: (a) the information and consent form; and (b) a brief demographic information sheet containing
details pertaining to age, gender, date of graduation, educational background, employment status, and length of time in current position (see Appendices C and D). The participants were also provided with time to ask questions about the study. As a means of expressing my gratitude for their support of the study, and as a thank-you for participating, each nurse received a $10.00 gift (coffee) card prior to the start of the interview. The participants were informed that they could withdraw from the study at any time. I did not rush the participants through this process and the audio recorder remained off until the participant felt comfortable and gave verbal consent to begin the interview.

Seven out of the nine interviews took place in my office at the university. Two interviews were conducted at UHNBC, as preferred by the participants, with the location arranged by mutual consent. One of the interviews took place in the participant's office, and the other interview took place in a prebooked meeting room. This last arrangement proved to be less than satisfactory as the room had been double booked, thus requiring a disruption in the interview partway through and a change in location. This caused an ethical dilemma concerning anonymity, and the participant was given the option to reconsider participation. After a brief discussion, the participant suggested that, since the room is one that is frequently used for lunchtime meetings, our being present together would not necessarily be cause for concern or inquiry and she thus agreed to continue with the interview. Every effort was made to reduce the impact of the potential loss of anonymity as those waiting for the room were asked to step aside, and this allowed us to move efficiently into another hallway and office. Nonetheless, this ethical concern reinforced my desire to have interviews take place away from the hospital setting.
At the conclusion of each interview, I took time to jot down my impressions in a field-notes journal. I began this reflective process by responding in writing to the question “what stood out for me?” I also included three other questions that Stone and Chiseri-Strater (2007) considered essential:

- what surprised me? (to track . . . [my] assumptions)
- what intrigued me? (to track . . . [my] positionality)
- what disturbed me? (to track tensions within . . . [my] values, attitude, and belief systems). (p. 106)

The responses to these questions helped me to identify my biases and assumptions and gave me a touchstone to which I could return during data analysis. These postinterview notes became one part of a larger reflexive process, as I also maintained a field-notes journal to track my ideas and thoughts about the study and to record my analytic decisions throughout the duration of the study.

**Data Analysis**

Spencer, Ritchie, and O’Connor (2003) explained a fundamental challenge inherent in qualitative research: “Unlike quantitative analysis, there are no clearly agreed rules or procedures for analyzing qualitative data” (p. 200). Patton (2002) concurred that no absolute rules exist, but rather implored researchers to do their “very best with . . . [their] full intellect to fairly represent the data and communicate what the data reveal given the purpose if the study” (p. 433). With this in mind, I used a general (conventional) inductive approach to recognize the core meanings that were evident in the text (Hsiu-Fang & Shannon, 2005; Thomas, 2006).

All of the interviews were audio-recorded and transcribed verbatim by a transcriptionist, familiar with health research, and who had signed a confidentiality form. I chose to use a professional transcriptionist because I am not a strong typist and have no
experience with transcription. By using an experienced transcriptionist I was able to continue
with the data collection confident in the accuracy of the documents being produced. Each of
the interview transcripts was read in its entirety while simultaneously listening to the audio
files. During this process, I underlined specific words or phrases that stood out and made
notes of the same in the margin of the texts. I was intentional about spending time to get to
know each of the participants by listening to each of the audio files a minimum of four times.
I found that, by returning to the actual voices of the participants, I could more clearly
perceive and understand each individual story, personality, tone of voice, and emphasis on
key words or phrases.

Seidel (1998) described qualitative data analysis as a means of noticing, collecting,
and thinking, emphasizing that, while the foundations of qualitative data analysis may seem
simple, the process is complex. It was, in fact, when listening to the audio recordings of the
interviews that I noticed keywords or categories jumping out at me that had not been evident
when I merely read the transcripts. I collected and made note of any themes or phrases that
stood out and recorded these in my field-notes book. This was in keeping with Patton’s
(2002) description of data analysis, which involves “making sense out of what people have
said, looking for patterns, putting together what is said in one place with what is said in
another place, and integrating what different people have said” (p. 380).

After listening to and reading all of the initial eight interviews, I used the cross-case
analysis, as described by Patton (2002), to group together keyword responses of each
participant by question, noting similarities and differences in the responses. In cases in which
I found significant overlap of the responses, I created my initial “first-blush” list of keywords
and visual mind map diagrams in order to unearth potential areas of intersection or divergence and to help me to think about the findings.

Each interview was read and reread, and key terms from individual interviews were constantly compared to terms used in other interviews. One way that this was accomplished was by using keyword searches within each transcript to compare each participant’s thoughts on keywords. For example, the term “clinical instructor” was searched in each transcript in order to gain an understanding of how this term was viewed by the participants overall and not merely when answering questions specific to this term. I tracked these initial key terms by placing sticky notes on a whiteboard; I then read each interview again, extracted exemplars from the narratives, and placed these around each key term in order to analyze the different perspectives on these central terms (see Appendix E). This visual representation allowed me to see where there were areas of greater overlap and/or discrepancy between the participants.

An attempt was initially made to collate all of the data of participants’ interviews onto individual sticky notes in order to categorize them. This method proved to be extremely time consuming. After completing three of the interviews in this manner, it became evident that the volume of notes would be unwieldy, so this method was discontinued. A revised version of this categorizing method was employed instead, using electronic cutting and pasting of data in order to categorize key phrases, labelled with the participant number as well as the line number in the original text. This allowed the information to be grouped in the categories while providing a direct link back to the original transcript for complete quotations and context.
I discussed my preliminary impressions or first-blush codes with my research supervisor, and larger themes emerged as we reviewed the topics together. Subsequent analysis involved going back into each interview, cleaning the data to remove the distracters (i.e., words such as ‘um’ and ‘ah’), collating all of the participants’ responses by question number, as well as revisiting the codes to see which ones needed to change, develop, expand, or be broken down into subcategories.

During this process, I found it helpful to ask questions of the data such as “what is happening here,” “why is this important,” “what does this mean,” “what are the dimensions of X,” and “what is the essence of what they are saying?” These questions allowed me to stay curious, to keep going back to the voices of the participants and their meanings, freeing me to acknowledge any of my biases or preconceptions and attempt to set these aside.

**Evaluative Criteria**

The issue of rigour in qualitative research has been debated and discussed by many authors (Lincoln & Guba, 1985; Morrow, 2005; Sandelowski, 1986; Whittemore, Chase, & Mandle, 2001), yet a unanimous conclusion has not been reached. Unlike quantitative data, qualitative data cannot be analyzed and interpreted in an objective manner. Every qualitative study is influenced by the expectations, experiences, and interpretations of the researcher. Qualitative researchers may utilise tools in an attempt to capture the most accurate account of their participants’ stories, but even the most helpful modern research methods can only capture a portion of the participants’ lived experience. Whittemore et al. (2001) proposed, for qualitative study to be considered scientifically sound, instead of using the term rigour from the quantitative paradigm of research that the term integrity be considered. Integrity incorporates the concepts of trustworthiness and wholeness. Likewise, Sandelowski (1993)
proposed that “evocative, true to life, and meaningful portraits, stories and landscapes of human experience” (p. 1) comprise the essence of qualitative research.

With this in mind, I employed several components that helped to strengthen the methodological integrity in this study and provided a clear framework for evaluating the study and establishing the trustworthiness of the findings. Credibility, or how well the findings describe the phenomenon being investigated, was facilitated in several ways (Creswell, 2009; Lincoln & Guba, 1985). All sources of data were audio recorded and then transcribed as close to verbatim as possible, by a professional transcriptionist to ensure that the data being analyzed were complete and accurately reflected participants’ personal experiences. All participants were offered the option of reviewing the transcribed interviews for accuracy and providing feedback about the accuracy of the transcription within a week of receipt of the document. Only one participant requested to review the transcript. The document was sent as requested and, despite a request to do so, this participant did not return any comments or concerns regarding the completeness or accuracy of the transcript. Sections of the transcribed data were also available to my supervisor for review to ensure the fidelity of the interview method.

To address dependability, the data were subjected to an iterative code recode procedure, in which I performed initial coding of the data and then waited 2 weeks to return to the data and compare the results (Krefting, 1991). My research supervisor scrutinized the accuracy and consistency of the categories, provided me with searching questions to deepen my reflexivity, and reviewed my process, codes, and initial findings. Despite the small sample size, the themes were present in all of the narratives, and saturation, described by Van Den Hoonaaard (2012) as the point at which “the researcher is no longer learning anything
new in collecting data” (p. 198), was achieved by interview eight. I used the ninth interview as an opportunity to confirm that a sufficient amount of data had been collected and that no new information was being presented for analysis.

Each theme or category contained data from several participants, providing assurance that any one participant did not overly influence the analysis and findings. The data from the clinical educator were analyzed alongside the other participants’ narratives and used to compare and contrast themes as they arose in the other RNs’ responses. Peer reviewers including practising RNs from my pilot interviews, researchers, nurse leaders in the practice setting, and the study’s transcriptionist, reviewed my findings and confirmed that the themes resonated with them. I attempted to contact the participants to review the findings and the one participant I was able to contact declined the invitation. I also conferred with my supervisor with respect to what constituted relevant and irrelevant units of data. Guba and Lincoln (1985) suggested that such external examination from impartial colleagues experienced in qualitative research provides a form of debriefing that keeps the researcher accountable and strengthens the trustworthiness of a study.

All research is subject to researcher bias (Morrow, 2005). In order to manage my own positionality and inherent subjectivity, I created a transparent interpretation of the staff nurses’ experiences by acknowledging the ways in which my own practice as a nurse and clinical instructor could have potentially influenced my interpretations of the data. Keeping the field-notes journal as a means of reflexivity (critical self-awareness) throughout the study allowed me to articulate and track my personal perspectives, challenges, questions, and biases. This process allowed me to accept my interactions as a researcher with the data as inevitable, and alter data collection and analysis as necessary to ensure that the themes were
grounded in the words of the participants, as is consistent with the descriptive approach (Krefting, 1990; Saldaña, 2013). The field-notes journal also provided a further means of transparency and reflexivity by capturing the day-to-day activities of the study, including logistics, methods, decisions, and rationales (Graneheim, 2004; Guba & Lincoln, 1985; Sandelowski, 1986).

Numerous data sources were compared for areas of agreement and divergence, including the literature review, my reflective journals, analytic memos, content analyses, and peer audits. The integration of these related but distinct sources of knowledge also helped to strengthen the confirmability of the findings (Creswell, 2009; Morrow, 2005; Whittemore et al., 2001).

As with all qualitative research, the goal of this study was not to achieve generalizability but rather to produce information-rich data that were relevant and spoke to the research issue (Patton, 2002). I have attempted to heed Patton’s (2002) caution that no absolute rules exist in qualitative research. My responsibility therefore, was to do my very best to bring all of my intellect to bear, to create a reasonable representation of the data, and to clearly and accurately communicate what the data revealed (Patton, 2002). Furthermore, it was my goal to provide such rich and accurate descriptions that people who have also shared this experience could readily recognize these descriptions (Sandelowski, 1998). The feedback received from the peer reviewers, RNs working in the field, and nurse leaders have all confirmed that the descriptions, while unique to the contexts of the individual nurse participants, did resonate with their own understanding of the issues. Therefore, nurses who wish to transfer the findings to a new context would themselves determine the applicability within their own settings (Krefting, Lincoln & Guba, 1985).
Ethical Considerations

Confidentiality and anonymity. The Research Ethics Board of UNBC and the Research Review Committee of NHA approved the proposed study (see Appendix F). Prior to beginning each interview, participants were informed verbally and in writing regarding the purpose and voluntary nature of the study as well as their right to withdraw at any time or to refuse to answer any of the interview questions. Participants were each able to receive a copy of their transcribed interview if they so wished. To maintain the confidentiality of interview participants, only I as the researcher (and the transcriptionist) accessed the audiotapes and original transcriptions, which have been securely stored under lock and key. Data will be kept for 5 years after the duration of the project (as per the timeline approved by UNBC Research Ethics Board) after which all of the audio recordings will be destroyed.

While anonymity is difficult to guarantee in smaller communities, concrete steps were taken to protect participants’ anonymity. I had initially invited participants to choose a pseudonym, but only one out of the nine chose to do so; therefore, I assigned numeric identifiers for referring to excerpts from the interviews. Further attempts to protect privacy, including omitting names and identifiers related to locations and genders of participants, were also implemented as needed.

Positionality. In addressing ethical questions, it was necessary to consider my own place within the health care and education system. As an experienced health care provider returning to a hospital setting as a beginner researcher, I needed to navigate multiple identities in the interactions with the research participants (Ledger, 2010). As a psychiatric nurse with 30 years of experience, I have had direct clinical, clinical educator, and nurse leader experience within the health system in which the study was located. Having worked
within the NHA for 15 years as a clinician, a clinical educator, and a director, I possessed some firsthand knowledge of the experience, which was the focus of this study. While it is true that some of the participants knew me, I have been away from the practice setting for 5 years and have never worked as a staff member or nurse leader on any of the wards from which the participants were drawn. I was not involved in any direct supervisory relationships with the participants, nor do I have the ability to exercise any independent power in their interest with respect to allocation of finances or other resources. Being known to participants may have influenced the nurses’ decisions to participate or not: some may have seen my study as a positive undertaking and felt a sense of comfort and trust, while others may have viewed this work as lacking privacy and decided not to participate. I remained very conscious that any preexisting relationships may have contributed to my ability to gain access and acceptance among participants (Punch, 1994), while potentially constraining the rigour of the analysis. Therefore, I was vigilant to monitor my responses and reactions, processed these within my field-notes journal, and sought guidance from my supervisor when necessary. For example, I did note that my previous experience in nursing, and the knowledge I have gained as a clinical instructor in particular, likely contributed to my ability to have empathy for, and build rapport with, the participants.
Chapter 4: Findings – It’s Complicated

The intent of this research has been to understand clinical education from the perspective of staff nurses; their responses can best be described as “it’s complicated” (Participant 9, Line 262). Nurses’ descriptions of how they contribute to nursing students’ learning during teacher-led practica were contextually situated within their current practice environment and their own past experience of being a student. Both the experiences that RNs had themselves as students, as well as their current practice of managing competing obligations and expectations within a complex health care system, influenced how they related to nursing students. Additionally, having nursing students on the wards brought both benefits and challenges. Nurses were willing to train the next generation but felt the tension of being caught between the competing priorities of caring for patients while also trying to contribute to the students’ learning. The nurses experienced these tensions as a burden of responsibility. Nurses’ responses to nursing students during teacher-led clinical practica were influenced by the reciprocal interactions among multiple factors, including (a) their practice environment, (b) their experience of the clinical instructor, (c) their attitudes towards students, (d) their contributions to student learning, and (e) what they experienced as their burden of responsibility. The balance (and often imbalance) between these five factors were both connected to, and contributed to, a broad metatheme of the nurses’ burden of responsibility.

In this chapter, I discuss the findings of my research and share my understanding of how staff nurses perceive their contributions to nursing students’ learning in teacher-led practica. One metatheme and four subthemes emerged from the analysis of the data. I begin by discussing the metatheme of nurses’ burden of responsibility, followed by an exploration
of the four subthemes: the nurses’ experience of the practice environment, the nurses’
experience of the clinical instructor, the nurses’ experience of students, and nurses’
contributions to students’ learning. Together, the interplay of these four subthemes
contributes to and influences the degree to which nursing students are felt to be a burden.
These findings are based on my analysis of audio recordings and transcripts of the
semistructured interviews with nine RNs.

Nurses’ Burden of Responsibility

Nurses work in complex and challenging environments. The nurses in this study
repeatedly described that the presence of students, together with their everyday tasks of
caring for patients, was an additional burden within a workload that was already
overwhelming. When asked to clarify what she meant by the term burden, one participant
explained,

This feeling about our task as nurses and what needs to be accomplished has been
complicated. It feels heavy and sometimes overwhelming. Then to add the component
of confusion and lack of communication and being unsure of where your patients
are—are they safe and are they looked after and are their meds given on time and is
the correct med given? Do these students understand what med they're giving and
are their vitals accurate in order to give these meds? These people’s lives are in our
hands. We have a huge responsibility and then to feel like sometimes you don’t even
know if those questions can be answered. . . . You’re just left with an unsafe situation
. . . that’s where the sense of burden comes, right? It adds to our workload, and it
makes our job as nurses more complicated. (Participant 9, Lines 249–261)

The nurses talked repeatedly about the competing professional responsibilities of
needing to provide safe patient care while having a desire to provide a positive clinical
experience for nursing students. Sometimes these two goals were not mutually compatible
and nurses identified students as potentially compromising their professional accountabilities.

For example, one participant explained that, when students are on the ward,

I don’t get any breaks, I stay late to do my own charting, and, I go home pretty
stressed out because it’s important to me to do a good job. Good client care is so
important to me and I also know how important it is for the students to get a good experience. So if I really didn’t care about the students, I could cut short on that, and if I didn’t care about my clients, I could cut this short too. For me it’s really stressful. (Participant 3, Lines 46–49)

These pressures are compounded by the fact that RNs are held responsible for the care provided to their patients, regardless of whether that care was provided by themselves or by the students. The RNs found this responsibility very stressful and described feeling overwhelmed by the recognition that the legal liability for the patients in their care rested with them. As one participant commented,

You’ve got the patients in the hallways and shower rooms and patients all over the place, and you can barely get by stuff. So at the end of the day my responsibility with my RN license is to still make sure that my patients are safe. (Participant 6, Line 140)

The expectation that the nurses take time with and create room for students on the floors was both physically and mentally exhausting for many of the nurses. Carving out psychological space within themselves in order to respond to students with generosity seemed to be influenced by the overall ward milieu (see “Nurses’ Experience of the Practice Environment” section). This is illustrated by the comments of one nurse:

I don’t think anyone sets out thinking, “Oh, I want to give this student a terrible time,” right? . . . There’s no one who does that. So I think it’s all related to (for lack of a better word), a selfish mindset of, “They’re taking away from what I want to be doing” or “Taking away from my day.” The floor is crazy some days; you have all these patients and way more patients sometimes than you should ever have. So I think it’s maybe just one more thing piled up on top of a mind that’s already overwhelmed by the current situation. (Participant 5, Lines 341–349)

Nurses were especially concerned that having to teach a student nurse could negatively impact on patient care and patient safety. This responsibility ultimately rested with the RNs and added to their feeling of burden.
Nurses’ Experience of the Practice Environment

The practice environment has been demonstrated to have a significant effect on the work lives of nurses. The practice environment refers to both the physical space in which nurses work as well as the nature of nurses’ relationships with other hospital staff; it includes nurses’ perceptions of procedures, practices, and behaviours of other nurses and hospital staff within the work setting. The nurses noted that high patient acuity, lack of nursing staff, patients being cared for in hallways and washrooms along with an overall urgency to discharge patients quickly made the current work environment overwhelming at times. Several nurses in the study spoke of their hospital practice environment as being stressful and used terms such as “toxic” (Participant 6, Line 246) and “poisonous” (Participant 6, Line 246) when describing this environment. The two key factors that contributed to a sense of burden for the nurses within their immediate practice settings were physical space, particularly when space became a risk for patient safety, and the ward milieu. Each of these will be discussed below.

Influence of space. When asked to identify the challenges associated with having nursing students on the ward, nurses frequently identified space (or lack thereof). The lack of dedicated space for student training alongside their own day-to-day tasks was a major challenge for the nurses in this study. Almost all of the RNs commented on or alluded to the inherent challenge of accommodating students within the physical space available to them. One participant identified space as the only concern related to having students on the ward: “There’s a space issue; everybody’s aware . . . that’s probably the only concern that students take up space. It’s not the time. It’s not anything else; it’s just a little bit challenging ‘cause we just don’t have the room” (Participant 4, Lines 34–40).
Nurses generally have to share their workspace with each other as well as with members of the multidisciplinary health care team. When discussing the additional challenge of making room for nursing students, it was clear that this additional strain could lead to feelings of resentment. The lack of space to do their own work, and the incursion of students into nurses’ workspace, was seen by many participants as an imposition that not only slowed down the daily tasks of the nurse but was also interpreted by some nurses as a sign of disrespect for their primary responsibility to complete their patient care. One participant felt quite strongly about this, as is evident in the following excerpt:

*When we come onto the unit, I do appreciate instructors that get the nursing students to go to the side because when they’re all sitting in our chairs and at the report table and then there’s nowhere for the staff nurses to go. It’s not like a hierarchal thing like, “Get out of my chair,” but it’s like, “I’m here to work” kind of thing, and I just feel like it should be that kind of respect.* (Participant 2, Lines 47–49)

The collision of competing agendas was most keenly felt when nursing students and staff nurses both needed to be at the computer, medication cart, or nursing station at the same time. Nurses noted that students did not recognize that their learning space is also the staff nurses’ workspace and, therefore, nurses felt that their work should take priority:

*Space, computers . . . we are an EMR-based [electronic-medical-record-based] system, and we currently don’t have enough computers running for staff, let alone for students, and so that becomes even more of a communication issue because students are having a more difficult time charting. There’s even more competition for the two or three functional computers . . . and so because the staff might have to hover a little bit more that there’s more of a perceived space issue.* (Participant 4, Line 250)

Nurses noted that, because the hospital existed prior to its designation as a teaching facility, the wards were not constructed to accommodate the current volume of students participating in clinical rotations. It is important to note that the congestion felt by the staff nurses was a result of increased practica within multiple disciplines and was not singularly caused by nursing students. Beyond the inconvenience and frustration of having to share
limited workstations, the nurses were even more concerned that the lack of suitable workspace could lead to errors, which could negatively affect patient care and, ultimately, patient safety. Patient safety was a primary concern of the nurses in this study, and the need to increase their vigilance for this when students were on the ward amplified their burden of responsibility.

**Impact of space on patient safety.** The combination of highly congested and cramped work sites and limited equipment with which nurses and students tried to accomplish the same task simultaneously led to what staff nurses described as a “perfect storm” situation, one in which errors were more likely to occur. The comments of one participant illustrated this concern:

> Our unit is not set up properly. When it was made (the new part of the hospital), they [UNBC] had their degree students coming through, but there wasn’t the volume. It wasn’t set up properly, and it’s that pod system. . . . We have one med cart here, one little desk there, and there’s no room, and then you get a million people around there. . . . It can be challenging, especially around the med cart. It’s very frustrating because there’s going to be a big error. You’ll be on, at the MAR [medication administration record], and they’re reaching in and you say, “No, you need to wait please, because if I’m making a mistake, it’s my error and not yours.” . . . I understand that their focus is one patient and they want to make sure that they get all their stuff done, but my focus is 10 patients and, so they need to just wait a few moments. It can be very frustrating, and it’s frustrating for us even when we don’t have the students. It’s just not set up properly. How do you change that? I don’t know . . . [sigh]. (Participant 6, Lines 74–88)

Another nurse shared how the lack of appropriate space significantly impacted work in a way that resulted in significant steps of patient care being missed:

> When the students come to us . . . we have got pitiful, little offices. . . . There’s no room for them to sit, and so we just send them over to the unit clerk’s desk. One day it was really, really, really busy and . . . [a student] came in and wanted to look at a patient’s chart, and I gave it to them. And then, of course, we were running around, and then they came to get this patient to go to the OR [Operating Room] and, “Oh my God we didn’t admit . . . [the patient]” because . . . [the student] had the chart over there. (Participant 7, Lines 578–580)
Both examples illustrate how lack of space and equipment were identified as patient safety issues and contributed to the increased sense of burden felt by the nurses when nursing students are present on the ward.

**Ward milieu.** Nurses described their immediate work environment as chaotic and disorganized, stemming in part from the lack of adequate physical space to complete their work. Some of the nurses described their wards even more negatively using terms such as “toxic” and “poisonous” (Participant 6, Line 246), and noted that with the understaffing and overcrowding of patients, the staff morale was “sometimes in the toilet” (Participant 6, Line 210). Those who had been practising for longer noted an increased patient acuity, a shift in focus away from quality of patient care to a focus on shorter hospital stays, and an attitude from management of “why are these people [patients] still here?” This environment influenced the way that nurses reacted to the addition of students into their workspace. As one participant elaborated,

> It is awful now in the new units. . . . It is a lot more difficult to take a student and say, “Okay, let’s go here,” and take the time. There’s times honestly, I’ll admit I can’t be bothered, because I’ve got a million other things to do. When I was a student, there weren’t 100 . . . [patients] on the wards, and it was a lot more welcoming. It was different because people had the time. We didn’t have patients in the hallways and stuff. In the old part of the hospital, there was the same number of patients but they were in rooms, it was set up differently, and there was space. We had a centralized nursing station, and then you had your charting room in the back, and you had three med carts in the front, so there was space. The ward clerk had their space, and it was designed differently. . . . You had busy shifts, but it wasn’t fly by the seat of your pants all the time. (Participant 6, Lines 150–192)

Despite the descriptions of the hospital culture being negative, the RNs remained intent on investing in their future colleagues. Unfortunately, this intent to invest in students was at times derailed by the competing demands of their workload, culminating in the nurses leaving work feeling as if they had failed. As a participant described,
It can be very busy and staffing can be an issue and you’re spread too thin. . . . When you wake up in the morning and you’re getting ready for work sometimes you think, “God it’s going to be another horrible day.” (Participant 8, Line 134)

In this context, when the nursing students showed up on the ward, they became “one more thing that is piled on top of a mind that is already overwhelmed” (Participant 5, Line 347). In spite of these challenging work demands, participants unanimously espoused the value of training the next generation of nurses. Some of the RNs had a true sense of passion for and commitment to teaching students and expressed a desire to model positive learning for students.

The clinical practice leads’ and ward managers’ outlook towards students seemed to be an important factor in setting the tone on the ward towards students. Despite inadequate and limited physical space, it appears that students can be seen as less of a burden, and even as a positive benefit, when mitigated by the attitudes of the ward leaders. Some nurses commented that their clinical practice lead and manager were supportive and modelled positive attitudes towards students; for example, “not wanting to throw the students under the bus” (Participant 6, Line 426). Even though nurses described the larger hospital culture as negative, related to systemic pressures of overcrowding of patients, understaffing and high patient acuity, at the individual ward level a more positive outlook was possible, especially when encouraged by the nurse leaders on the ward. The clinical practice leads and managers were credited with providing positive and supportive attitudes towards nursing students. This became evident when nurses were asked to describe a situation in which they had contributed to a student nurse’s learning in a teacher-led placement.

Surprisingly, only one nurse was able to bring to mind a situation in which she had made a positive contribution to nursing students within a teacher-led practicum. In this case, the nurse described her ward as team-oriented and credited her peers and manager with
setting a positive tone, which reinforces the importance of the clinical milieu in welcoming students:

_I think for the most part it is the personalities that I work with. Everybody is really positive, loving, supportive of each other and we all want to have a good environment, so we do our best to maintain it. I honestly think we all love our jobs. We are all there for the benefit of the patients and their families, and we all want to make sure that everyone has a positive outcome and a good experience with us. So we actively make the effort every single day to make sure that everyone knows they’re cared for, whether it’s our teammates, or our patients and their families._

(Participant 1, Lines 77–79)

It is important to point out that, even with a positive team work environment and a passion for teaching, this participant admitted that it is sometimes hard “not to get frustrated”

(Participant 1, Line 281) with students and to resist the temptation to “just go do it yourself”

(Participant 1, Line 281).

**Nurses’ Experiences of the Clinical Instructor**

Another theme that emerged was the influence of the clinical instructor on nurses’ perceptions of nursing students. Specifically, it seems as if both the actual actions of the clinical instructor as well as nurses’ expectations of the clinical instructor’s influence the degree to which nursing students were perceived as a burden. When a disconnect occurred between nurses’ expectations and what the clinical instructors actually did, the students were perceived as a considerable burden. When the expectations of the nurses and the actions of the clinical instructor were more closely aligned, the students were perceived as less of a burden, and often as a benefit. Specifically, nurses thought that the clinical instructors played, or should play, three key roles on the ward: to act as a cultural translator, to identify and bridge communication gaps, and to set and maintain expectations. These aspects will be discussed in the following sections.
Acts as cultural translator. One participant described the clinical instructor as a "cultural translator" (Participant 4, Line 297), assisting students to "navigate the cultural landmines that exist" (Participant 4, Line 299) between what has been learned in theory or a clinical lab setting and what the reality is on the ward. Ultimately, nurses expect the clinical instructor to help bridge any gaps between what students learn in theory classes and what actually happens in practice.

In order to be most effective in assisting students, almost all of the nurses reported a strong preference for having clinical instructors who were currently practising or who had at least worked on their wards previously. Having worked on the ward was understood as giving the clinical instructor a level of familiarity and comfort with the staff nurses, as well as the advantage of knowing the flow of the ward routines and paperwork specific to that unit. Nurses expressed that, if a given clinical instructor had not worked on their ward, then the students would have a less comprehensive experience and thus be disadvantaged. This was clearly expressed by one participant:

*It’s huge . . . when [the clinical instructor] doesn’t work on our unit, I feel like her students suffer . . . because she’s not there every day for the day to day, she doesn’t know how everything works, the charting changes, and she’s not aware of the new forms . . . things like that.* (Participant 2, Lines 209–211)

The nurses felt that those colleagues who were practising on the wards were better able to navigate the flow of ward routines and to act as a buffer between staff and students. The clinical instructors with more ward experience were also perceived as being able to provide a fuller orientation for students, helping them to be mindful that the nursing station is a workplace and to yield the space and equipment to staff nurses as necessary.

Identifies and bridges communication gaps. Many nurses commented that the communication structure between staff nurses, nursing students, and clinical instructors was
inadequate, and they looked to the clinical instructor to help bridge any communication gaps they identified with students. Nurses described the flow of communication as predominantly going only one way between students and clinical instructors, leaving the nurses often feeling out of the loop about clinical updates on their patients. Nurses articulated concerns that they did not always receive clinical updates from students about the care provided to their shared patients (e.g., whether or not an assessment was completed). Participants commented that this lack of reporting by the students to the RNs about patient care was a significant issue, and was one that they expected the clinical instructor to facilitate. While acknowledging that students do in fact contribute to patient care, one participant pointed out that the important clinical information gathered by students may be lost to the rest of the care team, resulting in an incomplete clinical picture of the patient.

Students do a lot. They're asked to do a lot of assessments. They're gathering a whole ton of data. They're administering medications, and this information primarily flows back to the clinical instructor. So there is a bit of a communication issue, because they're creating treatment plans on individuals they're working with, and so they're carrying out this little microcosm of care, often completely unbeknownst to the staff. They are treatment planning, and it doesn't necessarily get filtered into the broader care plan. So there's this weird little silo of care that exists when students are on the floor. (Participant 4, Lines 232–248)

This “silo of care” (Participant 4, Line 248) may negatively impact both the staff nurse and the patient. Students come and go on the wards, often taking important clinical information with them. The staff nurses expressed considerable anxiety with the knowledge that what had not been communicated to them by students might have serious consequences for the patients with whose care they had been entrusted. One participant explained,

Lack of communication can be a challenge when you're not sure what's happening on the ward, who's received what, if the charting has been completed, or if the meds have been given. So once everyone leaves, you're not sure where the patients are at and what's been done, and what still needs to be done. So you run the risk of a med error and your license, and these [patients] are ultimately your responsibility. (Participant 9, Line 207)
Another nurse also expressed frustration with the lack of communication:

*That actually is kind of the key point, where they report more to their instructor instead of to me, and, well, I'm the one that's responsible for the patient, and I need to know what's going on, not just your instructor needs to know that you've done this.*

(Participant 8, Line 540)

Nurses expressed challenges communicating with students and were looking to the clinical instructor to help set and maintain the standards for students as well as to facilitate the discussions. When asked if the nurses would take these concerns back to the clinical instructor, most agreed that the complaints tended to stay amongst the staff. Some nurses were reluctant to speak with the clinical instructors about their concerns, fearing that the clinical instructor would be overprotective of the student. One participant elaborated,

*One issue I mentioned before is if you have an issue with a student, and I think it is good that clinical instructors sort of protect their students, but too if you have an issue with one, and you bring it forth, sometimes an instructor is very defensive, you know, and when you talk about something you didn't mean it in a rude way, you know, “but this kind of happened, so why did that happen, and let's go over that kind of thing.” So I think it's great when they protect their students, but also let's look at the whole picture of why this incident happened or that kind of thing or if a med was missed.*

(Participant 2, Lines 283–285)

Nurses expect the clinical instructor to facilitate students reporting back to the RNs regarding patient care. They also want clearer direction about what feedback the RNs are to give to the clinical instructor regarding students' performance. When these communication points were absent, it led to an increased sense of burden for the RNs.

**Sets and monitors expectations.** Nurses expected the clinical instructors to be responsible for establishing and monitoring expectations of students. Additionally, nurses expected all clinical instructors to have consistent standards, not only for their students but also for the nurses who would supervise the students during their clinical experience. Nurses felt that they could more effectively contribute to students' learning if the nurses were clear about what the nursing students could or could not do, what skills students should be
focusing on in a particular setting, and how the staff nurses might be involved. This was an area of significant agreement among the nurses. When asked if the nurses had a sense of what the clinical instructor’s expectations are, one participant answered,

_Not a whole lot. I can speculate from what I’ve seen, but I don’t think there’s any formal, you know, “This is what our students can do and can’t do and this is what you can expect, and this is how you can contribute,” which I think would be valuable. . . . You would definitely understand where their roles lie and what is safe practice . . . where they’re at in their education._ (Participant 9, Lines 34–136, 148)

Lack of clarity regarding student competencies led to increased frustration among the staff nurses and potentially additional strain in the relationship with the clinical instructor. Nurses also noted several areas in which there appeared to be a discrepancy between what they expected from students and how students acted. For example, the nurses expressed frustration when students were not dressed professionally, were texting on their cell phones, or did not respond to patient call bells. The nurses admitted being reluctant to bring these concerns forward to the clinical instructor and noted that such complaints tended to stay among the staff. The nurses also had suggestions as to how the clinical instructors could remedy these concerns:

_Maybe all the clinical instructors could get together have the same expectations. That would help a lot. “This is what we expect for you to wear, when you have your assessments done, when to report off on these issues.” . . . So maybe they’re all on the same page, and make sure that they are actually enforcing those expectations._ (Participant 2, Lines 279–281)

Along with seeking clarity as to the clinical instructors’ expectations of the students, nurses wanted clearer communication as to what expectations the clinical instructor had of them. The nurses expressed their willingness to contribute to the clinical education of the nursing students, but they indicated that they were not always sure as to whether their insights were welcomed. Some were also reluctant to be perceived as intruding on the clinical instructor’s teaching process. As one RN
explained, “I’m mindful of the relationship that the instructor has with the student, so I don’t want to say, ‘Hey and did you know,’ and start offering education because that’s not my place” (Participant 4, Line 120).

One participant discussed how the communication flow also hindered nurses’ understanding of what is expected of them in regards to nursing students’ learning:

*The interactions are from the students to the patients or the students to the teachers, and then with some teacher guidance or encouragement, then it is directed from the student to the nurses. So if there was a question brought to us, or a concern or if there was an initiation encouraged by the clinical instructor, I think it would be a great honour to be able to contribute and assist in learning.* (Participant 9, Lines 160–162)

It is important to note that, despite the concerns expressed concerning the clinical instructors, the nurses expressed considerable empathy towards them. The nurses in this study noted that the clinical instructor might have to supervise several students who are spread across different pods or floors. As one nurse noted, “I mean she may have seven people, so how can one person do all that? That’s too many, in my opinion. So, I check in with the . . . [students], if the clinical instructor’s busy with another student” (Participant 2, Line 87).

Another nurse concurred that the clinical instructors were stretched thin:

*Those poor instructors. . . They have eight . . . [students], and that’s a lot. . . . I’ve shared a clinical group of second-year nursing students probably about 9 years ago, so I do know what it’s like to try and keep track of that number of students, and in a pod system . . . that’s tough.* (Participant 6, Line 108)

For some RNs, the presence or absence of the clinical instructor on the ward appeared to make a difference in the RN’s interactions with students. When the clinical instructor was present, some RNs felt they had more freedom to select learning experiences that the students might benefit from, as well as feeling they could send the students to the clinical instructor for questions when they themselves were too busy to respond. When the clinical instructor
was absent, the RNs felt that they needed to fulfill two roles, both nurse and teacher; this was a concern for the nurses. One participant explained,

*When I have a clinical instructor there I can pick and choose good learning experiences that the student could have throughout the day rather than being my shadow the entire day . . . because there's a lot of mundane things that the students don't need to know how to do but then there's those really good learning opportunities that, um, I can communicate with the clinical instructor and say, “Hey, this is coming up.”* (Participant 3, Lines 147–149)

The ability to choose when to participate with students, and when to redirect them to their clinical instructor, influenced the nurses' sense of burden.

**Nurses’ Experience of Students**

The nurses in this study acknowledged that their attitudes towards nursing students are very important and can make or break the clinical experience for the students. Almost all the nurses described the attitudes of their peers as positive or mostly positive towards students and were able to acknowledge benefits associated with having students on the ward. However, there were times when the nurses admitted that either they or their colleagues had negative attitudes towards students. When nurses did admit to having negative or even hostile reactions to the nursing students, it was usually related to students being an additional burden within their already overwhelming workload.

**Benefits of having students on the ward.** Nurses readily expressed positive attitudes towards, and could identify the benefits of having students on the wards. Nurses were excited about “being able to shape who your future coworkers are going to be” (Participant 1, Line 203). They enjoyed the invigorating energy that students brought to the ward, the change in routine, being brought up to date with the latest evidence-based practices, and the fact that sometimes students would notice patient concerns that they might miss in their harried day. The nurses were cognizant that students were supernumerary and not to be used to alleviate
workload. However, they were especially appreciative when students brought “an extra set of hands” (Participant 6, Line 68) and assisted with direct patient care, completed assessments, and even helped with simple but necessary tasks such as refilling the linen carts or restocking items. Other benefits that several nurses noted was that having students on the ward “kept them on their toes” (Participant 1, Line 310) and forced them to examine their own practice and biases. One participant elaborated,

Benefits . . . it keeps me up things . . . perfect example—inserting an NG [nasogastric tube], the placement thing . . . to check the pH and the litmus paper, . . . and that got me thinking, so then I went home and I’m looking it up. . . . So just little things like that to keep us up to date on the newest literature. (Participant 6, Lines 463–467)

This same participant continued on to note that the students are important members of the health care team because of what they notice.

They’re also our eyes and ears too. . . . Even though we are still responsible for checking out that person, but so many times they’ll notice something that somebody hasn’t noticed and mention it, and then we’ll let the doctor know or we’ll note it. . . . We rely on them because their assessments are more in depth than ours. Of course, they [only] have one patient. (Participant 6, Line 472)

Another nurse concurred,

Sometimes just having an extra set of eyes, like if you’ve been working with a patient forever and . . . then your students go and assess them and they’re like, “Oh did you notice this,” and it’s, “Well, no, I didn’t see that.” They look the same to me as they always have . . . they can bring the fresh eyes to the floor. (Participant 8, Lines 419–424)

Despite these benefits, the nurses noted that not all of the attitudes towards students were positive. Negative attitudes towards students were often related to challenges that were out of RNs’ control. These challenges seemed to stem either from systemic issues or from matters of concern specific to the students themselves.

Challenges of having students on the ward. When discussing the challenges associated with having students on the wards, nurses noted that their attitudes were
influenced by systemic issues associated with patient acuity, the ward set-up and milieu, and also those issues associated with the students themselves. Nurses noted that the length of time that students had been in the practice setting, and how prepared and willing to learn students were, influenced RNs’ attitudes towards students. The nurses described how these challenges had led some of their colleagues to resent both the students and the expectation that they would teach them. One participant noted,

*I know in particular there is one nurse who gets quite stressed immediately about it and, I hate to say but there’s almost a hostile feeling that I feel comes up, towards the students, with that individual . . . being overwhelmed with workload and feeling that . . . instructors are the ones who should be there teaching students how to do the job, not RNs taking on students.* (Participant 9, Lines 16–20)

Another nurse described the negative reactions that their colleagues display in response to this additional responsibility:

*I would have to say, unfortunately, it’s not always a positive attitude. I feel that, a lot of my colleagues feel that, nursing students are a burden, and they take up a lot of their time. They make the unit disorganized. There’s sometimes a lack of connection . . . between the nurses and the students in communicating, and so it makes . . . [nurses’] job[s] a lot harder . . . and so the nurses don’t always appreciate the students coming in.* (Participant 9, Lines 17–18)

Another nurse noted,

*I don’t like to generalize, but the nurses who have been there for 25 to 30 years—not all of them—do not like students, feel threatened by students, and are not helpful on the ward when there are students. Some are amazing, but there are a few that just see new education as a threat or disrespect . . . so how can we change those attitudes? You were a student once and the whole like, eating-your-young thing, why are you doing that?* (Participant 2, Lines 236–238)

I think it is significant to note that, when nurses described attitudes that were negative, resentful, or even hostile towards students, they described them in a tone of regret, embarrassment, and even shame. This was particularly strong for one of the participants whose voice dropped to a whisper, as if the nurse dared not speak of such negative reactions to the students. It seemed that to react so negatively towards students went against not only
the obligations that these nurses felt with regard to their professional responsibilities, such as the College of Registered Nurses of British Columbia (2015) professional standards, but also their own personal values. When staff nurses were feeling negative (angry, resentful, or hostile) towards students, they felt that they were letting themselves down.

There were several factors directly related to nursing students that influenced how staff nurses responded to the challenge of adding students to their workday. Along with the challenges related to communication described above of not knowing what the students were capable of doing and students not reporting back about what they had done, there were two other concerns reported by the RNs. The first challenge was the length of time that the students were within the practice setting. The second challenge was how students ‘show up,’ or their preparedness for learning.

**Length of time in practice setting.** How long a student had been in the program, or even how long the student had been on the ward, influenced staff nurses’ attitudes and willingness to contribute to their learning. Students who were brand new (Day 1) to the ward, or were first years, were perceived as more of a burden by the nurses, as evidenced by the following statement: “Well, if it’s a group of the first years and, you know, they’re all scared, and are usually just in your way or in your chair” (Participant 8, Line 512). First-year students or even third-year students who were brand new (first day) to the ward were perceived as being a greater burden and requiring extra time and attention, which some of the nurses felt hard pressed to give. One participant explained,

> *So when nurses show up in the morning and they see that they have a student, one of the first questions I’ve noticed that’s asked is, “How many days have you been here?” Because if it’s Day 1, I know right away that I’ve got a lot of work to put in with the student if I want to help them, right?* (Participant 3, Lines 43–45)
The nurses noted that they would give more time to students in fourth year, as those students were soon to be colleagues and, therefore needed the practical experience. One nurse put it this way:

*I will make sure I make even more of an effort if it is a preceptor student and you know they’re fourth year, “You need to come and let’s go do this,” even if it’s not my student because they’re closer to being finished.* (Participant 6, Line 162)

Nurses in this study wanted to assist students in their learning but found that when students were new to the practice setting that it took considerably more work on the RN’s part to orientate them. This additional time and effort contributed to RNs’ feelings of exhaustion and, at times, resentment of the additional burden.

**How students show up: Preparedness for learning.** Staff nurses expected that students show up prepared by being knowledgeable (about their scope of practice), dressed appropriately, with their cell phones stowed away, and demonstrating a willingness to learn. Several nurses were concerned that more recently students have not been meeting these expectations, which they found to be a shift from previous years. It is noteworthy that both recent graduates as well as more seasoned practitioners expressed these concerns. As a participant noted,

*I’ve only been working for 7 years, so I feel like at what point did that start slipping? . . . I felt like when I was taught there was a huge respect thing, for . . . [RNs] experience and how you carry yourself and, [to] look proper. . . . It was even serious, like, you do not wear black scrubs to work and you wear matching scrubs. . . . It was quite serious. . . . So where did that start slipping? Is it generational? Is it instructors?* (Participant 2, Lines 265–267)

Participants also expressed concerns regarding students’ attitudes towards clinical learning:

*For over a year and a half there seems to be this attitude [from students] that they know everything, and it is very frustrating because there’s a lot of students who are not receptive to learning; they’re not receptive to feedback.* (Participant 1, Lines 271–273)
Another nurse noted that, when students do not display a willingness to learn or are not receptive to feedback from RNs, the issue moves beyond being a frustration and becomes a safety concern:

*Some of your students . . . think they know everything. And to me that's a huge safety concern right there . . . because after 20 years I don't know everything. I go to work and learn something every day. And I try to tell them that too.* (Participant 6, Line 254)

Nurses were discouraged by the students’ lack of preparedness and lack of receptiveness to feedback and noted that it was difficult to maintain their professionalism and not snap at students when the strain became too much. Having students who are unwilling to learn and not prepared, negatively affects the attitudes of nurses towards students and contributed to nurses’ overall sense of burden.

**Nurses’ Experience of Their Own Contributions to Students’ Learning**

Within the interview process, nurses were asked what made them decide to take the time out of their busy schedules to participate in this study. Almost all participants noted that they wanted to be part of research that may help to change or improve the education of students and nursing practice. As one participant noted,

*I think it's important to take part in these research projects to be able to improve either the education of the students, the process that they're going through or the experiences, but also to be a part of the research process and make things better for people, especially when it comes to clinical practice and leadership.* (Participant 1, Line 328)

Implicit within the idea of change or improvement was the participants’ acknowledgement that elements of the current teacher-led clinical model were not working well. Some nurses accepted the interview invitation, hoping to discuss troubling issues in their own practice, those of their peers, or the clinical education process that they had observed. One nurse provided the following reason for wanting to participate:
Because I strongly feel, I'm not able to provide really good direction for the students when I have a full client load. I want to contribute toward to the knowledge around the relationship between RNs and nursing students and how do we improve that? Because it can be really tense in my work environment. . . . I see it within myself; . . . and I see it amongst my coworkers when they have new students beside them.

(Participant 3, Lines 21-29)

Another participant stated she took the time to meet with me,

because . . . we do work a lot with students on the ward I work on, and I have seen many changes through the years. . . . I do have some concerns actually, and so I thought that this is a place to voice it. . . . I do feel some of the stuff is a safety concern. I thought "perfect," that this could be my place to just voice my opinion and provide feedback, really. (Participant 6, Line 60)

A third nurse related,

I want to contribute to the improvement of nursing practice. My experiences during my undergrad were such that I felt the entire process could be better, and I have looked for every opportunity since then to contribute to the improvement of the student experience. (Participant 4, Line 276)

**Invisibility of nurses’ contributions.** When asked to share a situation in which they felt that they made a contribution to a student’s learning within a teacher-led practica, almost all of the nurses found this question difficult to answer. This question gave them significant pause and, in one case, the nurse asked to come back to it later in the interview. Despite espousing the desire to contribute positively to clinical learning, most nurses could not actually identify how their casual interactions with students helped students learn. Apart from the formalized preceptor relationship, many of the staff nurses simply did not perceive themselves as contributing to students’ learning. Only one of the nine nurses interviewed was able to provide an example that was not tied to a one-on-one preceptorship relationship. It was not that contributions to students’ learning were not occurring, but rather that the nurses were unable to recognize themselves as teaching within their day-to-day interactions with students. Their learning contributions were largely invisible to the nurses themselves. As one
participant explained, “I kind of like teaching and bringing them along” (Participant 1, Line 309). However, the same nurse later acknowledged,

> I don’t think about my contributions much... that’s hard because. I mean, you don’t get feedback on them or how they experienced that rotation with you, because you’re there for a day, and you might not see... [the student] again on their whole rotation. (Participant 5, Lines 162–182)

Another participant put it this way:

> I don’t think that we see students, and think, “Alright I’m going to make a difference, and contribute, and I’m going to teach somebody something.” I think we just go about trying to work hard and take good care of our patients and advocate on their behalf and, hopefully in the mix something good happens. (Participant 9, Line 323)

This is not to say that contributions to student learning were not occurring. When the nurses were asked how their interactions with students differed from when they were in school, it became apparent to me (if not to them) that staff nurses were modelling to students all the time and taking time for learning conversations with students. However, the RNs failed to see these informal interactions as teaching because it happened in the wake of their everyday tasks and was not formally labelled or acknowledged by themselves or others as teaching. Moreover, staff nurses seldom received individualized feedback, positive or negative, from either the students or the clinical instructor.

**Nurses’ intentions for teaching: “Do better or pay it forward.”** Nurses’ beliefs about clinical education were shaped by their own student experiences, and many nurses used these encounters as a student (both positive and negative) to influence how they interacted with students. Those who had excellent experiences wanted to ‘pay it forward,’ and those who had negative student experiences themselves used these to drive a desire to ‘do it better’ in their own practice. One participant explained how his own student experience influenced how he interacts with students today:
The people that I encountered over the process... really influenced how I learned. I think had I not had really wonderful preceptors and contact with really great nurses as a student that it could have been very different. If I can be the one person that have contact with who can remind them to do the appropriate things when they come out and look for the right answers, then that's great; there's one. (Participant 1, Lines 207–209)

Some nurses were clear that they enjoyed teaching and engaged students and that they tried to put themselves in the students' shoes and not repeat the negative experiences they themselves had during their own education. If they had been grilled with questions during their own clinical, and found this uncomfortable, then they chose to ask students what they knew about a particular issue and allow students time to look things up. The nurses also demonstrated procedures, allowing students to observe while the RN recounted why she was doing what she was doing as a means of teaching.

Despite a desire to teach students or even a determination to provide a better experience than they had received, some nurses acknowledged that, amidst the “incredible amount of roles they’re expected to fill” (Participant 4, Line 317), RNs are not necessarily well-prepared to teach:

We hire brand new staff that are asked to work with students now and... you know, it’s really the blind leading the blind... I didn’t have a sense of who I was professionally. I didn’t know my practice... I was making egregious errors that I was inadvertently modelling to students... Teaching is an important role of nurses, but we’re really not... well equipped to actually do it. (Participant 4, Lines 311–315)

Many nurses did not feel adequately equipped to fulfill the expectations of teaching students while continuing to complete their other nursing duties. This additional teaching task contributed to the sense of burden expressed by the participants.

Summary of Findings

This research has explored teacher-led clinical education from the perspective of the staff nurse. The findings showed that nurses wanted to train up the next generation but four
subthemes emerged from the data influencing nurses’ ability and willingness to do so: (a) the practice environment, (b) the experience of the clinical instructor, (c) RNs’ attitudes towards students, and (d) RNs’ contributions to student learning. The complex interplay between and within these themes contributed to the broader metatheme of burden of responsibility for the nurses. It is important to note that, although the balance (or imbalance) of these four themes result in a significant, and sometimes overwhelming, burden of responsibility for the nurses, it did not seem to diminish their overall willingness to contribute to nursing students’ learning in teacher-led practica and a desire to see the clinical experience improved.
Chapter 5: Discussion and Conclusion – The Burden of Responsibility

The purpose of this study was to understand teacher-led clinical nursing education from the staff nurse’s perspective. The nurses in this study shared their perceptions of their own contribution to nursing students’ learning within a teacher-led practica. In this research, one metatheme, burden, was identified. There were several factors that combined to create this burden of responsibility for the nurses in this study. These factors include the effects of moral distress as it was experienced within the context of the interplay of the practice environment, the clinical instructor, and the nursing students. The findings related to the staff nurses’ contributions are also considered.

The findings of the current study clearly demonstrate the complex and dynamic nature of staff nurse–student nurse relationships. This relationship rests within a broader and complex health care system. The competing demands experienced by the nurses within this system as it relates to student education must also be considered.

The interviews with nurses highlighted that the complex practice environment of health care contributes to their sense of being pulled by multiple and competing demands. The term “burden” arose frequently within the interviews, and it became necessary to clarify the meaning of the term as the participants described it. The nurses described a sense of burden that correspond to the following definitions: (a) “a difficult or worrying responsibility or duty” (“Burden,” 2009, para. 2); (b) “a load being carried” (para. 3); and (c) “to give somebody a task that is difficult to deal with or something worrying to think about” (para. 4). The challenges of trying to accommodate students within a milieu of high patient acuity, low staffing levels, and poorly designed work stations added to the nurses’ burden of responsibility.
In this section I will begin by discussing the findings of my research and link these findings to other research relevant to nursing clinical education. Commonalities and discrepancies between the current study and the existing body of research on this phenomenon are highlighted. Implications for both education and practice are reviewed. The limitations of the current study and the need for future research are examined.

**Moral Distress**

The nurses in this study repeatedly spoke of the increased responsibility they felt for ensuring the safety and quality of patient care while also trying to provide a positive clinical experience for students. These two goals were not always mutually compatible and led to competing tensions and ethical concerns for the nurses. One of the concerns the nurses named as difficult and worrisome was that students were assigned to care for nurses’ patients, yet the nurses did not know if that care had been completed. This posed an ethical concern for the nurses, as they felt ultimately responsible for the care of their patients. At such times, the staff nurses left work distressed and “feeling like a failure” (Participant 6, Line 341).

Ethical practice in nursing is both relational and contextual (Varcoe et al., 2004). Nurses often find themselves working in situations in which ethical concerns associated within their day-to-day practice can become “sidelined, dismissed as ordinary, or not actually seen or named as ‘ethical’” (Varcoe et al., 2004, p. 317). Varcoe et al. (2004) pointed out that nurses have tended to view ethical situations as those that occur in highly charged medical crises and have not paid enough attention to the ethical issues and tensions that are situated within their everyday experiences. While the ethical concerns noted by the nurses as they relate to nursing students are important, the nurses tended to bear these concerns themselves,
internalizing their distress. When these ethical concerns and value conflicts are embedded in nurses' daily practice and nurses perceive that they are powerless to change them, nurses may experience what is referred to as moral distress.

Moral distress is a significant topic of concern in the nursing literature, and is often (but not exclusively) associated with the “big E” ethical dilemmas in which life and death decisions are necessary (Elpern, Covert, & Kleinpell, 2005; Hamric, Borchers, & Epstein, 2012; Schluter, Winch, Holzhauser, & Henderson, 2008; Varcoe et al., 2004). Jameton (1984) is commonly credited as defining the concept of moral distress, arguing that what was typically termed as a moral dilemma in nursing was actually moral distress. Jameton defined moral distress as “arising when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action” (p. 6). For over 25 years there has been considerable interest in the concept of moral distress by nursing and other health disciplines (Hamric et al., 2012). Despite this sustained interest in the topic of moral distress there appears to be no central agreement on the defining characteristics of this concept (Hamric et al., 2012). However, a more recent, description of moral distress by Schluter et al. (2008) may prove valuable, as it relates to the experiences of the nurses in the current study:

[Moral distress is] an emotion that is expressed when the moral complexity of a situation is not leading to a resolution, thereby having the potential to cause harm to the individual nurse. [It includes] painful feelings and associated mental anguish as a result of being conscious of a morally appropriate action, which, despite every effort, cannot be performed owing to organisational or other constraints. (p. 306)

Indicators of moral distress include anger, frustration, guilt, anxiety, and a sense of powerlessness (Hamric et al., 2012). Many of the nurses in the present study expressed these emotional responses when they described some of their own and their peers’ reactions to the addition of nursing students on the ward. While it was not the intent of this research to study moral distress, the concept of burden as described by the participants in this study appears to
be closely associated with that of moral distress. This is consistent with Hamric et al.'s (2012) findings, as they noted many of the studies that have contributed to the concept of moral distress did not set out to study the phenomenon. Nurses in the current study certainly described distress when needing to balance the competing demands to provide safe patient care while also feeling obligated to accommodate students.

**Space and Place**

Nurses in this study said that the issues associated within their practice environment significantly influenced their experiences of having nursing students on the ward and their sense of burden. In order to contextualize the experiences of staff nurses as they relate to nursing students in clinical practica, it is imperative to consider the clinical learning and working environment within which this relationship takes place. Nursing is, by nature, a stressful occupation. In their daily work, nurses must respond to severe suffering, grief, and death as few other professions do (McGrath, Reid, & Boore, 2003). Nurses respond to these daily stresses within a multidimensional practice environment comprised of the physical environment, the interprofessional relationships, the beliefs and attitudes of the employees, as well as the organizational norms and practices (Sleutel, 2000). The participants in the current study frequently described the practice environment as chaotic, unsafe, and at times toxic. These findings are consistent with other studies that also reported the challenges associated with the practice environment, including staff shortages, increased patient care assignments, and workload, influenced nurses' perceptions of students (Grindel et al., 2001; Matsumura et al., 2004; Slaughter-Smith et al., 2012).

One unexpected but important finding in this study was the nurses' concerns regarding the lack of physical space to accommodate the growing number of students on the
wards. A key obstacle to the nurses in this study feeling hospitable towards nursing students was the need to compete with students for access to limited workspace and equipment. Vying for space and equipment contributed to the sense of burden felt by staff nurses. In order to contextualize the nurses' comments regarding lack of space in the current study, it is helpful to explore these within the context of definitions of both space and place provided by health geographers. Nordquist, Kitto, Peller, Ygge, and Reeves (2011), in their work on the subject of interprofessional education, offered helpful differentiations between the concepts of space and place. They defined space as “geographic location and material form” (Nordquist et al., 2011, p. 391), whereas place was defined “not only by geographic location and material form, but by the meaning and value that people associate, attach and invest in physical space” (p. 391). Indeed Andrews (2002) argued that the understanding of place is important to all of nursing research. Attention to the meaning of place and space within health care delivery helps to elucidate the importance and complexity of the everyday microgeographies within which nurses work and students learn (Andrews, 2002). However, Liaschenko (2001) contended that nurses tend to take their experiential geographies for granted and rarely have the time to reflect on how their daily work is impacted by its location.

When the nurses in the current study commented on their work location and space issues it was clear that considerable meaning and value were attached to their practice environment. The nurses were very conscious of not having enough physical space at the nursing station or the medication carts to accommodate students. In addition to the lack of physical space, nurses spoke of not having enough psychological space within them to accommodate students. In this case, students become “one more thing piled on top of a mind that is already overwhelmed” (Participant 5, Line 347). The notion of staff nurses needing
both physical and psychological space to accommodate students is an important and underrepresented view in clinical education.

Many of the studies that considered the effects of space on the clinical education process focused primarily on how place factors into student learning (Andrews et al., 2005; Bines & Jamieson, 2013; Nordenström, Kiessling, & Nordquist, 2013; Nordquist, Sundberg, Kitto, Ygge, & Reeves, 2013). A recent example is the review of a new children’s hospital in Australia where greater attention has been paid to having clinical learning spaces imbedded at the ward level (Bines & Jamieson, 2013). However, even within these more recent examples, the emphasis has been on students’ experience or even on patients’ and families’ experiences of the practice environment, not on the experience of actual nurses working within these settings. The current study shows that the space and place within the practice environment of clinical education is an important factor to consider if administration and leadership wish to engage staff nurses most effectively in the learning process.

The frustrations voiced by nurses in the current study echoed Nordquist et al.’s, (2013) assertion that many staff and students are working in ‘living museums’ that represent out-dated thinking regarding health education. Perhaps these space and place challenges persist because, unlike universities, the core business of hospitals (even those with a university affiliation) is to treat patients (Bines & Jamieson, 2013). Indeed, the findings of the current study illustrate that there is a misalignment between the curricula of nursing education and the physical learning spaces in many clinical practice environments. It is important to note that complaints regarding space were not restricted to those nurses working only in the older parts of the hospital; in fact, some of the nurses noted the newer ward layouts made it even more difficult to interact with students in a meaningful way.
Nurses were frustrated that, at the ward level these spaces have not evolved to accommodate the growing number of cohorts of nursing and other health care students. The overcrowding in crucial spaces, such as the nursing station and around computers, fuelled the sense of frustration nurses experienced when nursing students were in what the staff nurses believed was rightfully 'their space.' This sense of ownership by staff nurses over certain spaces is consistent with the work of Halford and Leonard (2003) who found that doctors and nursing managers were seen as visitors at the nursing station. Of all of the allied health care professionals, nurses have the least amount of dedicated workspace and have the least ability to move around the larger hospital setting (Halford & Leonard, 2003). While physicians, occupational therapists, physiotherapists, recreational therapists, and others move freely on and off the ward, nurses, due to the nature of their work, do not. Nurses are tied to the ward and especially to the patient bedside and/or the nursing station, often having to compete with others to access the equipment and space they need to complete their duties. This sense of place as a negotiated reality where nurses must interact with the physical environment and others to complete their work and at times compete for ‘their space’ is evident in the findings of this study. It is not surprising that, within this context, the nurses in the current study claimed ownership over certain spaces (e.g., nursing stations, computers, and medication carts) where other health care providers and students may be viewed by the staff nurses as “visitors” or “outsiders.” This finding is consistent with other research demonstrating that nurses perceive the ward and specifically the nursing station as ‘their’ space (Andrews, 2002; Halford & Leonard, 2003; Mannix et al., 2006).

The findings of the current study underscore the need to consider the role of space and place within clinical nursing education. The literature is clear that for nursing students to
learn well in clinical practica they must feel as if they belong (Campbell, Larrivee, Field, Day, & Reutter, 1994; Levett-Jones et al., 2007; MacLeod, 1994); the findings of the present study show that the physical space can work against this. Two questions arise from these findings: How can the profession claim that clinical education is central to nursing education, yet continue to have students and staff nurses compete for a “place at the table”? What is the link between the frustration staff nurses feel when students are “in the way or in their chair” (Participant 8, Line 152) and the fact that there appears to be no dedicated ‘chair’ for nursing students? It was evident in the stories of the nurses in this study that a paradox existed: nurses agreed that students are a welcome addition and that they would like to ‘train up’ the next generation, yet there is no space for students.

Clinical Instructor

Nurses in the current study identified the clinical instructor as having an important and influential role. The clinical instructor was seen as a potentially mitigating factor for the burden experienced by the staff nurses in relation to students. Staff nurses looked to the clinical instructor to clearly communicate expected outcomes and levels of competence of the students (the formal curriculum). The formal curriculum is the explicit learning outcomes and is usually planned by the educational institution, whereas the informal curriculum is unplanned, often unfolding within the interpersonal relationships between faculty, students, and staff nurses outside of the formal classroom (Castellani & Hafferty, 2006). The staff nurses also expected the clinical instructors to assist students in navigating the informal and even hidden curricula that is specific to the norms and mores of each ward. The hidden curriculum is “the one we are unaware of . . . the way we interact with students . . . [it] is the curriculum of subtle socialization; of . . . how to think and feel like nurses” (Tanner, 1990,
When participants identified the clinical instructor as a cultural translator they were expecting the clinical instructor to act as a buffer between students and staff and to help the students navigate the potential ‘landmines’ between theory and practice. As a result, clinical instructors with personal work experience on the wards where they also teach were clearly seen by the staff nurses as having a significant advantage. One might reasonably expect that within specialty areas nurses might naturally prefer to have a trusted colleague in the clinical instructor role. This was the case in the work of Gerhke (2012), who found that obstetric nurses preferred the clinical instructor to have obstetrics experience. However, in the current study, this preference was consistent and extended across the varied wards.

The staff nurses in the present study expressed the belief that clinical instructors familiar with ward routines and personnel could give students a superior clinical experience. The nurses said that they thought clinical instructors who were practising on the ward and familiar with the ward routines were both more capable and more approachable. These findings are consistent with the work of Langan (2003), who interviewed both clinical faculty (clinical instructors) and staff nurses about their roles with nursing students. Langan found staff nurses had a strong preference for working with practising versus nonpractising faculty. She also found that clinical faculty who practised on the same wards where they brought students for clinical experiences felt that they had an advantage of familiarity and were more effective in obtaining information about the ward and its personnel (Langan, 2003). The clinical instructors in Langan’s study also believed this advantage kept them up to date and made them better clinical instructors. The comments of the participants in the current study aligned with the findings of Langan (2003) and Mannix et al. (2006), which indicated teacher-led clinical education models should include clinical instructors who continue to
work on the wards between clinical groups. Langan further argued that staff nurses who worked with practising clinical instructors reported less role ambiguity, conflict, and overload than when they worked with nonpractising clinical instructors.

**Role ambiguity.** Nurses in this study commonly noted that they were not given clear guidelines or expectations for either the students or themselves from the clinical instructor. In the current study, some nurses articulated being afraid to step in without direction from the clinical instructor, concerned that without a clear sense of the students’ learning objectives they might be perceived as interfering. The lack of clear expectations regarding their function within teacher-led practica added to nurses’ burden of responsibility. The requests from nurses in this study to be given clear direction were consistent with others that showed staff nurses appreciate clear role expectations and support as they interact with students in the clinical setting (Atack et al., 2000; Grindel et al., 2001; Hathorn, 2006; Jackson & Neighbors, 1988; Matsumura et al., 2004; Ogier & Barnett, 1986; Slaughter-Smith et al., 2012).

Likewise, Omansky (2010) found even within the defined role of preceptor nurses experienced role ambiguity, conflict, and strain when interacting with students. Further, unclear and contradictory messages from educators and management were linked with poor retention and burnout of nurses (Omansky, 2010). The findings of the current study taken together with those of Hathorn (2006) and Omansky (2010) revealed the need for consistent and continued communication between the clinical instructor and the staff nurses if we are to create learning environments in which staff nurses feel supported and nursing students feel welcome.

**Communication gaps.** Staff nurses in this study felt out of the loop when they did not receive clear expectations from the clinical instructors. This feeling was amplified when
the nursing students spoke mostly to the clinical instructor. The lack of reporting back to the staff nurses from the students was a significant source of stress. The participants in the present study were aware that nursing students give a significant amount of patient care. While the nurses were appreciative of the workload students carried, they became extremely stressed when students left the floor or the shift without reporting off. Since the RNs were ultimately responsible for their patient assignment, this lack of information created safety issues and contributed to nurses’ sense of burden.

The need for clear expectations and the importance of communication between students and staff nurses has been well established in the literature (Atack et al., 2000; Chan, 2002; Hathorn, 2006; Langan, 2003; Löfmark & Wikblad, 2001). Not only does clear communication between the clinical instructor and the staff nurses reduce stress for the nurses but it also improves learning outcomes for students (Atack et al., 2000; Chan, 2002; Hathorn, 2006; Löfmark & Wikblad, 2001). Clearly, the staff nurses in this study viewed the clinical instructor as well positioned to assist in reducing the uncertainty by making the expectations and scope of practice of the nursing students more transparent and accessible to the RNs. By providing clear expectations for students to the staff nurses, the clinical instructor helps to minimize the amount of hostility directed at nursing students due to poor communication.

**Nursing students**

Nurses in this study acknowledged both benefits and challenges associated with having students on the ward. Nurses appreciated and acknowledged that nursing students assist with the personal care of patients, provide detailed assessments, and even help with simple housekeeping tasks. The staff nurses appreciated that students brought an extra set of
hands, freeing them up to attend to patient care that is too complex for students. The nurses also spoke positively about the fresh energy and cutting-edge information the students brought to the ward. However, these positive benefits were tempered as the participants also noted students can increase stress and workload. These findings were similar to those by Hathorn (2006), Matsumura et al. (2004), and Slaughter-Smith et al. (2012), who also found staff nurses experience nursing students to be both a benefit and a burden. Of note are the student-related findings in the current study that were in alignment with those by Matsumura et al. These include student preparation, the level of the student (i.e., experience), how students ‘show up,’ and the ways students promote professional development.

Nurses in the current study noted students who show up prepared for the shift and ready to learn are generally appreciated. The level of student (i.e., how long he or she has been on the ward and in the program) made a difference to the degree of burden nurses felt regarding nursing students. Students on Day 1 of their rotation were perceived as more work than the same student on Day 4. Nurses in the present study showed a clear preference for students in the later years of their training. In addition to the level of the student, the way students “show up” was important to the nurses. Not only were students expected to show up prepared but also dressed appropriately and with an attitude for learning. Some of the nurses were very concerned with what they saw as a lowering of professional standards in regards to dress and comportment of nursing students. On a positive note, the nurses in the current study enjoyed being ‘kept on their toes’ by students who offered staff nurses the benefit of the most up-to-date clinical information and challenged some of their out-dated practices.

Nurses experienced both benefits and challenges when students were on the ward. Additionally, when nurses are working with a high degree of patient acuity on wards that are
short staffed, it is difficult for nurses to view students as future colleagues to be guided and nurtured. These findings were consistent with those of Matsumura et al. (2004) and Slaughter-Smith et al. (2012). However, the current study differed from the work of Matsumura et al. (2004), who concluded staff nurses often had ambivalent feelings about working with students. In the current study, nurses expressed a commitment to juggling the burden and accommodating nursing students to the best of their abilities, despite the challenges they expressed.

**Staff Nurses’ Contributions**

The focus of this study was to extend the knowledge of teacher-led clinical practica from the perspective of the staff nurse. Nurses’ self-appraisal of their contributions to nursing students’ learning is an important element in enhancing understanding of clinical education. This is particularly important in nursing education where much of the integrated learning takes place within the context of complex hospital environments and is often rooted in the informal interactions that occur between students and staff nurses. Nurses learn to become nurses (i.e., are socialized into the profession) by practising professionals.

What the present study shows is that most staff nurses did not perceive their informal interactions with students as (necessarily) contributing to student nurse’ learning. Only one nurse out of the nine interviewed could readily convey an example of contribution with a group of students. The other participants focused on past preceptorship or mentoring relationships or could not produce an example at all. Implicit in their responses, it was clear that nurses were involved in teaching of nursing students; however, they themselves did not explicitly acknowledge their informal interactions as such. Many of the nurses shared examples of how they tried either to emulate past teachers who had been helpful to them or
to avoid the behaviours they had found unhelpful in their own training. When pushed during the interview process to examine their interactions within the context of “teachable moments,” some of the nurses were able to see these interactions as contributing to nursing students’ learning, whereas others downplayed these moments as “just doing my job.”

Perhaps it should not be surprising that if these informal interactions are defined as a part of the ‘hidden curriculum,’ then staff nurses would not necessarily recognize their informal interactions as teaching. To declare that these interactions are informal and part of a ‘hidden curriculum’ in no way diminishes their importance to clinical education. Indeed, over 20 years ago MacLeod (1994) argued that, despite nurses’ practices being complex, multifaceted, and goal directed, the daily practices of nurses are often minimized and not accorded the value they deserve. This is certainly true of nurses’ perceptions of their own contributions to students’ learning in this study. While the nurses may have felt they were ‘just doing their jobs,’ the examples they shared demonstrated engagement with students in the nursing process demonstrated role modelling of critical thinking and decision-making skills to the nursing students. However, the nurses did not perceive themselves as contributing to nursing students’ learning through their daily interactions with students. This finding presents a conundrum. How can we support staff nurses to help nursing students learn when they themselves do not see their informal interactions with students as contributing to nursing students’ learning?

The literature on clinical education indicated that these informal interactions have a significant impact on nursing students’ socialization into the profession and can even influence students to remain in the profession or not (Brammer, 2006; Hart & Rotem, 1994; Papp et al., 2003). Due to the importance of these interactions to nursing students learning in
the clinical setting it is imperative that staff nurses be informed of the significance of their causal interactions with nursing students.

Summary

Building upon the well-documented belief that clinical education of nurses is foundational to nursing practice, this qualitative descriptive study furthers the understanding of clinical education by focusing on the informal interactions between staff and nursing students during teacher-led practica. Nursing students are strongly influenced by the informal interactions they have with staff nurses and these interactions have the potential to either 'make or break' the student learning experience. Findings from the data in the current study revealed the metatheme of nurses' burden of responsibility. This metatheme was influenced by several other factors: nurses' experiences of the practice environment, the clinical instructor, the students, and their own contributions to students' learning. Despite the many challenges associated with having students on the ward, and despite not recognizing their own interactions with students as contributing to the nursing students' learning, the staff nurses remained committed to 'training up' their future colleagues.

Implications

Implications for nursing education. One of the implications of this study is for clinical instructors to take the lead on improving communication with nursing service. Clinical instructors need to provide clear instructions to students about the expectations of the faculty, the ward, and the staff nurses regarding the level of care the students are able to provide. Clinical faculty should clearly inform students of the expectation to report-off to staff nurses as part of their accountability and responsibility. Clinical instructors should make every effort to inform staff nurses regarding the clinical expectations and learning objectives
of the students. This could take the form of a brief presentation during the ward staff meeting every semester and could be reinforced with a copy of the general student expectations to be left on the ward for staff. Developing an effective communication process with the staff nurses and showing support and appreciation for them would improve relationships between staff nurses, clinical instructors, and students. Communication that is more effective would also foster a more favourable practice environment for the staff nurses and a quality learning environment for the students.

Clinical instructors are well placed to establish a means of giving staff feedback about what students appreciate in their informal interactions with nurses. Students could be encouraged to share positive stories that demonstrate the influence staff nurses have on their professional development. Letting staff nurses know that they can assist students' learning by sharing their decision-making techniques and problem-solving strategies may encourage staff nurses to view these interactions in a new light. Helping staff nurses to recognize the significant impact they can have on the kind of nurses that students become is important.

**Implications for nursing practice.** Nurses need to know how important they are as role models for future nurses and the impact their casual interactions have on the student's socialization into the profession. By willingly sharing their expertise with students, nurses can create a welcome learning environment and positively influence students to return to the ward after graduation.

Nursing service leaders should allow staff nurses to voice concerns and participate in problem-solving activities that are identified when working with nursing students. It would be useful to establish an expectation in the practice setting of teaching students. Including these expectations in the job descriptions of staff nurses would help establish this as a
normative practice. Work with students should be an explicit item in all staff nurse job descriptions and should be acknowledged and rewarded at staff nurse evaluations. Written guidelines including duties and responsibilities for both clinical instructors and staff nurses should be distributed to staff nurses. Nurses felt it would be very helpful to have a detailed list of nursing students’ goals and objectives for the day as well as the skills and competencies the students could perform independently and which ones the clinical instructor must be present for. Having students contribute to learning and teaching events on the wards may help staff nurses to engage with students outside of direct patient care and contribute to staff nurses remaining up to date in their practice.

It would also be helpful to look carefully at the current clinical practice spaces and consult with staff nurses as to how the flow of the ward might be improved when students are present. Minimizing the disruption for the staff nurses when students are present could help reduce the burden that staff feel in relation to space and place. It will be important to take seriously the implications of space and place in any future renovations or capital building and to consult with staff nurses to ensure that adequate space for teaching is given a priority.

**Implications for both nursing education and practice.** There is a clear need for continued dialogue and planning between education and practice. It is also important that a renewed commitment and support of student learning is evident at both the ward leadership level as well as at the senior leadership level. Establishing a memorandum of understanding to enable clinical instructors (who are not currently employed on the wards) to have ‘buddy shifts’ in order to remain current with the ward routines and mores would be helpful. Staff nurses should be informed of any agreements between the educational institution and the practice facilities as they relate to the expectation of nurses and clinical nursing placements.
Limitations

There are several limitations inherent in the current study. As a novice researcher undertaking my first qualitative research project, I have done my best to fairly and accurately represent and communicate the data that was so generously shared with me by the participants. I am, however, cognizant that my interpretations are open to human error. While the findings are not expected to be generalizable, the descriptions are such that they may resonate with nurses in other locations. Although participants were given the option of verifying the accuracy of the transcripts, only one participant chose this option and did not return any comments, despite being asked. The absence of member checking remains a methodological limitation. However, I attempted to mitigate these issues related to member checking for accuracy of the findings by having the findings vetted by three experienced clinicians. The majority of the participants were female, making it impossible to explore potential gender differences related to nurses’ perceptions of their contributions to nursing students’ learning. This study took place within a single regional hospital. Since the study participants were all from this single hospital, it is unclear if the findings related especially to space would be found in other locations.

Future Research

The current study has highlighted that staff nurses do not perceive their casual interactions with students to be ‘teaching.’ It may be useful to explore how hearing from students about what they value from staff nurses might influence staff nurses’ perceptions of their contributions. This could be accomplished through having students attend a staff meeting or focus group with staff nurses or even through a media campaign in which students present images and stories about the importance of the informal interactions with
staff nurses to their own development. Similarly, it would be helpful to build on this study by replicating the inquiry in both smaller rural and larger urban settings to evaluate if the findings might differ with the size of hospital.

The current study also highlights the significant burden that staff nurses experience when trying to cope with their daily patient care assignments while incorporating student nurses into their day. It would be interesting to look at the links between staff nurses’ moral distress as described in relation to patient safety and student nurses and relate this work to the studies on burnout and/or secondary trauma in nursing.

Conclusions

The clinical learning environment is a complex entity in which patients, nursing students, staff nurses, and clinical instructors coexist, each with their separate and competing objectives. The research literature was clear that nursing staff are crucial in setting the tone of the clinical working environment and that nursing students look to staff nurses to be approachable, positive, and treat them as future peers. The findings of this study provide new insights and add to the nursing literature on clinical education by highlighting the perceptions of staff nurses as they contribute to nursing students learning through their informal interactions. Nurses indicated that working in complex health care environments, the lack of appropriate space and equipment, and the communication challenges with clinical instructors and students created a significant burden of responsibility. However, despite this significant burden, nurses remained willing and committed to “training up” their future colleagues.

The complex and ever-changing health care terrain requires a significant reassessment of the content and direction of undergraduate nursing education. Existing stressors in both health care settings and education have created challenges in obtaining and providing
positive clinical experiences. There is a shared responsibility between educators, students, and service providers to cocreate a positive clinical learning environment. The findings in this study position the staff nurse as an important but underacknowledged contributor to clinical education. How staff nurses treat nursing students who will soon become colleagues is of great significance. How students learn and who they learn from ultimately impacts the quality of nursing care that they will provide. This is a concern that both nursing education and nursing service should share. It is imperative that all players who contribute to nursing students' learning and safe patient care perceive themselves as valued and contributing members of this challenging and comprehensive undertaking.
References


Appendix A: Invitation Poster

Staff Nurse Perceptions of their Influence on Student Nurses’ Learning in Teacher-led Practica

The purpose of this study is to understand teacher-led clinical nursing education from the staff nurse's perspective.

Voluntary Participants Needed: RNs or RPNs on a unit where teacher-led nursing clinical practica takes place.

You are invited to participate in a confidential 60 minute audio-taped interview where we will discuss your experiences working on a unit where teacher-led nursing clinical practica takes place.

A $30 coffee card will be provided for your time. For more information or to set up an interview time, please contact Sarah Hanson [phone number], text-to-call [phone number], or by email at [email address].

If you have concerns, you may contact the UNBC Office of Research [phone number], [email address]. My research supervisor, Dr. Macleod can be contacted at [phone number] or [email address].
Appendix B: Interview Questions

In an effort to focus on the research question "How do staff nurses' perceive their contributions to nursing students' learning during teacher-led practica?" guiding questions during the interview will include:

1. Students say that staff nurses’ are the most influential part of a clinical experience of their clinical experience. What do you think about that?

2. How would you describe the attitude of your peers towards nursing students?

3. How is the way you interact with students’ different (if at all) from how nurses interacted with you when you were a student?
   Probes:
   a. What do you think contributes to those differences?

4. How do you see yourself contributing to nursing students’ learning when the clinical instructor is on the ward?
   a. How does this change if the clinical instructor is not available

5. Could you tell me about a situation in which you feel you really made a difference to a nursing students’ learning?
   Probes:
   a. What makes this situation significant?
   b. What were you thinking about when this took place?
   c. What were you feeling during or after the situation?

6. We’ve been talking about your personal experiences with nursing students on the unit. Now I would like to ask you about some of benefits and challenges you face when students are on the ward?
   a. How does the clinical instructor effect the situation?

Interviews will end with the question, “Is there anything that I haven’t asked about that you would like to add?”
Appendix C: Participant Information and Consent Form

Staff Nurse Perceptions of their Influence on Nursing students’ Learning in Teacher-led Practica

A MScN Research Project by Sarah Hanson

UNBC Masters of Nursing student

What is the Purpose of this Study?

The purpose of this study is to understand teacher-led clinical nursing education from the staff nurse’s perspective. I am interested in discovering the ways in which staff nurses understand their contributions to the education and socialization of nursing students.

Why was I chosen?

You are being asked to participate in this study because:

- You are a registered nurse or registered psychiatric nurse
- You work in an acute care setting of the University Hospital of Northern BC
- You have experienced having nursing students on your ward for teacher-led practica

What would be expected of you?

Please read this Information Letter carefully. A copy of this information letter will be provided to you. You are invited to participate in an interview in which you will be asked to tell about your experiences working as an RN or RPN on a unit where teacher-led nursing clinical practica takes place. The interview will be audio taped, and then transcribed for analysis. The estimated length of the interview is one hour (flexibility with regard to time will be built in). If you are interested in participating please contact me. My contact details are on the next page. At our meeting I will ensure that you have had all your questions fully answered, before you are asked to sign a consent form (see attached).

Anonymity and Confidentiality. The interviews will be kept strictly confidential and will be only available to the researcher. A pseudonym will be used to identify your information within my research report—individual names will not be used in any presentations, reports, or journal articles that result from this research. The information from the interviews will be analyzed and only the researcher’s thesis committee, Dr. M MacLeod, Dr. L O’Neill, and Catharine Schiller (all of whom are faculty members at UNBC) will assist with the interpretations and/or analysis of the information. Confidentiality is important to me because I will learn the most from your honest responses.

All information from this study will be stored in a locked filing cabinet in my office or at my personal residence and on my password-protected computer. All data will be deleted or shredded five years following publication of the study. The analyzed material used after this time will be in the form of presentations and/or papers that relate to the study but that do not contain identifying information.
Participation in this Study is Voluntary

Your participation in this research is voluntary. You are free to withdraw from the study at any time. Should you choose to withdraw, your information will also be withdrawn unless you give consent to having it retained. You can refuse to answer any of the questions that I ask in the interview.

Potential Benefits and Risks

It is my hope that we will both benefit from this study. I would like to create the time and space for you to share your experiences working with nursing students. This information is crucial to nursing education so that we can more fully understand our current teaching models and make adjustments, if necessary, to promote the positive components and not perpetuate any negative. I do not believe there are any risks to participating in the study, however, if in answering questions regarding your experiences with nursing students you should you feel distressed, you may contact the NHA Employee and Family Assistance program at [telephone number].

Questions or Concerns about this Study

If you have questions about this study, please contact me, Sarah Hanson at [telephone number] or text to [telephone number], or by email at [email address]. You may also contact my supervisor, Dr. Martha Macleod, at [telephone number] or by email at [email address]. If you have concerns or complaints, you may contact the UNBC Office of Research at [email address] or [telephone number].

How Do I Get a Copy of the Results?

At the end of the study, I will provide you with an executive summary of the entire study if you so wish. If you are interested in reading my complete written report, I will send you an electronic version upon request.

Consent Form

I agree to participate in the STAFF NURSE PERCEPTIONS OF THEIR INFLUENCE ON NURSING STUDENTS LEARNING IN TEACHER-LED PRACTICA study as described in this Information Letter. I am agreeing participate in an audio-taped interview with S. Hanson and for that interview information to be used for the purpose of this study.

Signature: __________________ Printed Name: __________________ Date: __________
Appendix D: Demographic Information Sheet

Staff Nurse Perceptions of their Influence on Nursing students’ Learning in Teacher-Led Practica

Demographics:

Date: _________________________________

Age: _________________________________ Gender: _________________________________

Date of Graduation: _________________ Years Working: _______________________________

Education Background (check all that apply)

Diploma ___ Degree (Nsq) ___ Degree (Non-Nsq) ___ Grad (Master’s) ___ PhD ___

Employment status (check all that apply)

Full Time ___ Part Time ___ Casual___

Acute__________________________ Community__________________________

Length of time in Current position(s):
<1 Year___ 1 to 3 years___ 4 to 7 years___ 7 to 10 years___ >10 years___
Appendix E: Image Depicting Process for Data Analysis