

2008

First-year learning of novice emergency-hire clinical nursing faculty : a qualitative study

Ingrid Sheets

Follow this and additional works at: <https://repository.usfca.edu/diss>



Part of the [Education Commons](#)

Recommended Citation

Sheets, Ingrid, "First-year learning of novice emergency-hire clinical nursing faculty : a qualitative study" (2008). *Doctoral Dissertations*. 262.
<https://repository.usfca.edu/diss/262>

This Dissertation is brought to you for free and open access by the Theses, Dissertations, Capstones and Projects at USF Scholarship: a digital repository @ Gleeson Library | Geschke Center. It has been accepted for inclusion in Doctoral Dissertations by an authorized administrator of USF Scholarship: a digital repository @ Gleeson Library | Geschke Center. For more information, please contact repository@usfca.edu.

The University of San Francisco

FIRST-YEAR LEARNING OF NOVICE EMERGENCY-HIRE CLINICAL NURSING
FACULTY: A QUALITATIVE STUDY

A Dissertation Presented
to
The Faculty of the School of Education
Learning and Instruction Department

In Partial Fulfillment
of the Requirements for the Degree
Doctor of Education

by
Ingrid Sheets
San Francisco, CA
May 2008

This dissertation, written under the direction of the candidate's dissertation committee and approved by the members of the committee, has been presented to and accepted by the Faculty of the School of Education in partial fulfillment of the requirements for the degree of Doctor of Education. The content and research methodologies presented in this work represent the work of the candidate alone.

Ingrid Sheets

April 25, 2008

Candidate

Date

Dissertation Committee:

Dr. Patricia Busk

April 25, 2008

Chairperson

Dr. Lanna Andrews

April 25, 2008

Dr. Susan Prion

April 25, 2008

TABLE OF CONTENTS

	Page
TABLE OF CONTENTS.....	ii
LIST OF TABLES.....	v
LIST OF FIGURES.....	vi
CHAPTER	
I. INTRODUCTION.....	1
Statement of the Problem.....	1
Purpose of the Study.....	2
Background and Need.....	3
Significance of the Problem.....	5
Theoretical Rationale.....	9
Transformative Learning Theory.....	9
Novice to Expert.....	11
Research Questions.....	13
Definition of Terms.....	13
Summary.....	15
II. REVIEW OF THE LITERATURE.....	18
Clinical Teaching.....	19
Teacher Effectiveness.....	20
Part-time Clinical Faculty.....	26
Mentoring of Nursing Faculty.....	35
First-Year Learning.....	39
Summary.....	55
III. METHODOLOGY.....	58
Methodology Rationale.....	58
Research Design.....	59
Setting.....	61
Sample.....	62
Novice Clinical Nursing Instructors.....	62
Nursing Program Administrators.....	66
Protection of Human Subjects.....	68
The Researcher's Role.....	69
Pilot Study.....	71
Procedures.....	71
Novice Clinical Nursing Instructors.....	72

TABLE OF CONTENTS CONTINUED

	Page
Nursing Program Administrators.....	72
Data Collection.....	73
Novice Clinical Nursing Instructors.....	73
Nursing Program Administrators.....	74
Restatement of Research Questions.....	75
Data Analysis.....	76
Trustworthiness and Dependability.....	78
Summary	80
 IV. FINDINGS.....	 81
How Novice Emergency-Hire Clinical Nursing Instructors Learn to Teach in Clinical Settings in the First Year.....	 82
Relying on Self	82
Modeled Teaching after Former Nursing Instructors	83
Trial and Error.....	84
Past Preceptor Experience.....	88
The Nursing Program Affiliation.....	90
Orientation.....	91
Assigned Mentor.....	93
Hospital Clinical Site.....	95
Unit Manager.....	96
Hospital Nurse Educator.....	98
Workplace Support.....	100
Peer Mentors.....	100
Patient Teaching.....	101
Teacher Education Coursework.....	103
MSN Education Minor and Other Teacher Education Coursework.....	 103
Factors that Influenced New Instructor Learning in the First Year...	105
Past Preceptor Role.....	106
Teacher-Education.....	107
Support.....	109
Family, friends, peers.....	109
Mentor.....	110
Nursing Program Influence.....	111
Orientation, Guidance and Contact, Structure and Organization.....	 112
Familiarity with Clinical Placement.....	115
Familiarity with Hospital.....	116
Unfamiliarity with Hospital.....	117
Students Influence.....	119
Easy Group.....	120
Hard Group.....	121

TABLE OF CONTENTS CONTINUED

	Page
Novice Emergency Clinical Instructor Interpretation of Their Experience of the New Instructor Role.....	124
Adjunct Faculty of University Program of Nursing.....	125
Clinical Teacher.....	126
Liaison Between Students and Nursing Staff.....	128
Insider to the Nursing Unit.....	129
Outsider to the Nursing Unit.....	130
Mezirow's Transformative Learning Theory and Novice Clinical Nursing Instructors' Learning.....	133
Nursing Program Administrators' Perception of the Scope and Impact of Emergency-Hiring of Clinical Instructors.....	137
Scope of the Current Clinical Instructor Shortage.....	137
Retention of Clinical Instructors.....	140
Orientation to Teaching and to the Program of Nursing.....	142
Mentoring as Support.....	145
Innovation and Thoughts about the Future.....	147
Summary.....	152
 V. SUMMARY AND CONCLUSIONS.....	 155
Summary of Study.....	155
Limitations.....	161
Discussion.....	162
Conclusion and Implications.....	174
Recommendations for Future Research.....	181
Afterword.....	183
 VI. REFERENCES.....	 186
 VII. APPENDIXES.....	
A. Letters to Nursing Program Directors.....	195
B. Consent	198
C. Demographic Questionnaire.....	201
D. Predetermined Interview Questions.....	204
E. Timeline Instructions.....	207
F. Concept Map Instructions.....	209
G. Nursing Program Administrator Interview Guide.....	211
H. Example of Participant Interview Analysis Document.....	214

LIST OF TABLES

Table	Page
1. Steps of Mezirow's Transformative Learning Theory.....	10
2. Demographic Characteristics of Interviewed Clinical Instructors.....	64
3. Summary of Administrator Demographic and Program Information.....	67
4. Data Collection Categories and their Rationales.....	75
5. Accuracy of Participant Portrayal Member Check Summary.....	78

LIST OF FIGURES

Figure	Page
1. Novice to Expert Theory.....	13
2. Flow Diagram of Background for Research Study	16
3. Summary of Study's Procedures and Outcomes.....	77
4. Self-Reliance as a Means for Learning the CI Role.....	83
5. Nursing Program Contribution to NCNIs' Learning the Role of Clinical Instructor.....	91
6. NCNIs' Learning in the Clinical Site.....	96
7. NCNIs' Learning related to Personal Work Setting.....	100
8. Teacher Education Contribution to NCNI Learning.....	103
9. Concept Map of Emergency Hire NCNI Learning to Teach in Clinical Settings.....	105
10. Factors that Influenced NCNI Learning in the First Year.....	106
11. NCNIs' Interpretation of Their Role as Clinical Instructor.....	125
12. Program Administrators' Perspective of Scope and Impact of Emergency-Hiring of Clinical Instructors.....	138
13. New Employee Developmental Learning Tasks.....	165

CHAPTER I

INTRODUCTION

Statement of the Problem

There is a nursing shortage in the United States partially due to the lack of qualified nurse educators (American Association of Colleges of Nursing (AACN), 2003, 2005, 2007a, 2007b; Council on Collegiate Education for Nursing, 2002; Evans, 2005; National League for Nursing (NLN), 2002, 2007, 2008; Zungolo, 2004). According to AACN (2007a), nursing schools turned away 42,866 qualified applicants in 2006 primarily due to crippling faculty shortages, persistent lack of clinical placement sites, classroom space, clinical preceptors, and budget constraints. Most potential candidates met basic program requirements (Rosseter, 2006). As the baby boomer population grows and their health-related needs increase, the need for nurses will intensify. Expanding the enrollment in schools of nursing is necessary to meet this increased need.

With the increase in student enrollment to address the nursing shortage, additional part-time nursing faculty is an imperative and an urgent need for most schools. Without adequate faculty, clinical sections risk cancellation and courses may be postponed, effectively setting back students' progression through the program (Allan & McClellan, 2007). School administrators make desperate pleas to hire new instructors just prior to the semester to fill the need. Working nurses may agree to "fill in" for the semester and accept the "emergency-hire" position. An emergency-hire nurse may be defined as an instructor being hired immediately prior to the semester or quarter commencement. Without the fulfillment of the open position, the program would suffer a setback of some

clinical course for some students, or a clinical group would have to be distributed among the remaining clinical faculty, effectively putting existing faculty in an overload position.

Learning the role of instructor during the first semester or first year can be an onerous task. Emergency-hire novice clinical nursing instructors rarely have an academic teaching background, and although they may be expert clinicians, teaching in higher education is different from the typical nursing role of patient-care management in a health-care setting. With little or no time for preparation through orientation, new emergency-hires often lack the skills necessary for their role as instructor in the nursing program. Unlike other professions that scaffold entry and transitional processes, teaching is a stage-less profession where novice and expert teachers have the same work responsibilities (Cuddapah, 2005). Stakeholders, including students, clinical affiliations, and university and program administrators have an expectation of instructor competency. Learning the role of clinical nursing instructor during the first year following an emergency-hire into that position has not been investigated. Knowing what supports learning the new role of nursing instructor will allow schools of nursing to design appropriate scaffolding to support the emergency-hire nurse instructor.

Purpose of the Study

With the prediction that the current nursing faculty shortage is projected to intensify over the next 20 years, emergency hiring of part-time nursing faculty to fill in the gaps will intensify. Attention to the individual who takes the emergency-hire position is essential. The purpose of this study was to investigate first-year learning by novice clinical nursing faculty hired into a program of nursing where clinical faculty positions were not filled within several weeks before the start of the semester or quarter. This study

investigated what supports helped learning the faculty role by the novice emergency-hire clinical nursing instructors. Using Mezirow's (1991) transformative learning theory as a framework for investigation allowed in-depth attention to the process of instructor learning in the first year of teaching.

Background and Need for Study

A position statement by the National League of Nursing Board of Governors (2002) indicated that the nurse educator role requires specialized preparation and every individual engaged in academic teaching must be prepared to implement that role successfully. Core knowledge and skills are essential if the instructor is to be effective and achieve excellence in the role. The core knowledge and skills suggested by the position paper included the ability to facilitate learning, advance the total development and professional socialization of the learner, design appropriate learning experiences, and evaluate learning outcomes (NLN, 2002). Further, the position paper stated that the academic community should not assume that individuals are qualified to teach simply because they hold a particular credential (i.e., master's degree or doctorate) and have expertise in a particular area. The academic community should not assume that individuals learn to be teachers through "on-the-job-training" or "trial by fire" rather than by planned deliberate preparation for such roles and responsibilities (NLN, 2002).

Emphasizing the importance of preparation for the teaching role, a task group was formed at the National League of Nursing to create a research-based document delineating the core competencies with task statements for nurse educators. The final version was published in 2005 and includes the following nurse-educator competencies: facilitate learning, facilitate learner development and socialization, use assessment and

evaluation strategies, participate in curriculum design and evaluation of program outcomes, function as a change agent and leader, pursue continuous quality improvement in the nurse-educator role, engage in scholarship, and function within the educational environment (NLN, 2005). The standards based on these competencies constitute the basis for the current certification process for a nurse educator.

The need for qualified nurse educators in both the classroom and clinical settings has reached a critical point. According to an AACN (2004) survey, nearly 70% of responding nursing schools reported that lack of nursing faculty is the reason they must limit student enrollment. With the median age of nursing faculty at 51.5 years, experts predict a critical lack of teachers in the future as current faculty retires (Thrall, 2005). There is also a clinical bottleneck as schools try to find preceptors and clinical sites in health-care facilities where their students can receive real-world training to complete their studies. The shortage of nursing faculty, willing preceptors, and clinical placements complicates the educational and healthcare services workforce predicament.

There are strategies in place that currently address the nursing shortage and the nursing-faculty shortage. Grants and scholarships for students, schools of nursing, and faculty are available. Some legislation and grants include, but are not limited to, the Nurse Education, Expansion, and Development (NEED) Act that provides for capitation grants to hire new and retain current faculty, purchase educational equipment, and enhance audiovisual and clinical laboratories. The Nurse Faculty Education Act (S. 1575) provides doctoral-education incentives for nurses serving as nursing faculty. The Nurse Reinvestment Act provides a Nurse Faculty Loan Program, a Nurse Scholarship Program,

and other critical nursing-education programs. These programs seek to address the problem of the nursing shortage and nursing-faculty shortage.

Although legislation is in place for addressing the nursing shortage and the nursing-faculty shortage, graduate nursing education is a long process and typically prepares nurses for advanced practice roles at the master's level or research in nursing science at the doctoral level, rather than as nurse educators. New models for moving graduate students through nursing programs more rapidly have been created and implemented, however, these programs prepare Clinical Nurse Leaders at the Master's level, who are generalist nurses rather than advanced practice nurses, and the Doctorate of Nursing Practice (DNP) that is a clinical doctorate degree. None of the innovative programs address the education or preparation of nursing faculty. To date, doctoral education in nursing has not been revised to encompass the practices of teaching, nursing, and scholarship.

Significance of the Problem

Based on a U.S. Bureau of Labor Statistics publication in the February 2004 *Monthly Labor Review*, by 2012, health-care institutions will require one million new and replacement nurses. The National Council of State Boards of Nursing reported that the number of first-time, U.S. educated nursing-school graduates who sat for the NCLEX licensure examination for registered nurses, decreased by 10% from 1995 to 2004. A total of 9,353 fewer students in this category of test takers sat for the exam in 2004 as compared with 1995 (NCSBN, 2005). According to the American Hospital Association's June 2001 *Trendwatch*, 126,000 nurses are needed now to fill vacancies in the nation's hospitals, and 75% of all hospital vacancies are for nurses (AHA, 2001). In a report

published in the November/December 2003 issue of *Health Affairs*, Dr. Peter Buerhaus and his colleagues noted that because enrollment in schools of nursing has been below average over the past 20 years, it would take an increase of greater than 40% enrollment to replace the expected RN retirement offset (Buerhaus, Staiger, & Auerbach, 2004). The continued mandate to increase enrollment requires additional faculty, additional clinical placements, and educational resources provided by the university or college of nursing. Part-time faculty are hired to fill the gaps when permanent faculty cannot be found. Lack of preparation for the faculty role often leads to high turnover of the most likely source of additional faculty, the practicing nurse.

New part-time faculty satisfaction with the role of nursing instructor depends in part on their perception of support for their teaching. Pedagogical literacy is often absent and is critically apparent to both the first-year instructor and the students (Diekelmann, 2003). Although clinically competent, emergency-hired novice nursing instructors enter a world where the language of the job is different from the world of clinical practice. Expectations for varied pedagogies and the ability to change to a different teaching style exist when students appear dissatisfied, bored, or learning styles need accommodation. New instructors soon recognize that other nursing faculty rarely are available, including both clinical and classroom staff. When they are around, new instructors often find that, although there is a pleasant inquiry as to how they are doing in their new course, full-time faculty typically are not interested and seldom offer help (Diekelmann, 2004). Learning the role of instructor within the environment of teaching in an institution of higher learning is complex and difficult. Most novice faculty want to know more about the faculty role and the role responsibilities (Riner & Billings, 1999) but are too often left to

figure things out on their own, making the transition to the role more difficult (Siler & Kleiner, 2001).

The majority of novice emergency-hires start out as clinical instructors. Clinical teaching is a complicated undertaking. It is so complex that few researchers have tackled the issues that need to be addressed. Many seasoned faculty struggle with the intricacies involved in the process of clinical teaching. A clear theoretical base is lacking; therefore, clinical teaching is often structured on tradition, common sense, and feasibility (Scanlan, 2001). There is little empirical evidence indicating which model of clinical education yields the best results, what level of redundancy is necessary, and what teaching methods are most effective. The best teacher to student ratio, how much or how little supervision is necessary, whether quantity or quality of patient assignments is more valuable, and to what extent written clinical assignments are effective remain unclear (DeYoung, 1995).

The extent of variables in clinical-teaching research makes the task of scholarly examination difficult to pursue. Most research is based on clinical-instructor effectiveness. Until more empirical evidence is produced on which to base clinical teaching, clinical teaching will continue to be rooted in the collective wisdom brought about by more than a century of recorded teaching experiences (DeYoung, 1995). Clinical learning requires good clinical teaching.

Although faculty often make the transition from clinical expert to novice instructor in the academic environment, the role shift can be threatening and stressful to novice instructors. Without support, new instructors leave the academic setting after one semester to any of the more lucrative and supportive opportunities available for master's and doctorally prepared nurses (Brendtro & Hegge, 2000; Hessler & Ritchie, 2006; Siler

& Kleiner, 2001). The outcome is a decline in the quality of nursing programs and increased stress to remaining or continuing faculty (Lewallen, Crane, Letvak, Jones, & Hu, 2003). Lack of new faculty preparation for teaching, faculty shortage, discontent, and stress directly affect teaching and learning of current and future nursing students.

Recognizing and addressing the novice status of new faculty and the importance of adult learning theories related to the adult learners' experience will provide insight to the struggles and adjustments new faculty encounter in learning the role of instructor in the first year thus easing the transition.

Nursing education will continue to require additional nursing faculty to meet the growing shortage of nurses in the United States and world. Current graduate education often does not prepare nurses for the faculty role because the current emphasis is on clinical specialization and research. Lack of interest and support for teaching and teacher-education courses that prepare nurses to be faculty is evident (Diekelmann & Schulte, 2001; Southern Regional Education Board [SREB], 2002). For those masters and doctoral graduate students who foster the intent to teach, courses and teaching experience in their program of study is limited (Carpenter & Hudacek, 1996).

Lack of teacher preparation becomes a critical issue for those nursing graduates beginning their teaching role in an academic setting. Adapting to the demands of the faculty role becomes very stressful (Siler & Kleiner, 2001; Zebelman & Olswang, 1989). Nursing graduates with expertise in advanced clinical practice or research, who never intended to teach, are now finding that because the faculty shortage is at a critically high level, they are being recruited heavily to teach nursing in one of the desperate nursing programs. Therefore, novice nursing faculty and emergency-hire nursing faculty who

lack teaching background and experience often enter the teaching role only to suffer stress when expectations are not met. Furthermore, inadequately trained teachers impose a burden on other faculty members who, in addition to their full teaching load, must “teach the teacher how to teach” (Princeton, 1992). Grading clinical papers, documenting communication, and student evaluation have surfaced as three specific areas of concern for inexperienced and new clinical faculty (Duffy, Stuart, & Smith, 2008). The ultimate beneficiaries of inadequately prepared nursing faculty are the students. The importance of this issue cannot be underestimated in nursing education today.

Theoretical Rationale

Nursing instructors are adult learners who have had little attention in past research related to how they learn the teaching role. Student behavior or professional practice frequently defines how teacher-learning is perceived and described. Knowledge of pedagogical methods is often related to learning theories (Cuddapah, 2005). In contemplating teacher-learning, adult-learning theories provide a framework that is appropriate for research and analysis. Mezirow’s (1991, 2000) transformative learning theory was developed based on his qualitative study of women returning to higher education and can inform in a unique way the literature on the new teacher, teacher professional development, and learning to teach.

Transformative Learning Theory

In 1978, Jack Mezirow introduced the concept of transformative learning (Mezirow, 1991). The theory, which has evolved and been modified, is a comprehensive and complex description of how adult learners construe, validate, and reformulate the meaning of their experience (Cranton, 1994, 1997). Centrality of experience, critical

reflection, and rational discourse are three common themes in Mezirow's theory. Critical reflection about the life experiences is necessary to change learners' "meaning schemes" and may lead to a perspective transformation of specific beliefs, attitudes, or emotional reactions. (Mezirow, 1991, p. 167). Perspective transformation is the process of becoming critically aware of how and why one's assumptions have come to restrict the way one perceives, understands, and feels about one's world; changing these structures of habit to make possible a more inclusive, discriminating, and integrative perspective; then, making choices or otherwise acting on these new understandings (Mezirow, 1991). Over a lifetime, adults acquire meaning structures and those structures are altered through perspective transformations. Interpretation of events happen through meaning structures that are frames of reference and are based on the totality of individuals' culture and contextual experiences (Taylor, 1998). Table 1 illustrates the 10 steps of the Mezirow theory.

Table 1

Steps of Mezirow's Transformative Learning Theory

Steps	
1	A disorienting dilemma (trigger event that can be a singular critical incident or a combination of events e.g., being fired or ongoing discrimination)
2	Self-examination with feelings of fear, anger, guilt, or shame
3	A critical assessment of assumptions
4	Recognition that one's discontent and the process of transformation are shared
5	Exploration of options for new roles, relationships, and actions
6	Planning a course of action
7	Acquiring knowledge and skills for implementing one's plans
8	Provisional trying of new roles
9	Building competence and self-confidence in new roles and relationships
10	A reintegration into one's life on the basis of conditions dictated by one's new perspective (Mezirow, 2000, p. 22)

An individual's meaning structure will influence how he or she chooses to practice nursing or to teach nursing.

Through learning, meaning schemes are altered by adding or integrating ideas within an existing scheme; therefore, the meaning structures can and do change. Self-examination, critical assessment of assumptions, recognition that others have shared similar transformations, exploration of new roles or actions, development of a plan of action, acquisition of knowledge and skills for implementing the plan, tryout of the plan, development of competence and self-confidence in new roles, and reintegration into life on the bases of new perspectives all result from deconstructing meaning schemes and reconstructing new meaning schemes (Mezirow, 1995). Mezirow believed that perspective transformation that leads to transformative learning occurs infrequently and is triggered by a life crisis or major life transition, although it may result from an accumulation of transformations of meaning schemes over time (Mezirow, 1995). By changing ones' frame of reference after critical reflection on their assumptions and beliefs, then consciously changing and implementing ways that redefine their world, a transformative learning experience is created (Mezirow, 1995). Applying this theory to adults becoming new faculty helps to inform their learning challenges and ways of knowing.

Novice to Expert Theory

Benner (1984) applied the Dreyfus Model of Skill Acquisition (1986) to nursing practice in the framework of novice to expert. In this framework, there are five levels of skill acquisition: novice, advanced beginner, competent, proficient, and expert. The novice level is of particular importance due to its direct applicability to the new nursing

instructor. At this level, the novice has little to no experience with situations in which they are expected to perform tasks (Benner, 1982). This rule-guided level requires learning objective attributes that can be applied without situational experience (Benner, 1982). Discretionary judgment is intangible to the novice faced with a new experience, and context-free rules guide the task performance. The novice is faced with uncertainty about those tasks most relevant or when exceptions to the rules are appropriate (Benner, 1982). Nurses hired into clinical or didactic teaching positions fit the novice description and are commissioned to fulfill the role of teaching and evaluating student learning. The fact that many new instructors are hired “last-minute,” have no teaching background, and have no time for teacher role preparation before they commence their teaching may increase the stress of the novice-teacher status.

The expert does not apply analytical principles to connect understanding to the appropriate action. Intuition, based on extensive background and experience, provides the expert ability to evaluate the situation and focus directly on the defined aspect of the problem without losing time considering a large range of irrelevant possibilities (Benner, 1982). It takes years of experience as a faculty member to gain the skills of teaching and learning, counseling students, and appropriately assessing student learning. Figure 1 illustrates the novice to expert theory as explained by Benner (1984).

Theories of transformative learning and skill acquisition will be the basis for addressing the novice nursing instructor first-year learning experience in this qualitative study. Although not all adult learning is considered transformational, exploring what is a transforming learning experience for new nursing instructors will inform the administration of nursing programs, peers, and health-facility stakeholders about

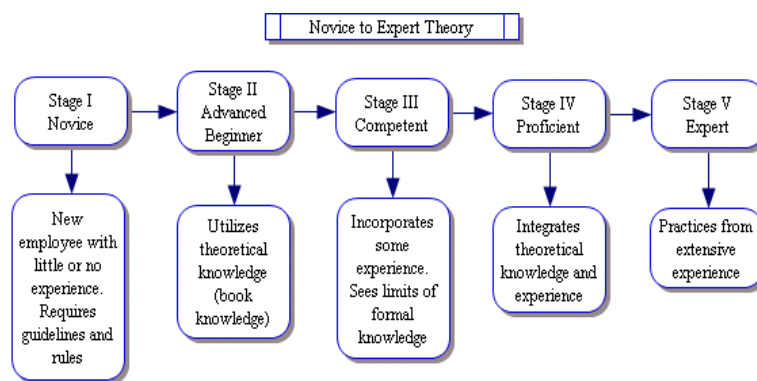


Figure 1. Novice to expert theory (Benner, 1984).

how new faculty learn and how they can be supported in that learning process. Because acquisition of teaching skills relates to this study, the novice will be viewed through the lens of the novice to expert theory.

Research Questions

1. How do novice emergency-hire clinical nursing instructors learn to teach in clinical settings in the first year?
2. What factors influence new clinical instructor learning in the first year?
3. How do novice emergency-hire clinical nursing instructors interpret their experience of the new instructor role and in what ways might these experiences be linked to transformative learning theory?

Definition of Terms

Terms frequently used in this work require explicit definitions and may be defined slightly differently than noted in common usage. For clarity, I have defined frequently used terms below.

Baccalaureate Nursing Program: A program of instruction to prepare registered nurses that admits with no previous nursing education, the completion of which results in a

baccalaureate degree with a major in nursing and eligibility to apply for licensure as an RN. The program requires at least 4 years but not more than 5 years of full time college academic work within a senior college or university (ICONS, 2006).

Clinical Teaching: The translation of basic theoretical knowledge into practice (White & Ewan, 1991).

Emergency-hire clinical nursing instructor: A nurse hired to teach a clinical course within 4 weeks prior to the start of the semester or quarter where the position has been vacant and a search has been ongoing (Dr. Luanne Linnard-Palmer, personal communication, Mar. 20, 2007).

Faculty Shortage: Insufficient nursing faculty to staff appropriately a nursing program offered by a school of nursing resulting from aging and retirement of faculty, decreased number of master's and doctorally prepared nurses, inadequate faculty salaries, lack of time to maintain clinical practice, and lack of educational preparedness (Beres, 2006).

Informal, incidental, informative learning: Learning that is unstructured, experiential, and noninstitutional, and that takes place through regular daily activities (Marsick & Volpe, 1999).

Mentoring: A developmental, empowering, nurturing relationship extending over time in which mutual sharing, learning and growth occur in an atmosphere of respect, collegiality, and affirmation (Vance & Olson, 1998)

Novice clinical nursing instructor: A nurse hired to teach a clinical nursing course who has never taught a clinical section before in a nursing education program.

Open coding: Generative or open coding as the term is used in qualitative methodology is the process of developing categories of concepts and themes emerging from your data. It

is an “open” process in that one engages in exploration of the data without making any prior assumptions about what might be discovered.

(<http://kerlins.net/bobbi/research/nudist/coding/strategies.html>)

Part-time faculty: Those members of the instructional, administrative, or research staff of the nursing academic program who are employed part-time as defined by the institution, may or may not hold academic rank, carry responsibility for a specific area, and may carry any number of titles (e.g., adjunct, clinical instructor). These faculty typically are not eligible for tenure (ICONS, 2006).

Transformative learning: When assumptions or premises are found to be distorting, inauthentic, or otherwise invalid, reflective learning becomes transformative as new or transformed meaning schemes, or when reflection focuses on premises, and meaning perspectives are transformed (Mezirow, 1991).

Trial and error: The process of making decisions in the dark, with little or no background knowledge, and discarding outcomes until an acceptable solution occurs, rather than engaging in data-based decision making (Fusarelli, 2008).

Summary

Presented in the first chapter are the problems outlining the state of nursing education today in relation to the shortage of nursing faculty, the impact of lack of faculty on the greater problem of the national and local nursing shortage, and the inevitable use of emergency-hire instructors to fill the gaps within nursing programs. Learning the role of nursing instructor by novice faculty can be viewed through the lenses of the adult learning theory, most specifically, transformative learning theory (Mezirow, 1991) and the novice to expert theory (Benner, 1984). To better support first-year learning by

novice emergency-hire nursing faculty, knowing how they learn and what they perceive as helping or hindering the process of learning the role will inform nursing programs support and scaffolding efforts. Creation of scaffolds to support new faculty where scaffolds currently may not be either effective or utilized is necessary if retention of new faculty is important. How new nursing faculty learn, during the first year of teaching, is lacking in the published literature. Figure 2 depicts the background of the proposed study.



Figure 2. Background conceptual framework for research study: First-year learning of novice emergency-hire clinical nursing faculty.

Chapter II contains a review of the relevant literature on aspects of the nursing instructor role relevant to novice instructors' learning in the first year of teaching. A

framework for the study will be established from the literature review. Methods to recruit and interview novice nursing faculty and program administrators, limitations, and significance will be described in Chapter III. Chapter IV contains the findings from the novice clinical instructor and nursing program administrator interviews with discussion of the major themes found. The last chapter includes the study summary, limitations, discussion, conclusions, implications for practice, and recommendations for future research.

CHAPTER II

REVIEW OF THE LITERATURE

The shortage of educationally well-prepared nursing faculty has been an issue for both the discipline and profession of nursing. According to the American Association of Colleges of Nursing (AACN, 2000), only 50% of all faculty teaching in baccalaureate and higher programs were doctorally prepared. That shortage is expected to escalate due to social and economic reasons in the future. The aging trend of current nursing faculty and decreased enrollment in doctoral programs are responsible for estimates of decreased doctorally-prepared faculty. Master's programs emphasize advanced-practice nursing tracks rather than nurse-educator tracks, which contributes to the belief that there will be a shortage of educationally well-prepared faculty (Hinshaw, 2001).

Schools of nursing are in constant need of additional faculty. New-hire faculty often have little or no preparation for the role. Most of the vacant positions are clinical-instructor positions, ideally filled by doctorally prepared nursing faculty, but most often filled by masters, and even baccalaureate-prepared nurses who have little or no preparation in teaching in higher education (AACN, 2005; Hinshaw, 2001). Many novice instructors learn to teach while teaching. Investigating how novice instructors, hired last minute, learn to become a teacher and what supports or hinders that learning is the focus of this study.

In order to provide a context for this study, components of the literature review have been divided into three sections. Section 1 will address clinical teaching because most of the emergency-hire instructors are clinical faculty and, although many are

working nurses, teaching in higher education may present unique challenges. Section 2 will address the role of mentoring and support for emergency-hire instructors. Section 3 will address first-year learning, how professionals learn their new role, and what supports that learning or makes that learning and adjustment more difficult.

The nursing-faculty shortage has created an atmosphere where schools are desperate to hire faculty, especially clinical faculty, or risk the possibility of having to cancel clinical sections or courses. Cancelling clinical sections retards student progression through already impacted programs and adds to the current nursing shortage faced by many health-care institutions. Finding qualified and experienced nursing faculty is difficult, and pleas increase toward the beginning of a semester for nurses in practice, especially with graduate degrees, to consider teaching a clinical group or course for the upcoming semester. Emergency-hire faculty are those nurses hired close to the start of the semester by a school of nursing desperate to fill a teaching position. Teacher education or teaching experience is not a prerequisite for the position and nurses often find themselves in uncharted territory as they commence to learn their teaching role (AACN, 2005; Berlin & Sechrist, 2002; Boyden, 2000; Thrall, 2005).

Clinical Teaching

Clinical instruction offers the real-life laboratory where students can integrate their background courses in the sciences, humanities, and nursing into the skills and behaviors necessary for successful nursing practice. Effective clinical instructors assist students with the critical-thinking and decision-making skills necessary for professional nursing (Allison-Jones & Hirt, 2004).

Research in nursing education indicates that effective clinical instructors are clinically competent, know how to teach, have collegial relationships with students and agency staff, and are friendly, supportive, and patient (Halstead, 1996; Nehring, 1990; Oermann, 1996; Reilly & Oermann, 1992; Sieh & Bell, 1994; Stuebbe, 1990; Tang, Chou, & Chiang, 2005).

Teacher Effectiveness

Teaching effectiveness is important to the quality of the program of nursing and to student learning. Measurement of teacher effectiveness rarely is evaluated for novice faculty and yet, student-learning outcomes are dependent on methods of teaching in both the classroom and clinical settings.

Knox and Morgan (1987) conducted a quantitative study to determine the “best” and “worst” clinical teaching as perceived by both university faculty and students. The Nursing Clinical Teacher Effectiveness Inventory (NCTEI) created for the Knox and Morgan study has been validated and utilized in numerous studies to ascertain the effectiveness of clinical teachers. The NCTEI is a 48-item checklist that describes discrete teacher characteristics clustered into five subscales or categories: teaching ability, nursing competence, personality traits, interpersonal relationship, and evaluation. Internal consistency (Cronbach’s coefficient alpha = .79 to .92) and stability ($r = .76$ to $.93$) estimates were obtained along with content and face validity evidence.

Nehring (1990) replicated the Knox and Morgan study to investigate the best and worst clinical teachers as perceived by 63 baccalaureate nursing faculty and 121 baccalaureate-nursing students (BSN) in Ohio. Nehring’s study was based on the premise that nursing needs effective faculty; that accountability of the clinical faculty is important

due to extreme financial constraints in schools of nursing; that the theoretical base for clinical teaching in nursing is important, yet lacking; and pragmatically, that the outcomes could be used to orient new instructors, teach future nurse educators, and create an evaluation tool for tenure and promotion purposes.

Nehring's (1990) descriptive study used mail surveys of 11 of the National League of Nursing's accredited baccalaureate-nursing programs in Ohio. Seventy-four percent of the faculty had 8 years or more of teaching experience, 41% were tenured, 51% were not tenured, and 8% were part-time faculty. One hundred and twenty-one student participants were seniors in their program, and 77% had experience with more than seven instructors in the clinical area. Students' ages ranged from 19 to 46 years.

The faculty and students were asked to think of their best and worst clinical teachers and rate the teachers using the NCTEI tool. Demographic data completed the data collection. The researcher had no personal contact with study participants. Analysis consisted of summing scores within categories. Highest rated and lowest rated were compared for students and faculty. Mean values for best and worst clinical teacher as perceived by students and faculty were calculated. Two-sample t tests were conducted on the NCTEI scales testing for differences between faculty and students. One set of tests was done for best teacher and one for worst teacher. A Bonferroni adjustment to detect significance was performed. Statistically significant differences were attained for teaching and personality habits where student mean scores were higher than faculty mean values on these two attributes. Results were then compared with the Knox and Morgan (1987) original study.

Study results indicated a statistically significant difference between students and faculty regarding best teacher on the subscale of teaching and personality traits. Student means were higher than faculty. No statistically significant difference was found for interpersonal relations, nursing competence, and evaluation. Highest rated characteristics for the best teacher for both students and faculty were good role models, enjoy nursing, enjoy teaching, and take responsibility for their own actions as well as encouraging mutual respect and providing support and encouragement. There was a high degree of agreement between the two groups on characteristics of best instructors. The top 10 characteristics perceived by students also were in the top 14 best characteristics chosen by faculty. The top 10 characteristics chosen by faculty were in the top 16 chosen by students.

Less agreement was found between the two groups on characteristics of worst teachers. Faculty and students did agree that the worst teachers rarely were good role models, rarely encouraged mutual respect, rarely demonstrated empathy, provided little support and encouragement, and rarely used self-criticism constructively. Three specific behaviors were agreed upon by both faculty and students for best and worst clinical instructors: good role model, encourages mutual respect, and provides support and encouragement, where “best” do it and “worst” do not. The results of the Nehring (1990) study reflected similar faculty and student perceptions to the Knox and Mogan (1987) study.

A weakness of the Nehring study was the low percentage (8%) of part-time faculty who participated. Given the current high percentage of part-time faculty in clinical instructor positions nationally and schools of nursing depend on the part-time

faculty to fulfill the clinical teaching positions, the study results may have had a different outcome had there been a higher percentage of part-time faculty represented.

In a later study, Allison-Jones and Hirt (2004) used the NCTEI tool to compare student and faculty perceptions of the teaching effectiveness of part-time and full-time clinical nursing faculty in associate degree nursing (ADN) programs. The recognition that schools of nursing are reliant on part-time faculty to provide clinical instruction due to the nursing faculty shortage leads to concern about teaching effectiveness. A convenience sample of 583 ADN students, 14 part-time faculty, and 30 full-time faculty were enlisted from seven ADN programs in a mid-Atlantic state for the survey research. Student ages ranged from 22 to 39 years. Two forms of the NCTEI were prepared. The student form directed participants to rate their current clinical nurse faculty; the faculty form directed the faculty to rate their own performance in the clinical course they were teaching currently. Demographic data were collected with the NCTEI survey.

Research questions for this study included the following:

- 1) Do ADN students perceive that the effectiveness of instruction of part-time clinical nurse faculty differs from the effectiveness of instruction of full-time clinical nurse faculty?
- 2) Are there differences in the way full-time and part-time ADN clinical nurse faculty perceive their own teaching effectiveness?
- 3) What differences are there in the way ADN students perceive their own instruction? (p. 239)

Means were calculated for each of the five scales. One-way analyses of variance were conducted at the .05 level to compare the overall mean scores. Independent t tests indicated differences between the full-time and part-time faculty. There was a statistically significant difference in age. Most full-time faculty (80.1%) were over 40 years and most part-time faculty (57.2%) were less than 39 years. Most full-time faculty had attained a

MSN degree or higher (55.2%) whereas most part-time faculty (78.6%) held a BSN degree. Years of teaching differed statistically significantly where full-time faculty (72.1%) had greater than 8 years of teaching, whereas part-time faculty (92.9%) had less than seven years teaching experience.

Results indicated that students ranked part-time faculty as statistically significantly less effective than full-time faculty on each of five categories measured by the NCTEI and on the overall scale. Faculty results showed no statistically significant difference between student ratings of teacher effectiveness and the self-ratings of the teachers themselves. The categories included teaching ability, nursing competence, evaluation, interpersonal relationships, and teacher's personality. Violations of the assumption of homogeneity were discovered in research questions one and three. Levene's test revealed that the populations from which the groups were sampled were not equal. There were twice as many full-time faculty than part-time faculty in the study. Additionally, full-time faculty had many more years teaching than part-time faculty. Research question two seemed to contradict the results of research questions one and three in that either full-time faculty underrated their effectiveness or part-time faculty overrated their effectiveness. Full-time faculty had more teaching experience than part-time faculty and, therefore, the ability to deal with students in all aspects may be different from part-time faculty.

Clinical teaching effectiveness findings, as indicated in the above studies, cannot be generalized to the overall population. Limitations in the Nehring (1990) and Allison-Jones and Kirt (2004) studies included a lack of adequate representation by part-time clinical faculty.

Tang, Chou, and Chiang (2005) conducted a study investigating four categories of qualities used to ascertain clinical-teaching effectiveness. The categories included professional competence, interpersonal relationship, personality characteristics, and teaching ability. A tool was created by the researchers for the survey research and tested in two pilot studies. Revisions were completed, and .92 Cronbach's coefficient alpha was attained for the tool. Students were asked to think of one faculty they liked and one they disliked and then rate them using the tool.

The sample consisted of 214 students in nursing schools in Taiwan, with 52 students from public schools and 162 students in private nursing schools. Survey return rate was 91%. No further information was provided about the sample.

The results indicated that effective teachers received excellent scores > 4.00 on a Likert type scale from 0 to 5. The means for interpersonal relationships (4.48), professional competence (4.46), personality characteristics (4.45), and teaching ability (4.43) were calculated. Receiving the highest rankings were "solves problems with students" (4.63), "has sufficient professional knowledge" (4.61), and "is a role model for students" (4.59). The lowest means for effective teachers was "tries to understand gaps in a student's learning experience" (4.22), and "endures students' mistakes and avoids scolding" (4.30). Regarding ineffective teachers, students felt that personality characteristics (2.67) were the most disliked aspect followed by interpersonal relationships and teaching ability. The lowest ranked items on the 40-item tool were "avoids subjectively judging students" (2.34), "is empathetic toward students" (2.39), and "endures students mistakes and avoids scolding" (2.49). A paired samples t test indicated statistically significant differences between the effective and ineffective teacher in all

four behavioral categories. Teachers' treatment of students is the key element contributing to teacher effectiveness. Correlation between the private and public schools $r = .48$ for effective teacher and $r = .87$ for ineffective teacher, which indicates the school results were the same at both schools. Additionally, the correlation regarding ineffective teacher was very strong between the public and private nursing schools. Conclusions of the study suggest that the best clinical teacher is one who is a role model for students and who establishes a relationship of mutual respect with students.

The studies of nursing-clinical-faculty teaching effectiveness using the NCTEI tool (Allison-Jones & Hirt, 2004; Knox & Morgan, 1987; Nehring, 1990) or the Tang, Chou, and Chiang (2005) study indicate strongly that effective clinical faculty are those who are good role models as well as respectful of nursing students. Clinical faculty are under tremendous pressure and stress because they are responsible for the patient care and well being while their students are administering to the patients. Such a responsibility can cause burnout in faculty members and may lead ultimately to negative attitudes. New faculty may suffer the additional stress of unfamiliarity with the clinical setting, staff, and procedures while they oversee the actions of their new clinical students.

Part-time Clinical Faculty

There has been a continuous trend of utilizing part-time faculty for clinical teaching positions in nursing since the 1960's. The nursing shortage influences health-care institutions and pressure to enroll more students affects every nursing-education program. Nursing faculty are retiring, leaving gaps in programs that must be filled both permanently and immediately. Part-time faculty are often hired on an emergency basis to teach clinical courses that may otherwise be canceled. Part-time status in a university

nursing program or community-college program brings with it many challenges as enumerated by several research studies.

Jackson (1996) conducted a survey of part-time faculty in baccalaureate schools of nursing to assess part-time nursing faculties' nursing and teaching educational backgrounds, and their perceived learning needs. Thirty-six participating BSN programs in three Northeast states were enlisted. Out of 460 surveys distributed, 239 surveys from part-time faculty were used in the final data set (51%). Mean years of part-time teaching was 3.2 years with 56% less than 2 years teaching and 70% less than 3 years teaching part-time. Teaching assignments for part-time faculty included 8.4% classroom teaching, 55.2 % clinical teaching, and 30.1% clinical teaching in conjunction with either a classroom course or a laboratory course or both. Most people gave the reason for working part-time as "having another job" (57%), 43.9% indicated that they wanted to only work part-time, and 32.6% stated that family obligations dictated that they only work part-time.

Descriptive research using a mailed survey was employed. The questionnaire was developed by researcher, pilot tested, and improved. Program heads were contacted and distributed the packets. Descriptive statistics were used to report findings. Content analysis with theme identification was utilized for the qualitative section.

The results indicated a 96.7% female sample between the ages of 35 to 54. On average, the sample participants had 20 years practice experience but less than 3 years teaching experience. Ninety-seven percent had master's degrees, and 6% had doctoral degrees. Eighty-five percent had a clinical teaching assignment. More than 50% had little or no orientation to the college or nursing department or department policies and procedures. More than 50% had no content on classroom or clinical teaching in their

master's program. Those who had more than 3 years teaching reported being more prepared for several aspects of the teaching role. Part-time faculty identified the need for an orientation to their role and reported feeling "out of touch" with full-time faculty and the nursing program.

Results of the Jackson (1996) study concurred with numerous previous and more current studies concluding that individualized orientation and support through mentoring needs to be provided to new faculty. Master's and doctoral nursing education needs to include how to teach in both classroom and clinical settings if one expects new nursing faculty to function in the role effectively. Aside from teaching, the new nursing-faculty role includes application of program concepts to clinical situations, adjustment to the university or college atmosphere, and interaction with clinical sites and personnel who may not be familiar.

Kelly (2006) conducted a descriptive study to explore the role of clinical faculty in baccalaureate programs of nursing. Role theory was used as a lens for the research. A convenience sample of schools accredited by National League for Nursing or AACN in four Eastern states were used. Three-hundred-and-forty-nine surveys were distributed, and 137 replied creating a 39% response rate. The sample averaged 18 years (3 to 45) of clinical practice and 15 years (1 to 35) of teaching nursing.

A tool created and tested by the researcher was utilized and tested three role concepts. A pilot study of the tool was conducted and Cronbach's coefficient alpha $>.64$ of the three concepts was attained. The use of Cronbach's coefficient alpha provided reliability evidence for the instrument. The full instrument (The Clinical Faculty Role Questionnaire [CFRQ]) of all items was subjected to factor analysis. The questionnaire

had 37 items in three domains: role conception, role performance, and role engagement. The sample size is too small for a valid factor analysis, however was employed in this study. A qualitative question was asked at the end of the survey. Content validity evidence was obtained by using a panel of 6 doctorally prepared expert judges, nationally known for their expertise in the areas of clinical teaching, clinical faculty education, and role theory. Several of the judges had experience in instrument development.

Correlation analyses were used to investigate the existence, type, and strength of relationship between demographic variables and the variables being studied. An independent samples t test was computed to investigate the differences between full-time and part-time faculty roles and role preparation. Qualitative data were analyzed by themes.

Results indicated a statistically significant difference between the full-time and part-time faculty conception of their faculty role. Full-time faculty showed understanding of their role and their teaching activities, and that they were fully involved in their positions. Part-time faculty saw their clinical activities as focusing on current clinical practice or based on their own experience as a student. There was no evidence of a focus on teaching activities such as the application of program concepts to clinical situations through the use of questioning. Students ranked part-time faculty less effective than full-time clinical faculty. Results showed MSN faculty used fewer teaching strategies than doctorally prepared faculty. The longer the faculty was in the role, the more developed were the teaching abilities.

In a study to ascertain if clinical faculty used high-level or low-level questions in clinical preconferences and postconferences, Sellappah, Hussey, Blackmore, & Mc

Murray (1998) conducted comparative-descriptive research. Low-level questions are thought to challenge the development of critical thinking, decision-making, and problem solving by nursing students, whereas high-level questions are more attuned to the objectives of the courses and stated levels of decision making and thinking expressed in syllabi.

A sample of 26 clinical teachers in one Australian university nursing program was enlisted in the research project. The sample professional qualifications included registered nurse, registered midwife, and post-basic specialist qualifications. The academic qualifications of the sample included those with undergraduate degree in nursing, undergraduate nursing degree with additional Diploma in Education or Nursing education, and a postgraduate degrees in either nursing or education.

Comparative-descriptive research design was employed. Independent variables included clinical teachers' academic qualifications, teaching qualifications, years of clinical experience, and years of classroom teaching and clinical teaching experience. The dependent variables were the types and levels of questions asked at post clinical conferences. Bloom's taxonomy as used in the Craig and Page (1981) study was the basis for analysis. Each clinical teacher recorded one post-clinical conference in the weeks 2 to 4 of the first rotation and at the same time in the next rotation. The researcher collected all of the tapes and transcribed them. Questions by the faculty were isolated for the data analysis.

The results indicated that clinical teachers asked more low-level questions (91.2%) mainly knowledge questions than high-level questions (4.4%) at the two post conferences. There was no statistically significant difference between experienced

teachers or novice teachers asking high-level or low-level questions, and no difference between teachers with higher educational degrees and those with lower educational degrees asking high-level or low-level questions to the students.

For teachers to ask the higher level questions that include analysis, evaluation, and synthesis of information, they need to be educated in how to ask the higher level questions, no matter what their experience teaching or their educational level. Clinical faculty very often have no teacher education and lack skills to move students to a higher levels of thinking.

Paterson (1997) looked at the clinical-teaching role from a systems point of view. Clinical instructors take groups of up to 10 students into hospitals, clinics, or community-health agencies for specific clinical experience. The clinical instructor is often an outsider and not employed by the particular hospital or agency. Paterson saw that clinical teachers were part of a temporary system within a permanent culture of the clinical area in which they taught. They struggled to maintain a differentiated identity within the permanent system and sought collegiality and belonging. The staff had a developed permanent structure of which the clinical teacher is not a part.

The purpose of the Paterson (1997) research was to explore and describe what takes place in the realm of clinical teaching in nursing education through consideration of the temporary system of clinical teaching. Six female participants, a convenience sample of volunteers who taught at medical-surgical nursing units in three urban hospitals were enlisted. Four were full-time faculty in diploma schools. Three participants had 3 years experience teaching, one had one-year experience, and two were first-time teachers. Two were teachers in BSN programs.

The research design employed ethnographic study and symbolic interaction was used for data collection and analysis. Data collection methods included participant observation, interviewing, concept mapping, and reviews of documents. A total of 1,242 hours of participant observation was completed. “Talking out loud” was common where the faculty talked to the researcher about her perceptions and feelings concerning the situations that arose in the clinical-teaching experience. It occurred in the halls and linen closets, where privacy was ensured. Structured interviews happened at beginning, middle, and end of the study in participants’ offices and predetermined questions from pertinent literature or data previously gathered were used. Interviews were audio taped. Unstandardized interviewing occurred at coffee and lunch breaks where the researcher would follow-up on something noticed in the clinical area or something that may have been said to other teachers. Field notes were written for ordering all of the unstandardized interviews and the “thinking aloud/talking out loud” sessions and were transcribed immediately after the observation period. Document analysis was done with documents that the teachers submitted of students’ clinical performance. These were compared with the teacher’s statements and observed behavior. Concept mapping was utilized at the end of the study as a strategy to help the participants to articulate their knowledge, beliefs, and values concerning clinical teaching. Maps were analyzed and then validated by all participants.

Results of the study indicated that the consequences of being a “temporary system” emerged as territoriality (unspoken rules of the space); separateness (lack of extensive interactions between them); defensiveness (especially first-year clinical teachers who were playing by the rules), in relation to those in the permanent system; and

distinct patterns of intergroup communication (where parties communicate poorly or not at all about matters they consider to be part of their territory).

Once nursing education left the hospitals and the “apprentice model” for university education, the creation of the temporary system coming in and out of the hospital permanent system emerged. The novice clinical instructor experiences the territoriality, separateness, and defensiveness of the permanent system within the hospital, as indicated in the Paterson (1997) study, along with the anxiety of being a new clinical instructor. The new emergency-hire must negotiate the process of teaching, but, as seen in this study, intense environmental teaching hurdles include new job teaching, new students, new clinical site, new contacts at the hospital, and very little if any direction in how to proceed!

To conclude the section of this literature review on clinical teaching, the last study investigates the troubling tension often experienced by both newly hired and experienced clinical and classroom nursing faculty. Because nursing is a professional practice, nurses must engage in the profession in a practicing capacity to maintain minimal clinical competence and to stay abreast of the constant practice modifications and changes.

Baillie (1994) explored nursing faculty feelings about participating in clinical practice. Focused interviews with 10 teachers explored their current participation in clinical practice and their feelings about that participation. Other areas addressed were perceived benefits and negative effects of participating in practice, as well as the factors that may inhibit or enable teachers participating in practice. Focused interview techniques as described by Polit and Hungler (1991) with open-ended predetermined questions were used for the one-hour interviews. Interviews were taped and transcribed. No subject

verification of analysis was employed. A nonprobability and purposive sample of 10 preregistration teachers who taught predominantly in the Nursing and Professional Studies theme on the Registered Nurse/Diploma in Higher Education Course at a school in England were enlisted as participants of the study. The researcher was a faculty member at the school.

Results indicated that only one of the 10 participants still practiced nursing. The teachers were dissatisfied with their clinical skills and their current level of clinical practice. All considered that their time was too limited by the teaching job and that they had no other time to actually practice or have a nursing job. A supportive environment and the college culture that values a teacher practicing nursing would be beneficial to encouraging teachers to continue to practice nursing.

The Ballie (1994) study demonstrated the conflicted nature of the faculty-nurse role and, although clinical teaching requires current clinical expertise, most nursing faculty cannot gain practice experience due to teaching and the tripartite demands of the university. New faculty with a significant learning curve would have a more difficult time trying to do it all and would find little support for the effort. Universities and colleges need to value clinical expertise for teaching nursing and provide the resources to promote that clinical expertise. A tension in faculty about keeping up with their professional skills, the need to do that, and the lack of time to do it provided full- or part-time employment by a university was demonstrated by the results of this qualitative study.

Effectiveness of clinical teaching, the engagement of new faculty in the role of clinical teacher, the reliance on part-time faculty and the experience of faculty in that role, the challenges of clinical teaching in hospitals and other health-care facilities, the lack of

teacher education for most nursing clinical faculty based on current graduate nursing programs, the tension generated in nursing faculty created by recognition that their nursing skills are lacking, and difficulty presented in working professionally due to teaching and university demands are all areas covered by research about the rigors of clinical teaching. Emergency-hire nursing instructors entering the teaching role last minute have many demands on their time and attention. Extensive mentoring may be necessary to provide new faculty with enough support to feel capable of managing the teaching role. Supporting what learning is necessary during that first year may allow the new faculty to engage positively in the new role and consider continuing to teach.

Mentoring of Nursing Faculty

New teachers face many challenges that are difficult and complex. Faculty hired last-minute find themselves in a rush to take over a position that requires their full attention, yet frequently they start without the benefit of an orientation to the program or the university (Genrich & Pappas 1997; Hand, 2008, Hessler & Ritchie, 2006; Kelly, 2006; Morin & Ashton, 2004). Offering a peer mentor program and other supportive orientation to the role of nursing faculty may provide the scaffold necessary to retain new faculty in teaching positions that are known for very high turnover.

Brown (1999) evaluated a 12-year-old new-nursing faculty-mentoring program at the University of North Carolina, Greensboro. The sample consisted of 48 nursing faculty members and 47 new faculty members. Each new faculty was paired with an experienced faculty member. The faculty taught in a variety of programs offered by the school of nursing both undergraduate and graduate programs. Half of the 48 experienced faculty were doctorally prepared, tenure-track professors, and the others were all master's

prepared and taught mainly in the undergraduate program. The criteria for inclusion as a mentor included positive attitude, relates well with others, and assigned to teach in courses with the new faculty member or have similar research interests as the new faculty member. The new faculty included doctorally prepared and master's prepared, full-time and part-time faculty.

The mentoring program had been in progress for 12 years. At the end of each mentoring year, the mentor was asked four questions: (a) List ways or activities you used to mentor your protégé and comment about how these activities were helpful or not helpful. (b) How did the protégé help you? (c) How could the partnering relationship and the benefits derived from it been improved? (d) Should we continue mentoring for new faculty?

Four questions also were asked of the protégés: (a) List ways or activities your mentor used to help you and comment about how these activities were helpful. (b) How did you help your mentor? (c) How could the partnering relationship and the benefits derived from it been improved? (d) Should we continue mentoring for new faculty? Questions three and four were the same as the mentor questions three and four. Response rate was 70% from the mentors and 83% from the protégés.

Mentors responded to question one with the following: the being available, having regular meetings to discuss questions, helping the protégé learn to prevent and handle problems, helping the protégé anticipate and prepare for “first” experiences, and helping with implementation of teaching responsibilities (classroom teaching, exams, grading, clinical orientation and teaching, dealing with problem students, and preparing a course syllabus). To question two, mentors responded that doing a good job teaching was the

most important help received from the protégé. Most dyads were team teaching. To question three, most mentors did not think any improvement was needed in the mentoring program. To question four, all mentors felt the mentoring program should continue.

The protégés responses to question one were that mentors being available, listening, and providing feedback about teaching and the protégé adjustment were the most important. Help in preparing course materials, ordering books, learning to use the computer and getting the computer to interface with the computer at home, handling problem students, and completing forms were considered very important. Protégés valued mentors availability and assistance with learning many things such as grant writing and the tenure and promotion process. All protégés felt the program should be continued. Suggestions included making a checklist of important basics for protégés for which mentor assistance was needed and having mentors continue introductions for them to faculty and staff for several months. Protégés did not think that their boss should be assigned to them as a mentor; a peer mentor was much more desirable.

The results of this study contribute to the knowledge about what supports new faculty desire when starting out in a new position as faculty in a baccalaureate program. The study cannot be generalized to the greater population, as it was limited to only one school and limited by the type of school program.

Frandsen (2003) conducted a study to investigate mentoring relationships of nursing faculty at baccalaureate institutions of higher education. The sample included 89 baccalaureate programs accredited by NLN or AACN, 250 nursing faculty members in 50 states with names of faculty obtained from the university website. A random sample was drawn from eligible nursing faculty that numbered 1,300. All levels of nursing

faculty were included: professor, associate professor, assistant professor, and nursing instructor.

A survey instrument created by Sands, Parsons, and Duane (1991) was utilized to obtain descriptive data on mentoring practices in higher education. Instrument validity and reliability information was not provided. The questionnaires were prenumbered, and 142 questionnaires were returned creating a 56.8% response rate. Mean age of faculty was 53 years old (33 to 68), 94% female and European American.

Results indicated that 67% of the sample was mentored as new faculty. Forty-four percent of the mentoring relationships resulted from mutual initiation, 19% by departmental assignment, 17% by the mentor, and 10 % by the new faculty alone. Average time spent with the mentor was 20 hours per quarter. Primary rank at the time of the mentoring was assistant professor (49%) and instructor (39%). For those not mentored, 88% reported that having a mentor would be useful.

Questionnaire ratings on the 29 mentoring dimensions (actual versus ideal) using a rating 5-point scale (1 = not at all important and 5 = very important) were analyzed. Dimensions rated highest for actual importance were very close to highest rated ideal importance and included role model, belief in capabilities, intellectual guidance, encouragement and coaching, and feedback. Dimensions rated lowest for actual importance were similar to those rated highest for ideal importance. The least important dimensions were: promote a dependent relationship, help with personal problems, employment help, and social activities. Paired samples t-test results indicated that the mean difference was rated statistically significantly more important in the ideal mentoring relationship as compared with the actual mentoring relationship in 19 of the 29

survey dimensions. The largest mean difference between ideal and actual mentoring was receiving advice on research, grants, and publications. Factor analysis was utilized to investigate whether the 29 dimensions clustered to form a reduced set of components. The sample size in this study is too small for a valid factor analysis, although it was carried out. Seven components with eignvalues of greater than 1.0 were extracted for both actual and ideal mentorship ratings. Varimax rotation further refined and identified five underlying components for actual mentorship and four underlying components for ideal mentorship. Role modeling was noted as the greatest value for both the actual and the ideal dimensions.

The study suggested an overwhelmingly positive response to mentoring and the support it provided to the new faculty was clear. The research supports the work of Brown (1999) on mentoring of nursing faculty.

In summary, mentoring emerges as one of the most desirable scaffolds that supports new nursing faculty in adjusting to their new role. Peer mentoring, rather than formal mentoring, gained the most support by new nursing faculty.

First-Year Learning

The following literature presents relevant research to better understand the process of first-year learning of the novice emergency-hire nursing instructor and what factors influenced that learning. The circumstance of emergency-hire, although potentially more stressful and disorienting to the individual, may have many similarities to new hires in any field or profession. The studies chosen for this review reflect first-year novice professionals in nursing, engineering, accounting, and teaching as they experience learning the new role they have prepared for. There are more similarities than

differences in how these professionals learn during their first year of employment.

Nursing educators typically lack preparation for academic teaching (Diekelmann, 2004).

Also reviewed in this section are studies of professionals in nursing, teacher-education, and counseling psychology as they entered academia as faculty in tertiary education.

Different from these professionals, who are often inducted into the role of faculty with a solid orientation program and formal mentor, novice nursing emergency-hire instructors are not prepared for teaching and lack the time for formal orientation to the nursing program and college or university.

Eraut et al. (2003) presented their research about learning in the first professional job to the American Educational Research Association conference titled “Accountability for Educational Quality: Shared Responsibility.” The purpose of their study was to explore the extent to which novices, whose learning is more explicit, learn in the workplace. The sample consisted of 40 nurses from 6 district general hospitals or teaching hospitals; 27 engineers from 4 companies in avionics, building services, civil engineering, and telecommunications; and 16 accountants from large accounting firms.

The study methodology included 1 to 2-day visits to each subject’s workplace where observation, interviews with trainee’s managers, mentors, as well as the participant were conducted. Workplace documents were utilized as data. The theoretical basis for the study centered around three questions: (a) What is being learned by the novice employee in the workplace and how is prior knowledge being used and expanded? (b) What is the influence of the structuring of work and learning and of social relations in the workplace? and (c) What factors affect motivation and engagement in learning in the workplace, and are they amenable to modification by appropriate intervention strategies? (Eraut et al.,

2003). Data analysis included examination of transcripts for the main themes. Codes were produced and a cluster diagram of theoretical implications was presented. Visit reports were created from over 400 transcripts and included field notes and interviews, which was effective in distilling process for the data.

Findings of the study were presented for each professional group. The first few months of full-time employment presented very different challenges for each professional group. The accountants started out with 3-year contracts that included both training for professional examinations and work-based induction into the profession through a very organized and structured apprenticeship system. The apprenticeship system featured immediate assignment of real tasks that increased in size and complexity quickly, working at the client's premises at least half of their time on short projects with tight timetables, the need to admit ignorance and ask questions, receiving support from those just a year or two ahead of them, engagement in work that is scaffolded by the structure of the working files, access to the year's previous audit files, pre-prepared protocols, and working along side more experienced accountants. The novices gained a greater understanding of the audit process and products while working on individual tasks that contributed to them.

The nurses had completed their professional examinations prior to starting work. The study found that the new nurses had a difficult transition from college to workplace caused by their sudden assumption of a great deal of responsibility and immersion into a highly demanding and pressurized environment with a very-high workload. The critical features of the transition for nurses were the immediate need to learn to manage their time, prioritize their work, and recognize when a patient needed immediate attention;

learning how to manage the multiple levels of communication tasks and relationships with doctors, colleagues, other professionals, patients, and families; managing the responsibility of drug administration and schedules; coping with shifts; learning a range of new procedures with varying levels of help; limited contact with other members of their peer group; varying levels of support from more experienced nurses; and access to further education constrained by staffing shortages. All the nurses were critical of their training, especially the disjunction between the theory and practice, the lack of scientific knowledge, and the pattern of work placements.

Engineers in this study require Charter Status. The postgraduate certification requires a portfolio of work cross-referenced to their Chartered Engineer criteria plus an oral examination based on the candidate's portfolio. Critical features of the transition from student to working engineer for participants in this study included working in an office environment that was open and the new engineer worked along side line managers and experienced engineers; making it easier to ask questions and enter into discussion; a strong base support of mentors, managers, and team members who were "happy to help;" all companies having an online training course and exercises for the graduates' own-paced self-learning; some companies providing skills-link, where new graduates could log on and inquire about something from their desktop with opportunity to link others in the office for discussion and problem solving; strong agreement that an apprentice year would be beneficial; graduates believing that they learned most from supervised situations; and finally by learning from senior engineers through observation and discussion.

The study results indicated that the novice professionals indicated that informal support of peers was more important to them than formal support; that, for engineering, mentor support was helpful in preparing for the Chartered Engineering application and for general career guidance; that knowledge gained at the university was difficult to apply for both nurses and engineers; and that the pressure at work has a positive effect on teamwork for accountants, is too high for sufficient reflection for nurses and affects retention of staff in the profession, and tends to be too low in engineering.

The Eraut et al. (2003) study provides some insight into new workplace requirements for professionals, and, although some professions enter the field having had their professional licensing examinations completed as in nursing, other professions support an internship or apprenticeship model where the professional examinations follow a year or more in the field under supervision of experienced professionals. The results of this study suggest that the model of apprenticeship or built-in mentoring provides a less stressful entry for the professional. Self-paced learning, skills-links for engineering and scaffolded and paced file management for accountants during the apprenticeship year were beneficial. Entry to the nursing profession had no such scaffolding or apprenticeship system and appeared to be the most stressful in terms of learning and adapting to the new professional role. First-year nursing can be compared with the first-year nursing instructor where the structured scaffolds often are not similar to those in accounting and engineering. The novice nurse seems to experience a similar situation to novice nursing instructors.

In first-year induction to the professional role of teacher, mentoring and peer support that were suggested in the prior studies were considered critical to the transition

process for teachers. In her dissertation research, Cuddapah (2005) explored first-year teacher learning through the lens of Mezirow's transformative learning theory. Based in constructivism, Mezirow's (2000) transformative learning theory seeks to explain the process of formulating more dependable beliefs about one's experience, assessing their contexts, seeking informed agreement on their meaning and justification, and making decisions on resulting insights (p. 4).

Learning as transformation was described by Mezirow (1991, 2000) after studying women returning to college to continue their education. Transformative learning involves changing one's frame of mind or meaning perspectives to make them more inclusive, discriminating, open, emotionally capable of change, and reflective so that they produce beliefs and opinions to guide one's actions with greater precision and justification. Transformation typically follows these steps in clarifying meaning for the individual. The steps may not necessarily follow any specific order, and all steps may not be completed. To reiterate the steps provided in Table 1, p. 10,

1. A disorienting dilemma
2. Self-examination with feelings of fear, anger, guilt, or shame
3. A critical assessment of assumptions
4. Recognition that one's discontent and the process of transformation are shared
5. Exploration of options for new roles, relationships, and actions
6. Planning a course of action
7. Acquiring knowledge and skills for implementing one's plans
8. Provisional trying of new roles
9. Building competence and self-confidence in new roles and relationships
10. A reintegration into one's life on the basis of conditions dictated by one's new perspective. (Mezirow, 2000, p. 22)

Cuddapah's (2005) study participants consisted of a purposive sample of 10 new elementary-school teachers who worked in one of two school districts and who were enrolled in the New Teacher Program (NTP). The NTP was a professional development

program developed to bridge a new teacher from academia to the school community. The 15-session program allowed 12 to 20 new teachers to work with the NTP facilitator every other week on topics relevant to the new teacher experiences.

The research was a qualitative case-study design situated within the post positivist paradigm. In post positivist inquiry, understanding constructed knowledge, processes, experiences, and perceptions from the participants was sought. Each participant was interviewed three times. Data collection, through semi structured interviews, demographic surveys, overview timelines, concept maps, critical incidents, and developmental dilemmas were collected for each individual participant. Analysis of individual and across sample data were completed to note the extent to which experiences were connected to the transformative learning theory. Both informative and transformative learning experiences were presented for each participant based on their transcripts and analysis of the data.

Results of the study indicated that experiences of the first year for each new teacher were very unique. Eight of 10 participants experienced transformative learning to a greater or lesser extent. Alignment of the different phases of the transformative learning theory varied with each individual who experienced the transformation. Trigger events occurred and were unique for each teacher. There was no predictability of when a disorienting dilemma would occur leading the learner through the transformation process. Colleagues emerged as the strongest support of first-year learning by most of the sample and the participants did not identify a “hindrance” to their learning.

Implications for practice included four themes that were interpreted from the findings: (a) new teachers learn in context, therefore, it is important to consider the

setting when supporting them; (b) new teachers learn in community, and companionship among them should be encouraged and supported; (c) new teacher learning is experiential and providing literal and figurative spaces supports them in processing these experiences; and (d) catalysts to new teacher's learning occur at different times and may or may not lead to transformative learning (Cuddapah, 2005).

The NTP in this study served as an orientation and a mentoring program and included time for peer socialization and support. It provided much of the same support noted in the Eraut et al. (2003) study for accountants and engineers. Peers surface again as the main source of support in the first year.

Eraut et al. (2003) indicated that the professions of accounting and engineering had built in scaffolding to support the first year of professional work. The Cuddapah (2005) study of new teachers in the NTP provided a similar scheme of scaffolding for new teachers in the two districts studied. Kindergarten through high-school teacher education typically provides a postbaccalaureate year where both course-work and student-teaching are required to become certified as a single-subject or elementary teacher. During the student-teaching experience, students are precepted by master teachers providing oversight to their planning and teaching experience. Once certified and employed as a teacher, unless there is a program like the NTP program suggested in the Cuddapah (2005) study, new teachers are left on their own. Complicating the issue of new teacher induction to teaching is alternative certification (AC) where, similar to emergency-hire nursing instructors, new teachers bypass traditional teacher-education programs and are granted emergency permits on the basis of having a bachelor's degree (Fullan, 1991). There are more than 40 states that currently grant AC to candidates who

posses a bachelor's degree and the programs are varied. Controversy over the increased utilization of AC teachers in the field has surfaced. "Nothing calls into question the reputation of the entire teaching profession as emphatically as the suggestion that anyone with good content knowledge can be rapidly prepared for teaching" (Fullan, 1991, p. 309). The lack of qualified nursing faculty provokes a similar emergency-hire situation where new nursing faculty must learn how to teach typically without the advantage of teacher-education preparation in their graduate program. The following study will identify the challenges of new nursing faculty learning to lecture and teach in the first year of employment in a program of nursing.

In a qualitative study investigating how new nursing teachers learn to lecture, Young and Diekelmann (2002) interviewed 17 new nursing teachers: 8 master's prepared, 6 doctorally prepared, and 3 in progress with doctoral education. The study design utilized the interpretive phenomenological approach based on Heidegger's philosophical writings that were later introduced to nursing by Benner (1984). Transcribed data were analyzed hermeneutically using multiple stages of interpretation to identify the common experiences and shared practices and meanings of being new faculty learning to lecture.

Learning to Lecture as a theme was described based on data analysis. Knowing and Connecting (or not knowing and not connecting) with students emerged as a very important practice for the new teachers. The teachers described this practice as "figuring out where students are at" (Young & Diekelmann, 2002, p. 408). The importance of this was in understanding what students were bringing to learning situations. Quizzing was initiated by one of the new teachers and resulted in listening to the students sigh during

the quiz, then noting that the quiz did not produce any knowledge about what the students know, only what they do not know. The new teacher presenced herself as she listened and attended to the students' reactions to the quiz. Being open and listening to students is very important to gaining the understanding of what students already know. Reflection on teaching experiences increases teaching expertise. Some of the new teachers were able to utilize reflection and some were closed to reflection. Even in the face of poor evaluations, one of the new teachers took measures to keep her job but did not invest any time in learning how to teach. The individual viewed lecturing and teaching as a game that had to be played to gain tenure. The individual was very interested in gaining a large grant and doing research and expressed that there would never be time to spend on teaching.

Many of the new teachers focused on teaching rather than on student learning. When the technology failed for utilizing the overhead projector due to a burned-out bulb, one teacher spent the class time ordering another overhead projector and that was delivered with a burned-out bulb. Much time was wasted on the equipment failures, and the new instructor did not have an alternative plan. Finally, the teacher started to draw a diagram on the board to explain to the students the concepts she had planned to use with the overhead. The students started to participate in filling out the diagram and as the exercise progressed, the teacher could tell where the students were weak on knowledge and what they did know. Questioning, dialogue, connecting with, reading the faces of the students, and interpreting a learning situation all came from being forced off the lesson plan and into a more interactive teaching situation.

Unlearning teacher preparation was necessary for some of the new faculty where teacher-centered rather than student-centered learning was adopted. Most of the new

teachers did not believe they were equipped to teach nursing courses even though a number of them had previous education courses in their graduate programs. Despite having taken two courses in teacher preparation, one of the new teachers, who described how he was unprepared for his first year of teaching, expressed that it was a joke and that the real world was nothing like those courses!

Challenging the new teachers were the assumptions of conventional pedagogies. Implications of the study suggest that new teachers need not only better preparation for teaching inclusive of the conventional pedagogies but also critical, feminist, postmodern, and phenomenological pedagogies. Faculty who teach teacher-preparation courses in nursing masters and doctoral programs need to increase their literacy in the new pedagogies.

Learning by new teachers in this study appeared to be experiential and unsupported by past education. Lack of teacher preparation for teaching in the environments of classrooms today and the minimal scaffolding and support for new nursing instructors to practice new pedagogies is evidenced by this study.

The environment of academic teaching in a college or university provides its own challenges. Although new nursing instructors must learn to teach in the classroom and or clinical setting, they must also function as part of the greater college or university by providing service and performing scholarship if in a full-time position.

Siler and Kleiner (2001) studied novice nursing faculty in academia. The purpose of the phenomenological study was to gain an understanding of the meaning of the new faculty experience. Twelve participants, six novice and six experienced but new to the position of nursing faculty, were enlisted in the study from 24 American Association of

Colleges of Nursing accredited nursing schools. All participants were full-time faculty, located in five states representing 11 schools of nursing, and were in their first year of teaching full time in a nursing program.

Phenomenology guided the study as described by Martin Heidegger. Interviews were conducted after permissions were achieved. Hermeneutic analysis, where descriptions of individual's experiences and practices are studied to uncover shared meanings was utilized. The researchers read the transcripts together to uncover the meaning of the new-faculty experience.

Results of the study produced four themes: expectations, learning the game, being mentored, and fitting in. Results also suggested a great deal about the participants' lack of role preparation and socialization for university requirements. Unfamiliarity with the university routine and expectations was a universal finding for all novice faculty. The culture of the university, as experienced by the novices, was different from their prior clinical-work settings. Those novice faculty who had 20 to 30 years of nursing experience in many clinical settings were shocked by how different everything was. Everything they did was "new." Many incongruities were noted by the novice faculty related to their expectations. Faculty workload was considered much more than expected. All participants were assigned to teach a course or courses, and all participants lacked any prior teaching experience. Committee and project work was expected of them, and many perceived that they lagged behind in everything they attempted, and nothing was ever finished. This perception created frustration. Mentoring from colleagues was provided to all novice participants with mixed results. Most participants stated that they did receive some help with constructing a syllabus and preparing a test. As novice teachers, many

struggled to learn the basic rules of teaching. The novice faculty worried about their performance as teachers and judged themselves by their successes or failures with students. If students did poorly on examinations or in the clinical setting, novice faculty would reflect back on their teaching practices. They found little support for their teaching and described a solitary process of putting things together and in perspective. Student evaluations were the chief source of teaching effectiveness. The “agony” of failing a student prompted novice faculty to question their choice of teaching. All novice faculty experienced critical periods and stressful times during the first year. Many questioned if teaching was really what they wanted to do. One participant gave an analogy to her experience teaching the first year by explaining the story of the donkey that fell into a well and people tried to get him out but could not. So the people started dumping dirt on him to bury him. The donkey stomped the dirt down, the more they dumped the more he stomped it down, and finally he walked out (p. 402). Exasperated teachers felt similarly and used numerous ways to cope with the stresses and inexperience of the first year.

Implications of the study suggest that assignments of major course responsibilities to novice instructors who have no teaching experience and lack any degree of guidance needs reconsideration. Workload accommodation needs to be adjusted for mentor faculty to provide new faculty with the support necessary to successfully complete the first year of teaching. The mentoring needs to be sustainable and effective. The isolation noted by many of the participants has been supported in other studies on new professionals and new faculty (Cuddapah, 2005; Eraut et al., 2003; Guilfoyle, 1995; Magnuson, 2002).

Novice counselor assistant professors have many adjustments to the role of faculty issues that have not been addressed including high levels of stress, dissatisfaction,

and loneliness in the job. Magnuson (2002) examined the experiences of novice counselor assistant professors during their first year and their satisfaction, stress and anxiety, and perceptions of connections. The sample consisted of 38 new assistant professors including 26 women and 12 men. Participants' age ranged from 27 to 60 years old.

The survey design research utilized midyear and end-of-year questionnaires with numeric ratings and anecdotal data that addressed (a) factors that contributed to participants' perception of the support they received, (b) strategies or environments that promoted satisfaction and success, and (c) working environments that resulted in dissatisfaction or discouragement. Participants were asked to rate their stress and anxiety, satisfaction, and perception of connectedness on the midyear instrument using a Likert-type rating scale. The end-of-year scale deleted one question and added several more questions. Validity and reliability issues were addressed.

Quantitative and qualitative results were analyzed. Mean ratings for degree of satisfaction, level of stress and anxiety, and experience of connectedness were calculated. The mean rating for degree of satisfaction decreased by the end-of-year, rating for connectedness decreased, and mean ratings for stress increased. No statistically significant finding was produced.

For the anecdotal or qualitative questions, three broad categories emerged: (a) consistently positive comments and satisfaction, (b) generally positive commentary qualified by difficult circumstances, and (c) consistently negative comments and diminished ratings of satisfaction. Positive comments about the first year of teaching included that the job was "exciting, interesting, and exhilarating" (p. 310). The positive

but also difficult category included sentiments that although it was “exciting, validating, and sometimes even fun, also frightening, depressing, frustrating, and very, very difficult” (p. 310). Negative responses included “I have felt very much in the dark” and it was “difficult, disappointing and very unpleasant” (p. 310). Most participants emphasized their learning in the first year and what a tremendous effort that was leaving them “exhausted” (p. 311). Eight participants reported high levels of isolation and loneliness at the end of the year, whereas many of the participants indicated that their first year was highly satisfactory.

The most prominent recommendations for a successful first year included orientation and consistent mentoring. Faculty-development seminars were endorsed as helpful if they included pragmatic information about university structures and helping new faculty learn how to teach effectively. The tenure and promotion requirements were daunting to all new faculty, balancing their lives and then adding scholarship requirements of “publish or perish” added extra pressure and stress to most of the participants. Although these results cannot be generalized, they are not inconsistent with other studies of first-year faculty in the academic setting.

Guifoyle (1995) noted the struggle that occurs when teaching for the first time in academia, where new faculty must become involved in a variety of roles, form a variety of relationships, and understand many contexts. The purpose of her study was to understand the tension, issues, and dilemmas that emerged as new faculty interacted with others (students, faculty, and administration) in the context of the university faculty position. The sample was 4 newly hired women teacher-educators at four different universities in the United States.

Qualitative research design with data collection over a 4-year period used numerous data-collection methods. Following a feminist perspective, the context of the inquiry included their universities, colleges, departments, and classrooms as well as settings in public schools. Multileveled and multidimensional data were generated over the 4-year period. Data sources included participant observations; interviews with faculty, graduate and undergraduate students, and classroom teachers; student self-assessments and course evaluations; interactive journals with students and colleagues; and field notes in the form of personal critical reflections on practice, academia, and research. Data analysis included speculative analysis, classifying and categorizing, and concept formation utilizing a constructivist perspective of qualitative research.

Results of the study indicated a very visible struggle between the roles teacher-educators are expected to assume. New faculty discovered their primary role was that of teacher, whereas their graduate programs prepared them for the role of researcher. Graduate education gave little or no attention to the role of academic teaching in the faculty role, research was considered the primary role of faculty. No interaction with novice faculty during graduate education was provided; experienced faculty taught in the graduate program. After the first year of teaching, all 4 participants were still struggling to extend their understanding of the role of teacher at the college level. The role was not valued by the university system, in their view. Quantitative research was viewed as the primary way to keep current, be productive, influence and improve the educational process, and gain tenure. The emphasis on research conflicted with the role of teacher for the first-year educators. Contributing to the struggles were issues that surfaced for the novice faculty at all four universities and created a general disequilibrium. Included as

struggles were lack of time, lack of research on teaching in higher education, lack of modeling of teaching and good practice where new theories of teaching and learning were rejected by the system and lecture and multiple-choice tests were standard with anything else frowned upon by both students and peers, lack of mentoring, lack of reflective practitioners, politics, and pressure to become a published researcher.

The results of the Guilfoyle (1995) research were very similar to the results of the Siler and Kleiner (2001) research on novice nursing faculty in academia and Magnuson (2002) who investigated novice counselor assistant professors in their first year. The lack of teacher preparation for the academic teaching position, the pressure of the new job, the lack of mentoring and support, and isolation seem to resonate as issues for first-year faculty. Most of the studies in this literature review suggest that mentoring is most supportive of first-year learning and adjustment to the new teaching role. It needs to be friendly and constant throughout the first year and beyond. The informal support from peers is invaluable as are self-paced learning modules and programs designed to support the use of new teaching pedagogies.

Summary

The review of literature just presented situates the study of nursing emergency-hire and novice-teacher learning in the first year by relating contextual chunks of the new teaching experience including the clinical teaching environment and demands, the university and program demands, mentoring as a support, first-year learning by professionals in their chosen fields, and first-year teaching in the college or university. Issues of lack of teaching experience, the mentoring component, and various conceptions

of professional development highlight points of convergence and divergence in these areas of the literature.

The literature indicates that most nursing instructors are prepared and socialized for experiences in advanced nursing practice or research rather than teaching. This focus reflects the situation in the wider university where graduate students predominantly are prepared and socialized as researchers rather than as teachers. Those pursuing graduate study do not view developing teaching expertise as the primary purpose of their study at the doctoral or the master's level. In spite of the focus on research in nursing doctoral education, there is little research on nurse-educator related topics. If considered at all, the approach to learning about teaching is an additive approach where adding education courses to a curriculum schedule of advanced practice nursing or adding education courses to doctoral study is attempted.

Understanding the background of current nursing program requirements for teaching positions and the atmosphere for new faculty in both the clinical and classroom settings are key to understanding the challenges to first-year learning by new nursing instructors. How new instructors learn to teach is dependent on a variety of factors that help or hinder new learning. Critical incidents occurring throughout the novice teaching experience will challenge new instructor past frames of reference about teaching and learning. Based on interaction with others, new meaning can be constructed and new skills can be utilized. Having experts facilitate new learning by modeling problem-solving strategies and guiding learners in reflection and articulation of their thought processes will facilitate new instructor learning. Transformative learning theory applied

to the challenges to and changes in frames of reference will help to understand the process and experience of the new instructor.

The literature suggested that nurses and nursing instructors typically enter their profession with little mentoring and support for the role they take. Although survey descriptions and interviews of nursing faculty were found in the literature, little is known about specific factors that shape new instructors' knowledge of teaching and the faculty role. Qualitative explorations of factors that influence how novice and or emergency-hire nursing instructors learn their role most effectively and what was perceived as most supportive and least supportive may contribute to the body of knowledge about the kinds of program and system changes that could be instituted to support new instructor learning. Centering on the meaning-making process through which instructors understand their role describes the constructivist view of new teacher learning. Inquiry and meaning making about the role of instructor for emergency-hire and novice nursing instructors will be investigated in the proposed study.

The increased need for new faculty has focused attention on the nursing shortage and the nursing-faculty shortage. Effectiveness of teaching has been the main focus of prior research about nursing faculty, and little is known about how new instructors learn to teach under the current conditions. The literature review has demonstrated the complexity of induction into the field of academic and clinical teaching in the university and college environment and has demonstrated the need for research that investigates novice and emergency-hire first-year learning the role of clinical nursing instructor. Chapter III will outline the research methodology utilized in this study.

CHAPTER III

METHODOLOGY

With the prediction that the current nursing faculty shortage is projected to intensify, emergency-hiring of part-time nursing faculty to fill in the gaps will likewise intensify (Curl, Smith, Chisholm, Hamilton, & McGee, 2007). Attention to the individual who takes the emergency-hire position is essential. The purpose of this study was to investigate first-year learning by novice clinical-nursing instructors (NCNI) hired into a program of nursing where clinical-faculty positions were not filled within several weeks before the start of the semester or quarter. This study endeavored to investigate what support either helped or hindered learning of the clinical instructor role by the novice emergency-hire nursing instructors. Using Mezirow's (1991) transformative learning theory as a framework for investigation allowed in-depth attention to the process of instructor learning in the first year of teaching.

The methodology used to study first-year learning of NCNIs and the role of support in that first-year of teaching is provided in this section. Learning experiences were sought through varying data-collection methods. The following research procedures utilized in the study are described: interviews, sampling procedures, protection of human subjects, researcher's role, pilot study, data-collection procedures, and data analyses.

Methodology Rationale

A research paradigm refers to a set of very general philosophical assumptions about the nature of the world (ontology) and how one comes to understand it (epistemology). The paradigm includes assumptions shared by researchers working in specific fields or traditions. Paradigms include specific methodological strategies that

connect to the philosophical assumptions (Maxwell, 2005). My study was situated within the postpositivist paradigm where reality was seen as constructed, socially and historically situated, and fluid. To understand the constructed knowledge, processes, experiences, and perceptions from participants' point of view was at the heart of this study. Qualitative methodology provided the framework for collection and analysis of the data. According to Bogdan and Biklen (2007), qualitative research utilizes multiple data-collection methods, which are interactive and descriptive. Qualitative researchers are concerned that they capture perspectives accurately and set up strategies and procedures to enable them to consider experiences from the participants' point of view. There exists interplay between the researcher and the participant in qualitative research (Bogdan & Biklen, 2007). The above methodological rationale, as a basis for this study's research design, provides a framework and context for the research operations.

Research Design

Description of qualitative research varies greatly in the literature, but there are common characteristics that many authors cite. Included in these similarities are factors such as the researcher is considered a key instrument in data collection, natural settings are common, interactive and descriptive multiple data-collection methods are utilized, and the participants' perspectives on meaning-making are sought (Bogdan & Biklen, 2007; Creswell, 1998; Maxwell, 2005; Patton, 2002). The naturalistic or constructionist paradigm of qualitative inquiry that Patton (2002) presented is a strategy that focuses and builds on a number of interconnected themes: naturalistic inquiry, inductive analysis, holistic perspective, dynamic systems, qualitative data, personal contact and insight, empathic neutrality, unique case orientation, design flexibility, and context sensitivity.

The descriptions of these themes were useful in the preparation of the design for this study.

I used several qualitative data-collection techniques to obtain information about learning the faculty role in the first year by 10 emergency-hire NCNIs. The inquiry design partially was patterned after the research conducted by Cuddapah (2005), and permission to modify and utilize the tools designed for that study was obtained. The primary concern was to understand the phenomena of interest from the NCNIs' perspective and each participant was interviewed once in a setting conducive for recording. After NCNI interviews were completed and preliminary analysis had taken place, I recognized that seeking a possible alternative point of view may add credibility and that the administrator voice regarding hiring of NCNIs last minute, on an emergency basis, would augment the data already attained. The position of nursing programs is that of needing to fulfill their obligation to teach nursing students who are relying on professional education in an ordered curriculum with a sequential class structure. If clinical instructor positions are vacant, which is the norm now that programs have increased enrollment to address the nursing shortage, administrators must try desperately to fill the vacancies. The tension of having unfilled clinical instructor positions causes great stress as the potential for canceling courses looms. Emergency hiring, even hiring within one day of classes commencing, is becoming more common despite growing sophistication of the recruitment process. Resources are very scarce, and although recruitment may vie for the available budget focus, support of the new hire once employed may go unfulfilled.

Therefore, a research question was added to the current research questions pertinent to the study and institutional review board (IRB) modification was sought and attained to interview nursing-program administrators. Nursing program-administrators from the three chosen schools were asked to participate in an interview, and 3 program administrators agreed to be interviewed for this study. Information about the study was sent to the administrator prior to the interview. Each interview lasted approximately one hour.

Setting

The setting for this study was a large metropolitan area on the Pacific Coast. Three Bachelor of Science in Nursing (BSN) programs that hire last-minute NCNIs to fill positions that require an instructor were utilized. The nursing programs were located in private universities varying in size from roughly 500 to 800 prelicensure students. University A enrolled about 520 nursing students out of approximately 1,469 undergraduate students, total. University B enrolled approximately 600 undergraduate nursing students, out of a total undergraduate enrollment of 5,278 students. Program C is located within a Health Sciences College and enrolls approximately 850 prelicensure nursing students, 403 of which are undergraduate nursing students, out of 1200 total students. Each school offered various types of Bachelor of Nursing (BSN) program options including traditional 4-year generic BSN programs, degree completion programs, accelerated BSN programs as well as other nursing prelicensure programs including several master's entry programs in nursing. All programs have increased their enrollment to address the nursing shortage and have hired or attempted to hire new faculty.

NCNI participants or the interviewer chose the setting for the personal interviews where it is most comfortable, convenient, and provided as few distractions and noise as possible. Settings for the interviews included university library sound-proof study rooms, a school of nursing faculty lounge, private apartments or homes, and my personal campus office. The administrator interviews were conducted in the offices of the administrators.

Sample

Most qualitative studies use purposeful sampling, a conscious selection of a small number of data sources that meet particular criteria. The logic and power of purposive sampling lie in the selection of information rich cases for in-depth study to illuminate the questions of interest (Patton, 2002).

Novice Clinical Nursing Instructors

Purposive nonprobability sampling, specifically criterion sampling, where all cases met some predetermined criteria (novice instructor, taught at least one clinical rotation within the last year, employed by a BSN program of nursing in a private university) was utilized. Electronic mail (email) messages were sent to directors of the three programs of nursing asking their assistance in recruiting participants by sending all current faculty an attachment letter recruiting new faculty to the study (Appendix A). Fifteen candidates responded who met the study criteria. Candidates were selected to represent each program as equally as possible. The 10 candidates chosen and interviewed had no prior teaching experience with a group of students in a clinical-facility setting in a BSN program prior to completing one semester to one year of teaching in the clinical instructor position. Ten NCNI participants were enlisted in the study. Each NCNI had completed teaching at least one clinical course in the BSN program between August 2006

and August 2007 and were hired to the clinical instructor position within 4 weeks of school starting. Four NCNIs each were recruited from two programs and two NCNIs were recruited from the third program. Table 2 provides demographic data on the NCNI participants. The information provided is each participants' education level, age, hiring date in relation to when school started, how many times the NCNI had taught a clinical group at the time of the interview, what specialty area the NCNI taught in, whether or not the clinical teaching site was their workplace or not, if the NCNI had any orientation to the role, teaching, or the university through the BSN program, if they were assigned a mentor or found a mentor, the NCNI prior teacher education or preparation, prior teaching experience, and finally, if the NCNI would consider teaching as a career change.

To summarize the information in Table 2, there were 7 females and 3 male participants. The participants ranged from their mid-20s to the early 60s with the mean age of 41 years. NCNIs were hired between one and 4 weeks prior to school starting with a mean of 3 weeks hired prior to classes starting. Sixty percent of the NCNIs taught two clinical rotations at the time of the interview, and 40 % had taught one clinical rotation. Courses taught by NCNIs covered all nursing curriculum areas except community-health nursing. Fifty percent of the NCNIs taught in the same clinical setting where they were employed as working nurses. Seventy percent of the NCNI participants claimed they had no orientation to the nursing program, and 60 % claimed they either were assigned a mentor or sought their own peer mentor. Two NCNIs attained a nursing-education minor while in their masters program, and another NCNI currently is working on a nursing education minor in a masters program. One NCNI stated he was an education major prior to entering the field of nursing, and another NCNI has recent postmasters coursework and

Table 2
Demographic Overview of Participants

Participant*	Highest Degree	Age	Hired Weeks Prior to Semester	Clinical Rotations Taught	Course Topic	Teaching Site Same as Work	Orientation to BSN Program	Mentor	Prior Teacher Education	Prior Teaching Experience	Career Change to Teaching Nursing
Alex	MSN, MA	>60	4	2	Psychiatric Nursing	Yes	No	No	MSN program-Nurse Educator minor	Student teacher in grad program	Desired for future employment, yes
Beth	BSN	30-39	3	2	Medical Surgical Nursing	No	No	Yes	No	Precept new nurses	Add to current RN career
Carmen	MSN	30-39	4	1	Advanced Medical Surgical Nursing	Yes	No	No	MSN program-Nurse Educator minor	Precept new nurses	Add to current RN career
Douglas	BSN	20-29	4	2	Pediatrics	Yes	Yes	Yes	No	Precept new nurses	Occasionally only
Elise	BSN	30-39	3	1	OB/Women's Health	Yes	No	No	No	Precept new nurses	Occasionally only
Frances	BSN	50-59	3	2	OB/Women's Health	No	No	Yes	30 years ago hospital based new instructor program	Precept nurse-midwife students and interns	Desired for future employment
Glena	MSN	40-49	2	2	Fundamentals of Nursing	No	Yes	Yes	No	Precept nurse practitioner students	Add to current FNP career
Harriet	BSN	20-29	4	1	Pediatrics	Yes	No	Yes	Currently enrolled in education minor	Taught one clinical simulation lab sp 07	Add to current RN career
Ian	BSN	50-59	1	2	Advanced Medical/Surgical Nursing	No	Yes	No	Education Minor in college	Precept new nurses	Add to current RN career
Janet	MSN	40-49	2	1	Medical/Surgical	No	No	Yes	New CI education program, Spring 2007	Precept new nurses	Desired for future employment

*Names of participants have been changed.

certification as a clinical instructor. One NCNI entered a “nursing-instructor” training program 30 years ago after her BSN program and certification as a nurse-midwife. All NCNIs claimed they had precepted new nurses hired in their place of work and considered that role as prior teaching experience. When considering whether they were planning to change their career path to clinical teaching from nursing, the results were very mixed. Thirty percent stated they desired to move from clinical nursing to clinical teaching as their future or retirement job, 50% stated they would continue to both work as nurses or nurse practitioners and teach clinical groups, and 20% were clear that adding clinical teaching to their full-time nursing position was going to be occasional at best.

Although all were practicing nurses, not all NCNIs were as prepared clinically as others for their teaching role. Seven NCNIs were working nurses in their specialty area of clinical teaching; 3 were clinic nurses or nurse practitioners not working currently in the hospital and not as familiar with hospital policies and procedures or current hospital equipment.

Novice emergency-hire nursing clinical instructors typically learned about the open position of clinical instructor in their workplace. Peers at work were instrumental in recruiting their co-workers to positions as clinical instructors and often were past clinical instructors themselves or were current clinical instructors. Although 5 of the 10 participants were recruited by peers at work, five came to the position by various connections with schools of nursing. All of the new instructors were first-time clinical instructors in programs of nursing. Because the participants were all nurses, they were used to patient and family teaching, something that is a requisite nursing skill for the profession of nursing. All study participants were working as registered nurses, 3 were

current master's students and working nurses, and all taught clinical sections for nursing programs for their first time within one year or less of the interview for this study.

The next section provides a description of the nursing program administrators' position concerning hiring of emergency clinical instructors and what supports the program provides for the new hires.

Nursing Program Administrators

Adding nursing-program administrators (NPAs) from the three BSN programs utilized for the NCNI sample was a logical adjunct and followed analysis of the NCNI data. The decision to increase the sample rested with the notion that the integrity of the study would be enhanced by seeking alternative themes, divergent patterns, and rival explanations as well as alternative points of view (Patten, 2002). With the addition of the NPAs, I was looking for data that supported alternative explanations. An additional research question was added to accommodate this decision.

The administrator sample consisted of purposive criterion-based sampling where a nursing-program administrator was sought from each school who participated in hiring of clinical faculty and had knowledge about the program supports for new faculty. Program administrators were contacted by phone and asked if they would be available for an interview and if not, did they have a suggestion for someone in the department who would fit the criteria for the study. Each administrator was familiar with the research based on the initial contact when they were asked to forward a recruitment letter to their faculty when seeking NCNI participants. One program administrator was interviewed from each program of nursing, and the one hour interviews took place in the administrator's office. Each interview was recorded on a digital recorder, and consent

forms were signed by all three administrators. To maintain consistency between the three interviews predetermined open-ended questions were asked. The demographic and program information attained from the program administrators is summarized in Table 3.

The programs were similar in some ways but different in many ways. All three programs had a generic BSN program, were situated within a private university or college, and utilized the same geographical metropolitan area where student clinical placements were shared and the pool for potential new clinical instructors was the same. Program A concentrated on the undergraduate BSN program and enrolled approximately 520 undergraduate students with a very small number of LVN to RN students

Table 3

Summary of Administrator Demographic and Program Information

Participant	Administrative Position	Size of Prelicensure Nursing Program	Approximate Clinical Sections Annually
Dr. Aragon	Chair of the Department of Nursing	520 students	116
Dr. Bartell	Dean of the School of Nursing	600 students	170
Dr. Carriger	Former Chair of the Undergraduate Nursing Program	850 students	200

matriculated in with the BSN students. Program A added a new MSN track recently to the current MSN program to educate Geriatric CNS students and to produce clinical nursing educators. The new program was an attempt to address the nursing faculty shortage. Programs B and C offered the generic undergraduate BSN program, and included in their offerings were options for prelicensure students such as accelerated BSN programs, master's entry to nursing programs that included clinical nurse leader

programs and RN to MSN programs. Enrollment differed for the programs and varied from twice yearly enrollment to seven or more enrollment dates per year. Each of the administrators was expressive of their response to the nursing shortage and the size of their current enrollment. Drs. Bartell and Carriger stated that their programs were year-round and that clinical sections in summer are open to prelicensure students who are not in the generic BSN programs. Generic BSN student cannot attain financial aid during the summer, but the accelerated BSN and MSN-entry students can take advantage of the summer courses.

Protection of Human Subjects

Human subjects consideration was addressed by gaining approval from the Institutional Review Board of the University of San Francisco. Research was governed by the ethical principles and standards as set out by the American Psychological Association (2002). All participants signed a consent form (Appendix B).

Participants were informed of the purpose of the study during the recruitment process. The expected involvement of the participant was explained inclusive of a one-hour interview and member check of data following transcription and analysis. Participation was voluntary, and each participant was informed that he or she may withdraw at any time during the study. Anonymity was protected. Interviews were digitally recorded with participant permission and downloaded to a computer editorial program for transcription. The researcher transcribed the first four interviews, and a professional transcriber was utilized for the remaining nine interviews. All transcriptions were checked against the audio recording for accuracy. Each participant was assigned a

number, and, at the time of analysis, each was assigned a pseudonym. Data were stored in electronic files with password protection and access was held by the study investigator.

The Researcher's Role

I am a nurse with many years of experience in community, geriatric, and public-health nursing and a faculty member of a small liberal-arts university department of nursing since 2000. My first experience as a new clinical faculty member gives me a background that may not be dissimilar to those who were recruited for this study, making me an insider. I anticipated some basic understanding of the teachers' lived experiences as my own entry into the profession of teaching is fairly recent. My master's education included primarily clinical nurse specialist education; however, I did complete an education minor. Although I had one course in curriculum development and one course in teaching and learning with a teaching practicum, my emphasis at the time was staff development and not academic teaching.

My first faculty position was as a clinical instructor in a major university medical-center institution, and I was mentored closely by a very caring and available faculty member. The assignment was in my area of expertise: geriatric community health. My affiliation at the home-care agency was enhanced by a close relationship to a former preceptor in the master's program. My second faculty position was not so smooth, I changed schools, my clinical teaching assignment was not in my area of expertise, and the faculty of record was not a mentor; communication was poor. I was very isolated, frustrated, and ill-equipped to handle the group of students in a rehabilitation hospital. I had no orientation to the position from the nursing department but attended the university-wide orientation for new faculty. I found the university orientation helpful in

becoming acclimated to a faculty position in higher education in a small liberal-arts college, but it did not prepare me for the clinical-nursing-instructor teaching role. A full-time position became available in my area of expertise, and I again felt comfortable as a content expert, although never fully confident teaching. I believed I was a novice. My orientation to the role of a full-time tenure track faculty member came as I moved into the position after the resignation of my direct supervising faculty after search committee interviews. I did audit my predecessor's didactic course for a full semester to observe teaching. Unfortunately, the observation did not provide me with much confidence in the role, but I had a summer to prepare for my attempt at teaching the 8-unit community-health nursing course.

I believed I was ready to enter the classroom, but when I did, I recognized that although I was an expert in the content being presented I was a novice at management of different student learning requirements, out of sync with evaluation of student learning through testing and performance assessment, and surprised by the ongoing student problems to be resolved and addressed each semester. Having three part-time clinical faculty to mentor, as well as supervise their teaching and student assessment, was a daunting task. It became apparent to me that teaching nursing requires more than being a nurse, it requires education in teaching and strong mentorship from an experienced nursing faculty. I believed academic teaching was a different profession for which I was uneducated, and an imposter. This persistent feeling motivated me to pursue a doctoral program in education. As a current doctoral student in a school of education and full-time employee as tenure-track nursing faculty, my position within this inquiry will be that of a

researcher-participant. As the observer, interpreter, and data collector, my position is that of an outside researcher.

Pilot Study

A pilot study was conducted in Fall 2006 to test the research design. Two participants who were emergency-hire nursing instructors were enlisted in the study. Two interviews and one teaching observation were planned for each participant. Predetermined questions were utilized for the interview, a timeline activity mapping significant events during the first year of teaching, and a concept map of teaching were tested. Modifications to the interview protocol based on the pilot study were made to the predetermined questions; some of the questions were redundant. Observation of the participants current teaching did not gain new information about how the instructor learned in the first year; however, the observation did confirm participants' description of how they stated they taught.

Study participants were working nurses and clinical instructors and did not have the time available to participate in two interviews. They suggested a slightly longer interview if necessary rather than trying to plan on a second interview. This adoption was made in the final methodology.

Procedures

This section describes the data-collection procedures. NCNI data collection was started on June 6, 2007 and completed August 31, 2007. Administrator data collection was started on Nov. 28, 2007 and completed January 15, 2008. Sample size was determined based on reasonable expectation coverage of the study phenomenon of interest (Seidman, 1998). Following transcription and analysis of the data, participants

were asked to validate researcher analysis. University of San Francisco Institutional Review Board for the Protection of Human Subjects approval was gained April 25, 2007.

Novice Clinical-Nursing Instructors

Directors of nursing programs were contacted by email and telephone and the research was explained (Appendix A). The directors were asked to forward the email message to all faculty and to provide a list of newly hired clinical instructors. A list was provided to the researcher and calls were made or emails of introduction were sent. When a potential candidate responded and asked for more information, a follow-up email was sent or phone call made to explain the study. Once the prospective study candidate was identified, a phone call was made or email was sent to further explain the study. After the candidate agreed to participate, a participant consent letter (Appendix B) was emailed along with the demographic questions (Appendix C) and predetermined questions (Appendix D) for the interview. A time, date, and place were set up for the interview. All consent forms were signed at the interview, and participants were provided with an original consent form.

Nursing Program Administrators

Telephone calls were made, and emails were sent inviting each administrator to participate in an interview. Each NPA was familiar with the research study based on the initial contact for recruitment of NCNIs in their programs. NPAs assisted by providing a list of the most recently hired clinical instructors in their programs and their contact information to the researcher. Once the NPA agreed to participate in a personal interview, a time and date for the interview were set.

Data Collection

Qualitative research utilizes multiple data-collection methods, is interactive, and is descriptive (Bogdan & Biklen, 2007). This section describes how data were collected for all participants.

Novice Clinical Nursing Instructors

I used a variety of methods to collect data. To reconstruct their personal experiences about learning during the first-year of teaching, the purpose of the interview was to establish rapport, discuss the predetermined questions (Appendix D), chart a timeline (Appendix E) of the first semester or first-year of teaching, and create a concept map (Appendix F) of teaching as they see teaching now. Concept maps are a way of indicating what we generally believe, think, feel, or value at a particular period of time (Deshler, 1990). Critical incidents identified by the participant through discussion, timeline, or concept map were discussed. The first 3 participants were asked the difference in the concept map of teaching now versus what that map may have looked like when they first started to teach. Supports or hindrances to first-year learning were identified and discussed.

It was difficult to engage the participants in the activities of drawing a timeline and creating a concept map of teaching. After the third participant interview, the decision was made to discuss a timeline of activities during the first teaching experience and to discuss concepts of teaching rather than actually have the participant become involved in an activity. The participants were not familiar with concept mapping, and it was too time consuming to teach that concept during an hour interview. Participants were more

interested in telling their story through dialog rather than engaging in the timeline or concept mapping.

All interviews were recorded digitally and backed up with an audio tape. The digital files were downloaded to the digital editor on the computer and transcribed. Field notes were entered directly into the computer and stored in designated electronic files. The computer is password protected for assurance of confidentiality, and once transcribed, electronic files were maintained.

Categories of information needed to inform the research questions were identified in the Cuddapah (2005) study of first-year elementary teachers' learning. Although a different population of teachers, a replication of the study was the intention to the degree it could be replicated. Circumstances are very different for the nursing instructor population, and modifications were necessary to the tools and timing of data collection. The categories and rationales for data collection are found in Table 4. The first column identifies the type of information sought in the interview, the second column displays the reasoning behind the choice of information sought, and the final column identifies the exact source of the information needed to answer the research questions.

Nursing Program Administrators

Each NPA agreed to an interview lasting one hour. Open-ended predetermined questions were asked each administrator and follow-up questions were added at the time to fully explore NPAs' point of view (Appendix G). All NPA interviews took place in their respective offices and lasted about an hour. The interview was digitally recorded and downloaded to a digital editor, transcribed, and checked for accuracy.

Table 4
Data-Collection Categories and Their Rationales

Category of Information	Rationale	Data Source
1. Demographic	Demographic information defines the participants more fully	Questions, questionnaire (Appendix C)
2. Contextual	Prior experiences, past and current teaching contexts provide for getting to know participants better, ability to explain context of the case, establishing where frames of reference come from	Questions, follow-up questions to concept of teaching
3. Instructors' indications of their own first-year learning experiences	Gaining an understanding of what the first year teaching/learning experience was could only come from each instructor. This understanding will then be applied to the transformative learning theory.	Interview, critical incidents (high point or low point)
4. Instructors' perceptions of supports that fostered or hindered their learning	This category presents what helped or hindered new instructor learning	Probes to interview timeline, follow up questions to critical incidents
5. Evidence of Transformative Learning	Lens through which the experiences are viewed, data are collected, and data are analyzed.	Questions, overview timeline, follow up questions to critical incidents
a. Prior assumptions, habits of mind, frames of reference	Prior perspectives need to be known to understand if transformative changes are made.	Concepts of teaching and learning, questions, critical incidents
b. Trigger events, disorienting dilemma	Trigger events precipitate transformative learning and must be identified	Overview timeline, critical incidents, questions
c. Evidence of critical reflection	Critical reflection on deeply imbedded assumptions to determine if frames of reference are adequate is part of the transformative learning process. Knowing that critical reflection has taken place helps determine if transformative learning happened.	Follow-up questions to critical incidents
d. Indication of discourse	Discourse about new perspective is important in transformative learning where the individual checks with others to discern in their frames of reference were problematic or not.	Critical incidents, follow-up questions
e. Progression through steps of transformative learning	The 10 steps of Mezirow's theory	Critical incidents
f. Qualitative differences between prior assumptions or habits of mind, frames of reference and current ones		Questions, follow up to overview timeline, critical incidents.

Restatement of the Research Questions and Additional Research Question

1. How do novice emergency-hire clinical nursing instructors learn to teach in clinical settings in the first year?
2. What factors influence new clinical instructor learning in the first year?

3. How do novice emergency-hire clinical nursing instructors interpret their experience of the new instructor role and in what ways might these experiences be linked to transformative learning theory?
4. What is the perception of the scope and impact of emergency-hiring of clinical instructors by nursing program administrators?

Data Analysis

All interviews were transcribed and read multiple times. Data were analyzed by developing a coding system described by Krathwohl (1998). The open coding process included use of the ATLAS.ti® software program. The software program assists in coding, where once the raw transcript is converted to a rich text word document; the document is imported to the Hermeneutic Unit Editor (HU), the main workspace for the analysis. Each individual participant transcript is imported and managed within the HU as a primary document. The primary document is displayed with numbering per line on the left side of the screen and a sizeable margin on the right side of the screen where codes are displayed. Pull-down screens above the document display primary documents, quotes, codes, and memos. Content was analyzed by compiling a list of the most frequently used words that could be scanned for suggestions of coding categories. Each sentence or paragraph was coded line by line with a descriptive word or phrase, and some passages had more than one code describing the data. Transcript data, concepts linked to the research questions, literature connected to teaching and learning, or the theoretical frameworks of novice to expert and transformative learning generated the codes. All codes were defined and definitions were modified as more data were analyzed. Codes could easily be retrieved from all 10 NCNI documents, listed, and compared for like

meaning. The codes were then grouped together in “families” of similar meaning within the ATLAS.ti® software. These families produced the themes that emerged from the data.

For the NCNIs, once the transcripts were coded and analyzed, data were cut and pasted to organize the high point, low point, and critical incidents along with developmental interview responses and were compiled into charts for analysis. Reflection practices were identified for each participant. A chart with the steps of transformative learning was produced to organize data for each participant. Quotes were aligned with the theory if present. Ways of learning the role of clinical instructor were identified, and learning was identified as either transformative or informative. Factors influencing learning that helped or hindered learning the role of clinical instructor were identified. I created analysis documents that captured all of the above for each participant. Appendix H is an example of one individual-participant-analysis document as described.

For the NPAs, once the transcripts were coded, codes were organized into themes where meaning was identified in the same manner as the NCNI data, utilizing ATLAS.ti® software.

Figure 3 is a summary of the qualitative methods utilized for data analysis and for answering the research questions.

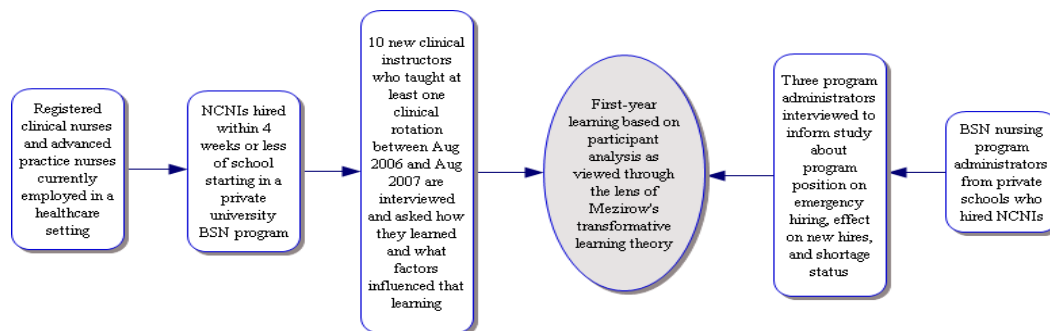


Figure 3. Summary of the study's procedures and outcomes.

Trustworthiness and Dependability

Trustworthiness and dependability are vital to the acceptance of qualitative research as a worthy producer of knowledge. When validity is explained as a positivist concept, scientific knowledge may be reduced to a logical system that was grounded in indisputable data. Validity is relative and can never be proven or taken for granted (Maxwell, 2005). Validity concerns truth where instruments actually test what they are purported to test (Scheurich, 1997). Because instruments that measure specific phenomenon were not be utilized in this study, validity as a truth gauge was not sought. Instead, validity concerns centered on the trustworthiness of the research effort. Participants were asked to clarify, change, or confirm their ideas, and a final member check was conducted to affirm the trustworthy re-representations of their experiences.

Table 5 is a summary of the member check responses.

Table 5

Accuracy of Participant Portrayal—Member Check Summary

Study Participant	Response Date	Changes to Document
Alex	No Response	
Beth	Dec. 21, 2007	No change, satisfied with document
Carmen	Jan. 7, 2007	No change, satisfied with document
David	Dec. 21, 2007	Small change, clarification related to contact with mentor: unavailable mentor
Elise	Dec. 21, 2007	No change, satisfied with document
Frances	Dec. 24, 2007	Some editorial changes and additive information for clarification.
Glena	Jan. 4, 2008	Some editorial changes and additive information for clarification.
Harriet	Dec. 30, 2007	Clarified mentor status: had one but was not in contact with her.
Ian	Dec. 21, 2007	Small change regarding mentor availability: not available
Janet	Dec. 23, 2007	Changes to assure school could not be identified

Analysis documents were sent to all 10 NCNIs, and I received nine responses back.

Threats to validity may include researcher bias where subjectivity in the selection of data that fit the researcher's existing theory about learning to teach in the first-year may "stand out" (Miles & Huberman, 1994, p. 263).

Explanations of researcher biases were communicated as honestly as possible. Although quantitative methods control for the effect of the researcher, it is impossible to control for researcher influence in qualitative research (Maxwell, 2005). Addressing reactivity as a possible bias in this study, I tried to understand it and use it productively. Understanding how I influenced what the participant said and how this influence may have affected the validity of the inferences I drew from the interview were considered.

Dependability rather than reliability, as used in the quantitative research methods, was sought. The data-analysis process, as described above within the ATLAS.ti® software system, provides an ability to retrieve and trace specific supporting development, wording, or illustration of a particular code or theme. Analysis categories and coding were reviewed by three full-time faculty, qualitative researchers, in two different programs of nursing. Each reviewer was provided with a packet containing codes with definitions of the codes, sections of raw data coded, and sections of data not coded. Each individual was asked to read each document and then code the final document not coded either using the available codes or their own coding. Comparison of coding of the data found a high degree of consistency between the reviewers and me. Where differences existed, discussion was followed by consensus.

Summary

This chapter focused on the organization, inspiration, and methodology that informs the process of inquiry for this work. This study contains findings from 10 NCNIs' and 3 NPAs' interviews that described how NCNIs learned to teach and learned the role of clinical instructor in the first year and what influenced that learning. Nursing-program administrators' perception of the scope and impact of emergency hiring of clinical instructors informed the study and gave perspective to the NCNI findings. The results were verified by the participants through member checks. The next chapter presents the study findings and the themes that emerged from the data.

CHAPTER IV

FINDINGS

The purpose of this study was to investigate first-year learning by novice clinical nursing instructors (NCNIs) hired into a program of nursing where clinical faculty positions were not filled within several weeks before the start of the semester or quarter. The study investigated what supports helped or hindered learning the faculty role by the novice emergency-hire clinical nursing instructors. Using Mezirow's (1991) transformative learning theory as a framework for investigation (see p. 10) allowed in-depth attention to the process of instructor learning in the first year of teaching. The perspective of the program administrator was added following analysis of the NCNI data to allow for a more informed view of the phenomena of emergency-hiring of clinical instructors currently in schools of nursing and to inform the discussion chapter.

I interviewed 10 NCNIs and a program administrator from each of the three programs utilized for recruiting NCNI study participants. The results are organized by addressing each research question and providing a summary. A final summary of the results concludes the chapter.

I present the results of this study in this chapter. I have organized the presentation by main findings about how emergency-hire, NCNIs learned to teach and learned the role of clinical instructor in the first year and what factors affected that learning. Findings are supported by interview data from the study. Throughout Chapter IV, all transcripts are identified in the text by assigned pseudonyms. Through the interviews, a view emerged of NCNI perspectives on learning in the first year of teaching and factors that influenced

that learning. Nursing-program administrators' perspectives of program need and program support to new faculty also surfaced.

How Novice Emergency-Hire Clinical Nursing Instructors Learn to Teach in Clinical Settings in the First Year

Research findings are presented as they relate to the major themes identified from the data by the researcher. Five main themes for how NCNI learned to teach emerged from the analysis of the data: (a) relying on self, (b) nursing program support, (c) formal clinical teacher education, (d) workplace support, and (e) hospital clinical site. Excerpts from the interview transcripts are provided that support findings of each theme. A conceptual framework that summarized the NCNI perspective of factors that promoted their learning during the first year is found at the end of this section and labeled Figure 8. Each theme presentation ends with a figure outlining the thematic categories.

The sections that follow include explanations of the themes that emerged from the analysis of data. Each theme is further divided into subsections that demonstrate the web of meaning within the themes.

Relying on Self

In this study, relying on self emerged as a theme related to how NCNIs learned in the first year. They demonstrated constant self-motivation and self-reliance as novice clinical instructors attempting to negotiate the new position of clinical instructor (CI). Help was elusive and so depending on themselves was how they progressed through the semester. Figure 4 graphically presents these categories.

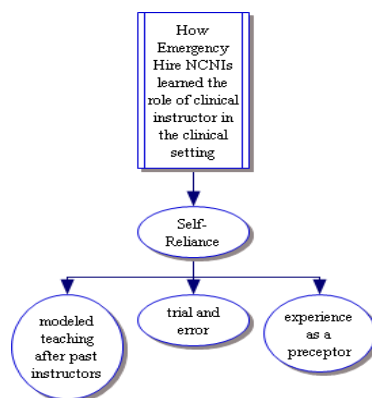


Figure 4. Self-reliance as means for learning clinical instructor role.

Modeled teaching after former nursing instructors. Eight NCNIs indicated they modeled their teaching after former nursing instructors they encountered as nursing students themselves. Memories of former instructors' methods of teaching resonated well with the participants, and they were quick to point out the attributes that they emulated and those teaching practices they distinctly and purposely avoided in their own teaching. One NCNI explained,

I think in terms of me being an instructor, I took from my own experience with instructors what I hated and what I liked. I had some instructors that [sic] were very mean sometimes, they would hound you and harass you, and I totally did not think that was a good teaching style. Then, I had other ones that [sic] were handling you way too much, they didn't give you any independence at all and I didn't like that. I had some other ones that [sic] kind of really challenged you, and I liked that but at the same time they didn't make you cry. So, that is how I learned my own teaching style.....previous example from when I was a student (Douglas).

Similarly, Carmen stated,

I think that I have taught them something, that I have made some positive changes. I look back to when I was a student and the faculty was scrutinizing, all negative. I didn't want to be like that. I didn't want to cause despair.

Additionally, a participant echoed her recollection of nursing faculty when she was a student.

I think I remember the teachers that [sic] I enjoyed. I remember what their [teaching] techniques were. They were not, you know, authoritarian, or laissez-faire either. Laissez-faire teachers don't get you there! [prepared to pass the nursing boards]. (Glena)

Remembering how clinical instructors taught while a student was not difficult because nine of the participants had graduated from their undergraduate programs within the past 2 to 10 years or either graduated from or are enrolled in a master's program. Exposure to teaching from the student perspective was current among the participants, and their ability to scrutinize different styles of teaching helped them to develop their own teaching style.

Trial and error. Trial and error is a three-word phrase that NCNIs referred to in explaining one of the ways they learned the role of clinical instructor. Referring to trying out different alternatives where experimenting with alternatives and eliminating failures, Wayne, Youngs, and Fleishman (2005), in an article about improving teacher induction, suggested that “unfortunately, new teachers learn mostly through trial and error” p. 76. Bartels (2007) suggested, in her article regarding preparing faculty for baccalaureate and graduate nursing programs, that preparation for teaching typically has been a matter of trial and error and that both good and bad habits are learned by the novice faculty in the first several semesters of teaching. Many teach the way they were taught regardless of the effectiveness of that approach.

Beth said that teaching her first two rotations were circumstances of “trial and error.” As an example, she explained her methods of managing the post conference following each clinical day where she created a game for her students.

I would bring little prizes, like stickers or something. The first group was all girls, and they just loved it. They would get upset if I didn't bring the prize, so upset, if I would forget. And, it wasn't anything bad. They had to do the work, answer the

questions, but it was fun, and it was fun for me too. I had to get myself re-engaged with the material and it was a good way to do it. My second group I couldn't do that with them; it was a completely different dynamic, and I couldn't do it. It nearly drove me crazy, the second group. But, the first group was a lot of trial and error.

Although struggling with many parts of becoming a clinical instructor in the BSN program, Alex was especially prone to trial-and-error learning demonstrated in his remarks about the evaluation process for clinical students,

I had to figure it out by being asked for it. And then, I had to look for it and find things, going through syllabuses, and saying "this must be what they are talking about." And, here are different versions depending on the syllabus. I did it, made up the tool. I'm sure some of it was superfluous but when I was done, you could get a picture. And, to this day, I didn't get any feedback. That's good I guess. I'm sure, because if something was wrong, they would tell me. Not hearing from them, I am presuming it is OK.

All NCNIs referred to learning the role of instructor on their own once in the clinical setting and with the students. NCNIs had no apparent supervision, tutoring, mentoring, or other cuing about how to proceed with the process of clinical teaching. They did what came naturally to them working on what little or robust schema they might have had, and, if what they did was not adequate, they received feedback from the students, from the hospital nursing staff, or from unit manager. Douglas took the opportunity, as new CI, to try things he imagined would be successful and important for his students to know. He stated,

So you're constantly learning from doing. Yes, from the first semester to now I've definitely learned. Because, I don't really have a teaching background and I've had to learn on the fly, so a lot comes into play there. I think it is difficult when you just jump right in.

For five NCNIs, unfamiliarity with the teaching site was a common link. When commencing to teach for the first time, they also entered the clinical teaching setting as a complete stranger. Whereas each participant managed this entry over time, there were

differing degrees of stress associated with the start-up. Each NCNI tried to set up a meeting with the contact person at the new facility with varying success. Critical to bringing students to the facility in the following days or weeks, the new hires were desperate to meet the staff and become familiar with the site prior to bringing a group of students. One participant commented,

Then we were going to meet Andrew, the former clinical instructor. He worked there. That was me and Rita, the other new hire. We went over there, and he gave us about an hour walk-through, that's all. I finally, 2 days before the class started, got a hold of Anna. She is in charge of anyone who comes into the hospital making sure that students, new hires, have their HIPAA [Health Insurance Portability and Accountability Act] stuff together. I finally got in touch with her 2 days before the class started so she could walk us around. She said she could meet us very quickly in the lobby only for about a half hour given the short notice. Granted, I had tried to contact her for almost 3 weeks with email and phone messages, and she did not return my phone messages. It wasn't until the nursing-program coordinator actually called that she would respond. When she showed up, she didn't realize there were two groups even though I told her there would be two groups. We were doing our orientation on the same day. And, so she didn't have enough paperwork. The start was really bad. (Beth)

Similarly, but in a different setting, another NCNI had a difficult beginning. She stated,

I was walking into a brand new hospital, with all new people, literally no orientation, and I hadn't been at the bedside in 12 years. One thing that really disturbed me as the new instructor was that, I had gone on a Monday, school started on Wednesday, and the school program had never been to this hospital before; it was a brand new contract. I had never been to that hospital before, and of course, besides the time I went up to be hired, I hadn't met anybody at the school. So, three of the people from the nursing program came on Monday, it was supposed to be my orientation. Okay, so here I am, the lowly little instructor, and I felt like these people, who are kind of my bosses were coming into the hospital to meet the hospital educator and these three really wanted to talk contract and future needs to meet their student requirements. I felt like, "I thought it was supposed to be my orientation so that, you know, I could start on Wednesday with the students." We did go around and look at the different areas of the hospital. One particular floor was laid out very oddly because there was like an old part of the building and then a new tower or something, and when the educator was taking us around, she showed me one of the units, where my students could be. You know, "this is where your students will be, okay?" So then, we went to another area, and she said, "This is another part of the third floor and your students can be on part of the floor, but they can't have the CV [cardio-vascular]

patients.” I said, “Oh okay.” And so, I get there on Wednesday, and that’s okay because we had to do computer training and all this, so students only did a scavenger hunt on one part of that floor, and that was okay. But, I had assigned them all a patient for the next day. Well, then, I get there the next day, and the charge nurse looks at the patients that the students were going to have, and what nurses were going to have those students, because they were just going to shadow the first day, and she goes, “Oh no, this is not going to work!” It was like they were afraid of different nurse personalities, so they crossed off and crossed off and go, “we don’t even want these nurses to know that they were going to have a student.” I’m like, “okay.” So then, I’m like... “wow!” (Janet)

Another NCNI, although teaching a clinical group for the first time, managed the entry to the clinical setting more aggressively. Regarding her start in the clinical setting Frances remarked,

I actually asked, I am a bit of an assertive person myself, so if I don’t get what I need, I’m the type of person who goes and asks for it. And, not everybody has that personality, and perhaps maybe 20 years ago, I may not have done that, but at this stage in my life, if I need something, I go and get it. I feel that if I had worked at the facility, there may have been more of rapport with the nurses, themselves, who were asked to fulfill some of the clinical teaching role by accepting students to shadow them or work with them. As the clinical instructor, there wasn’t one group of nurses [sic] I was dealing with or working with together to help facilitate this clinical experience for the students. There were a great number of nurses, each one in their own area, and in order for them to be willing to accept students and to be happy to accept students, I felt that I needed to go to the site at least an hour, sometimes an hour and a half or 2 hours ahead of time to set it up.

Once acclimated to the clinical site, teaching responsibilities varied for each NCNI. Most instructors realized that the role of clinical instructor involved being a liaison between the students and the nursing staff rather than direct oversight and teaching on the floor. Although trying to model their teaching after their former instructors, many of the participants found that clinical instruction has changed, and clinical instructors are not located on one unit with their group of students, with each assigned one or two patients. Most instructors had students spread throughout the hospital on different floors, each student assigned to a registered nurse to shadow or work with.

Arrangement of assignments fell on the shoulders of the new clinical instructor who needed to work with nurse managers and staff nurses to secure positions for all students each clinical day. Some clinical sites were warm and welcoming to the new clinical instructor and others were not. Where the NCNI had difficulty with having students on site, tension and stress was apparent in the NCNI throughout the semester. Each NCNI managed this stress alone; rarely did the NCNI turn to the nursing-program administration for help. Because of the “outsider” position (not an employee of the facility), the five NCNIs each expressed frustration with the first clinical rotation as they learned, often by trial and error, how to negotiate with the new facility and staff and manage to keep track of each of their students.

Past preceptor experience. All NCNIs stated that they had been former preceptors for newly hired nurses in their place of work, or, as a staff nurse, they had taken a student nurse for the day much as was being asked by them of staff nurses in their new role as instructor. Each NCNI stated that they volunteered often to take a student or new nurse to precept and enjoyed the teaching one-on-one experience. Very similar to what the other NCNIs reported, Beth stated,

As a preceptor I used to sit down, get report, and I would say to the student “which of these is your sickest patient?” things like that. And, just go through my thought process and think about what the student could get out of it. I have now just tried to transfer it to 8 students instead of one. It is much different, much more complicated.

Teaching new nurses and taking student nurses to precept at work was reported as a beginning teaching experience for the NCNIs. One participant who is a nurse practitioner in a multicultural clinic mentioned,

From my precepting at the clinic, nurse practitioner students, and my patients that [sic] I have to teach and because there are many illiterate patients and non-English

speakers from many different cultures you have to develop all these different teaching techniques that I now apply to my nursing students. (Glena)

Although meeting the needs of the group of students for the first time was challenging, that is, adjusting to the clinical teaching role and recognizing what that role consisted of, presented learning challenges for the NCNIs. Several NCNIs appeared to have very creative and individualized approaches to their teaching. They managed their group of students based on what their interpretation was of what the student needed to know. All NCNIs received a syllabus of the clinical course they were teaching, and, although the majority of the NCNIs read it and followed it, there were a few who did not receive the current iteration or did not find it in their mailbox because they did not know they had a box in the nursing office. Student written assignments were graded without prior training about grading, the process of midterm and final student evaluations was unknown to all NCNIs. No formal discussion about how to evaluate student performance was mentioned by any NCNI. Several NCNIs looked at the evaluation tool and recognized that it was not “user friendly” and, therefore, opted to evaluate students on their own standards, filling out the form later. Some NCNIs mentioned calling the school to get instruction about the evaluation process, and 8 of 10 NCNIs struggled with the process and the forms. Most NCNIs expressed feeling inadequately prepared to grade students. One participant complained,

But, there’s nobody really willing to tell me things, only when they need something. I had no idea what they were really talking about. Like, they wanted this evaluation to be done by the faculty and the students, it is mandatory, you know, for the class. Nobody told me anything about it: not (Leon), not anybody. I was totally clueless when the director of the program called and said “where is it?” “Well, I don’t know, where is it? What is it?” Well, it turns out they have forms for this, they were supposedly in the syllabus, you know. Well, the first syllabus I got was a few years old. (Alex)

Another NCNI stated,

No, I read the evaluation form before I had to do it, and then, I understood because I have a masters so I understood that the school needs to have that theoretical explanation of things, and there is an agenda there that you have to fulfill. But, that evaluation did not make much sense in the clinical setting. If I was going to write a clinical evaluation, I would create it in a different way. But, we have been doing it, and somehow, we get it done. What I told the students is, you know, “you read and answer the questions.” Oh, and that I did not find out the first semester, but then, I learned with time. It is the best way, if I tell them to give me examples of things. It was not a smooth process. (Glena)

In summary, each NCNI learned to teach and learned the instructor role quietly and individually, depending mainly on themselves and no one else. They all took the position seriously and gave it as much of their attention as they could given each one was employed as a nurse or nurse practitioner, and most full time. Models of teaching were their past instructors, they relied on experience as a preceptor to inform their teaching efforts, and they learned by doing, by trial and error. The next section explores NCNIs’ affiliation with the program of nursing.

The Nursing Program Affiliation

This section will present the findings regarding the impact of, and affiliation with, the program of nursing on NCNIs learning the role of clinical instructor and learning to teach. Each NCNI met at least once with the a nursing-program official for an employment interview. The length of interview exposure to the nursing program was brief for most NCNIs and that was their only face-to-face communication with any personnel from the nursing program. Because of the emergency nature of their hiring, NCNIs were immediately deployed to their clinical site and expected to start teaching. Varying degrees of communication back and forth between the NCNIs and a program representative took place. The nursing programs endeavored to provide some form of

orientation to the program, but because of the emergency-hire circumstances for most NCNIs, complete orientation was not possible. Assigned mentors were provided for some NCNIs with varying results. Figure 5 depicts the analysis of research findings.

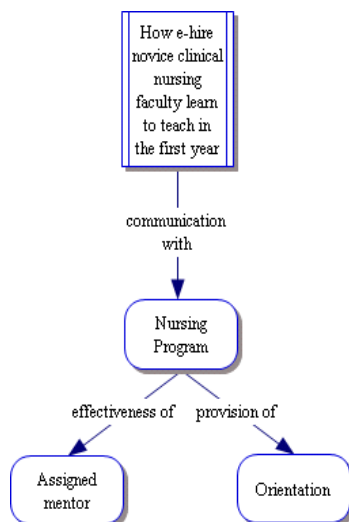


Figure 5. Nursing program contribution to NCNIs' learning the role of clinical instructor.

Orientation. Each NCNI was hired last minute into a BSN program of nursing, all within 4 weeks of classes starting and one NCNI within 2 days of the program starting. Different hiring procedures were apparent depending upon the selected program and the time available prior to the start of classes. When asked if they attended an orientation to the university or to the nursing program, all NCNIs stated they did not attend an orientation to the university, and 7 stated they had no orientation to the nursing program prior to starting to teach. Two NCNIs from the same nursing program stated that although they attended an orientation, it was mainly about hiring procedures. Although 6 NCNIs were invited to an orientation for the nursing program, they were not able to attend due to their work schedule. Two NCNIs met personally with a program representative on the day they were hired, and they considered that meeting as their orientation; no other formal orientation was offered. Time was of the essence, and practically, for some of the

NCNIs, there was no time for orientation, although all NCNIs raised the issue during the interview that they wished they had a formal orientation to the program even if the timing was close to the start of the course. An orientation could have been scheduled in the weeks after the start of the class, some NCNIs suggested. Several of the NCNIs were quite vocal about orientation and the hiring process. One participant stated the following when asked about orientation:

No, none. Like a general orientation? No. I did meet with Dr. Carter [faculty of record for the course] as I said, and I did meet with the director, you know. I had to formally sign some papers. Nothing, nothing at all, no orientation to the program or the school. It would have been good to have it. After I met with Dr. Carter, she asked me if I signed the contract. I said, "What contract?" I didn't know anything about the contract. I didn't know what I was doing. There is supposed to be somebody to help you with it named Laura, but she wasn't there; there was no help. (Carmen)

Four NCNIs maintained they had problems with the hiring process that were not resolved quickly; one started teaching without signing a contract. Others had problems with payroll and the human-resources department and found little or no help from the nursing department staff in resolving those problems. Two NCNIs were so discouraged by the disorganization of the whole process and compared it with their entry to the field of nursing as a new nurse. Each explained that the hospital and the process of hiring were organized well, even if hired last minute. There was an orientation program for every new hire, and the NCNIs stated they were treated as professionals when hired as nurses, but treatment by the nursing program as new instructors was different. Harriet expressed herself,

I called her and told her that I never received a contract in the mail, I don't know how much I'm getting paid, I don't know the course number, you know, it's just little things like this. And again, "Who am I contacting?" "Who's going to tell me about this?" "Where am I going?" you know, just like, "oh my goodness!" And then she said, "Oh, well, I'm sorry, we have to send it out to you," And this is the

contract also for the seminar, which I was already teaching. I was 2 weeks into it already, and I'm like "wow!"...No, I had never signed a contract yet. And, I'm like, "you know, this is really unprofessional." I talked to Penny and she was like, "you never got a contract?", and I said, "no", and she said, "you need to get a contract," she said, "I'm going to call the director; this is absurd." And finally, like the week later, someone emails it to me, as an attachment! We had never discussed what the amount was going to be that I was getting paid originally, which is something that yes, I need to learn. I've learned now that this is how it's done. I got no help.

Harriet's frustration communicating with the nursing department was not unlike several other NCNI who did not have the opportunity to receive an orientation to the department and learn about contracts and other department policies and procedures.

Assigned mentor. Each nursing program was organized differently, and 2 of the programs assigned mentors to the NCNIs. The mentors were not connected necessarily to the clinical course that the NCNI taught. Clinical courses were not connected directly to the theory courses and were scheduled through a central hub in those 2 programs. The 3rd program expected the faculty of record or course manager to be the mentor and supervise all adjunct faculty for the clinical course connected to their theory course. In the view of the participants in this study, neither approach was fully effective. In one program, mentoring was an email address provided to the new hire. The NCNIs from that program stated they both did not receive a reply from the mentor when contacted, so they declined to try again. The 2nd program that assigned mentors had similar contact problems. Phone and email messages rarely were answered by the mentor except one. The one mentor who was responsive was greatly valued. The mentee stated, "The first semester she didn't hear from me that much, once or twice, because I had no real idea what to write for the evaluations." The 2nd semester the mentor was in constant contact with the NCNI due to

student and faculty conflicts. Another mentee expressed himself about the program assigned mentor,

I contacted her once because I was having trouble getting the paperwork for the sheets that the students were supposed to fill out, and she didn't have it. Luckily, there was another faculty at the school, where I had precepted one of her students and we had a good relationship so I contacted her and found my own mentor. She definitely assisted me better and was more of a close contact. I still used the initial person I met with as kind of an email resource. When I didn't understand how to do something, I would email her but I don't think she was necessarily the right person to do it, but she still was it. So, that is basically how I learned to teach: previous example from when I was a student, but no help from a mentor. (Douglas)

Another NCNI from the same program stated,

I don't feel that I had any true support from a mentor. The person that [sic] was assigned as a mentor, I could reach via phone or email. I went with her for her initial orientation of her student group and role model after that initial orientation, which was a few hours long, but I didn't find that particularly helpful. I feel that I needed to fall back on my own prior knowledge and resources to be able to manage that student group. (Frances)

Two NCNIs expressed in their member check that they would have utilized a mentor if a mentor was available to them, but after repeated tries, they were unsuccessful in contacting their assigned mentor. Lack of contact with the nursing program was isolating. NCNIs attempted to manage on their own, and some sought mentors outside the nursing program. In summary, most NCNIs interviewed had minimal support from the program of nursing regarding orientation to the nursing program, the role of clinical instructor, or teaching in the clinical setting. NCNIs did not benefit from an assigned mentor other than one NCNI teaching her second semester. The next section addresses the hospital as a clinical site and the influence of that environment on NCNIs learning the role of clinical instructor and learning how to teach in the clinical setting.

Hospital Clinical Site

The healthcare facility, the hospital in this study, is primarily where clinical teaching takes place. Clinical instructors are responsible for teaching nursing content and skills and to oversee up to 10 students in the clinical setting. For those nurses with a clinical assignment in their place of employment, where they knew the staff and the policy and procedures for the hospital, there was a seamless entry into the teaching environment and relationships with key personnel already were established. Although there appeared to be a little resistance from peers when NCNIs were working as a clinical instructor, most unit staff were friendly, supportive of their teaching role, and cooperative. The NCNIs felt comfortable managing the students in the environment because they were familiar with the routine. Only one NCNI, who was teaching where she worked as a nurse, commented that she received mixed messages from her peers when she was in her teaching role.

And I would say that was my biggest job, was being a liaison between nurses and students. There's a nurse on our post partum unit who wouldn't let the students do anything unless I was available. And you know, once they had done something, once with myself, and once with their nurse, then if both of us are confident about their ability to do it, then they are free to kind of take over, in that regard. And, this nurse is a very, uuhhmm, "your teacher's not there, I am sorry, we cannot do it." You know, "go sit down, it's my job now." Really a little bit hostile, and she is still somebody who sees me and says, "What are you, instructor or real nurse today?" (Elise)

Figure 6 depicts the relationship of the hospital clinical site with NCNIs learning in the first year.

The following subsections identify the importance of relationships within the clinical setting and how the unit manager and the nurse educator impact either positively or negatively learning by the NCNIs.

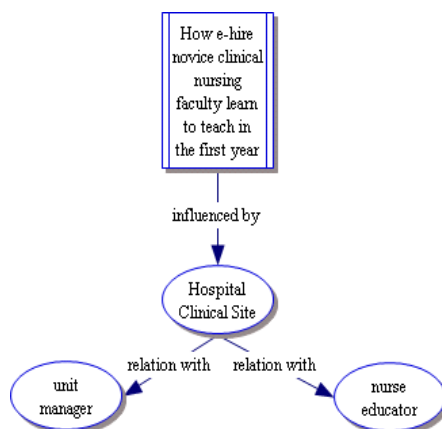


Figure 6. NCNIs' learning related to the clinical site and significant relationships within the hospital.

Unit manager. The structure of the hospital unit consists of the unit manager, the charge nurse, the staff nurses, and the ancillary staff. To gain entry to this structure as outsiders, the CIs must forge relationships with those who will direct the student experience as well as those who will participate in the education of the nursing students. The clinical-education process involves the whole unit because students and instructor are present on the unit at least one shift per week and sometimes more. Numerous schools utilize the same hospital and the same units, typically on different days or evenings. The nursing staff may have students on the unit every day. Some nurses welcome the students and others are reluctant to participate in teaching students. The unit manager sets the tone for the clinical teaching environment by openly supporting the students, the instructor, and the staff nurses while students are on the unit. For NCNIs who work on the units as employees, it is much easier to negotiate the teaching experience with the unit manager and staff. For the five NCNIs who were strangers to the clinical teaching site, the task of entry to the unit for the first time was considerably more challenging. "Learning the ropes" of a new facility while keeping track of 8 students required honed ambassador skills. Frances remarked,

I was on a 3-to-9 shift, so I would arrive there at 1:30 or so to talk to the day shift to see which patients would be appropriate for the students, to sort of chat with the nurses, to discuss how important it was and what a great job they were doing by helping. There was a lot of extraneous work involved here to make sure that the students were well received..... encouraging the nurses to be amenable to the students. I, many times, deferred to some of the opinions that the nurses had about patients and asked for their opinions. I had them sit with the students, and we all listened so that they felt like they were an important part of the student education experience, rather than just being a warm body that [sic] was asked to have a student shadow or work with. So, I think it is very important for the instructor to recognize that the nurses, themselves, have a caseload of patients, and this is an extra task, and yes it's beneficial for both, us and for them, but we truly appreciate their efforts.

Often NCNIs were told that there were too many students on the unit and that they would have to find a different place for some of the students that day. This circumstance may have related to patient census on the floor or the number of staff available, any number of reasons. NCNIs would then find themselves in a position of calling unit managers to try to outplace a student or several students for the day. One NCNI remembered,

They were just saying, "it's so crowded," and "it's either really slow or really busy," and so, "can we please go into the OR [operating room]?", which is something I facilitated. I didn't know the OR unit manager, but I called her and I asked her, and she said it was fine. I got scrubs for the student. And so, the next week, one of my students was actually able to see heart surgery, and the other one followed her patient from the ICU [intensive care unit] to getting a brain tumor resection. It was just really great timing, and it worked out really wonderfully. And then, them saying in their journals that this was a great experience, "I want to be an OR nurse now!" It was just amazing to see. And I'm like, "wow, you know, it paid off, all this work I've done to try to facilitate these things, it paid off." (Harriet)

Forging a positive relationship with the unit manager provided for ease of negotiation with staff nurses. Not all relationships were positive. More than one NCNI had difficulty managing in the foreign environment where conflict ensued and was difficult to resolve. One NCNI explained that his second teaching rotation was in another

new facility, which was not a teaching hospital, and he had difficulty with the staff and unit manager the whole time they were there. Poor communication appeared to be the root of the problem, and the NCNI ended up in a power struggle with the unit manager regarding the student schedule and student abilities within the facility. Ian declared,

I thought, “Why are you doing that to my students?” I said, “You know, fully well, that I can’t run around there and watch them every time they do a procedure or something.” I said, “You’re just punishing me because you want them there.”

After involving numerous of his program contacts, Ian realized that although this was the first major facility conflict for him and an important learning experience, it was not an uncommon situation on that particular unit. Other faculty emailed him to support him and suggested that they had had similar problems with that particular unit in the past. Several of the NCNIs had similar confrontations with hospital-unit managers and worked to resolve the issues while trying not to affect student learning or status on the particular hospital unit.

Hospital nurse educators. The link between the program of nursing and the hospital often is through the hospital employed nurse educator. The nurse-educator position is one that includes planning and producing staff-development programs through in-service education offerings. The nurse educator interfaces with the clinical instructor by planning which units will be used for clinical instruction sites, arranging for the students to be on different units, and generally making sure that the clinical instructor has what he or she requires to meet the clinical needs for instruction. The relationship between the hospital nurse educator and clinical instructor for the NCNIs varied. Some NCNIs believed that they received no assistance from the nurse educator or that the nurse educator was not available to them, whereas others believed that their clinical rotation

was enhanced by their relationship with the nurse educator who set them up with meeting rooms, relationships, and guided them in their teaching throughout the semester.

Demonstrating support or lack of support from the nurse educator are seen in the below comments.

We have an education person at the hospital, and she coordinates everything. She had worked with Leon [former CI for the course] previously, so when I told her I was taking over Leon's class she was good to go. Yeah, up to speed. She told me a lot of things, gave me the keys I needed to have. I worked with her to get classroom space and such. She is the teaching coordinator and not hard to find.
(Alex)

Lack of support was articulated by Frances,

I was given a name of one person who was in charge of nursing education for the clinical staff there, and emailed her repeatedly and persistently in order to have a meeting because school was supposed to start within a few days and I'd never been in the facility myself. But, being an experienced older nurse, I don't give up very quickly, and I called repeatedly, talked to this one woman, Rosemary, her name is, and said, "I really want to come in and I really want to spend some time with you. I really want to be oriented to the floor" and she did finally agree.

NCNIs, although registering some frustration with the nurse educator depending on the facility, generally benefited from their relationship. Those who worked in the facility in which they were teaching, knew the nurse educator prior to becoming a clinical instructor and immediately tapped that resource. Those who did not work in the facility they taught in had a more tenuous relationship with the nurse educator and did not seek support and help as often.

In summary, familiarity with the hospital, the unit, and the staff had a positive impact on NCNIs learning the role of nursing clinical instructor. Those not familiar with the clinical environment had a much greater initial undertaking where learning requirements were accelerated by the necessity of forging relationships with unit managers, nurse educators, and the nursing staff.

Workplace Support

Their employment workplace environment, for most NCNIs, added a dimension they appreciated and utilized. Eight NCNIs commented that they discussed their position as clinical instructor with their peers at work and with their supervisors. Five NCNIs were introduced to the idea of taking a clinical instructor position by peers or supervisors, someone in their workplace. When mentors assigned by the school program failed, several NCNIs sought mentors at their workplace, people who had, or were currently, teaching clinical nursing students in a different program, or had done so in the past. Taking student management issues to their peers at work helped several NCNIs formulate how to proceed. Advice was not hard to find from peers in the workplace and seemed greatly appreciated by the novice instructors. The next two subsections help to describe the relationships with the workplace that helped NCNIs in learning to become clinical instructors. A model of the influence of personal workplace contributions to NCNIs' learning in the first year is provided in Figure 7.

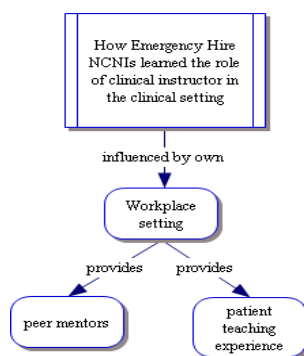


Figure 7. NCNIs' learning in the first year as influenced by their personal work setting.

Peer mentors. A peer mentor is an experienced and trusted adviser that is considered an equal (Oxford Concise Dictionary, 10th ed.). At least 4 NCNIs were supported in the workplace by a peer mentor who advised them about different aspects of

the CI role. The mentors were current or past CIs and passed on their experiences to help the NCNIs manage different aspects of the role.

Janet established a peer mentor relationship at work with someone who had been a clinical instructor and could offer her support and guidance. When asked about her relationships with workplace peers, she stated,

Not from the university, but I didn't ask for it, okay, I didn't sit there and go, "You know, I really feel that I need help here." But, where I work there are other people that [sic] are clinical instructors, and one that [sic] had just started in the last year. She's now done three clinical rotations with students in a MEPN [masters entry program in nursing] program. So, she's used to this accelerated program idea. Her students, though, are at our hospital workplace, so it was a little bit more familiar. She knew more of the personalities, but it was just really good to get key points, and I could talk with her about, about issues that had come up.

Janet's experience was not unlike the other peer mentor relationships. The NCNIs valued having a peer mentor at work to discuss their students and experiences.

Supervisors of NCNIs generally were openly grateful that the NCNIs would consider taking a teaching position because they believed that teaching enhanced the NCNIs' professional growth. Every effort was made by the workplace or supervisor to accommodate the NCNIs' teaching schedule. Permanent days off were required for the teaching schedule, and all NCNIs were granted the day off that they needed to teach. NCNIs generally found support for their "extra job" even though all peers knew that it was very time consuming and the remuneration was poor compared with nursing in practice. Supervisors and peers supported clinical teaching with programs of nursing, knowing that the outcome of this work would help to ease the nursing shortage.

Patient teaching as a background for student teaching. In their professional education process, all nurses learn the basics of teaching, the adult learning theory, and how to teach patients of all ages in a culturally appropriate manner. Patient teaching is a

major part of the nursing profession, and every nurse is involved in patient teaching to varying degrees. Although all NCNIs claimed they were preceptors for new nurses and that this background helped them learn how to teach, most claimed they also applied their knowledge of patient teaching to teaching student nurses who were culturally diverse and came with different learning styles and capabilities. For the older nurses who had been nursing for 20 years or more, student teaching came more naturally. The older NCNIs claimed this ease with clinical teaching was related directly to patient and family teaching and to their being mentors and preceptors for new nurses over the years. Frances specifically stated,

One of the roles of midwifery is teaching, so midwives teach residents, and interns, and nursing students, and midwifery students, nurse practitioners, patients, and families. So, the expectation is that we will teach, and I felt that that prepared me well for this role.

Another NCNI claimed,

The way I teach patients is complex because I have a variety of ethnic backgrounds everything from you know, Latinos, Indians, White Africans, and others. So, the way I teach them is different for each one. It is the same thing with the students because with our students, too, we have people with different backgrounds, so it is different how you talk to one and how you talk to another. (Glena)

To summarize, their workplace setting provided many NCNIs with support, mentoring, and advice about how to teach in the clinical setting. The workplace environment also provided opportunities for individual and group teaching experiences with patients, an experience that NCNIs valued. NCNIs believed they could transfer their patient teaching skills to clinical teaching. The following section describes how teacher education affected NCNIs' learning in the first year.

Teacher-Education Coursework

Six of the 10 NCNIs had prior teacher-education coursework. Those who had the education felt that they may have benefited from taking courses in how students or patients learned and how knowing selected teaching methods may improve student or patient learning. The next subsections provide an overview of what teacher-education background NCNIs had attained. A display of the relationship of teacher education to NCNIs learning to teach is found in Figure 8.

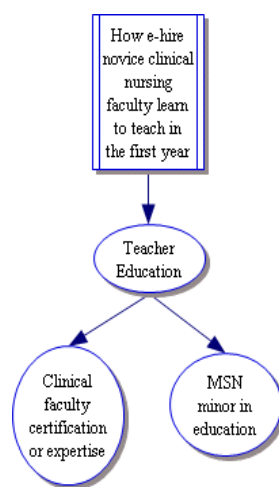


Figure 8. Teacher-education contribution to NCNI learning.

MSN teaching minor and education coursework. Chapter III included a description of the education minor and coursework attained by NCNIs. All NCNIs with prior education coursework stated that the coursework was helpful especially if accompanied by a student-teaching practicum. Taking on the responsibility of teaching a clinical group became more learning about the role of the instructor as a liaison between students and the facility rather than learning how to teach students.

Those NCNIs without education coursework struggled with managing the student group and individual students and stated that, if they were going to continue to teach,

they would seek masters education so they would be more knowledgeable as an instructor. Beth's comments were typical,

It is a little different, it [clinical teaching] is not like being on the floor, or like that, it gets my brain thinking a little differently. I would like to be lecturing I think. I am playing with the idea of taking the Spring semester off and going back to school for a masters. We'll see.

Another NCNI expressed similar aspirations,

Talking now is a reflection on that semester, and, whereas I said I wouldn't do it again, now that I have talked with you and reviewed so much of what I did and what happened makes me realize what a worthwhile experience it was for both me and the students. I would really like to go to graduate school and become a teacher, it adds so much to your practice to have students testing you all the time with their questions. (Elise)

In summary, this section, based on NCNI perspectives, described what contributed to NCNIs learning to teach and learning the role of clinical nursing instructor in the first year and included (a) relying on self, (b) nursing program support, (c) clinical teaching site, (d) workplace, and (e) teacher-education coursework. All NCNIs expressed the above contributions to their learning but the extent of the contribution depended on the individual, the program they taught for, the specific clinical site they taught in, their workplace support, and any prior teacher-education coursework. A concept map summarizing the NCNIs' perspectives is presented in Figure 9. Understanding how NCNIs learned to teach in the clinical setting must be considered prior to exploring what factors influenced their learning in the first year and how the NCNIs interpreted their experience of new instructor, which are both covered in the remainder of this chapter.

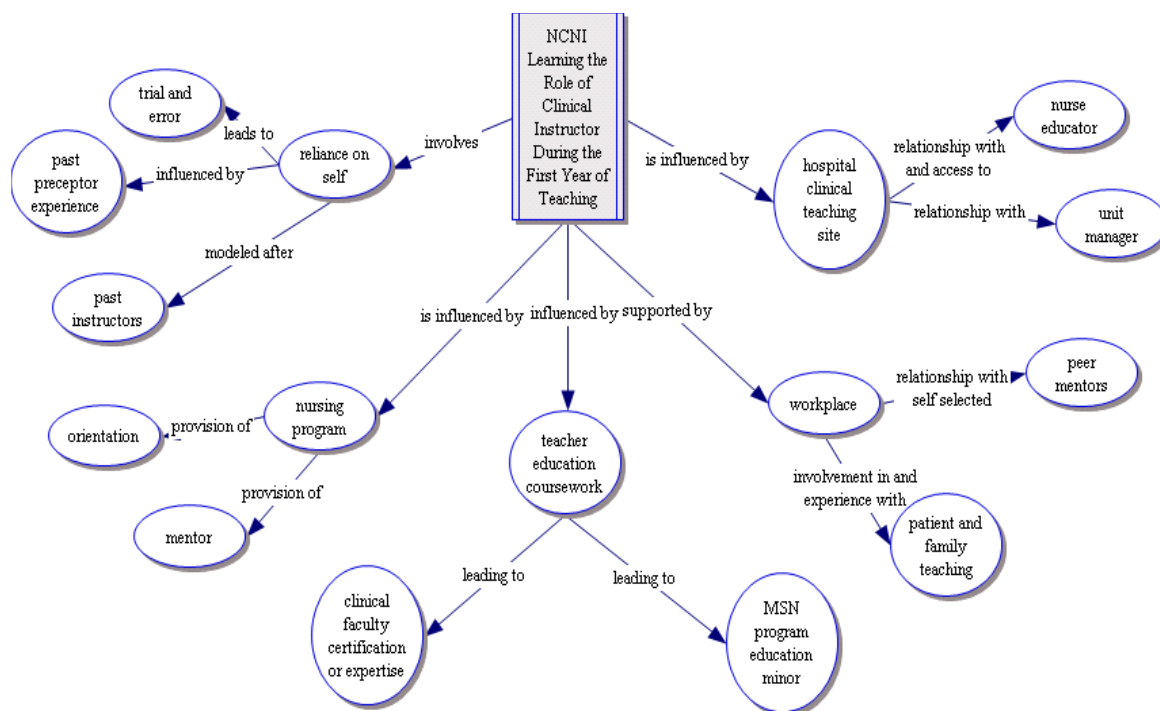


Figure 9. Concept map of emergency-hire NCNIs learning to teach in clinical settings in the first year.

Factors that Influenced New Instructor Learning in the First Year

The multitude of factors that influenced NCNIs learning to teach in the first year and learning the role of nursing instructor are presented in this section. NCNIs relayed many factors that both helped and hindered their learning. Six themes emerged as being important factors related to learning in the first year and were universal. The themes included influence from being a prior preceptor, teacher education or experience, support, the nursing program, the clinical site, and the students. The six themes are discussed, and a Figure 10 is provided to depict the relationships of the variables noted from analysis of the data.

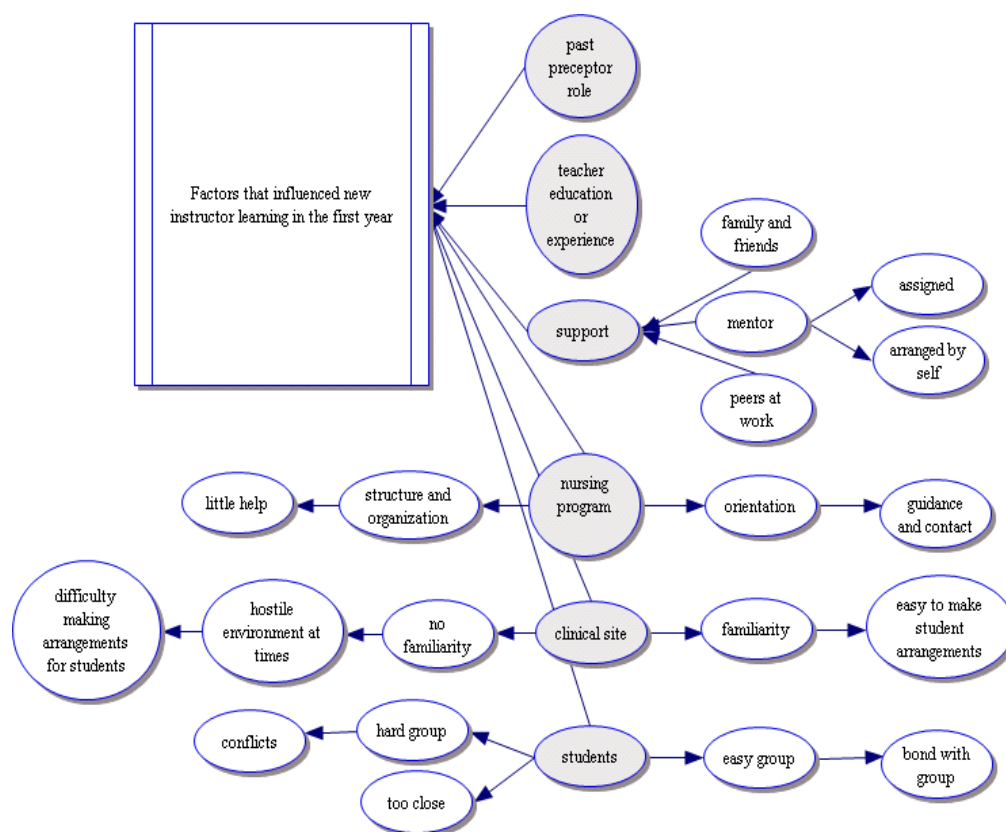


Figure 10. Factors that influenced NCNI learning in the first year.

Past Preceptor Role as an Influence on First-Year Learning

All study participants were preceptors for newly hired nurses in their workplace. Some of the participants also precepted other disciplines like Frances who taught interns, residents, nurse practitioners, and nursing students as well as newly hired midwives. Precepting to the NCNIs consisted of having a new hire shadow them on their unit where they provided an in-depth orientation to the unit and the role of nurse on the unit. Precepting involved helping new nurses become familiar with the policies and procedures utilized on the unit, paperwork necessary for the clinical setting, and interaction with the other departments and units in the hospital. Most NCNIs perceived that precepting new nurses, in some way, prepared them for teaching a clinical group. Some of the participants had years of precepting, whereas the newer nurses had only several

experiences of precepting a new nurse. The perception was that being a former preceptor added to one's ability to teach as mentioned by several of the NCNIs. Beth was confident and boasted,

At work, I have precepted new hires. I was a little intrigued by it and wondered if I could do it with one student could I do it with 8 students possibly? I thought I probably could do it. I've got a lot of experience behind me right now, good bragging rights right now!

Another NCNI stated that he learned to teach by precepting students and new hires and recognized that not all nurses are cut out to be teachers. He stated,

I precept at the hospital a lot and so if it is not dangerous to the patient, you just kind of let people figure things out. Sometimes you have to bite your tongue. And some of the nurses I know don't have any formal or past experience teaching. They say, "I hate working with students, it takes them so long" and I'm like "that's the whole point!" (Douglas)

Although one NCNI recognized that precepting influenced her learning to teach students, patient teaching was influential as well. Glena observed,

And, also from my precepting new FNPs at the clinic and teaching patients that [sic] I have to teach, I learned about teaching in general. Some of the patients are illiterate people, or they are non-English speakers; they are different cultures. You have to develop all these different teaching techniques that I apply to my students.

These examples were common to all NCNIs in the study and echoed the collective notion that precepting in the workplace somehow influenced how they learned to teach a clinical group of nursing students.

Teacher-Education that Influenced First-Year Learning

Five of the NCNIs had formal teaching coursework, 5 did not. Those who had previous coursework stated that they were more aware of some of the learning theories and were able to utilize some of the theoretical knowledge to apply to their clinical teaching. One NCNI had a teaching minor from his masters program and believed that

the clinical teaching practicum he had completed in one of his courses prepared him well for his new role. Another NCNI had just finished an education minor in a nursing program and stated, when asked if the clinical teaching course helped,

Oh yes! Diane taught the class, about the clinical instructor and what to expect. It was a combination of both the theory and teaching practicum. And, I had the experience working in the hospital for 14 years. It is in me to be patient with the students, and then the clinical course, and the curriculum course, all of that helped. (Carmen)

One NCNI currently was taking education-minor coursework and was utilizing the new knowledge every week in trying to teach her clinical group. Several other NCNIs stated that they had education coursework many years ago, but they remembered the education theory and utilized it when teaching their students.

Those NCNIs who lacked any teacher education, either formal or informal relied on their patient teaching background as a nurse, which did or did not serve them well when teaching students. Anxiety about how to teach surfaced among some of those individuals as evidenced in this statement by Elise,

Grading papers for the first time was awful and made me nervous. How specific the information needed to be, or how points were deducted from things I thought I didn't even know existed was crazy. I thought "who am I to grade these papers?" Its like, these students, probably, are more informed than I am about a lot of this stuff. And, how to guide them on how to write the paper properly, in the first place, I felt at a loss, in that way.

Grading student performance through use of evaluation tools also provided challenges to those not familiar with the teacher-evaluation method required for all clinical courses. Beth stated, during her second rotation, with some frustration,

Going into the second semester, my contact at the school gave me some kind of a template for evaluations, something he used to do. It was all filled out, and I said, "Jeff, I don't feel like I know how to do this yet." It came up at one of our faculty meetings. I basically said, "This is not a user friendly tool, I can't even evaluate with this, you need an interpretation tool for it." I go, "Sometimes they are

passing, sometimes not, I almost need a gauge of 1 to 5 to say where they are for the semester.”

Another influence that affected all NCNI learning was support and the various levels and degrees provided. Although 2 NCNIs stated they had no support at all for their teaching position, most NCNIs claimed support was helpful.

Support that Influenced NCNIs' First-year Learning

Support or lack of support was voiced by the NCNIs as something that influenced their learning the role of instructor and their learning to teach. Whereas 2 NCNS were clear that they did not feel supported in learning the role or acclimating to the role of clinical instructor by anyone including the program of nursing, peers, relatives, or friends, all of the other NCNIs had family backing and peer support to varying degrees. The subsections that follow introduce the kinds of support claimed by NCNIs and the value they perceived the support provided them.

Family, friends, and peers at work. Family and friends' support was most appreciated by those who received it. Because most of the NCNIs were adding this new clinical teaching position to their already full-time workload, it meant less time at home. One NCNI, when asked about support from family reported,

Well my partner, he is fine with it depending on how much I teach, 2 days a week or one day a week. If I work 2 days a week for the school, I work 6 days a week total because I work four 10-hour days. That means only one day off and that is too much. My friends think it is awesome that I teach. They're like "that's really cool." The people that [sic] I work with think it is awesome. The management is flexible and will say you can have every Monday off if you want to teach as long as you are flexible with the rest of the days. So I think it is supportive, it's just my own personal life that gives me a restriction on how much I teach. (Douglas)

One NCNI who worked as a clinical instructor on the same unit she worked as a nurse the rest of the week commented,

Most nurses on my unit were really helpful. I already had a relationship with a lot of these nurses; they were very open to talking with me about the students and their experience with the students. They were very open and would discuss things about the students that happened when I wasn't there as an instructor, so actually, it made it feel like I got a lot of information, like, really got good feedback. It was good. (Elise)

Support was demonstrated often in the workplace where supervisors allowed for a permanent day off accommodating teaching schedules or peers would want to engage in discussion about the new teaching role and provide support and advice. Two NCNIs had no support that they could think of and although both took groups to their place of work, they were not assigned to the unit they worked on specifically and, therefore, did not have close relationships with those on the staff.

Mentor. Mentor is defined as “an experienced and trusted adviser or an experienced person in an institution who trains and counsels new employees or students” (Concise Oxford Dictionary, 10th ed.). Six NCNIs in two programs were assigned mentors but had little or no contact with the person assigned. The four remaining NCNIs supposedly were mentored by the course manager. In one case, the NCNI found the assigned mentor to be an experienced and trusted advisor, someone whom she could and did call about either student issues or program-requirement inquiries. All other assigned mentor relationships were less satisfying or not satisfying at all. In the case where the relationship was less satisfying, the NCNI would either find his or her own peer mentor or do without. When asked about mentors in the interview, NCNIs all stated that they would have preferred to have a good mentor who was engaged and available. They would have used that person for help.

Frustration with mentors mainly occurred due to access or contact failure. The NCNIs would email the assigned mentor to ask a question and would never receive

contact back. This lack of help spurred two NCNIs to establish mentors at work, their peers. They were able to gain a strong mentoring relationship from someone who was either currently teaching a clinical group or had done it before, albeit, not the same school. Lesser, more casual mentoring relationships were described where one NCNI talked to people at the lunch table at work, his peers, and they gave him advice if he asked.

Lack of mentoring, or inadequate mentoring, influenced learning in the first year by forcing NCNIs to struggle through the process without help, making their way by learning on the fly or learning the hard way, as some put it.

And, Paula, I guess she lives in the mountains at a vacation home. It was hard to get in touch with her because her phone's reception didn't work really well. So, I think I remember calling her to touch base with her. I didn't hear back from her, so after awhile, I'm just like, "I'm not going to call her." And I didn't; you know, it's fine. But she did try to reach me once, but it definitely wasn't for like, holding my hand, or helping me through it, not at all. (Harriet)

No mentor relationship was formalized with regularly scheduled meeting times or contact points. Most contacts were sporadic in nature, and the mentor was called by the supposed mentee; no mention was made of the mentor ever calling and checking in on the mentee. Learning was self-driven with little help or influence by a mentor.

In summary, support was manifested for most NCNIs through their families or from peers at work. Assigned mentors were not effective for the most part, so those who could, found peer mentors at work that were very helpful in assisting them to learn the role of CI.

Nursing-program Influence on Instructor Learning

NCNIs were vocal about the nursing-program influence on their learning. Because all NCNIs were hired on an emergency basis, and within the last 4 weeks prior

to school starting, for some, there was no time for much orientation to the new position. NCNIs were all new to clinical teaching and there was no formal or informal attempt by any program to provide quickly instruction about how to teach clinical groups. Because time was short, most NCNIs got no help with learning the role of clinical instructor from the nursing program.

Orientation, guidance and contact, and structure and organization. Orientation to the clinical teaching role was loosely defined by the NCNIs. Seven NCNIs had no orientation to the nursing program or to clinical teaching provided by the nursing program. One of the nursing programs has periodic formal orientation programs for new hires, but the NCNIs were hired after the orientation was over or hired too close to the orientation to change their work schedule and attend. In one program where a NCNI was hired 2 days before classes started, on the day the NCNI was hired, he was given a short personal orientation and an orientation binder (see p. 138 for details) to work from with information about the program, forms, contact information, and articles on how to teach groups, among other sections. The NCNI who received this comprehensive binder felt he had a resource that did influence his learning positively during the first rotation teaching. Two NCNIs from that program carried the binder with them into the clinical setting and referred to it as necessary when they were unsure what to do or how to do it. Of this process, Ian commented,

When I was hired, they showed me the people who worked at program office; they did a real good job. They were very good, you know, they gave me a badge, they gave me a tour of the school facilities, and kind of, briefly, told me what I was going to do. They issued me a book like this. The faculty did a very good job of putting it together, kind of like, what's expected. They had the course syllabus, and see, the emergency contacts. And, what they've done with me, they, using Blackboard® and email, they update me with information so I can keep my binder fresh. I use the binder every day I'm here, it has everything I need.

Two NCNIs actually attended a nursing program orientation for new employees.

The review of this orientation was less than enthusiastic by Douglas.

It was about 2 weeks before the course started. There were two or three other people in the same boat as me, also new to the university. We had an orientation day; it was more a paperwork day, all administrative stuff. It was about signing forms, getting an ID, sexual harassment, nothing really that pertained to me teaching. I was assigned officially a mentor, but I never saw her.

Once in the clinical setting with the group of students, guidance and contact from the nursing program was almost nonexistent for the NCNIs. One NCNI received a visit to the clinical setting from the course manager early in the rotation, but the 9 other NCNIs had little to no contact coming from the nursing department during the rotation other than asking for paperwork. If they needed information or asked for advice, the NCNIs called the nursing program office and some claimed that they had less than positive results.

Alex was most frustrated by lack of contact and little help when he stated,

Every once in awhile they surprised me, like the evaluation tool thing. Nobody let me in on it, they did nothing for me. I mean I got practically no help from them except a lot of frustration every time I tried to get a question answered. I have to say I got a little attitude from them. Every time I tried to ask a question it was like “why are you bothering me?” kind of attitude. Then they would say, “I don’t have time.” My calls were not returned so I would jump in the car and drive there and look up someone to answer my questions.

One NCNI expressed that the program was disorganized and that she received little help, guidance, and no contact about the simulation clinical activity. She stated,

We went to the simulation lab. Well, there’s one person Maggie who runs the simulation lab, but they need clear roles for who does what at the lab. Does she facilitate a clinical group, or is she there to just back me up for technical problems? Or, should I be leaving the students there? What are the responsibilities? What was happening? No one told me about it. And, to meet with the faculty, that would be good. (Carmen)

The NCNI was unclear what her role was in the scheduled simulation-laboratory experience, and there was no communication from the course manager or the program director about the scheduled day in the simulation laboratory. Additionally, the NCNI had no experience with the simulation-laboratory and was distressed about bringing her group to the lab. Lack of communication, guidance, and contact influenced her learning the role of instructor.

Alternatively, one NCNI did receive the help she needed when she called the nursing office. Glena remarked,

There was support from the program director, which was very important. I always felt I could go to her, like I told you, I never felt intimidated. She was always available, even though she was very busy, she always had the time, and was being very gracious, always.

Each program structure and organization was different, and how the program communicated with or tracked the progress of the NCNI who was hired last-minute differed. Email was utilized by one program and was effective to a point. The NCNIs could email their contact and expect a response back. One NCNI from the program commented,

All that said, I really think that it is a good school from what I can tell. From the emails, the community online is very active, very alive, and like I said, I had some of the pros, would come and speak at this course I took. So, I really know that they put out quality information and can teach, it's just that being that clinical instructor, sort of, out there on your own, you're distant. (Janet)

Ian, the other NCNI from the same program had a similar endorsement of the email system by saying, "I've contacted them with email, they update me all along, and I know different people that [sic] I get emails from, I can kind of, go back here and say, okay, now where are they in this system?" Ian was referring to the organizational chart he could look up in his binder where he identified who he was in contact with by email. The

other two programs had no such email structure, and several NCNIs claimed clinical teaching was a lonely position, and nobody checked in on them during their semester or rotation. The influence of limited program communication on learning the role of clinical instructor and learning how to teach on the job cannot be underestimated.

Familiarity with the Clinical Placement

Clinical placements occur most often in a hospital setting; however, because nurses practice in many non hospital settings such as clinics, public-health departments, home care and hospice, as well as other community settings such as schools, CIs and nursing students are not always situated in hospitals. All NCNIs in this study were assigned hospital settings. NCNIs and their students experienced a variety of hospital units that ranged from psychiatric inpatient nursing to obstetrics, pediatrics, critical care and medical and surgical units. A hospital unit can be described as a hub on a floor of the hospital that services a given number of inpatients and is administered by a unit manager who oversees many nurses, nurses' aides, and other ancillary personnel. There may be several units on a single floor of the hospital. Only 2 of the 10 NCNIs had groups in the same hospital, one in the psychiatric unit and the other in the critical-care unit of a large county hospital. The groups met on different days, and the students were juniors and seniors. All other groups met in different hospitals, and NCNIs from the same nursing program were not acquainted with any other clinical faculty from their school or any other school in their clinical setting, except for Douglas, who occasionally met other CIs from other schools in the cafeteria. The subsections that follow are descriptive of how hospital familiarity influenced NCNIs' learning in the first year.

Familiarity with hospital. Five NCNIs worked as nurses in the hospital they were assigned to take their clinical group. As discussed in the section on liaison between the students and the staff on nursing units, the NCNIs who worked on the unit as a registered nurse had the advantage of being an “insider” because they already were familiar with staff, environment, policies, and procedures. Although novices at teaching, the NCNIs were not strangers to the hospital unit and had working relationships with peers and the unit manager. Not all of the five had the advantage of being assigned to their particular unit, three of the five were located within the hospital where they worked but not on their unit. All of the five NCNIs, who were familiar with the hospital because they were employed there, may have had several students on their unit, but had to place students in other units as well. Most hospitals seemed to require spreading the students out on the different floors. The NCNIs familiar with the workplace layout and who knew many staff members were comfortable making arrangements by calling on people they knew around the hospital. Harriet explained,

I don't work on those floors. I work in ICU. So sometimes we are floated to those units, and the way I introduced myself onto the unit was that I got in touch with one of my old friends, her name is Paula, who does the clinical placements at the hospital. She's an old friend in terms of, I met her a long time ago when I was getting hired, and she remembered me. I was told by the program director, I believe, that she was the one who was helping do the clinical placements. I asked her, I was like, “how do I get in touch with the managers?” So, I emailed her, and she sent me the contact information of the managers, and actually, on my day I was working, I went to the offices of the managers and introduced myself, but they weren't in there, so I just ended up emailing them and introducing myself that way and trying to set up students. And then, in terms of getting them to have observations of units, to go to like, ICU or somewhere, I arranged that too. So, it really worked for my benefit that I worked in ICU and that I used to work in the recovery room as a nurse assistant while I was in school. It just happened that everything kind of worked out because of my background in the hospital.

Elise talked about negotiating the student experiences in her unit by confiding,

We got a new head nurse, two new department managers, by the second part of our rotation, and one of them, the labor-and-delivery manager, was a little bit hands off, but supportive, and ICU manager, actually, he was very forthright with me... “no students!” The nursery has been challenging in the past, and the manager said she really wanted feedback from me because “this is, we’ve agreed as a unit, we are teaching hospital, or teaching unit, and we really want to provide a good experience for the students. So, let me know how we can make it better.” That is fantastic.

In summary, learning to set up student-learning experiences was relatively easy for all NCNIs who were familiar with the hospital because it was their worksite. They concentrated their efforts on learning the role of CI without the added responsibility of having to establish new relationships with the staff at the hospital.

Unfamiliarity with the hospital. Making arrangements for student-learning experiences for the 5 NCNIs who were not familiar with the hospital setting took more effort and work than if they were familiar with the setting. First, the NCNIs had to establish a working relationship with all of the unit managers with whom they would be placing students. Establishing a relationship was not easy for some of the NCNIs because the unit managers in some cases were like moving targets. If they had days off when the NCNI was in the hospital, then a delay would occur. Gaining entry was fraught with challenges for the NCNIs, and 4 of them were overwhelmed with the process initially.

Resistance was met when trying to assign students to different nurses on units. Although some of the hospital units asked nurses to volunteer to take a student, some units assigned working nurses a student, and there was no negotiation. Where working nurses were not inclined to take a student, the experience was less than satisfactory for the student according to the NCNIs. The NCNIs spent their day going from one unit to the next trying to make sure all student-nurse dyads were working well. Until the NCNIs gained adequate entry to the units and established working relationships with the nurses

and unit manager, the NCNIs had a very difficult time making arrangements for students. Beth worked hard on establishing relationships with the nurses, and that effort paid off dividends to her over time. She recalled when asked if she would go back to that hospital again next semester,

Yes! I'm looking forward to it because I feel there is so much that I've learned. I'm planning on making the next semester be perfect; I know it won't be; I mean I know there will always be glitches and things that come up. But now I know the hospital, the nurses know me there, they like me, that trust is a big deal. They know they can always find me. Trust is a big thing. But, I think they have learned that I am serious with them and that I take them seriously so if they have an issue with a student, I listen. They brag about the students, they tell me "ah, your student is doing so well, I hope you know that." They would say, "do you want to start an IV [intravenous] and help me out?" I would say "sure." They then said, "I'm just not good at it." Well, I've been doing IVs since I was on the infusion team in NY; I helped them with their work a little. So, I have a nice rapport with them, the nurses in the hospital. I guess I didn't realize how important it was until the nurses were worried about the students and I said "You know how this works, don't be that way" concerning a student. "I have 8 students, you know how this works." I want the nurses to come to me and tell me about things if they are concerned. The students want to impress me, they do their best when I am there and I have to sneak up to find out how things really are. But, the nurses know. I want them to tell me about the students, the good, and the bad. They are great now, we get along. (Beth)

Beth's experience was exceptional, and other NCNIs did not share as gratifying an outcome. One NCNI had her first semester teaching in one hospital and the second semester teaching in a different hospital. The entry to both hospitals was trying and difficult, but for this individual, the first hospital was much easier and more welcoming to faculty and students. The second assignment presented many challenges for the NCNI as she negotiated the path to gaining entry to the hospital, and then to the units where she would be placing students. Glenna expressed herself well,

And, then, the other thing is dealing with the staff and dealing with the unit managers. They look at you like you have authority, and you should have experience, and, if you are teaching somebody, you should know what you are doing, right? So, it was very challenging to be prepared, and it was a lot of

homework for the clinical. I thought the nurses were looking at you and evaluating you; it was hard. They didn't make it easy, at times they seemed even hostile. That was my second clinical.

Glena added,

And, it helped that St. Vincent's Hospital staff is wonderful. It was my first clinical. They were better than my second clinical at Trinity who were not as friendly. They were more receptive to students at St. Vincent's, so I lucked out that I got in a very warm environment, you know, the first time. The night shift helped, they had all these nuns on the night shift, so they really helped me to choose the patients and which one needed a bath, and this. And, the day shift, all the physical therapists, all the therapists and the nurses always treated us well. So, I lucked out on that floor. It makes a big difference.

Glena's experiences were very similar to the other NCNIs who were not familiar with the hospital they were assigned to. It was a steep learning curve at the beginning, and all NCNIs in this position struggled to set the stage for their students to gain a respectful place on the unit and begin to learn the nursing skills for that particular rotation. The next section provides information about how the students influenced NCNIs learning the role of clinical instructor and how to teach during the first year.

Students Influence on NCNI Learning

Each NCNI had 6 to 10 students assigned to their group for the rotation or semester depending on the program. The average number of students was eight per rotation. Each school program was configured differently and the groups met 5 weeks, or 7 weeks per rotation, one, 2 or 3 days per week. Some NCNIs were taking students for their first clinical exposure; others took groups for critical care, typically a senior course. Although the neophyte students' entry into the clinical setting would be with their first clinical group, the juniors and seniors often knew people in the group prior to the start because they made friends with people in other courses. Placement into a clinical group typically is random, and clinical section lists are posted once sections are decided. In

some schools, students can switch with others for a geographically closer hospital to where they live; other programs do not permit switching sections. One program blended masters-entry pre licensure students in the same clinical groups such as traditional BSN students. Getting used to having a group of students as opposed to one precepted student was not difficult for most NCNIs. Douglas observed,

The schools are good to the emergency hires, they will move out one or two students in the group that may be a hassle, so they do make it a little lighter for you. So, it's kind of a nice thing, your group is pretty easy then.

Easy group. An “easy” first group was articulated by 7 of the NCNIs. Easy first group generally was described by having students that arrived on time, prepared for what they were going to do that day, professional in their comportment both on the unit and to each other and the instructor during the pre- or post-conference time. Assignments were on time and done correctly. Student attitude was positive in general or at least neutral. Seven of the NCNIs enjoyed this entry into the clinical teaching role. Examples of NCNI descriptions of their easy groups follow.

At post-conference we do a lot of sharing. I know that the area of the drugs was a problem. They were coming from community health and maybe a year away. Now that they were seniors, stool softeners, they should know it. I listed all of the common drugs for the unit. I set up two groups, and they had to tell me what drug and what was it used for. It was two teams like a game. They learned from it, they really liked it. Again, that they can come to me and tell me that they “haven’t done this in a long time and can you show me or work with me?” So, that was good, I got lucky, it was a good group. (Carmen)

Elise commented about her first group,

Well, I had a few experiences; first of all, my first group was so fabulous; they were go-getters, they were into it, they were excited, they had questions, and they were just, they were just ready to learn. It was easy to teach them, because they, they helped the ball to roll.

Glena had a surprise when she experienced her first group and explained,

They were a great group; my first group was excellent. I had not so excellent groups after that, but I think they spoiled me. They were very dedicated students, and they were a mixed group. They were all very respectful; I think that surprised me. They were older students; people in their second careers. Some students were older than me there, and it was a little challenging at the beginning because of the same thing about, you know, having somebody that [sic] they were older than me, and I had to teach them something. But, then, they were very respectful.

Several of the younger NCNIs recognized that they were beginning to bond and become too close to the group, too friendly. It occurred to them that they were crossing the professional boundaries between teacher and student, and each of them commented about how they had to keep that relationship in check. Elise stated,

I didn't realize, you know, how different the experience would be, with different groups. Oh, yes. So different. And how attached I would be to the personalities of one group versus another, so that was definitely, that was definitely eye-opening..... I felt like, it was part of my responsibility to have to maintain that professionalism, and a boundary. I am a teacher, not part of the group, in a way, and so, I didn't realize that would be a dynamic. I mean, I am walking in as a teacher, you know, but part of teaching is that you really need to relate to your group. And, I didn't realize how in relating, I would feel so attached, and a part of being in this group, and really had to consciously maintain, the boundary of teacher. I did not count on that at all.

Beth had a very similar experience and found herself too close to the students. She remarked,

Yes, pretty much. I found myself, about 3 weeks before the end, getting too close. It wasn't bad, but all of a sudden you kind of catch yourself and say "I'm creating a problem here and I better be careful." Part of it is I want to be accepted as much as they do.

In summary, the 7 NCNIs who stated they had an easy first group were thankful. Having an easy group was perceived as giving them time to learn how to function in their new role without extra complications.

Hard group. Three NCNIs had student challenges with their first groups and did not seem to have as positive an experience as those who claimed they had easy groups.

Two NCNIs were teaching accelerated BSN students who were adults with a BS degree in a different major and were coming into nursing as a second career. The two NCNIs found these students very demanding from the start, and it was difficult for them to assert their teacher authority as a novice. With only one problem student in the group, the NCNIs considered they had a “hard group” because the energy and expertise to manage problem students were very limited. When discussing the first group, Janet claimed,

I said, “okay, for every action there is a reaction, and maybe you didn’t like how I reacted on Friday, but I didn’t like what I was seeing, and this is what we’re having to do to address it.” That shocked me, how sometimes they stretch, you know, you kind of lay the rule there, and they see how they can bend it, and then you have to kind of, bring them back to that, and that’s hard; it’s like, it’s very much like parenting. The first group constantly challenged my word; it was rough getting started with them.

At the time of the interview, 6 NCNIs completed teaching one rotation, and 4 NCNIs completed teaching two rotations or were in the midst of teaching the second or third rotation. In several of the cases, having easy first groups fueled anticipation that the second group would be the same and what joy they had bonding and teaching the first group would be similar with the second group. Having an easy second group was not the case for Glena. About her second group, Glena remarked,

I had a group after that that was rougher, maybe because I got confident with that first one and I thought every group was going to be like that and that was when my expectations went “whoa, roller coaster here!” Everything was different, I had to rethink, to change, “okay, I can do that.” The first one, the students were excellent, the staff was excellent, there were all these little kinks on paperwork and things I did not know I was responsible for, but then, because they knew I was new, they were very lenient with me too. The second group was so different and difficult, I was not prepared for it. And, I was in another new hospital that wasn’t as inviting as the first. The whole thing was challenging, I didn’t want to ever do this again.

Beth commented about her second group of students,

The difference between the first semester and the second semester is that the first semester was all BSN students. In the second semester, 5 out of the 7 [students] were the masters-level entry students. “Oh, my God, it is torture!” These students have a very different maturity level. So, I had two of the students at the BSN level so they are 19 to 20 age range, and they were acting like 19 to 20 year olds. Basically, they are all taking the same classes; it’s just that the BSN students had 2 ½ years working their way into it where the masters students have been working on it for only 5 months. The masters-level students are a little bit older, which I thought would be helpful....the problem was that they wanted to challenge ... I had one girl that [sic] was... probably a personality disorder. Talk about some issues! But, because of their backgrounds and because they had no nursing experience at all, they were different. I had one say “I know I’m here, the kids that [sic] are bitching about tests and assignments and everything, why are they here? This is nursing school, this is a masters program. It makes sense that we’re doing all this.” She had the right attitude. But, they were just waiting to get out of school at this point. I thought, “you guys will not pass the boards!” They were looking at what was going to happen after the boards. I’m sure two of them are not going to pass the boards. The second-semester group was fraught with challenges, both individual stuff and bad group dynamics.

Elise compared her first group with her second group and how she saw them differently,

The second group, as a whole, was much more passive and nervous. I felt like it was a challenge to get anybody to speak up. I couldn’t shut up the first group. We could have talked and talked, and with this group, you know, I would want to discuss an experience that they’d have, and the person who’d had the experience would kind of recede... they were just very quiet. And, so that was, that was my challenge. I felt terrible; I felt like I really liked the first group, and about the second group, “you guys are too challenging, you don’t feel so good.”

By having what was considered a hard group, the NCNIs found themselves treading new water again. They had the experience of one semester or rotation of teaching where they were able to learn the rhythm of the hospital, connect with people, make things happen for the students’ learning experiences, and conduct pre- and post-conferences at the beginning level. NCNIs were confident taking the second group and thought they would only improve and be more comfortable with the teaching position. The addition of problem students or significant issues related to management of students frustrated NCNIs, and, although one NCNI sought and received help from the university

program, other NCNIs managed the situation by trial and error or seeking advice from their peer mentor at work. The challenge of difficult students prompted NCNIs who had them to consider not returning to the teaching position. Learning the role of CI was influenced by student-management issues and behaviors, the stress of having two different levels of students in the same group, and individual student personalities or contrasts.

Figure 10 (p.106) is a concept map depiction and summary of the main factors that influenced new instructor learning in the first year. This section described how NCNIs learning in the first year was influenced by (a) their past preceptor role, (b) teacher education, (c) support, (d) the nursing program, (e) the clinical teaching site, and (f) the students. Although for each NCNI, there were other factors that had an influence on learning including levels of stress, personality differences, attitude, confidence, and age or life experience, among others, they did not resonate with enough of the NCNIs to be considered the main factors that influenced learning in the first year.

Novice Emergency-Hire Clinical Nursing Instructors' Interpretation of Their Experience of the New Instructor Role

This section of Chapter IV contains the NCNIs interpretation of their clinical instructor role. Although each NCNI saw themselves as a novice clinical instructor, their interviews produced information about their role as they viewed themselves within the hospital structure as well as outside the hospital environment. Transformative learning theory as applied to the NCNI interpretation of their role and learning in the first year will be discussed at the end of this chapter. Figure 11 is a conceptual map of the findings based on analysis of the data.

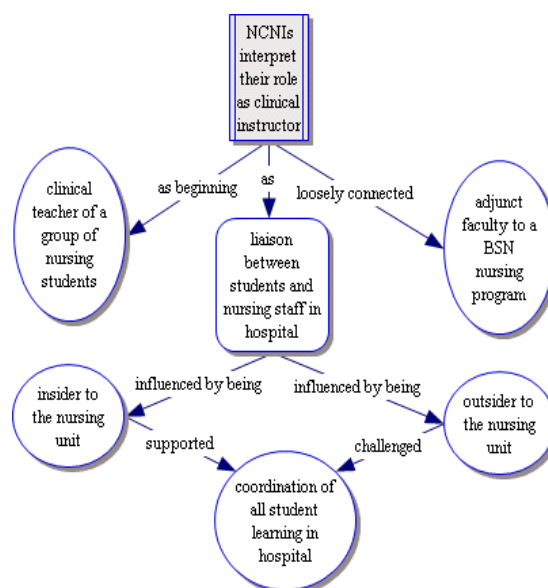


Figure 11. NCNIs' Interpretation of their role as clinical instructor.

Adjunct Faculty of University Program of Nursing

Initial contact with the nursing program, for all NCNIs, was the nursing program office on campus where interviews took place. Whereas each program had different procedures for the hiring process, NCNIs were emergency-hires, and, in several cases, paperwork was not processed appropriately, and payroll issues ensued. For 5 NCNIs, the first interview was the only time they were on the university campus, and the only face-to-face contact they had with program administrators or faculty. One NCNI was interviewed in the Spring for an open Fall position and stated that she did not hear back from the program administrator until 2 weeks before school started when the school contacted her “in a panic.” In the initial interview, she stated that the program administrator told her that he did not have information at that time about the funding for additional clinical positions and he would get back to her within a week. Four months later, she received a call. Frustration of the NCNIs over hiring paperwork was a common theme. Janet expressed what others claimed,

The other thing is..... they didn't get me into the payroll. So, guess what? I didn't get paid. So, here I'm like, "this is only a 5 week course, and they're supposed to get paid every 2 weeks, here I'm almost doing the finals before I even get my first check." Okay, and get this, just so you know, because programs do whatever they do, they said I would be teaching two rotations and that is what I thought I was hired for. I've heard nothing about what is next. I didn't know, maybe they had seven students choose to drop out of the program, so maybe they're not even going to have this site next rotation, or maybe these 7 students will end up at other clinical sites. No one is communicating with me, right? No one!

Other NCNIs explained that they liked being connected to the university, however loosely that connection really was. When she told her mother that she was teaching at the university, Beth said her mother was very happy and excited. When Beth explained that actually, it was not on the campus but in a hospital, her mother was less impressed. Most other NCNIs were connected so loosely with the university and nursing program that it did not even register. They looked at the teaching position as a solitary and sometimes lonely job where each NCNI showed a sincere obligation to teaching the students and that was all.

Clinical Teacher

Because all NCNIs were nurses and former or current preceptors, the transition to teaching a group of about eight was not threatening except for 2 NCNIs specifically. Because the 2 were recent graduates of BSN programs themselves, they were very nervous about taking the position. Elise had been a nurse for about 3 years when the nursing faculty from her former program started to recruit her to teach a clinical group. Elise was reluctant but took the position after about 3 months of discussions to get her to the point of agreement. She recalled,

The reason that I agreed to teach, or the reason that I had the opportunity to teach, was because I worked where my former instructor had students in the facility; she was there. I always took a student, and so she was around, and I guess, I had good feedback from her students, some nurses really loved to have a student, and some

don't... Karen thought that was a good thing and asked me somewhere in the middle of the semester if I had been interested in teaching and pursued me kind of throughout the semester. And, I said, "I don't think so, I am much too new." I tried to introduce certain other people I thought would be great at it and had a lot more experience than I did, but she thought being new, and having that perspective, and also having a really strong handle on the information, made me a good choice.... I felt I knew I could teach one-on-one, but, I didn't know what it would entail to teach a group. And, that didn't really change, at some point, I just, after a lot of conversations with Karen, I thought, "let's do it, and see what happens!"

Each NCNI followed the syllabus schedule and performed their clinical teaching duties as best they could. NCNIs conducted pre- or post-conferences where students and faculty met to discuss current patient-related care issues, make presentations on specific topics, discuss ethical or other related professional issues, or work on case studies. It was a time for preparing or debriefing the students, and the clinical instructor was the facilitator and director of the discussion. Several NCNIs had difficulty with their second group of students because they could not engage them in discussions. Based on the new mix of students, every clinical group is different. Eight NCNIs stated they had a "great first group" of students who got along together, were energetically participating in the clinical work on the units, and were willing participants in the pre- or post-discussion groups. The second group, for some of the NCNIs, challenged them with complex student behavior issues that they had a difficult time managing, or students just "wouldn't talk" in the pre- or post-conferences. Inability to work with the second group as easily as they did the first was very discouraging to NCNIs, and more than one NCNI expressed that it was at that point they considered never teaching a group again.

Challenges for the new instructors were manifested not only in group differences but also grading student nursing care-plans and evaluating student clinical performance using an evaluation tool, were especially difficult. Eight of 10 NCNIs commented on how

they did not have experience or direction in how to evaluate the students at midterm and were no better at it at the end of the semester for the final performance evaluations. No NCNI received instruction or help with evaluations and several asked for help. Help was offered after the fact where the student evaluation was reviewed by a superior, and the problems were discussed at that time if the supervising faculty disagreed with the outcome. One NCNI expressed the frustration that many NCNIs claimed about the process.

Nobody really told me about the evaluations. I knew I had to do it, but I didn't know where it was or how to do it. Final evaluations were not much different from the midterms. I didn't know anything more then about the process. (Beth)

Entering grades at the end of the semester in one of the programs was online and required training and a password to access the site. Several NCNIs from that program stated they had trouble and needed to call for help to accomplish posting of grades and varying levels of help were provided. One NCNI ended up "figuring it out by myself" due to lack of response and was discouraged with the poor response time to her questions.

Liaison between Students and Nursing Staff

NCNIs saw themselves as liaisons between the students and the nursing staff, and at times a liaison between the nursing program and the hospital. The liaison role was not anticipated by most NCNIs, and the idea that the group would be assigned as one to a unit in the hospital did not exist for any of the NCNIs. All NCNIs found themselves as the go-between where several students were scheduled to be in one unit following nurses on that unit, and other students would be on another unit doing the same thing. In some cases, the NCNIs had eight students spread out on four floors of the hospital and arrangements and assignments for each student had to be negotiated by the NCNIs prior to students arriving

for the day. Some NCNIs went to the hospital the day before to make the arrangements; others went several hours earlier than the students on the same day of clinical. In some clinical groups, the students would rotate in and out of the hospital, spending some of their clinical time in the simulation laboratory on campus. Students would have to be “off loaded” from the units when the census was low or for other reasons, and NCNIs would have to make arrangements for alternative experiences in the hospital somewhere that related to their rotation focus. Douglas remarked,

The school was introducing the use of the simulation lab, so sometimes I didn't see my students for a month. Um, and I got disconnected, had to remember who they were. I had to remember what was their skill level, and I kind of had to start over with them. It was a little distracting. Yeah, I had a total of 10 students, four of them would go to sim lab and then two, I would have one with the babies, and one with radiology. Sometimes it would be sim lab, sim lab, nursery, and radiology, so that's 4 weeks! I wouldn't see them for a month..... The offload sites are all managed by the clinical faculty, you had to find places ...you had to figure that out yourself.

Insider to the nursing unit. To make all the arrangements for student learning experiences required planning and knowledge of what was available in addition to access to available sites. As stated before, NCNIs who worked in the facility as a nurse would be considered an “insider” to the unit and facility because they would know, intimately, their own unit and staff associated with the unit and the unit manager. Most likely, they would know of others throughout the hospital who they could contact to make an arrangement for student learning experiences. Alex, who worked in the hospital where he taught, expressed what many of the NCNIs did who were in the same position.

I would then hand-pick their preceptors, people who I knew were good. And, more than that, you could see people who were good at bonding, it is so important to be able to make friends. And some people have authority problems; they like to be the “big boss” and like to intimidate the students. There are plenty of them out there. So I know all the people that [sic] work there, I know how they are, so I can “go with that one, or go with that one.” So, that is how I do it, setting them

[students] up with preceptors, and making sure their situation is therapeutic to them....What I'm looking for is when it doesn't work out. I'm around every situation constantly. I can't be 6 places at once, but I am around enough, several times a day. I can see what is going on; I can question them "what are you doing?"

Being familiar with the environment and staff made the role of liaison considerably less stressful for the 5 NCNIs who were fortunate enough to have a clinical group in their place of work.

Outsider to the nursing unit. As stated before, an "outsider" to the nursing unit meant that the NCNI was not employed as a nurse in the facility where he or she was teaching. Each of the 5 NCNIs who were outsiders started to call the facility to connect with someone who could give them an orientation to the facility and to the unit where they would take students. There was very little time between when they were hired and when school started to have this orientation accomplished, and, in addition, they were all working nurses in a different facility and schedule conflicts were hard to overcome. The connection provided the NCNIs by the school, the person and or phone number, was not always accurate, and time was spent trying to establish a contact where no contact was made. All 5 NCNIs who were outsiders, had a difficult start to the semester, and, for some, it improved very little before it was over. Gaining entry to the facility and the nursing unit meant that a working relationship needed to be established immediately with the unit manager. Without that entry to the unit, the working nurses would not be available to the students. The nurse educator was instrumental in introducing the NCNIs to the unit manager and in some instances helped to establish the new clinical group on the unit. Vacations and other situations precluded two NCNIs from having the nurse-

educator introduction, and those NCNIs made the connections and introductions themselves by being assertive and persistent.

Once on the unit with the group, there was a constant effort required by the NCNI to match the students with appropriate nurses. In all hospitals, the student scheduling required entry to several nursing units and dispersing students over several floors. Negotiations for student experiences required tremendous effort, hard work, and excellent diplomacy. Frances echoed the plight of the outsider NCNIs in her statement.

I think one of the problems with the perinatal clinical nursing experience is that the students need to rotate through so many different areas, which include labor and delivery, antenatal, postpartum, and as I said, the labor and deliveries, the intra partum, and the NICU [neonatal intensive care unit]. There was a lot of extraneous work involved here to make sure that the students were well received and encouraging the nurses to be amenable to the students.

NCNIs were particularly sensitive to the working nurses and the added workload each one had when they agreed to take a student. Frances articulated well the difficulty of having students associated with some of the nursing units.

There was quite a bit of resistance from certain nurses. I think many were just tired of it. They have several nursing schools with students at that one particular site, and there were some students who seemed more committed from certain schools than other schools. It was difficult for the nurses because they were just, were sort of, given students without consulting with them. It was considered part of their nursing role in addition to everything else that they had to do, which made it very difficult for them. In addition, there were also new hires, I think there were 13 newly hired RNs, just out of school themselves. They were orienting, and the experienced nurses needed to train the newer nurses, who were orienting, and really didn't have the time to have a student shadow them, even for the labor-and-delivery experience, because they were occupied with the new hires.

In an attempt to bolster the nurses and to recognize them for their heroic efforts, Frances would take the time to talk with them and to listen to their side. She related,

One of the things I discussed with the nurses is that by having these students, they can first of all, identify students that [sic] they potentially may want to hire in the future, and they get first dibs. If they see a great student, and the student's

experience is positive, that student may potentially want to go and work on that floor, in that unit, so, this is an opportunity for the nurses. The newer hires didn't understand that, but the experienced nurses did understand that.

Three of the 4 other NCNI outsiders, although not as polished at public relations and diplomacy as Frances, eventually did establish good working relationships with the nursing units by the end of the term. One NCNI did not have a good experience and remained an outsider with communication problems and student placement issues throughout the 5-week rotation.

NCNIs did not ask the nursing program for help with entry to the hospital environment, and little or no help was offered by the nursing program. Communication back and forth from the NCNI to the nursing program was limited. Most NCNIs related that no one from the nursing program checked with them to learn how things were going, thus the "loose" connection with the nursing program was perceived. In summary, NCNIs interpreted their role as clinical instructor as a beginning clinical teacher of a group of nursing students, a liaison between students and staff, and the facility and the nursing program, and an adjunct faculty for the university. The role adjustment was more or less complicated by their work status on the unit or facility they had their teaching responsibility. For the 5 NCNIs who had the clinical group in their workplace, arranging and managing student learning experiences was simplified greatly by their familiarity with the facility, staff, policies, and procedures. For the 5 NCNIs who did not work in the clinical placement site, there was much more learning required to become acquainted with the environment, staff, policies, and procedures of the facility in order to arrange and manage student learning experiences in the hospital. The next section of this chapter

will present how NCNIs learning was viewed through the lens of Mezirow's transformative learning theory.

Mezirow's Transformative Learning Theory and NCNIs' Learning

Mezirow's transformative learning theory posits that adults come to their learning experience with a life history and an acquired frame of reference. Because there are no fixed truths and circumstances change all the time, one's frame of reference is unceasingly challenged to negotiate the contested meanings (Mezirow, 2000). The frame of reference consists of varying ideologies, different learning styles, diverse social and cultural norms, personal values, and ways of feeling. All new experiences are filtered through this frame of reference, which has influence on perceptions and interpretations. A meaning scheme is developed from the filtering process and learners use frames of reference and the outcome meaning scheme to form new assumptions about their new experience. New assumptions are carried into the process of learning. To be considered transformational learning, the meaning schemes become transformed or confirmed through critical reflection on the assumptions during the learning process (Neese, 2003). Mezirow's theory was viewed as fairly concrete and linear where, after a triggering event, certain steps are taken in an orderly manner.

Mezirow's (2002) theory suggests that we attempt to construct a more dependable belief about our experience after assessing the context of the experience. We also seek informed agreement on the meaning and justification that eventually results in making decisions on the newly formulated insights (Mezirow). Exceptions to this theory being thought of as a linear process have surfaced in recent research and suggest a more fluid journey to learning. Alternatively, informational or informative learning is described by

Kegan (2000) as seeking to bring valuable new contents into the existing form of our way of knowing. Kegan suggested that informative learning seeks to increase our fund of knowledge or our repertoire of skills or to extend our already established cognitive capacities. Learning is extraordinarily complex incorporating many theories and ways of knowing.

NCNIs' learning was analyzed through the lens of the Mezirow model and an example analysis document may be found in Appendix H. Learning was identified as either informative or transformative based on application of the Mezirow theory. Examples of what the NCNIs learned and the process of that learning were identified. Informative learning was broken into two sections: (a) adding to existing frame of reference or (b) gaining a new frame of reference. Transformative learning was likewise divided into two sections: (a) point of view and (b) habit of mind, both outcomes of the transformative learning experience.

Results of the analysis produced one identified transformative learning experience where a point of view was transformed by proceeding through most of the steps of the theoretical model. All other learning experiences for NCNIs fell into the informational or informative learning category. Based on evidence that the requisite trigger event did not happen, that critical reflection was denied by the NCNIs when asked, that engagement in discourse was not apparent, and that revisions to former habits of mind or points of view were not revised based on the process being followed, learning appeared to be more informative and additive.

The situation that prompted the transformative learning occurred with Beth. Beth had a preconceived notion, meaning scheme, frame of reference about how she would be

able to handle a difficult student. A trigger event occurred when a student activated a challenge outside the frame of reference or meaning scheme and challenged Beth's notion of how she would manage a difficult student. Beth stated,

I had issues this last semester, a very difficult student, and I didn't know what to do. I came really close to really walking out, quitting.... I can't imagine that I would ever have another student like that. If I had another student like that next semester, it would be over. I wouldn't do this anymore, that would be that. This was taking over my life, it was taking over my life. I said "George [program director], I don't know what to do, I've gotten these insulting emails, having her telling me how to criticize, you know, I don't know how to answer her. I don't want to take this too personally, I go, I need to vent to you because this is going on. It was help between him and my mentor that really helped. I wanted a certain degree of respect, because, I thought, I'm in that kind of position. I was really surprised that a student would so unabashedly say those things!.... I think having a student like that never really occurred to me. I thought that I could handle a student that wasn't doing well and would have to repeat a semester or something like that. Things like that happened in my nursing school, not all people pass every time. But, this kind of communication completely took me off guard, completely.

Beth was confronted with inappropriate and insulting emails from a student after she corrected the student for not knowing about her patient's condition of a thoracentsis.

Questioning of the student was tense and authoritative. Following the incident the student was angry with Beth and tried to rally her fellow students against Beth. This created a lengthy power struggle between Beth and her student leaving Beth very frustrated knowing she was inadequately prepared for teaching and managing student problems of this nature.

Critical reflection occurred based on the challenge to the frame of reference and Beth began to think of other ways she would or should handle the student. This was not a student who was failing as Beth had imagined might be a challenge in the past, this was a student who she considered unprepared, unprofessional, and undermining. Beth reflected on the incidents and her reactions to them and designed a new approach to handling the

student issue. She sought others to discuss her alternative new point of view with, her boss and peers at work, as well as her mentor provided by the school. Beth revised her assumptions based on reflection and the discourse with peer mentors and acted on her revision of the former frame of reference. She utilized her new point of view in managing student conflicts with more understanding, reflection, and authority. The steps of the transformative learning theory were accomplished and there appeared to be an unambiguous conclusion. A transformed frame of reference is the outcome of the transformative learning process.

In summary, this section addressed how the Mezirow theory of transformative learning was utilized as a lens to view new instructor learning. Although only one study participant appeared to meet the steps outlined in the transformative learning theory, others showed that one step or two steps were accomplished but expressions of critical reflection, discourse, and changing a point of view were absent, excluding the learning process from the theoretical framework. It may be too early to ascertain now, but at a later point there may be transformative learning experiences by the other NCNI as they begin to emerge from the rank novice status and the experience of the NCNI position. Experiential informative learning was more evident in all NCNIs as they ventured into the unknown role as clinical instructor in a school of nursing.

Institutional support for any learning at the time of induction into clinical teaching role by NCNIs was sought with interviews from program directors. The last section of this chapter will address research question 4: What is the perception of the scope and impact of emergency-hiring of clinical instructors by nursing program administrators? The perspective of the administrators of schools of nursing hiring last minute clinical

instructors was sought to provide a more comprehensive viewpoint of the faculty shortage crisis at the base of this research and to investigate any potential for an alternative viewpoint. A summary of the chapter will follow.

Nursing-Program Administrators' Perception of the Scope and Impact of Emergency-Hiring of Clinical Instructors

This section will provide an overview of the nursing-program administrators' (NPAs) perspectives about the current nursing-clinical-faculty shortage and the consequences to their program. The scope of the clinical instructor (CI) shortage, retention of CIs, orientation of CIs, mentoring and support, and ideas administrators had about possible solutions to address the current clinical nursing faculty shortage will be addressed by Dr. Aragon from Program A, Dr. Bartell from program B, and Dr. Carriger from Program C. Figure 12 represents a summary of administrators' perceptions of the scope and impact of the CI shortage and management of new hires.

Scope of the Current Clinical Instructor Shortage

Every nursing clinical course has multiple clinical sections, each section typically has from 6 to 10 clinical nursing students depending on the structure of the course. Each clinical section requires a clinical instructor. Although each of the schools' administrators claimed that they have a core group of reliable CIs who have been employed for many years in CI positions, there are always clinical sections that do not have instructors until the last minute. With the addition of more students to each program to address the nursing shortage, each school currently has more clinical sections than in the past. Filling the positions for CIs and making sure the new employee is oriented to the position is a constant worry for the administrator as evidenced by these comments.

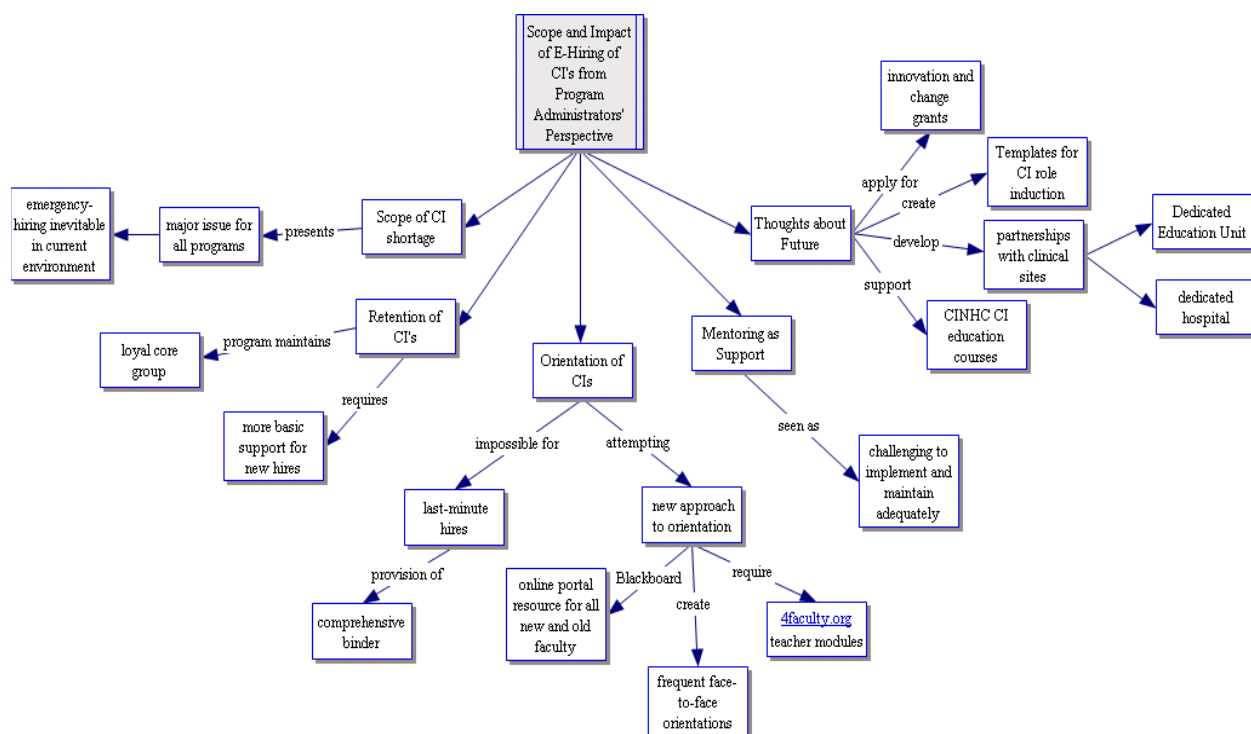


Figure 12. Program administrators' perspective of scope and impact of emergency-hiring of clinical instructors.

It worries me, I wake up at 4 in the morning, and I lay in bed, and I worry about the clinical openings that we have and what would happen if I could not fill position. Would there be a lawsuit against the university when we have guaranteed them [students] progression through our program? (Dr. Aragon)

And,

It keeps you awake at night, it's distressing because you want what is the best for students, and how can it be the best for students when there is someone who is getting oriented themselves especially if this is the first time teaching and a first time at med-surg? (Dr. Carriger)

All programs have increased their pre-licensure programs with student enrollment for Program A about 520 students, Program B at about 600 students, and Program C at about 850 students. Although programs B and C have not cancelled clinical sections due to lack of CIs, Program A has experienced coping with lack of instructors at the start of the semester more than once. Dr. Aragon commented when asked to explain the situation.

Well, I can tell you. Both Ann Marie [undergraduate program chair] and I have been in sobbing tears the last two Januarys. She and I both have been in sobbing

tears of worry. Yes, absolutely to the point of emotional breakdowns between us. Last Spring we had to cancel one of the basic patient-care and geriatric-clinical sections and break the students up. This semester we had to do it with pediatrics. [Tears]

Further discussing the lack of CIs and how the school adjusts to the situation, Dr. Aragon stated,

So as much as I worry and I wake up and I grind my teeth and I do have this sobbing thing, there is always a solution that is put forward to us regardless of how much we advertise or what we do. It is not life or death. It is very unfortunate and it has always created problems. We have had to do that with a very rough start to pediatrics this year. It was very rough when two CIs had 11 people in their clinical [section] and the person I hired for the .25 position really did not fulfill what they were supposed to fulfill. That is the kind of thing I want to avoid. It is going to work out; even if we have to take the resources we have and creatively massage it. I know that at the JC, they only get 4 days of pediatric clinical due to lack of faculty and placements. There is no BRN requirement of how many hours [of clinical], except public health in any of these areas.

Dr. Bartell, from program B, had only been in her administrative position on the Pacific Coast for approximately 18 months at the time of the interview and was surprised by the complexity and scope of the nursing-faculty shortage in the area. When asked about her impression of the problem, she shared,

The scope is big. I've been here for a year and a half now. So, when I first came here last Fall, I didn't know what was going on so that really didn't count. I became acutely aware of the issue for January, and we scrambled. We had trouble for summer, and, we had trouble for Fall and we are having trouble for this Spring ...but it has only been this way for a year so I still am relatively surprised that it is this bad.

Dr. Carriger has been involved in hiring CIs for a long time for her program and stated,

Let me say, first of all we have not cancelled sections, and we have not increased the size of clinical [sections]. So, when you ask what happens a week or so before when we don't have anybody, let me talk about two different points in time. My background here is that at one time, I was the chair of all of our prelicensure programs, and I hired all the part-time faculty. So, when you ask what would happen, you would beg, you would borrow, you would call in any favor you possibly could. You would pay faculty overload, and you would beat the bushes to try to get someone who had taught for you before. And, that might mean

changing the day of the clinical, which we don't like to do and do it very carefully because it could be disruptive to students, their child-care arrangements, work arrangements etc. But, the two things that we have not had to do are cancel sections or increase the size of clinical. One of the reasons that I think it's at least become a little easier for us to do this isthat we hired a specific person to do all of our recruiting.

Discussion of solutions to the CI shortage and the effects of hiring last-minute prompted discussion where two of the NPAs related that they have had CIs quit their new position within weeks of starting to teach, and this unanticipated resignation caused tremendous program stress. Moving students into the simulation laboratory and designing other experiences to substitute for the original planned clinical rotation, although not a frequent occurrence, is as stressful or more stressful than not having CIs to begin the semester with.

Recruitment of CIs is managed similarly in the three programs, and NPAs agreed that word of mouth provides their greatest success for contacting potential new CIs. Current faculty recruit in their clinical placement sites and in their personal workplace site for new CIs. Administrators have utilized Craig's List (<http://www.craigslist.org>) with some success, and flyers are created and sent to hospitals announcing CI positions that need to be filled. Administrators of all schools meet with administrators or nurse educators of the hospital partners to ask for identification of possible CIs currently employed as nurses. Program C recently hired a dedicated full time recruiter to manage securing CIs for every available clinical section. Likewise, program A recently hired a part-time employee to recruit and manage clinical section CIs and placements.

Retention of Clinical Instructors

Once hired, retention of CIs is important for all programs. Program administrators discussed their program supports, and all agreed that when hired within days of school

starting, there is no effective way to provide that new hire with an orientation to the program and support them as well as if hired ahead of time. Programs B and C conducted formal program-orientation sessions and invited and paid new hires to attend. Program A did not have a formal orientation program, rather, a checklist of what should be covered with the new hire. If the new hire is not available for the orientation or was hired after the orientation offering, little was available to make up for the loss once school started.

Program A expected course managers, otherwise known as faculty of record, to be in contact with the new hire and to be the “mentor.” Program B assigned mentors to the new hires, and that person typically was the department chair. Program C assigned a course manager to be available for contact by a new hire. NPAs agreed that support through orientation and mentoring in their program required attention and that ideal support and mentoring was not provided to NCNIs at this time. Program directors appeared to be aware of the different issues that arise related to the struggles of NCNIs in the new clinical teaching role and are attempting to address them in various ways. All NPAs agreed that resources are very limited, and any attempt to address the problems requires creative thinking. Retention of CIs to continue teaching in the program is a high priority and support of new CIs has gained the attention of all schools. The importance of retention is articulated by Dr. Aragon,

New people need to have a relationship with us so they feel supported, and they have all their questions answered because our goal is retaining. I want to retain them, especially if they want to be with us, and even more so, “how can I help you if it’s your desire to stay with us?” Kate has been my adjunct for 11 years. What keeps her at our program? She feels loved, absolutely, not the compensation, but she is very well respected, and we care for them.

Retention of the new emergency-hires was a priority for all programs and finding ways to orient the new hires to the program and support the first-semester teaching

challenged all three programs. Without appropriate orientation and support, chances of the new CI leaving the program persisted.

Orientation to Teaching and to the Program of Nursing

Program C is working on all aspects of their orientation to teaching and orientation to their particular nursing program. Recently they instituted options for orientation as explained by Dr. Carriger,

There is a wonderful online course that we require of all of our new clinical faculty. It's called 4faculty.org. So it's getting oriented, getting started, and the modules are easy to read. It is pedagogically sound. Now, we have not yet said unless you take it, you can't teach for us. We have said that in order for you to be paid for your one day of faculty orientation with me you must attend orientation and you must complete 4faculty.org [modules]. "Give us the certificate and then we will pay you for attending orientation."

Dr. Carriger claimed that efforts are underway to establish face-to-face orientations monthly in all of the satellite sites so that a new CI can attend at any one of the sites even after the start of classes. She explained,

But, at some point, we hope they will get to attend an onsite orientation. We've set dates here at the main campus. I'm in process of setting the calendar for the year with our, people don't like to call them, remote sites. But, we will establish on-site orientations in our other three learning centers so that, if faculty X is hired on April 3rd and the orientation was on February 20, we let them know when the next one is coming up. Because, we hope that they will continue to teach for us, and that they will want to do this again.

In program C, a comprehensive binder is distributed in the face-to-face orientation. The binder comes complete with very specific information regarding the School of Nursing, policy, and procedures, as well as the course syllabus for the new CI. The table of contents for the binder includes the following:

Administration/introduction/general administrative issues, travel and mileage reimbursement; Clinical instructor contact list/School of nursing department

listing/faculty/site contact lists; Student facility contact list; Faculty orientation; Course syllabus; Clinical evaluation forms/clinical evaluation legends/agency evaluation of nursing instructor; Faculty guidelines for student performance documentation; Clinical or classroom injuries/occupational exposures procedure; HIPAA privacy training for limited-time workforce members; and Miscellaneous. Administrative assistants in the nursing department assemble the binders. Dr. Carriger stated that even if the new hire does not attend the face-to-face orientation, they receive the binder upon hiring. The binder materials are updated as necessary and documents are issued to CIs as pdf attachments through email. The information for CIs is kept as current as possible. The advantage of the binder for the CI is that they can carry the hard copy with them to the clinical site so they always have the needed information at their fingertips throughout the clinical day.

Program B administrator, Dr. Bartell, explained that orientation for emergency-hires is not possible if the new hire is employed just before classes start. Their program is planning to institute more face-to-face orientation offerings as was explained when talking about a NCNI who started to teach without an orientation,

The fact she did such a great job has nothing to do with us doing a good job. She just happens to be terrific, and I want to keep her and do whatever I can to groom her. We are rectifying that I hope by having... a day orientation in January for all of our part-time people: new and old part-time people. We are going to do the whole new orientation. We do have a website in which everything is...all the stuff is there...forms, we put on hints on how to do coaching and how to do teaching ...we tell all of our part-time people that it's really a "just in time" kind of ...(Dr. Bartell)

New to School B in Fall 2007, online support for new faculty and returning faculty is situated on the Blackboard® site. The new "Faculty Orientation & Resources Portal" provides all nursing faculty with useful information such as a New Faculty

module, School of Nursing operations, teaching and learning, advising and counseling, faculty development, and video clips. Faculty are encouraged to utilize the format to enter into dialog with fellow instructors using the discussion-board component. The site was constructed by nursing faculty within the program, and although almost complete, the site continues to evolve and improve.

Addressing orientation, program A created a subcommittee to evaluate the current orientation plan and the committee will be making recommendations to the full nursing faculty body for improvement of the current orientation and support structure for new program employees. Dr. Aragon commented about the current status of orienting and mentoring in program A.

The majority of orientation has to come from the faculty of record, and the faculty of record gets this measly 0.5 units [to administer the course], which actually should equate to 20 hours a semester in providing exactly this kind of leadership and mentoring. And, I know some do that and I know some who don't do that. But it is kind of a dual responsibility between our office, the two of us, and the faculty of record. But we do have a checklist of things that we go through and it varies tremendously when a person is coming to us. If they taught before, they know a lot of the ropes, which is okay, "let me navigate around here." If they are brand new to teaching, they will have more questions, and they will require more of our support.

Regarding orientation to the university and nursing program, Dr. Aragon stated,

But, it is really, it's the office and the faculty recruiter and the university that puts these on [orientations]. Are we doing a really good job? We are with some people and we are not with others. We are better if they come and seek us out.

Although orientation to the program is a necessity for any new employee, those hired last minute most likely do not have the option for face-to-face orientation. All three programs are considering alternative plans for this deficit as the condition of emergency hiring becomes more commonplace.

Mentoring as Support

There is no assigned mentor for NCNIs in program A, and although the faculty of record or course manager should take the responsibility to mentor new CIs, it often does not happen. The course manager typically has his or her own clinical group of up to 10 students and the responsibility of overseeing six CIs teaching the same rotation such as pediatrics, maternity and women's health, and geriatrics. It can be overwhelming. Addressing the orientation and mentoring of the NCNI is not part of the workload calculation for the faculty of record, and, therefore, the extent to which it is carried out is voluntary much of the time in program A.

Dr. Bartell, when asked about her thoughts related to program B mentoring, remarked,

I've been in nursing education a really long time, and every year one of my number one priorities is better mentoring of the new faculty whether emergency-hire or tenured people and to arrive at a structure where they can be successful. Every year I feel I haven't met that goal...every year! So, I am optimistic, I keep planning we are going to do better job in this, we are going to do a better orientation, and I have some, I think, very specific ideas. But the truth of the matter is, it's just like those people who get hired into a nursing job, at you know, St. Ann's Hospital, and they get 4 weeks of orientation before they take patient load. That is fine and dandy until you are at the hospital where they need you today to take care of patients and say "I'm sorry, the orientation will be when you are done." [Referring to emergency-hire nurses]

Dr. Bartell sees little difference between the emergency-hire CI and the emergency-hire nurse in a hospital desperate for nurses, where no orientation is provided the emergency-hire nurse until after the employment crisis is resolved and orientation can be scheduled for the new hire.

In program B, NCNIs are assigned a contact person and typically that is the department chair. At times, the department chair will assign someone else to mentor the

NCNI. The relationship with the mentor is usually over the phone and informational in nature. Dr. Bartell stated when asked if the “mentors” keep in touch with the NCNIs, “That’s a big part of it and they talk about issues.” Then I tell all new hires that “if we don’t hear anything from you, then everything’s fine.” The responsibility for contact with the program is left up to the NCNIs as in program A.

Dr. Carriger, from program C, discussed the differences between mentor, preceptor, and coach. She made it clear that the true mentor relationship was a chosen relationship and reciprocal. What commonly is referred to as a mentor in a nursing program is not actually a mentor, rather, simply a contact. The word mentor is used interchangeably with preceptor, and technically they are two different things. About this distinction regarding mentors, Dr. Carriger commented,

That’s an area that we could do really much better on. The literature that I’ve read, distinguishes between mentor, preceptor, and coach. If you’ve not been in the literature, you may not understand that the mentor is a chosen relationship. So they may be thinking of that as a coach.So right now what we have, the person who mentors is the person who is the Course Manager in which this person [NCNI] is working. So, they get tied up that way. No one has as yet said to me, this isn’t working. But, if you look at the difference in the literature, that would be more of a preceptor than a mentor. We haven’t distinguished as much. So, that’s the next phase of our development.

Mentoring the emergency-hire NCNI, although discussed by NPAs as important to the new employee as a supporting measure, admit that the systematic implementation of such a measure is less than successful in their programs. Orientation and mentoring of new hires is recognized as needing attention, and solid attempts to improve both aspects of new hire support are being addressed in all three programs.

Innovation and Thoughts about the Future

All 3 NPAs voiced their thoughts and recommendations related to needed improvements to current CI mentoring, support, and clinical structure issues for their programs.

Recognizing the novice status of the NCNIs, Dr. Bartell specifically addressed creating series of templates to guide the novice through the clinical-teaching experience where teaching and liaison activities would be spelled out in advance and each NCNI would follow the template day by day. She explained,

The strategies that I am working on, very specifically, to help with this, there are like three of them. One of them is that I want to prepare for every clinical faculty what I call the template for deploying the students, just like you teach the students how to do a head-to-toe physical assessment. “Well, you start with this first...well, here is the rule”... we need to provide the new clinical instructor with, “this is what we do, first you do this, you leave the students here, you do this”... a little template and this is how you do it. The second one is that...you need to prepare the instructor to have, for the nurses, the clinical expectations for the day. So, even if I have never taught this clinical before, by week one, the first day of pediatrics, students are expected to do XYZ, and there would be a page for everyday. And, the third one is the template for the postconference that every postconference you should talk about this, this, this. The national guidelines on safety goals whatever they are, you can talk about other things but you must cover these things. And, those are the three strategies that I am having one of my Doctorate of Nursing Practice (DNP) students develop for me.

Providing NCNIs with a guide for operations, when they have no background for the clinical-teaching experience, is imagined by Dr. Bartell as a necessary aid for grooming the NCNI for clinical teaching. Templates for clinical teaching, an online portal of resources, and added face-to-face orientations to the program are strategies that program B is seeking to complete.

Administrators talked about partnerships with clinical facilities and how hospitals could be enlisted to contribute to solving the CI shortage. One plan was discussed where

a hospital unit would be dedicated to only one school, something currently being proposed by the University of Portland as the Dedicated Education Unit. In this model, the nursing program provides nurses on the unit with clinical instructor status and offers teacher education accordingly, provides them with benefits from the university, and, in turn, the nurses take students from that school exclusively. A coordinating faculty from the school makes the arrangement with the unit manager, and the nurses are part of the discussion. Currently this plan does not exist for the three programs represented in this study.

Dr. Bartell spoke of her idea regarding a different and innovative arrangement where the student would stay at a certain hospital during the entire student experience.

Another thing I honestly believe in,I know it can happen, we did a lot of things differently [in former nursing-program administrator position], but one of them was our students chose one clinical facility and stayed there all the clinical time. We called it “depth versus the breadth.” You know what you miss, sure, they never got to see St. Ann’s and sure, they never got to see the VA, but they also got depth. And, we never assigned them to patients, we assigned them to nurses. So, we had the depth focus versus the breadth and the nurses focus versus the patients. We are trying some of those possibilities [in the current program].

As a different method of providing students with a clinical learning experience, Dr. Bartell feels that the constant struggle to find new CIs is diminished when the hospital provides the instructors from within their nursing employee pool. Dr. Bartell further explained her idea,

But by doing that instead of my casting about where in the hell I am going to find more faculty...I could go directly to the Director of Nursing saying, “Okay, you now have 12 students across 5 semesters in your facility. So the Kaiser-program would be occupied by 45 to 50 students and every student every year... “So this is what I am doing for you, what I need from you is a [dedicated nurse] faculty member.” And, what they did was they identified 2 days a week, this group was here for just one faculty member given to us for the team, and we could spend that however we wanted to spend that for 20 hours a week during the 15 weeks of the semester. So, in the Fall semester, they said “Brittany is your nurse, your

[clinical] instructor,” and she was a master credit [prepared] person and we would utilize her wherever we needed her [in the hospital]. ...And it worked perfectly and every hospital used to do that [in former nursing program]. The VA gave us the site person, Memorial gave us somebody from med-surg, the St. Ann’s gave us a cancer nurse, I mean every one of these. One hospice was only 10 hours because they had fewer students, but every facility participated because we went to them and said this is why we have to do this as a partnership. So...

The benefit of this type of an arrangement is that it is concrete and both the hospital and the partner school both benefit. Dr. Bartell explained that having students throughout their full clinical education exclusively, in one place, is a strategy for recruitment for employment. It benefits the hospital to hire one of those students who have “been raised” in the system. Orientation to the new nursing role would be negligible and the hospital would have had years to evaluate the student in every phase of the process. For the school, Dr. Bartell envisions a more solid relationship with the surrounding hospitals and less stress for the hospital and the nursing program as new instructors would not be taking groups of students to different places, the instructors would be nurses in the hospital and educated into the educator role by the university.

Regarding program C and new efforts to address faculty shortage and declining student placements, Dr. Carriger mentioned partnerships that her program is involved in through grants.

The other things that we have working in our favor are grant opportunities, ... and my activity in state-wide organizations. We have a grant from Kaiser to expand our accelerated program. And, as part of that grant, a former faculty here and who is now the coordinator liaison of their academic activities [at Kaiser] works with us to find faculty in Kaiser sites for Kaiser sponsored accelerated students. Now, that has been a huge, huge help to us. Because one, they’re clinically competent, and, two, they’re clinically current. Then our challenge, which is a whole other aspect of my role now, is to orient and to help them shift into [the teaching] role, etc. So, we work with her to get a clinical faculty for Kaiser sites. I’m on the board of directors of the American Nurses Association of California and in my role as board member, I was one of the founding advisory council members of the California Institute for Nursing and Healthcare (CINHC), which is now full

blown. So, I have been actively involved in CINHC and am on the advisory council for a faculty development program that is being offered for CINHC with Betty and Gordon Moore grant money.

Grant funding also provided the ability for program A to create a Geriatric CNS / Nurse Educator track in their graduate nursing program. The purpose of the funding was mainly to ensure that 15 nurse educators would be created yearly to address the immediate nurse educator shortage in the geographic area. Program A currently employs 11 program graduates who teach as clinical instructors and teach in skills course sections and physical assessment course sections. Other graduates of that program are serving as instructors in associate degree programs of nursing in the area.

Working with hospitals to identify nurses for clinical joint appointments between the school and the hospital is another method of addressing the nursing faculty shortage. The two larger programs, B and C, are both working toward changing the way systems are currently managing clinical nursing education. Both school administrators admit that much more collaboration and cooperation needs to take place between the schools and the hospitals for change to happen. Dr. Carriger explained,

What hasn't happened in our area, and so thank you for this opportunity for dialogue, I don't think that we've used, well enough, a collaborative approach even within the private schools. To take a look at what is it that we could be doing together to prepare. I think working through the CINHC program that may be a way. But, in one sense, we're all competing for the same pot and for the same limited pool [of CIs]. I'm not aware of any educational research that's going on. I'm not aware of anyone looking at what is the impact of all this, and, if we did this [collaborate], would we get a different outcome?

Finally, NPAs discussed attracting new CIs and the issue of wages. Nursing salaries are very different from what they used to be. Hospitals advertise their salary and benefit packages to new graduates to attract them and a signing bonus is not uncommon. Comparing nurses' salaries and nursing clinical instructor salaries often cause nurses to

look away from the position of teaching because they are not equitable. Although not similar positions, each position can be very stressful as noted in this research. All three BSN programs in this research study have addressed the part-time-faculty-salary issue, and, although articulating that teaching is not nursing and there are inherent benefits to teaching in terms of adding to one's professional background, if strictly compared financially, teaching does not compare. Dr. Carriger commented on the attempt by program C to bring salaries to within a comparable range to attract and retain more CIs,

I will tell you one of the things that I am very proud about my College, that is, it is working toward having its salaries for faculty to be about 90% of what the equivalent would be in service. Now, we're not there yet, but there is that goal. The other thing we're looking at, are joint appointments. So someone, we have one nurse who just loves being a clinician. And, she's going to be in one of the [joint appointments], I think it's the ICU or CCU [cardiac care unit] at one of our partner hospitals and the other half of her load is going to be here teaching. So, she's going to be blending that. We're looking at joint appointments, and that particular hospital right now has been amiable.

In summary, this section looked at the NPAs' perception of the scope and impact of emergency hiring of CIs and pilot testing of new ideas related to solutions for the CI shortage. Emergency-hiring was perceived as a stressful expectation that currently occurs prior to every start of classes and, although exacerbated by the nursing faculty shortage and the nursing shortage, it has existed as a phenomenon in the past. Lack of faculty, close to commencing of the semester or clinical rotation, causes personal stress for the NPAs responsible for program operations. The problem of faculty shortage was considered "big" in the particular geographical location where the three schools are located. The impact of hiring last-minute NCNIs is complex. Program administrators recognized that adequate, or any, orientation to the program or to teaching is not possible when someone is hired within days of commencement of the class. To address support or

lack of support for the NCNI, NPAs explained what each program attempts to provide the NCNI in terms of orientation and mentoring. Every administrator recognized that their program is lacking and improvements are necessary. NPAs are working to address the shortfall with innovative solutions to address support for NCNIs and all CIs. With creation and implementation of more frequent face-to-face orientations, online modules, online Blackboard® portals, binder support, and future planning for creation of teaching templates, aspects of program support for new employees are being addressed.

More globally, the problem of recruitment and retention of clinical faculty was discussed by all NPAs and changes in how clinical settings and programs of nursing conceptualize clinical partnerships needs to change, according to the NPAs. To that end, grants have provided one school with innovative opportunities to try new models of clinical faculty recruitment, and administrators are considering other models such as the dedicated educational unit. A model where students spend all of their clinical time in one particular hospital where nurses in the hospital are the clinical instructors and students are potentially groomed to work in that setting in the future was discussed. NPAs were not opposed to thinking of new and creative ways of addressing the continuing problem of clinical faculty shortage, which they recognize will continue for the near future. In the next section is a summary of the results presented in Chapter Four.

Chapter Summary

The findings presented in Chapter IV are about NCNIs learning in the first year of teaching as a clinical instructor in a program of nursing. These results were based on 10 novice instructor interviews. Five major themes emerged based on research question one

asking how nursing instructors learned to teach in clinical settings in the first year: (a) relying on self, (b) nursing program support, (c) formal clinical teacher education, (d) workplace support, and (e) hospital clinical site. Factors that influenced NCNIs learning in the first year, research question two, produced six main themes: (a) past preceptor role, (b) teacher education or experience, (c) support, (d) the nursing program, (e) the clinical site, and (f) students. In exploring research question three, analysis of the findings produced three main themes regarding the NCNI interpretation of their role of instructor: (a) clinical instructor of a group of nursing students, (b) liaison between students and staff in the clinical setting, and (c) adjunct faculty to a BSN nursing program.

Mezirow's transformative learning theory was utilized as the lens to analyze learning by NCNIs in the first year. One NCNI appeared to have a transformative learning experience; all other learning appeared to be informative learning based on the transformative learning theoretical model.

Interviews with program administrators revealed concern about the scope and impact of the nursing clinical faculty shortage and emergency hiring of NCNIs. The scope of the problem was considered big and worrisome to NPAs, and the impact of hiring last-minute NCNIs stressed program resources. Inadequate support related to orientation, and mentoring was addressed by all NPAs. Discussion of current and future plans for change included more frequent face-to-face orientation offerings, online programs for orientation, and templates for teaching in the clinical setting for NCNIs. The more global question of clinical instruction of nursing students and the relationship of hospital partners surfaced with NPAs questioning use of currently employed nurses within the hospital being provided by the hospitals as instructors rather than programs of

nursing seeking and hiring independent CIs as currently is practiced. The next and final chapter presents the purpose of the study, overview of the chapter, summary of the findings, limitations, discussion, implications for practice, recommendations for future research, and conclusion.

CHAPTER V

SUMMARY, LIMITATIONS, DISCUSSION, CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS

The purpose of this study was to describe first-year learning of emergency-hire novice clinical nursing instructors (NCNIs), what factors influenced that learning, how NCNIs interpreted their role as clinical instructor, how new learning resonated with Mezirow's transformative learning theory, and how nursing program administrators (NPAs) perceived the scope and impact of the nursing faculty shortage and emergency-hiring to their program and their new employees. I interviewed 10 NCNIs and 3 NPAs to gain perspective of the experience of novice clinical instructors learning to teach and acclimate to the new role as clinical instructor. Major themes emerged in response to the four research questions. This chapter contains a summary of the study findings, limitations, discussion, conclusions, practice implications, and recommendations for future research.

Summary of Study

Interpretation of data from 10 NCNIs provide the findings for this study that include how NCNIs learned to function as clinical instructors after being hired to a program of nursing on an emergency basis, less than 4 weeks prior to the semester starting. Informing the program perspective, 3 NPAs' interviews provided interpretation leading to findings of what administrators saw as the scope and the impact of faculty shortage and emergency hiring had on their programs. In this section, the initial research questions are revisited and addressed by the study findings.

Research question # 1 was "How do novice emergency-hire clinical nursing instructors learn to teach in clinical settings in the first-year?" NCNIs were asked this

question directly, and, based on their response, many questions followed. My intent was to elicit, through predetermined and follow-up questions, all aspects of new-hire learning the role of clinical instructor and learning how to teach. Themes that emerged from this investigation included (a) reliance on self, where NCNIs learned through trial and error, calling on their past preceptor experience, or modeling themselves after past instructors; (b) nursing program provision of, or lack of provision of, orientation or assigned mentoring; (c) teacher education coursework including MSN teaching minor or past education coursework and or certification; (d) workplace support that included peer mentors as well as ability to learn teaching techniques when teaching individual patients or families; and (e) the hospital clinical teaching site where relationships with the unit manager and the nurse educator played a role in learning the role of clinical instructor. In summary, how NCNIs learned in the first year depended to varying degrees on the above themes that emerged from their interviews.

Research question #2 stated “What factors influenced new clinical instructor learning in the first-year?” There were many complex factors that influenced NCNIs learning in the first year. Themes that resonated most with the majority of NCNIs were the influences of (a) their past experience as a preceptor; (b) former, or lack of, teacher education or teaching experience; (c) what kind and how much support they were provided; (d) what the nursing program offered or did not offer; (e) being familiar with the clinical site for teaching or not; and (f) the degree of difficulty managing the students themselves. All NCNIs stated that they drew on their past preceptor experience and attempted to transfer any skill in teaching from that experience to managing a group of students. For those NCNIs who had an education minor or previous coursework, they

drew on that knowledge and applied it to teaching in the clinical setting. For those NCNIs who did not have an education background, they claimed it was harder to learn all aspects of the role of instructor because they lacked the basic tenants of teaching and learning. Support was crucial for ease of learning the role, and most NCNIs claimed lack of adequate support. Tied to support was the nursing program. If adequate orientation to the program and to the clinical site were provided, NCNIs had less difficulty negotiating the web of responsibilities and paperwork required of the role. If the structure and organization of the program lacked adequate orientation and mentor support, NCNIs had a very loose connection to the program and felt they had to learn on their own. Most NCNIs claimed they had little orientation or mentoring from the program. Familiarity with the clinical site for teaching was present for half of the NCNIs, they worked in the facility as nurses. That circumstance provided them with an advantage when taking on the new role of clinical instructor over those who were not familiar with the clinical facility they were to teach in. They had a prior relationship with the staff, unit manager, nurse educator, and knew the policy and procedures for the institution. The 5 NCNIs who did not have familiarity with the institution they were assigned to teach had a much harder learning challenge. The challenge was exemplified by the need to forge new relationships with managers and staff of the new facility, learn the policy and procedures of the institution, and become acquainted with where and how they would set up learning experiences for their new students. Finally, the students impacted new instructor learning the role of instructor or how to teach mainly by group dynamics. Instructors perceived they had an “easy group” if their group showed up on time, behaved professionally, cooperated with them, and handed assignments in completed and on time. When those

things did not happen, or if there was a particular student who was challenging, the instructor perceived he or she had a “hard group,” and it was much more a trial to learn how to teach or manage the group. In summary, there were many factors that influenced NCNIs learning and provided the new instructor with either support for that learning or challenges to that learning.

Research question #3 asked “How do novice emergency-hire clinical nursing instructors interpret their experience of the new instructor role and in what ways might these experiences be linked to transformative learning theory?” NCNIs viewed themselves in three distinct and separate ways as new clinical instructors. First, they interpreted their role as clinical instructor of a group of nursing students. Clinical instructor meant recognizing they were responsible for teaching and guiding the students in the clinical setting and fulfilling teaching responsibilities set out by the syllabus for their course. Second, NCNIs realized a key role they played as clinical instructor was a liaison between the students and staff or between the hospital clinical setting and the nursing program. The extent of this aspect of their new role was unanticipated. For those NCNIs who were employed in the same institution where they were assigned for clinical teaching, they considered themselves as “insiders” in that they knew the nursing staff, managers, nurse educator, policies and procedures of the institution and generally were very familiar with the surroundings. Those NCNIs not employed by the facility where they were teaching, considered themselves “outsiders” and everything was new to them, not just the role of clinical instructor, everything. Finally, NCNIs saw themselves as adjunct faculty for the university, however loosely connected the relationship was.

Mezirow's transformative learning theory was the lens through which learning was viewed in this study. One transformative experience surfaced and was based on how a NCNI initially saw her role as clinical instructor and how she expected that role to proceed when handling student issues. She had a frame of reference about what would constitute a student failing the course or needing counseling. The trigger event that tested her frame of reference and questioned her view of teacher authority moved her eventually through all of the steps of the transformation, and, as she emerged from the experience weeks later, she had a changed frame of reference and was able to implement that new frame of mind in her actions. Her schema was deconstructed and reconstructed to provide an operational base for the role of clinical instructor. All other learning appeared to be informal, informative, and incidental learning where NCNI had no prior set frame of reference and required new learning to meet the requirements of the new job.

Research question #4 inquired "What is the perception of the scope and impact of emergency-hiring of clinical instructors by nursing program administrators?" Each program administrator offered their thoughts about the scope of the nursing faculty shortage and about the impact lack of clinical instructors had on their expanding programs. There was consensus among the 3 NPAs that the problem of lack of clinical faculty was troublesome and affected program operations every semester. Emergency-hiring was seen as inevitable in the current environment. Retention of new CIs was expressed as a priority by NPAs even though each school had a solid core group of loyal CIs who taught the majority of clinical sections. New hires do not receive sufficient support especially if hired last minute, and programs risk NCNIs leaving after a difficult semester. NPAs agreed that if hired days prior to the start of the semester, an orientation

most likely is not possible. New approaches to address lack of orientation currently are being implemented by utilizing online resources, requiring online clinical instructor courses, and adding more face-to-face orientations. A comprehensive binder provides one program NCNIs with information at their fingertips to utilize in the clinical setting. All programs are aware of the need to improve their orientation efforts. Mentoring as support to NCNIs was not formalized in the three programs participating in this research. Assigning mentors generally was not successful, only one NCNI found the mentor relationship very helpful in her second semester of teaching. All other NCNIs were not engaged in a true mentoring relationship with an assigned mentor.

NPAs were very forward thinking and were working on improving their program support of new CIs. Grants had been obtained by two programs, one created a masters of science in nursing (MSN) Geriatric Clinical Nurse Specialist (CNS) and Nurse Educator track, and MSN students in that track had two semesters of clinical teaching practicums under the supervision of a master teacher. Eleven of the graduates subsequently have been hired by the program as clinical instructors, skills instructors, or physical-assessment instructors. The other program utilized their grant to provide Kaiser-sponsored students with placements and clinical instructors from Kaiser through use of a liaison working closely with the program. The programs were encouraging their clinical faculty to sponsor a student from the California Institute for Nursing and Health Care (CINHC) clinical instructor training course and precept them for a semester for a teaching practicum. Other ideas included instituting a dedicated education unit, where the hospital would dedicate one unit exclusively to one nursing program with nurses on the unit being utilized as clinical instructors or a dedicated hospital where students would

spend their entire clinical coursework within one institution. Advantages and disadvantages are being discussed for both options, and plans are being made to propose these options to the healthcare facilities. Finally, creating templates for CI role induction should improve adjustment and learning of the new role by providing less anxiety and stress to the NCNI.

In summary, the results of this research provided an excellent portrayal of how the new emergency-hire clinical nursing instructor learned in the first year, what influenced that learning, how they interpreted their new role, and how program directors viewed the scope and impact of emergency hiring on their program and the instructors themselves. Learning was viewed through the lens of Mezirow's transformative learning theory and although there appeared to be one experience of transformative learning, all other learning was informal and informative learning where new information was gained and processed.

Limitations

Limitations are inherent in all research; there are weaknesses and variables that cannot be controlled. Because this study sought to explore first-year learning by novice emergency-hire clinical nursing instructors, it was retrospective in nature. This type of research may be fraught with limitations associated with any memory work. Obtaining direct measures of learning (knowledge and expertise) was not sought and may be considered a limitation. Participant observation is a method often associated with qualitative research (Bogdan & Biklen, 2007). Because of the timing of data collection, observation of new instructor teaching was not attempted in this study and may be considered a limitation. Other limitations may include participant selection, participant

characteristics, qualitative research methods, and the possibility of researcher bias.

Participant enrollment was self-determined and may not represent the depth and breathe of the NCNI population.

Because of the qualitative nature of this study, the findings could be interpreted in other ways than I have described. Minimizing this threat was attempted through triangulation of the data, member-checking, clarification bias, peer review of coding processes, and strategies recommended by qualitative researchers and discussed in Chapter III.

Discussion

Adult learning can be defined as “the process of adults gaining knowledge and expertise” (Knowles, Holton, & Swanson, 2005, p. 174). Ten nurses were hired into clinical teaching positions in BSN programs and described how they learned in their first-year as a clinical instructor. Learning for the 10 NCNIs varied in intensity and scope and depended upon prior and current experiences. Learning was individual. As criteria for the research sample, all individuals had to be nurses who were hired into the BSN nursing program within 4 weeks of classes starting and who had never taught a clinical group before. As new employees to the university and nursing program, each crossed an organizational boundary that required performance in a new organizational culture or subculture.

As an attempt to enhance quality and credibility of this study, triangulation was discussed in Chapter III. An additional triangulation effort was attempted following analysis of the data and writing of Chapter IV. Patton (2002) described “theory/perspective triangulation” as “using multiple perspectives or theories to interpret

data” (p. 556). Although both the Mezirow theory of transformative learning and the novice-to-expert theories were utilized to interpret the NCNIs data, it was found that the Mezirow theory had a somewhat limited application to this study of NCNIs learning. The transformative learning process requires critical reflection, something the novice instructors seemed to lack in their induction process to the role of clinical teaching. What they needed to know was immediate foundational information on which to base their teaching. Lack of schema about the clinical teaching role would inhibit their ability to reflect and transform. As novices to the clinical teaching role, NCNIs struggled to acquire information to base their action upon, something consistent with the novice to expert theory. Although Benner (1984) based her novice to expert theory on nursing students and clinical nurses, the application to clinical instructors in this study was very appropriate. The rule governed novice description resonated well with the transcripts of the NCNIs where what little instruction they had or guideline they might have gained from an instructor binder, they utilized. More typically, it was the induction of the emergency hire into a role where no guideline or binder was provided and lack of support caused the majority of NCNIs to struggle with the first teaching rotation especially student grading and performance evaluations.

Patten (2002) suggested that theory triangulation may involve “examining the data from perspectives of various stakeholder positions” (p. 562). The point of theory triangulation in this study was to gain some understanding of how different assumptions and premises of the NPAs, as stakeholders, affected the findings and interpretations of NCNI data if different points of view existed. A theoretical model from the human-resources literature was utilized as a lens to view the same data.

In Human Resources Development literature, new employee development is defined as “all development processes organizations use to advance new employees to desired levels of performance” (Knowles et al., 2005, p. 309). Based on development activities provided regardless of formal or informal, planned or unplanned, the expected outputs of new employee development are (a) an employee performing at a targeted level of performance, and (b) the employee staying with the institution (Knowles et al., 2005). Where new employee turnover rates are high, research indicates that employee-development processes during the first year can be held responsible (Leibowitz, Schlossberg, & Shore, 1992).

Some understanding of the Holton model of new employee development (Holton, 1998) may provide perspective to NCNIs’ learning in the first year. The taxonomy for this model includes four domain areas of new employee learning: individual, people, organization, and work tasks. The first three areas are considered socialization areas and the last, work tasks, is considered job training. Each domain is subdivided into three learning tasks. A conceptual map of the new employee development model is seen in Figure 13. Each learning domain was addressed by NCNIs research interview data. In the individual domain, NCNIs generally had a very positive attitude about taking on the position of CI and expressed limited expectations about their new role. Each expected more support from the nursing program and where that expectation was not met, they encountered frustration. “Breaking-in,” according to Baum (1990), takes 9 to 12 months typically and special skills needed to cross successfully an organizational boundary are learned during that time. Depending on NCNIs’ internal schemas and scripts about the



Figure 13. New employee development learning tasks (Knowles et al., 2005).

new role and support for learning the skills needed, differing reactions to breaking-in were noted.

In the people domain, much of the social-learning process was divided between the nursing-program organization and the hospital-setting organization. For NCNIs, these two different environments meant establishing relationships with new people in both. Building interpersonal relationships was mandatory in both settings. If perceived as different, as in the case of the NCNIs in unfamiliar clinical settings, the newcomer may have a more difficult time acclimating and building those important relationships (Knowles et al., 2005). Success with building new relationships for the 5 NCNIs who were new to the hospital settings was challenging, although several NCNIs also noted that building relationships with those at the university was very challenging. In the nursing arena, nurses' report to a supervisor and their supervisor is present in the work environment. Where people build strong relationships with their supervisors, they can obtain more critical information about the position, and they learn more about the organizational culture, which results in greater satisfaction and commitment as well as less stress and intent to leave (Ostroff & Kozlowski, 1992). When NCNIs did not have a

“supervisor” relationship with individuals in the nursing program that employed them, they had little or no oversight; therefore, such a link to the culture of the organization was missing.

The culture of organizations is not written down and, in most cases, is not formalized. The interpersonal relationships forged by NCNIs were often difficult to establish because NCNIs were not privy to informal systems, roles people played, the “taboos” of the organization, and other aspects of organizational life when dealing with the university nursing program and for half of the NCNIs who were unfamiliar with the hospital clinical setting when dealing with the hospital. Without culture understanding, new employees may be ineffective even though technically competent at his or her tasks (Knowles et al., 2005). Another aspect of the organizational domain is organizational savvy. Organizational savvy requires an understanding of the informal systems and methods that comprise the way things are done in the organization. Inclusive of learning about the systems are learning about the politics of the organization and learning how to negotiate the formal and informal power structures and systems in the organization.

NCNIs had two organizational systems to learn about and although some had difficulties and challenges with the nursing program; others had difficulties and challenges with the hospital settings. It was a formidable task to learn quickly about both organizations and to understand where they fit in both. Learning about their role meant locating themselves in the larger perspective of the organization, understanding their role as a newcomer, learning what appropriate expectations and activities are for that role, and accepting role limits and realities, along with reconciling conflicts and ambiguities. Because of the duality of the role that included two organizations, the emergency-hire

status, lack of systematic efforts to help with orientation to the new role, initially most NCNIs struggled with their new position as a novice clinical instructor.

Finally, the model for employee effectiveness addresses the work-task domain. Included in this domain are work savvy, task knowledge, and knowledge, skills, and abilities. Understanding the tasks of the job and having the correct knowledge, skills, and abilities is essential to new employee success (Knowles et al., 2005). As emergency-hire NCNIs, little time was available for considering how to apply knowledge and skills to the job or acquire generic professional skills necessary to function in the job. The schema or system for understanding task assignments and for prioritizing, processing, and accomplishing the job were just developing. Information must be sorted to determine what is important, limited resources must be allocated, and skills, if learned in training, must be applied to their work problems.

Feldon (2007) discussed how cognitive overload often limits the abilities of novice teachers to adapt effectively to complex classroom dynamics. He suggested that cognitive overload occurs if total processing demands of external stimuli and internal cognitions exceed available attentional resources. The limited working memory is occupied and, therefore, constrains the attention available for other cognitive activities. As skills become less effortful with practice, or more automatic, they require less cognitive load (Anderson, 1995). Therefore, novices, when faced with a problem, endure high cognitive load simply because they lack the experience and conceptual framework that make cognitive processing more efficient. Mastery of job tasks is necessary for success, and, as mastery occurs, automated knowledge occupies very little space in the working memory allowing more resources for other cognitive activities.

NCNIs hired last minute had little time to prepare for job tasks, for that matter, to even understand the job tasks. Their learning was on a need-to-know basis and had to occur as quickly as possible. They were not privy to a complete understanding of the tasks on the job and the newcomer's role. Many depended on what schema they had from their student days and attempted to apply what they remembered about the best and worst of their former instructors, they attempted to apply prior knowledge from formal teaching education, or both.

Novice-to-expert theory suggests that novices function in a new situation typically by utilizing rule-governed behavior, and, although limited and inflexible, it provides the inexperienced a guide for performance (Benner, 1984). NCNIs who were provided a comprehensive orientation binder to take with them to the clinical setting had at their fingertips something to guide their beginning activities with students and staff. Although the binder was a help, it could not tell them the most relevant tasks to perform in an actual situation. Context-dependent judgments and skill can be acquired only in real situations and can be distinguished from the level of judgment acquired from principles and theory (Dreyfus, 1982). Therefore, for those NCNIs who had it, application of any teacher education required active clinical teaching starting at the novice level.

Entry into the organization, the clinical teaching position, was complex. Most NCNIs did not enter with the background knowledge for a smooth transition. Social and informal learning as well as on-the-job-training took place in the hospital setting while attempting to teach students in a clinical rotation. The nature of clinical teaching was not evident to them fully as they started their position.

Clinical learning is the heart and soul of nursing education and is where professional practice is shaped from nursing knowledge. Generally speaking, clinical learning goals can be described as (a) professional-nurse role development, (b) theoretical knowledge application, (c) communication-skills development, (d) skill in performing caring-therapeutic nursing interventions, (e) ability to evaluate ethical aspects of clinical practice, and (f) collaborative- and leadership-skills development (Emerson, 2007).

Important contributions CIs can provide new students are stories and examples of their own experience as nurses. Emerson (2007) claimed that working with a group of students in the clinical setting is not the same as precepting new nurses in practice or serving as a resource to other nurses, which the NCNIs stated they thought gave them background for the CI role. Novice clinical faculty tend to focus on the patient as they would do in their nursing practice; however, as a clinical instructor, a broader perspective is required that takes in consideration the student learning needs. Nursing expertise with a lack of understanding of teaching and learning theory was exemplified by the NCNI example of Beth who experienced a critical incident with a student over a patient diagnosis of a thoracentesis. Inability to understand student learning needs in this situation created a power struggle between student and NCNI that caused communication discord, hard feelings, and much distress. Emerson (2007) stated that “as a nursing faculty member in the clinical setting, the role is more one of ‘query and quest’ than of ‘know and show’” (p.7). New skills required for the role of CI are not found in professional nursing, such as, awareness of legal issues and their ramifications associated with academia, theoretical foundations of clinical nursing practice, models of clinical teaching, or student characteristics. These skills provide the foundation for methods of instruction and

evaluation of student learning (Emerson, 2007). Lack of knowledge of these skills for NCNIs hampered their performance, and, through experiential informal and incidental learning, they slowly made progress toward gaining the skills necessary for adequate teaching. Even at the end of the semester, several NCNIs stated that they were no closer to understanding how to evaluate student performance than when they first started out.

Novice CIs without formal teaching preparation are hampered by educational knowledge deficits as evidenced by insufficient knowledge required to design clinical-learning experiences and evaluate student functioning in the clinical setting (Oermann, 2004). With or without teaching preparation, learning to teach remains overwhelmingly experiential, a form of on-the-job training that was exemplified by the NCNIs' interview responses.

Factors influencing NCNIs learning resonate with the above discussion of new employee learning needs and entry into the organizational frameworks of the hospital clinical site and the university. Where prior schema could be employed, they were; where new schema needed construction, they were constructed; and where scaffolding would have helped, little was offered. The nursing programs lacked an organizational climate that fostered individual growth in the position for the NCNIs. There was little evidence that giving or receiving feedback was fostered. What little feedback was given by NCNIs to the program administrators was rarely backed up with appropriate coaching. NPAs recognized the lack of scaffolding of new faculty and are attempting to address support by adding innovative methods of orientation through the use of technology both with an online portal on Blackboard® dedicated to orienting and supporting faculty, and with requiring participation in online module coursework on www.4faculty.org. Although

these methods most likely will improve what scaffolding of new faculty that currently exists, more direct connection with and supervision and support by, the nursing program would help to improve the personal lack of training and skills with which NCNIs enter the teaching role. Scaffolding in the form of practical template guidelines for entry into the new role, as one NPA envisions, may provide the NCNI, hired last-minute, with the bare minimum tools for operation. NCNIs expressed in interviews that it was distressing not to know how to proceed, what to do next, what students needed, how to provide what students needed, and a multitude of other operational new hire need-to-know skills for clinical teaching.

The results of my study resonate with and confirm many of the results of the studies in Chapter II. The results of the Jackson (1996) study concurred with those of numerous previous studies indicating that individualized orientation and support through mentoring needs to be provided to new faculty, graduate education needs to include how to teach in both classroom and clinical settings if role adjustment is an outcome of new faculty employment, assistance and oversight in applying program concepts to clinical situations, and assistance with initial interactions with the clinical facilities and personnel who are not familiar. NCNIs in my study expressed the same needs for orientation, mentoring, assistance with how to teach, and 5 NCNIs unfamiliar with the clinical site would have benefited by assistance with initial introductions to personnel within the assigned facility. NPAs recognized that inadequate mentoring and orientation existed in their programs and attempts to address the above needs are underway in the three schools studied.

Kelly (2006) investigated role concepts by faculty in BSN programs. Results indicated that full-time faculty conceptualized their role much differently than part-time faculty and part-time faculty were less proficient at application of program concepts to clinical situations with the use of questioning. All NCNIs in this study were part-time faculty, and most believed that their teaching skills were underdeveloped; however, those with education coursework eventually were able to manage student learning experiences with more ease than those with no education background at all. Because of the emergency nature of the hiring process for the NCNIs in my study, new instructors were not aware of program concepts due to lack of orientation to the program. Most NCNIs developed their own basis for judging what clinical concepts they desired to pass on to the students rather than being guided by any program concept. Clear rejection of suggestions provided in the syllabus for postconference agendas and activities were modified at will based on what the NCNI was comfortable with or thought was important. Lack of any supervision, mentoring, or support in this regard provided NCNIs the freedom to choose what the students would learn about in their particular rotation. Some skills of teaching and managing students in a clinical group were improved somewhat for NCNIs teaching a second rotation, but continuing problems with evaluation of students and communicating with students persisted through the second rotation.

Paterson (1997) looked at the clinical teaching role from a systems point of view. The results of the Paterson study indicated that the current clinical-teaching practice for most nursing programs where clinical faculty take a group of up to 10 students to a hospital, clinic, or community-health setting was subject to being a “temporary system.” The study participants experienced territoriality, separateness, defensiveness, and distinct

patterns of intergroup communication of which the clinical faculty was not a part.

NCNIs, especially those who were entering the hospital as strangers, expressed the same feeling, as the Paterson study participants, of being an “outsider” to the nursing unit and the hospital. Those NCNIs who did work in the facility where they were assigned with a clinical group did perceive some of the “temporary-system” attributes expressed in the Paterson study because they were in a different role and had the responsibility for teaching up to 10 students. Because they were “insiders,” the negotiating between the temporary system or outsider position and the insider position was much less than their outsider counterparts.

The results of the Eraut (2003) study of novice professionals learning in the workplace suggested that the model of apprenticeship or built-in mentoring provided a less-stressful entry for the professional accountant, engineer, or nurse. NCNIs in this study did not have the opportunity for an apprenticeship or built-in mentoring alliance within the hospital environment or nursing program where they carried out their teaching role. Where possible, teaching practicums, for masters students acquiring a teaching minor, would provide a limited apprenticeship. During a teaching practicum, the masters student is scaffolded and mentored by a master teacher as they learn all aspects of teaching and management of a clinical nursing group. The teaching minor was not an attribute of most NCNIs and time since the education process for those who did have a teaching minor may have required new learning without the benefit of a master teacher once they started to teach their first group. All NCNIs were novice instructors in this study whether they had a teaching minor or not and all lacked any built-in mentoring as suggested by the Eraut study.

The four themes produced by the Siler and Kleiner (2001) study of novice nursing faculty in academia, resonated with the results of my study. The themes included expectations, learning the game, being mentored, and fitting in. NCNIs, like the participants in the Siler and Kleiner study, suffered from lack of role preparation and socialization for university requirements as evidenced by the NCNIs' universal lack of knowledge related to student performance evaluations and grading of student papers. NCNIs found little help with the process of evaluation of student learning in the clinical setting, and many expressed that they were no better at the process at the end of the semester. The Siler and Kleiner participants found little support for their teaching and described a solitary process of putting things together and in perspective. NCNIs found little support for their teaching, and many described how lonely they believed the job was. Most lacked any contact from the nursing-program administrators or faculty to monitor their progress or to offer any assistance during their first teaching rotation. All Siler and Kleiner participants experienced critical periods and stressful times during the first year that resonated with NCNIs comments in their interviews.

In summary, the results of this study of NCNIs' learning in the first year supports results of previous studies regarding many aspects of learning to teach and learning the role of CI in the first year.

Conclusions and Implications for Practice

This qualitative study contributes to a better understanding of how emergency-hire NCNIs learn to teach in the first year and what factors influence that learning. Of particular interest was viewing NCNIs learning through the lens of Mezirow's transformative learning theory, noting that application of this lens generated only one

potential transformative learning experience, verifying Mezirow's (1995) suggestion that transformative learning occurs infrequently.

Learning the role of clinical instructor and learning how to teach was achieved mainly by doing, by the experience of on-the-job, self-reliant, experiential immersion. For the emergency hires, it was a sink-or-swim occurrence. Learning in this stressful manner is not optimal, and performance is often problematic due to incomplete task mastery.

Increasing support for novice clinical instructors, especially when hired last minute, will result in better prepared and more confident new instructors. NCNIs learning in the first year was comprised of mainly informal and incidental experiential learning, and, as any new hire, gaining entry to organizational structures, routines, and politics and establishing interpersonal relationships were imperative and time consuming. For NCNIs who were not familiar with the clinical setting, two organizations must be negotiated: the university and the hospital setting, which added a major component to their on-the-job learning task. When time precludes any organizational ability to orient NCNIs to the job, measures to support and scaffold NCNIs for learning-in-place are necessary to provide job training sufficient to ensure job satisfaction and, more importantly, for their students to attain the necessary clinical experiences, oversight, and evaluation intended by the course and nursing program. As with any novice employee, clear guidelines with explicit directions and instructions as well as supervision and mentoring on site would support or scaffold the NCNIs during the initial learning phase of beginning teaching.

The current faculty shortage and clinical placement crisis has prompted creation of alternative clinical teaching models where the employed nurse remains in place and

assumes part time new responsibilities of clinical teaching. The new models suggested in the literature (Fetherstonhaugh, Nay, & Heather, 2008; Ranse & Grealish, 2007) and by two of the NPAs in this study are alternative models such as the Dedicated Education Unit for clinical teaching or dedicated hospital facilities. Nurses who are employed by the hospital, through partnerships with the university nursing programs, become the clinical instructors and are trained to teach by the university. This model may address both the tremendous faculty shortage issue and change the face of clinical instruction from the current traditional or modified model in the NCNIs experience, to something possibly more efficient. The apprentice clinical model from the past, modified to include teacher education and joint appointments for current working nurses to accommodate clinical teaching workload, may address both the current clinical faculty shortage and issues of current clinical expertise noted in research about faculty concerns (Baillie, 1994). Some combination of both old and new models of clinical teaching may surface to improve the way clinical courses are taught.

With increasing student enrollment, increasing demand on the hospitals for clinical nursing placement sites for students, and the increasingly desperate clinical nursing faculty shortage, the generation of unique and effective partnerships for student teaching and learning the profession of nursing are imperative. This study examined how new instructors learned the role of new clinical instructor in the current environment of clinical nursing education. The findings reveal the importance and need for authentic mentoring and support for new CIs and resonate with prior studies of new nursing instructors (Frandsen, 2003; Jackson, 1996; Siler & Kleiner, 2001), as well as literature related to human-resources development (Knowles et al., 2005). Emergency hiring is an

added aspect that compounds the complexity of the new-hire experience. Emergency hiring is inevitable and will increase if the model of clinical nursing education remains the same with an independent clinical instructor hired by the university to take 8 to 10 students to a hospital for clinical instruction.

Consideration of alternative methods of educating nurses that increases simulation learning of nursing skills, as many programs are choosing to do, must be explored to reduce student load in the often over subscribed hospital settings. Adding more simulation time and less hospital time does not address the added need for clinical instructors required in both settings. In this era of faculty shortage and lack of nursing educator training, staffing a simulation laboratory with appropriate clinical content experts who understand academic teaching and learning and maintaining full or partial clinical groups in the hospitals requires careful consideration of program resources. Adding more simulation may provide the nursing program an opportunity to increase their enrollment by alternating students in and out of the simulation laboratory more often, or for longer periods of time, but it does not address the hiring and support process for any and all new nursing faculty who agree to teach. One NCNI in this study was asked to take her clinical group to a scheduled simulation experience, and it caused her great anxiety due to total lack of role preparation for assuming any teaching responsibility in the simulation laboratory. The NCNI was not prepared for the technological or pedagogical requirements of the experience. Research is required that would investigate how much simulation, as an adjunct to clinical placement, is appropriate to meet the student learning objectives for the clinical course. Because simulation is still relatively new and each program uses it differently, as evidenced in this

study, what expertise is necessary to staff the simulation laboratories and the responsibilities of the clinical instructors related to simulation laboratories is yet to be standardized. Clearly, simulation for new hires is another hurdle if a program of training is not instituted prior to any expected teaching experience.

The findings of my study contribute to the research on new clinical-instructor learning, on what factors influence that learning, and on how new instructors view their new role. Results of this study suggest several implications for supporting new hires in the clinical teaching role, especially if hired last minute, and suggest conceptualizing clinical teaching utilizing different organizational models. A priority on faculty development, especially development of emergency hires, requires nursing education programs to support novices' "learning-on-the-job" by coaching, communicating, orienting, mentoring, supervising, providing feedback, educating through innovative learner-centered processes such as online programs and frequently offered face-to-face in-service teaching workshops timed to accommodate working nurses, and scaffolding the NCNIs. If it is not possible to assign an emergency-hire NCNI in their place of employment with a group of students, then supporting the NCNI by having a nursing-program mentor visit regularly in the first rotation to assist making the necessary introductions and connections in the new facility as well as assisting the NCNI navigate through the first pre- and postconferences is essential for success of both students and the NCNI. Offering every new employee a comprehensive program binder as outlined by program C in this study would provide each emergency hire NCNI material to follow at their fingertips. Electronic versions of the binder could be issued in the form of a PDA® or Blackberry® download, a CD-ROM, or other innovative electronic medium. The

orientation binder materials would be situated and updated frequently on a Blackboard® site where materials could be downloaded to the electronic device or printed for the binder. Access to current and useful program information for the new instructors is imperative if they are to acclimate to the role of clinical faculty successfully.

The nursing programs in this study are attempting to address many of the above support measures. The online portal created by program B is a strategy to connect new and continuing faculty with a resource repository that attempts to provide new teacher training, current information, forms, teaching and learning resources, video clips, discussion board, faculty handbooks, and more. This strategy of utilizing either Blackboard® or WebCT® as a vehicle for communication is being instituted in numerous programs nationally and provides real-time, anytime, resources for both new and seasoned faculty (Duffy, Stuart, & Smith, 2008).

More globally, attention to eliminating the strong academic salary disparities may impact how many more nurses in practice would consider clinical and academic teaching. Program C in this study is preparing to address this disparity by providing faculty with approximately 90% of the nursing practice salary. Efforts like this one will catch the attention of nurses who may be looking for a change in their career after serving as a nurse for years in a hospital or community setting.

Doctoral and masters-level-graduate nursing programs should include teaching theory as a priority and encourage graduates to seek employment in the university and college programs of nursing. Program A in this study created a masters-level dual CNS and Nurse Educator track that has provided 17 new clinical faculty to the region and a class of 10 will graduate at the end of the current semester. The new instructors have

completed clinical teaching courses and clinical teaching practicums under the guidance of an experienced faculty. Program C provides faculty for a postmasters clinical instructor certification course that currently produces about 30 new clinical faculty per session. These new instructors currently are hired immediately, and one was interviewed in this study.

Face-to-face faculty meetings that include all part-time faculty should occur at least annually, if not more frequently to update all faculty on program changes as well as provide a time for part-time faculty to meet and socialize with full-time faculty and administration. Most NCNIs stated that they would have appreciated an orientation that included a face-to-face meeting designed to communicate program information and provide introductions. Many NCNIs stated that they felt removed from the program and staff. They claimed they were not a part of the university setting because they did not attend faculty meetings or orientation, and their work was situated off campus. Faculty meetings for the NCNIs were held during the day when all NCNIs were working as nurses. This distancing was considered isolating. Occasional face-to-face meetings, scheduled in the evenings or at a more convenient time for working nurses, would improve relations with the NCNIs and provide them with the opportunity to be a part of the program.

All newly hired nursing clinical faculty require the above support; however, the circumstance of emergency hiring adds a dimension to the new hire situation that demands much more attention. My research study provides nursing programs with a better understanding of the position that emergency hiring places a new employee in. Although emergency hiring will continue to exist, the NCNI that is scaffolded by the

specific support measures outlined in this study should demonstrate improved outcomes for learning the new clinical faculty role and demonstrate a higher level of satisfaction with the process.

Recommendations for Future Research

Whereas emergency hiring NCNIs is an immediate solution to a nursing program seeking clinical instructors where there are numerous slots to fill, the impact of such an unprepared instructor on nursing-student learning and satisfaction has not been studied. The nursing student is the ultimate stakeholder and suffers the consequences when the clinical instructor is not prepared to teach a group. In a recent article by Hanson and Stenvig (2008) looking at attributes of good clinical-nursing educators, a participant commented about a new instructor in a new facility stating “If your instructor’s lost [in the facility] there’s no hope for you” (p.40).

Recommendations for future research include investigating the impact of having an emergency-hire NCNI as a clinical instructor on nursing students and student learning outcomes. NCNIs in this study claimed they were unprepared to teach or manage a group in the clinical setting and did not realize the full extent of the role when they agreed to take the position. These were emergency-hire instructors, and no time was available to prepare them for the position. How does it affect the student of a NCNI if the uncertainty of teaching and of the role is evident week to week? Do the students of NCNIs claim they are satisfied with their clinical rotation and clinical instructor? Do the students of NCNIs meet the learning objectives of the course as well as students in courses with experienced clinical instructors? The NCTEI tool could be utilized to ascertain emergency hire NCNI clinical teaching effectiveness.

Future research exploring the effect of joint-appointments on new nursing clinical instructors, programs of nursing, and the hospital would be beneficial in assessing if modifying the current clinical teaching model is appropriate or not. A joint-appointment position results from a partnership between the hospital or community setting and the university nursing program where an employee is paid by both entities and a schedule of employment for each entity is formulated for the full-time position. Although this model of clinical teaching has been utilized for some time, it is not utilized to the extent the current model is where clinical instructors are employees of the university program of nursing.

For NCNIs who begin to teach without any education background, having a written plan of operation for everything that is expected would help to guide the novice through the first days, weeks, and months of the rotation. Considering the efficacy of templates for operation for NCNIs being inducted into the clinical teaching role is a research priority for the future as suggested by Dr. Bartell of program B.

Further research might involve examining the effect of online orientation, support, and teaching on NCNIs' learning the role of clinical instructor and learning to teach. Is online support and learning a mode that working nurses are familiar enough with to embrace as their preferred method of entry to the part-time faculty position? Is online instruction likely to be utilized, as in the modules on www.4faculty.org , if new and emergency hire faculty are appraised of the availability? To what degree do financial or other incentives for completion of the orientation to the role of clinical faculty modules work? What is the difference between NCNIs who complete the online training and those who don't related to role adjustment and teacher effectiveness?

Finally, examining the retention rate of emergency hire NCNIs versus NCNIs hired who attended optimal orientation and training for new CIs would help to understand if there is a real consequence to last minute hiring related to retention.

Afterword

My experience with this research has provided me with a glimpse at the complexity of the emergency-hire NCNIs' induction into the clinical-teaching role. Even though all NCNIs in this study were working nurses and 8 of them full time, their willingness to take on the additional workload and role of clinical instructor was astonishing. They responded to an emergency plea by the nursing programs, and all NCNIs considered that their response and contribution to relieve the nursing shortage by teaching a clinical group was temporary only. The learning curve was steep for all emergency-hire NCNIs in this study, and for the 5 who were placed in unfamiliar clinical settings even more challenging. I was surprised at the general positive attitude of all participants in the face of their trials and tribulations and now that they had at least one semester or rotation completed, most were willing to teach again considering that the worst was over related to their many learning challenges. I thought that overall, the NCNIs managed stress well considering most already were working full time in a nursing or nurse-practitioner position. The demands of the new position were more than most anticipated, but they were resilient.

Because NCNIs were working nurses, obtaining a sample to participate in this study was very difficult. Once enlisted, the study participants were on a very tight schedule and would agree to being interviewed only once. During the interviews, because the first three nurse participants were less than enthusiastic to participate in constructing a

timeline or concept map, I decided to abandon both of these data gathering measures and ask direct questions instead. [See Appendix D for addition to predetermined questions that replaced the timeline and concept map.] I felt most participants were pressed for time, and I wanted to honor the agreement to keep the interview to about an hour. The concept map and timeline activities were not familiar to the nurses, and it did not seem a good use of time to teach the methods during the interview. All participants were very engaged in the interview and seemed happy to have an opportunity to tell their story to me.

I gained tremendous insight about clinical teaching through the experiences of the emergency-hire NCNIs in this study. I anticipated some degree of angst and struggle by the NCNIs simply because of the nature of emergency hiring with no time for adequate orientation to the role or program. However, I did not expect the seemingly minimal response to supporting these individuals as rank novices responsible for clinical instruction of up to 10 nursing students each, by the nursing programs. It reminded me of the old saying that “nurses eat their young.” I am very encouraged by the steps all three programs are taking to improve orientation for new faculty and support them through creative online and face-to-face faculty meetings at times appropriate for working nurses. How these measures actually support a NCNI, hired last minute, will remain to be seen. Personal, on-site mentoring and coaching in the clinical facility where the basis of the struggle to learn exists may bear some attention. Periodical supervisory visits and oversight with evaluation by nursing-program representatives may uncover areas where educational support could be provided to the CI and improvement of instructors’ teaching and learning as well as satisfaction with the role would be an outcome.

I learned that there is much work left to be done in an environment that is stressed both at the service level and in the academic setting as schools respond to the ongoing nursing shortage by increasing enrollment. National, state, and local attention to increasing nursing faculty to meet the demands of the increased enrollment have surfaced with creative programs of education including accelerated doctoral programs, CI certification programs, dual MSN programs that include the Nurse Educator certification, and online programs such as mentioned in this study. The thrust to increase the number of nursing faculty with the educative processes outlined will continue to make a positive difference, however, any emergency hiring of NCNIs to fill the gap, requires a different kind of attention and support to produce an acceptable outcome because they enter the workplace at a distinct disadvantage.

REFERENCES

- Allan, J.D., & McClellan, S. (2007). Maryland's agenda: Moving the faculty shortage to the forefront. *Journal of Nursing Education*, 46, 187-189.
- Allison-Jones, L. L., & Hirt, J. B. (2004). Comparing the teaching effectiveness of part-time and full-time clinical nurse faculty. *Nursing Education Perspectives*, 25, 238-243.
- American Association of Colleges of Nursing. (2000). *1999-2000 Salaries of instructional and administrative nursing faculty in baccalaureate and graduate programs in nursing*. Washington, DC: Author
- American Association of Colleges of Nursing. (2003). *Faculty shortages in baccalaureate and graduate nursing programs: Scope of the problem and strategies for expanding the supply*. Retrieved Oct. 3, 2006, from <http://www.aacn.nche.edu/IDS>
- American Association of Colleges of Nursing. (2004). *2004-2005 Enrollment and Graduations in Baccalaureate and Graduate Programs of Nursing*. Retrieved Oct. 3, 2006, from <http://www.aacn.nche.edu/IDS>
- American Association of Colleges of Nursing. (2005). *Thirty-two thousand students turned away from the nation's nursing schools due to insufficient number of faculty, clinical sites, classroom space, preceptors, and budget constraints*. Retrieved Oct. 3, 2006 from <http://www.aacn.nche.edu/I>
- American Association of Colleges of Nursing. (2006). *Nursing faculty shortage fact sheet*. Retrieved Feb. 2, 2007, from <http://www.aacn.nche.edu/Media/FacSheets/FacultyShortage.htm>
- American Association of Colleges of Nursing. (2007a). Nursing shortage fact sheet. Retrieved Nov. 20, 2007, from <http://www.aacn.nche.edu/Media/FactSheets/NursingShortage.htm>
- American Association of Colleges of Nursing. (2007b). Enrollment growth slows at U.S. nursing colleges and universities in 2007. Retrieved Jan 26, 2008, from <https://vpn.dominican.edu/Media/NewsReleases/2007/DanaInfo=www.aacn.nche.edu+enr.htm>
- American Hospital Association. (2001). *Trendwatch*. Retrieved Oct 4, 2006, from <http://www.ahs.org>
- American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. Retrieved Oct 6, 2007, from <http://www.apa.org/code2002.pdf>.

- Anderson, J. R. (1995). *Cognitive psychology and its implications*. (4th ed.). New York: Freeman.
- Baillie, L. (1994). Nurse teachers' feelings about participating in clinical practice: An exploratory study. *Journal of Advanced Nursing*, 20, 150-159.
- Bartels, J. E. (2007). Preparing nursing faculty for Baccalaureate-level and Graduate-level nursing programs: Role preparation for the academy. *Journal of Nursing Education*, 46, 154-158.
- Baum, H. S. (1990). *Organizational membership*. New York: State University of New York Press.
- Benner, P. (1982, March). From novice to expert. *American Journal of Nursing*, 402-407.
- Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. Menlo Park, CA: Addison-Wesley.
- Beres, J. (2006). Staff development to university faculty: Reflections of a nurse educator. *Nursing Forum*, 41, 141-145.
- Berlin, L.E., & Sechrist, K.R. (2002). The shortage of doctorally prepared nursing faculty: A dire situation. *Nursing Outlook*, 50, 50-56.
- Bogdan, R. C., & Biklen, S. K. (2007). *Qualitative research for education: An introduction to theories and methods* (5th ed.). Boston: Pearson Education Inc.
- Boyden, K.M. (2000). Development of new faculty in higher education. *Journal of Professional Nursing*, 16, 104-111.
- Brendtro, M., & Hegge, C. (2000). Nursing faculty: One generation from extinction? *Journal of Professional Nursing*, 16, 97-103.
- Brown, H. (1999). Mentoring new faculty. *Nurse Educator*, 24, 48-51.
- Buerhaus, P. I., Staiger, D.O., & Auerbach, D.I. (2004). *New signs of a strengthening U.S. nurse labor market?* Retrieved Oct 3, 2006, from <http://content.healthaffairs.org>
- Carpenter, D. R., & Hudacek, S. (1996). *On doctoral education in nursing: The voice of the student*. New York: National League for Nursing. Pub. No. 14-6703.
- Council of Collegiate Education for Nursing. (2002). *Nurse Educator Competencies*. Unpublished manuscript, Atlanta, GA. Retrieved Oct. 1, 2006, from <http://www.sreg.org>

- Craig, J. L., & Page, G. (1981). The questioning skill of nursing instructors. *Journal of Nursing Education*, 20, 18-23.
- Cranton, P. E. (1994). *Understanding and promoting transformative learning: A guide for educators of adults*. San Francisco: Jossey-Bass Publishers.
- Cranton, P. E. (1997). *Transformative learning in action: Insights from practice*. San Francisco: Jossey-Bass.
- Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage.
- Cuddapah, J. L. (2005). Exploring first-year teacher learning through the lens of Mezirow's transformative learning theory. *Dissertation Abstracts International*, 66 (05), 1721. (UMI No. 3175680).
- Curl, E. D., Smith, S., Chisholm, L., Hamilton, J., & McGee, L. A. (2007). Multidimensional approaches to extending nurse faculty resources without testing faculty's patience. *Journal of Nursing Education*, 46, 193-195.
- Deshler, (1990). Conceptual mapping. Drawing charts of the mind. In J. Mezirow & Associates (Eds.), *Fostering critical reflection in adulthood: A guide to transformative and emancipatory learning*, (pp. 336-353). San Francisco: Jossey Bass.
- DeYoung, S. B., & Bliss, J. B. (1995). Nursing faculty: An endangered species? *Journal of Professional Nursing*, 11, 84-88.
- Diekelmann, N. (2003). *Distance desktop faculty development in the new pedagogies for community-based care*. Madison, WI: University of Wisconsin-Madison.
- Diekelmann, N. (2004). Experienced practitioners as new faculty: New pedagogies and new possibilities. *Journal of Nursing Education*, 43, 101-103.
- Diekelmann, N., & Schulte, H. D. (2001). Funding for research in nursing education. *Journal of Nursing Education*, 40, 339-341.
- Dreyfus, S. E. (1982). Formal models vs. human situational understanding: Inherent limitations on the modeling of business expertise. *Office: Technology and People* 1, 133-155.
- Dreyfus, H. L., & Dreyfus, S. E. (1986). *Mind over machine, the power of human intuition and expertise in the era of the computer*. New York: The Free Press.
- Duffy, N., Stuart, G., & Smith, S. (2008). Assuring success of part-time faculty. *Nurse Educator*, 33, 53-54.

- Emerson, R. J. (2007). *Nursing education in the clinical setting*. St. Louis: Mosby.
- Eraut, M., Millardet, F., Miller, C., Steadman, S., Ali, A., Blackman, C., & Furner, J. (2003, April). *Learning in the first professional job: The first year of full time employment after college for accountants, engineers, and nurses*. Paper presented at the annual meeting of the American Educational Research Association "Accountability for Educational Quality: Shared Responsibility," Chicago.
- Evans, M. (2005). Loosing their faculty. *Modern Healthcare*, 35, 24-27.
- Feldon, D. F. (2007). Cognitive load and classroom teaching: The double-edged sword of automaticity. *Educational Psychologist*, 42, 123-137.
- Fetherstonhaugh, D., Nay, R., & Heather, M. (2008). Clinical school partnerships: The way forward in nursing education, research and clinical practice. *Australian Health Review*, 32, 121-126.
- Frandsen, G. M. (2003). Mentoring nursing faculty in higher education. *Dissertation Abstracts International*, 64 (08), 2801. (UMI NO. 3102895).
- Fullan, M. G. (1991). *The new meaning of educational change*. New York: Teachers College Press.
- Fusarelli, L.D. (2008). Flying (partially) blind: School leaders' use of research in decision making. *Phi Delta Kappan*, 89(5), 365-368.
- Genrich, S., & Pappas, A. (1997). Retooling faculty orientation. *Journal of Professional Nursing*, 13, 84-89.
- Guilfoyle, K. (1995, Summer). Constructing the meaning of teacher educator: The struggle to learn the roles. *Teacher Education Quarterly*, 11-27.
- Halstead, J. A. (1996). The significance of student-faculty interactions. In K. R. Stevens (Ed.), *Review of research in nursing education* (Vol. III, p. 154-156). New York: National League for Nursing Press.
- Hand, M. W. (2008). Formalized new-faculty orientation programs: Necessity or luxury? *Nurse Educator*, 33, 63-66.
- Hanson, K. J., & Stenvig, T. E. (2008). The good clinical nursing educator and the baccalaureate nursing clinical experience: Attributes and praxis. *Journal of Nursing Education*, 47, 38-42.
- Hessler, K. & Ritchie, H. (2006). Recruitment and retention of novice faculty. *Journal of Nursing Education*, 45, 150-154.

- Hinshaw, A. S. (2001). A continuing challenge: The shortage of educationally prepared nursing faculty. *Online Journal of Issues in Nursing*, 6 (3). Retrieved Oct. 6, 2006, from http://www.nursingworld.org/ojin/topic14/tpc14_3.htm
- Holton, E. F. (1998). Newcomer entry into organizational cultures: A neglected performance issue. In P. Dean (Ed.), *Pursuing performance improvement*. Washington: International Society for Performance Improvement.
- Interagency Collaborative on Nursing Statistics (ICONS). (2006). Nurses, nursing education, and nursing workforce: Definitions. Retrieved February 19, 2007, from <http://www.iconsdata.org/educationrelated.htm>
- Jackson, N. V. (1996). A survey of part-time faculty in baccalaureate schools of nursing and their learning needs. *Dissertations Abstracts International*, 57 (02), 998. (UMI: No. 9620154).
- Kegan, R. (2002). What “form” transforms? A constructive-developmental approach to transformative learning. In J. Mezirow (Ed.), *Learning as transformation: Critical perspectives on a theory in progress* (pp. 35-69). San Francisco: Jossey-Bass.
- Kelly, R.E. (2006). Engaging baccalaureate clinical faculty. *International Journal of Nursing Education Scholarship*, 3, 1-16.
- Knowles, M. S., Horton III, E. F., & Swanson, R. A. (2005). *The adult learner* (6th ed.). Boston: Elsevier
- Knox, J. E., & Morgan, J. (1987). Characteristics of ‘best’ and ‘worst’ clinical teachers as perceived by university nursing faculty and students. *Journal of Advanced Nursing*, 12, 331-337.
- Krathwohl, D. R. (1998). *Methods of educational and social science research: An integrated approach* (2nd ed.). New York: Longman.
- Leibowitz, Z. B., Schlossberg, N.K., & Shore, J.E. (1991, February). Stopping the revolving door. *Training and Development Journal*, 43-50.
- Lewallen, L. P., Crane, P. B., Letvak, S., Jones, E., & Hu, J. (2003). An innovative strategy to enhance new faculty success. *Nursing Education Perspectives*, 24, 257-260.
- Magnuson, S. (2002). New assistant professors of counselor education: Their 1st year. *Counselor Education & Supervision*, 41, 306-320.
- Marsick, V., & Volpe, M. (1999). The nature and need for informal learning. In R. Swanson (Ed.), *Advances in developing human resources*, 3, 1-9.

- Maxwell, J. A. (2005). *Qualitative research design: An interactive approach*. Thousand Oaks, CA: Sage Publications.
- Mezirow, J. (1991). *Transformative dimensions of adult learning*. San Francisco: Jossey-Bass.
- Mezirow, J. (1995). Transformation theory of adult learning. In M. R. Welton (Ed.), *In defense of the lifeworld* (pp. 39-70). New York: Sunny Press.
- Mezirow, J. (2000). *Learning as transformation: Critical perspectives on a theory in progress*. San Francisco: Jossey-Bass.
- Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed.). Thousand Oaks, CA: Sage.
- Morin, K. H., & Ashton, K. C. (2004). Research on faculty orientation programs: Guidelines and directions for nurse educators. *Journal of Professional Nursing*, 20, 239-250.
- National Council of State Boards of Nursing. (2005). *Number of Candidates Taking the NCLEX-RN Exam*. Retrieved Oct 4, 2006, from <http://ncsbn.org>
- National League of Nursing. (2005). *Core competencies of nurse educators with task statements*. Retrieved Feb. 3, 2007, from <http://www.nln.org/facultydevelopment/pdf/corecompetencies.pdf>
- National League of Nursing. (2007). *Strategies to reverse the new nursing shortage*. Retrieved Jan. 26, 2008, from http://www.nln.org/aboutnln/news_tricouncil2.htm
- National League of Nursing. (2008). *Annual nursing data review*. Retrieved Mar. 3, 2008, www.nln.org/research/datareview/executive_summary.pdf
- National League of Nursing, Board of Governors. (2002). *The preparation of nurse educators*. Unpublished manuscript. Retrieved Oct. 3, 2006, from <http://www.nln.orgfrom>
- Neese, R. (2003). A transformational journey from clinician to educator. *The Journal of Continuing Education in Nursing*, 34, 258-262.
- Nehring, V. (1990). Nursing and clinical teacher effectiveness inventory: A replication study of the characteristics of the best and worst clinical teachers as perceived by nursing faculty and students. *Journal of Advanced Nursing*, 15, 934-940.
- Oermann, M. H. (1996). Research on teaching in the clinical setting. In K. R. Stevens (Ed.), *Review of research in nursing education* (Vol. VII, pp. 91-126). New York: National League of Nursing.

- Oermann, M. H. (2004). Reflection on undergraduate nursing education: A look to the future. *International Journal of Nursing Education Scholarship*, 1(1), Article 5. Retrieved Feb 7, 2007, from The Berkeley Electronic Press website: <http://www.bepress.com/ijnes/vol1/iss1/art5>
- Ostroff, C., & Kozlowski, S. W. J. (1992). Organizational socialization as a learning process: The role of information acquisition. *Personal Psychology*, 45, 849-874.
- Oxford Concise English Dictionary* (10th ed.) on CD-ROM 2001 Version 1.1. Oxford, UK: Oxford University Press
- Paterson, B. L. (1997). The negotiated order of clinical teaching. *Journal of Nursing Education*, 36, 197-205.
- Patton, M. Q. (2002). *Qualitative research & evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.
- Polit, D. F., & Hungler, B. P. (1991). *Nursing Research Principles and Methods* (4th ed.). Philadelphia: Lippincott.
- Princeton, J. C. (1992). The teacher crisis in nursing education: Revisited. *Nurse Educator*, 17, 34-37.
- Ranse, K., & Grealish, L. (2007). Nursing students' perceptions of learning in the clinical setting of the Dedicated Education Unit. *Journal of Advanced Nursing*, 58, 171-179.
- Reilly, D., & Oermann, M. (1992). *Clinical teaching in nursing education* (2nd ed.). New York: National League for Nursing.
- Riner, M. E., & Billings, D.M. (1999). Faculty development for teaching in a changing health care environment: A statewide needs assessment. *Journal of Nursing Education*, 38, 427-430.
- Rosseter, R. J. (2006). *Nursing Shortage Fact Sheet*. Retrieved Sept 20, 2006, from <http://www.aacn.nche.edu>
- Sands, R. G., Parson, L. A., & Duane, J. (1991). Faculty mentoring in a public university. *Journal of Higher Education*, 62, 174-193.
- Scanlan, J. M. (2001). Learning clinical teaching: Is it magic? *Nursing and Health Care Perspectives*, 22, 240-246.
- Scheurich, J. J. (1997). *Research method in the postmodern*. London: Falmer Press.

- Seidman, I. (1998). *Interviewing as qualitative research: A guide for researchers in education and the social sciences* (2nd ed.). New York: Teachers College Press.
- Sellappah, S., Hussey, T., Blackmore, A.M., & McMurray, A. (1998). The use of questioning by clinical teachers. *Journal of Advanced Nursing*, 28, 142-148.
- Sieh, J., & Bell, S. (1994). Perceptions of effective clinical teachers in associate degree programs. *Journal of Nursing Education*, 33, 389-394.
- Siler, B. B., & Kleiner, C. (2001). Novice faculty: Encountering expectation in academia. *Journal of Nursing Education*, 40, 397-403.
- Southern Regional Education Board. (2002). *Nurse educator competencies*. Atlanta, GA: Author. Retrieved March 20, 2007, from <http://www.sreb.org>.
- Statistics, U. S. B. O. L. (2004, 2005). *Monthly Labor Review*. Retrieved Oct. 4, 2006, from www.bls.gov/news.release/ecopro.toc.htm
- Stuebbe, B. (1990). Student and faculty perspectives in the role of a nursing instructor. *Journal of Nursing Education*, 19, 4-9.
- Tang, F. I., Chou, S. M., & Chiang, H. H. (2005). Students' perceptions of effective and ineffective clinical instructors. *Journal of Nursing Education*, 44, 187-192.
- Taylor, E. W. (1998). *The theory and practice of transformative learning: A critical review*. Unpublished manuscript, Columbus, OH.
- Thrall, T. H. (2005). Teachers wanted. *Hospitals and Health Networks*, 78, 5.
- Vance, C. & Olson, R. (Eds.). (1998). *The mentor connection in nursing*. New York: Springer.
- Wayne, A.J., Youngs, P., & Fleischman, S. (2005). Improving teacher induction. *Educational Leadership*, 62, 76-78.
- White, R., & Ewan, C. (1991). *Clinical Teaching in Nursing*. London: Chapman and Hall.
- Young, P., & Diekelmann, N. (2002). Learning to lecture: Exploring the skills, strategies, and practices of new teachers in nursing education. *Journal of Nursing Education*, 41, 405-412.
- Zebelman, E. S., & Olswang, S. S. (1989). Student career goal changes during doctoral education in nursing. *Journal of Nursing Education*, 28, 53-60.

Zungolo, E. (2004). Faculty preparation: Is clinical specialization a benefit or a deterrent to quality nursing education? *Journal of Continuing Education in Nursing*, 35, 19-23.

Appendix A

Letter to Nursing Program Directors
Explaining the Research Study

Letter Attachment to Nursing Faculty

Letter to Nursing Program Directors

June , 2007

Director, Department of Nursing

Dear ,

I am conducting a study of first-year learning of novice emergency-hire nursing instructors. With the current nursing faculty shortage, new faculty are often hired last-minute to fill a position that is critical to the integrity of the program on nursing. The research will be used for purposes of writing a doctoral dissertation at the University of San Francisco's School of Education. Other ways this research might be used is in conference presentations or published professional journal articles.

Through this project, I am interested in exploring instructor learning the role of clinical teacher during the first year of teaching and the supports and hindrances to that learning. I am specifically interested in "last-minute" or "emergency" hires because of the desperate faculty need by schools of nursing today. First-year nursing faculty's learning has not been studied in light of Mezirow's Transformative Learning Theory. Because this theory takes teachers' thoughts, emotions, and motivations into consideration, it has potential for helping in the understanding how faculty, in this time of severe faculty shortage, learn in their first year of teaching.

Given my focus, I am requesting your help in recruitment of faculty participants. I am specifically looking for individuals who have never taught before in an academic setting. I have attached a letter and am asking that you forward this email to all faculty. New faculty will then be able to self-select, and other faculty may have suggestions for colleagues that they know from other settings. Understanding the experience of the emergency hire nursing faculty may inform the process of scaffolding and supporting new teacher learning on the job in the first year.

I would appreciate any assistance you can provide in identifying possible research participants.

Thank you very much for your consideration.

Ingrid Sheets, MS, RN, CNS

5-1-07

Dear Nursing Faculty:

My name is Ingrid Sheets and I am a doctoral student in the School of Education at the University of San Francisco and nursing faculty at Dominican University of California. I am planning a dissertation research study on first-year learning by novice emergency-hire clinical nursing instructors. I am interested in understanding how novice emergency-hire clinical nursing instructors learn the role of nursing faculty in the first year and what either helped or hindered that learning.

You are being asked to participate in this research if you are a new nursing faculty hired in the past year and that you consider that you were hired "last-minute" prior to a semester starting. Last minute is defined as within 4 weeks prior to school starting for the purposes of this study. I am particularly interested in nurses who have no prior background in teaching in an academic setting. If you are not teaching clinical courses and are not newly hired, please pass this message along to one of your colleagues who might fit the criteria for the study.

If you agree to be in this study, you will participate in two interviews where you will receive the pre-determined questions prior to the interview. The interview will be recorded as a data collection method. During the interview, you will be asked to draw a timeline of the events during your first semester/year of teaching and construct a concept map of your current thoughts about teaching in nursing. The second interview will be for me to clarify the information with you about the first interview and ask several more questions. Once the data has been transcribed and analyzed, I will ask that you verify that I understood your meaning. Each interview may last about an hour and take place at a mutually agreed upon place and time.

Although there will be no direct benefit to you from participating in this study, the anticipated benefit of this study is to better understand the experience of the novice emergency-hire nurse's transition into a clinical teaching position, how they learned the role of teaching and what either helped or hindered that learning. This information may help to improve the systems in schools of nursing to support newly hired nursing faculty.

There will be no costs to you as a result of taking part in this study, nor will you be reimbursed for your participation in this study.

If you have questions about the research, you may contact me at my office. If you have further questions about the study, you may contact the IRBPHS at the University of San Francisco, which is concerned with protection of volunteers in research projects. You may reach the IRBPHS office by calling (415) 422-6091 and leaving a voicemail message, by emailing IRBPHS@usfca.edu, or by writing to the Department of Counseling Psychology, University of San Francisco, 2130 Fulton Street, San Francisco, Ca 94117-1080.

PARTICIPATION IN RESEARCH IS VOLUNTARY. You are free to decline to be in this study, or to withdraw from it at any point. The Nursing Department is aware of this study but does not require that you participate in this research and your decision as to whether or not to participate will have no influence on your present or future status as faculty in your program.

Thank you for your attention. If you agree to participate, you will complete the appropriate consent form prior to the initiation of the first interview. I hope you will consider participating in this interesting and potentially enlightening research or telling someone you know about it if you think they might qualify as a new clinical faculty.

Sincerely,
Ingrid Sheets, MS, RN
Doctoral Student
University of San Francisco

Appendix B

Consent Letter

Appendix B

UNIVERSITY OF SAN FRANCISCO**CONSENT TO BE A RESEARCH SUBJECT****Purpose and Background**

Ms. Ingrid Sheets, a graduate student in the School of Education at the University of San Francisco is doing a study on first-year learning by novice emergency-hire clinical nursing instructors. Due to the severe nursing faculty shortage and the continuing nursing shortage, nurses are recruited to become nursing instructors and may not have background for teaching in higher education. The researcher is interested in understanding how novice clinical nursing instructors learn the role of nursing faculty in the first year and what supported that learning.

I am being asked to participate because I have been a novice emergency-hire clinical nursing instructor and have taught for one semester or one year.

Procedures

If I agree to be a participant in this study, the following will happen:

1. I will complete a short questionnaire giving basic information about me, including age, gender, race, and information about my educational background.
2. I will agree to meet with the researcher for two interviews to discuss my first year of teaching. I will agree to create a concept map and fill in a timeline of first year teaching events. I will agree to have the interviews recorded and transcribed.
3. I will be offered the opportunity to review the analysis of my interviews for accuracy of interpretation.

Risks and/or Discomforts

1. It is possible that some of the questions about my first year of teaching may make me feel uncomfortable or anxious, but I am free to decline to answer any questions I do not wish to answer or stop participation at any time.
2. Confidentiality is a primary concern and every effort will be made to insure complete confidentiality. Study records will be kept as confidential as possible. No individual identities will be used in any reports or publications resulting from the study. Study information will be coded and kept in locked files at all times. Only the researcher will have access to the files.

3. Because the time required for my participation will be 2 one-hour interviews, I may become tired or bored.

Benefits

There will be no direct benefits for me from participating in this study. The anticipated benefit of this study is a better understanding of how new and emergency-hired nursing faculty learn on the job and what supported or did not support that learning.

Costs/Financial Considerations

There will be no financial costs to me as a result of taking part in this study.

Payment/Reimbursement

As a thank-you, I will be offered the newest edition of the National League of Nursing publication titled “A Nuts-and-Bolts Approach to Teaching Nursing” published in 2006. If I decide to withdraw from the study before I have completed participating or the researcher decided to terminate my study participation, I will still receive the offer.

Questions

I have talked with Ms. Ingrid Sheets about this study and have had my questions answered. If I have further questions about the study, I may call her at her provided number.

If I have any questions or comments about participation in this study, I should first talk with Ms. Sheets. If for some reason I do not wish to do this, I may contact the IRBPHS, which is concerned with protection of volunteers in research projects. I may reach the IRBPHS office by calling 415-422-6091 and leaving a voicemail message, by e-mailing IRBPHS@usfca.edu, or by writing to the IRBPHS, Counseling Psychology Department, Education Building # 017, University of San Francisco, 2130 Fulton St. San Francisco, CA 94117-1080.

Consent

I have been given a copy of the “Research Subject’s Bill of Rights,” and I have been given a copy of this consent form to keep.

PARTICIPATION IN RESEARCH IS VOLUNTARY. I am free to decline to be in this study or to withdraw from it at any point. My decision as to whether or not to participate in this study will have no influence on my present or future status as an employee in the program of nursing where I currently work.

My signature below indicates that I agree to participate in this study.

Participant’s Signature

Date of Signature

Signature of Person Obtaining Consent

Date of Signature

Appendix C

Demographic Questions

New Nursing Instructor Demographic Information*Please fill in your contact information below*

Name: _____ Date: _____

Home Address: _____

Home phone: _____ Cell: _____

email: _____

My highest degree is: _____ BSN _____ MSN _____ PhD _____ EdD
_____ Other

School(s) at which you currently teach:

Subject(s) you currently teach:

Is what you teach your current area of expertise? _____ yes _____ no

Grade level you currently teach:

Clinical placement(s) location:

Do you currently work as a nurse? _____ yes _____ no If yes, where?

Your position at work is:

I was hired to the nursing program about _____ weeks before school started.

I attended an orientation to the nursing program I taught in this year _____ yes _____ no

I was assigned or offered a formal mentor _____ yes _____ no

I found a peer mentor on my own in the nursing program _____ yes _____ no

Place a check mark next to the option that best indicates your answer

Indicate your gender _____ Male _____ Female

Indicate your age category _____ 20-29 _____ 30-39 _____ 40-49 _____ 50-59 _____ >60

Indicate your ethnicity

Indicate your teaching experience

_____ This was my first semester/quarter

_____ This was my 1st_____ This was my 2nd yearIndicate your **teaching preparation** prior to your 1st year of teaching. Check all that apply.

_____ Major in Nursing Education in Graduate School

- ___ Major in Education in Graduate School
- ___ Minor in Nursing Education in Graduate School
- ___ I did a full semester (or more) of student teaching
- ___ I did less than a full semester of student teaching
- ___ I have received continuing education units in Nursing Education
- ___ I have attended national conferences on Nursing Education
- ___ I am/was considered an Education Specialist at my place of work prior to teaching in a school of nursing
- ___ I had no academic teaching preparation prior to my 1st year of teaching in a school of nursing

Appendix D

Predetermined Questions

PERDETERMINED INTERVIEW QUESTIONS

FIRST-YEAR LEARNING OF NOVICE EMERGENCY-HIRE CLINICAL NURSING FACULTY: A QUALITATIVE STUDY

Background

1. Tell me a little bit about your current clinical teaching position.
 - a. What do you teach?
 - b. What are your main job responsibilities?
2. Talk a little bit about what drew you to teaching nursing? How did this job happen?
 - a. Why did you choose this position?
 - i. Was it a career change for you?
 - ii. When did you decide to teach?
 - b. What did you believe were your skills in the area of teaching back when you first began?
 - c. How did you come to teach in this nursing program?
 - d. Compare the context where you are working now with your own nursing-school experiences.
 - i. In what ways are they similar?
 - ii. In what ways are they different?
3. Think back to when you started as a clinical nursing instructor.
 - a. Explain the formal preparation for teaching you received prior to entering clinical teaching setting.
 - b. What was it about teaching that you looked forward to?
 - c. What challenges did you anticipate encountering?
 - d. What hopes and goals did you have for yourself, your students, in general?
 - e. What views did your family or friends have about your choice to teach nursing?
 - f. When you were just starting out, did you think you would be teaching for a long period of time or for just a semester or year?
 - g. In thinking about what teaching would be like, was it what you thought it would be?
 - i. If yes or if no
 1. How did the actual clinical teaching experience compare with what you envisioned it to be?

Additional Questions

Added questions after timeline and concept map were discontinued after interview 3.

4. What were some significant events that happened in your first year of teaching?
 - a. What was the high point of the year or semester?
 - b. What was the low point of the year or semester?
 - c. What surprised you most about the first year?
5. How did you learn the role of clinical instructor?
6. How did you learn to teach nursing students?
7. What would you say influenced that learning, or hindered your learning?

8. What did you think of your role as clinical instructor: how it was evolving, and how you were handling it?
9. What challenged you this past year about the new teaching role?
10. What about support, what support did you have for your new role?
11. Tell me about mentoring.
12. Tell me about the orientation process.

Appendix E

Timeline Instructions

FIRST-YEAR OVERVIEW TIMELINE

Think back to your first day of clinical teaching and think through how the rest of the semester/rotation/year unfolded. Please indicate some of the events and experiences that stood out for you during your first semester/clinical rotation/year. If you can place them in a time sequence, like Fall semester, Spring semester, or first, second, third quarters, that would be great.

Some questions that might help prompt your thinking are

- ◆ What was your first day like?
- ◆ What were some of the significant events that occurred throughout the semester/year?
- ◆ Who were the people involved with each event?
- ◆ Do you recall the emotions you felt surrounding each event?
- ◆ Can you attach months or general time periods to these events?
- ◆ Are there particular months that stood out for you?

Use the space on this paper to chart out your 1st year of teaching noting events, people, places, and any feelings you recall having at the time.

(Modified and used with permission of J. L. Cuddapah, 2007).

(When overview timeline and concept maps were abandoned, questions to ascertain high point, low point, and surprising points during NCNI first teaching rotations were added to predetermined questions.)

Appendix F

Concept-Map Instructions

CONCEPT MAP

Instructions:

Concept Map of Teaching

Now that you have begun thinking about clinical teaching during the first year, I want to get a deeper understanding of your current conceptions about clinical teaching. To do this, I am going to ask you to create a concept map, which is a sketch of your thinking today. Concept maps can indicate what words or phrases we associate with a particular topic at a given time. They may provide a summary of what we believe, think, feel, or value at a particular point in time. The form that your concept map may take can vary; you may want to list phrases, draw circles and lines, and cluster words. Neatness is not an issue here, and if I have any trouble reading something, I'll ask.

The topic of this concept map is TEACHING. There are probably many concepts, names, and words you associate with this topic. The concept-mapping activity is one where the phrases and ideas you associate with teaching are captured in some visual format. These maps contain concepts, names, and linking words, and there are differences between each of these.

Create a concept map of Clinical Teaching that includes concepts, names, and linking words. The form that your concept map may take can vary; you may want to list phrases, draw circles and lines, and cluster words. Remember, neatness is not an issue!

- ◆ *A concept* is an abstract or generic idea generalized from particular instances, a real pattern of which existing things are imperfect representations.
- ◆ *Names* are words or phrases that designate a person or thing.
- ◆ *Linking words* are prepositions, prepositional phrases, or verb phrases that connect concepts to other concepts or connect concepts to names.

Steps:

1. Take 2 minutes to brainstorm a list of key concepts you associate with the topic, CLINICAL TEACHING.
2. Select what you think is the most general concept on your list.
3. Arrange the other concepts in relation to that identified general concept.
4. Draw lines and indicate linking words to show how you see the relationship between the concepts.
5. Let me know when you think your map is at a discussion point.

(Modified and used with permission of J. L. Cuddapah, 2007).

Appendix G

Nursing Program Administrator Interview Guide

The Administrator's Position

Interview guide for the Nursing Dept Chair and/or Director of Nursing Program

The nursing clinical faculty shortage has created a situation where people are hired last minute to fill positions that if unfilled, leave the potential of the section being canceled. Or the consequence may be dispersing those students to other groups which effectively means 10-12 students per clinical group. This number is excessive for current clinical faculty to manage in any one site.

1. What is the scope of the problem from your point of view?
2. What are the three key issues?
3. What is the turn-over rate of new hires here?
 - a. Why do they leave or not return?
4. How is recruiting new clinical faculty currently done by this institution?
5. How do you fill emergency-hire positions?
6. Do you use hospital unit specific recruitment in facilities where you have contracts?
 - a. Why or why not?
7. What is the procedure when someone is hired?
8. What do you view as your program's relationship with the new hire and what does your program feel obligated to provide to the new hire?
9. What do you think will help this situation in the future given the faculty shortage and nursing shortage are not going to be resolved any time soon?
10. What are your expectations of those doing the hiring?
11. What would you like to see done related to hiring instructors "last minute"?
12. What is the support provided to the e-hire NCNI from the nursing program?
13. At your institution, how frequent is the contact with the new hire and by whom if the contact is made?
 - a. How is the contact initiated?
 - b. What is the follow-up to issues raised?

14. The emergency hire instructor has to grade student papers (care-plans, etc) as well as student performance. Is there help with grading for nurses who have never been in a teaching role?
15. Is there anything in place for orientation to the program and/or the course specifically for the new hire?
16. Does the new hire meet with the theory course faculty if there is enough time?
17. Is there a mechanism for new hires to be mentored in this program?
 - a. If so, how does it work?
 - b. Assignment or chosen?
18. If no mentor program, who and what is there for new hire contact sources in the program?
19. What is your view about retention of clinical faculty related to competitive pay, flex hours, accommodation of current work schedule?

Appendix H

Example of Participant Interview Analysis Document

Beth: On Coming to Teach

Beth is a second career nurse in her mid-thirties. She started out as a journalist and after writing for a sports magazine began working at a sports shop. It wasn't long before Beth found herself working for Outward Bound and she attained her wilderness EMT specific for guides. Beth worked on a local ambulance crew, but did not care for it. At the urging of a friend Beth moved to Colorado where she worked as an EMT, nurses aide, cast tech, IV tech, and other allied health positions for seven years. It was then that Beth decided to go to nursing school. Beth attained an associate degree in nursing and once done decided to work and put herself through a BSN program. Beth began working as an oncology nurse at Slone Kettering in New York upon graduation. After two years she stated "I got burned out, I was working with horrible nurses, bad technique and stuff." Beth became a traveling nurse and was sent to a west coast hospital where she attained permanent employment and continues to work full time. She is extremely happy with her position as an oncology nurse and states "I have done some amazing things there. I just love my job. I love going there, I come home. But, there is very little I bring home. I was just awarded the "Daisy" award!" The Daisy Award is awarded to extraordinary nurses as chosen by patients, peers, supervisors and physicians.

When asked how she came to teach, Beth stated that one of the nurses in her unit at work was an alumna of the school that sent a flyer to their unit. "She loves this school and brags to anyone who will hear about it, the best school on earth!" The nurse encouraged Beth to consider trying clinical teaching. Beth had "precepted new hires and an occasional nursing student" and wondered if she could "do it with one student could I do it with eight students possibly?" Beth responded to the flyer and was interviewed in

May, however she did not hear back again from the school until three weeks before school started in the fall when she was hired. Beth missed the scheduled new faculty orientation because she was working. A syllabus, clinical schedule, and name of an assigned formal mentor for the semester was provided to Beth once she was hired. At the time of the data collection, Beth had completed teaching one semester of BSN students and a second semester of combined undergraduate BSN students and MSN nursing entry students at the university nursing program. Beth was a BSN prepared nurse with no formal or informal education courses in how to teach when she took the new nursing instructor position.

Beth's First Year Overview.

Prior to school starting, Beth became involved in trying to set up the clinical orientation for her and her students. Beth was assigned to an unfamiliar hospital in a near by city. She did not know anyone in the facility when she started. Whereas she contacted the hospital liaison person for the school and left three messages to set an orientation appointment, her calls were never answered. Once in contact, there was confusion and her needs were not immediately met. Beth did have a discussion with the instructor who taught the clinical rotation the past semester. There was no meeting room assigned for faculty and students to gather at the hospital so Beth had to find a room at the university and ended up in a cold basement the first day that was “the pit of all rooms around here. It was very bad. I thought, if this is how it is going to be, I’m not going to dig it at all. That was the beginning of the semester!”

When asked what she thought her job responsibilities were with the junior level medical/surgical students Beth replied, “To make sure the students did no harm at that

point, I guess. And part of it was, I can't be in eight places at once and I had students on three different floors." Beth remembered how her nursing instructors handled teaching yet was not able to model her teaching after that. She stated,

The instructor picked out your patients, they were the ones doing the meds with you, and they did everything. The trend of what I see now blew me away when it happened to me at work. The student "buddies" with the nurse and I said "you mean they follow me around all day?" It is a completely different model the new way of doing things. I think it works well though. At the hospital I don't have a code to any of the Pyxis information and I can't get into their computers. I didn't know about any of their charting, they do paper charting but the medications are all in the computers. I now have to rely on the nurses on the floor for things. As a preceptor I used to sit down, get report, and I would say to the student "which of these is your sickest patient?" things like that. And, just go through my thought process and think about what the student could get out of it. I have now just tried to transfer it to eight students instead of one.

Beth had good insight to what the students were or were not comfortable with. She recognized that just getting students comfortable at the bedside was a challenge. Beth remarked,

I know they are very task oriented at this point. Just getting them comfortable at the bedside, I watch them doing certain things and then I have them watch me doing certain things. Depending on the student and how they were feeling comfortable, I would say "let me know when you're going to do something with the patient." I wanted to be there to get a visual on it, because to me it is very different from reading on paper to see it yourself. I wanted to meet the patient. I try to just give them the real experience, you know, because there are always things you do that you don't learn in nursing school.

Quite satisfied with herself, she admitted that her learning the position of nursing instructor was "trial and error." Some of the strategies that she employed with the first group of students did not work at all for the second group. When discussing a weekly email correspondence she had with the students where she would pose a question per week and students would proceed to answer, she would provide little stickers or other

prizes for those who answered correctly. “It was fun for them and fun for me too. I had to get myself re-engaged with the material and it was a good way to do it” Beth claimed.

There were students with whom Beth had discussions regarding their outward display of love of nursing itself. Beth talked about how she would advise students about how their presence on the unit lacked enough enthusiasm for the profession of nursing. “I know you like what you are doing, but I don’t know you love what you are doing!” She would go on to explain to the student that in the interview process for a nursing position, it was very important to make sure that enthusiasm and love for nursing comes across so the employer would think they were a good fit in their facility.

There were many times when Beth questioned what she should do, how she should proceed. She was learning the role of clinical instructor as she went along.

Recognizing her novice instructor status Beth remarked,

The first semester I was too nice, I’m sure. But, if someone would have really back-talked me or something, would I have written them up? I wanted to be accepted, I wanted to enjoy it. The second semester was completely different, I mean, I was writing advisories all over the place.

Beth agreed that the first semester students were fairly “easy” and she did not have student related issues with any of them. One challenge Beth did find difficult, because she had no experience or training, was student evaluations at midterm and the end of the semester. Of this Beth mentioned,

At midterm evaluations, I was going by the seat of my pants, no training, or orientation to this. I kind of made up my own thing about it and hopefully they understand what I am saying. But, I didn’t even have examples to go from, I really didn’t know what I was doing. I just did it.

I asked, “Did you think, ‘at this point I have to make a decision about whether this person is failing or not’?” Beth responded,

It didn't even occur to me that that was something that would have to come up. I had a good group, some of them were exceeding some on target, most were either one or the other. I just tried to let them know that at the time. I had a little notebook where I would keep notes about what went on. Like "Mercy tried to start an IV and then backed off. She had two opportunities to start IVs and didn't do it, she shouldn't become a wall flower". I tried to think of the things that might bring them along. I had a star student, I can't wait until she becomes a nurse, she's doing exceedingly well. She was accepted into the nursing honor society and other things. They need their ego's boosted, you know, other than getting grades in other classes, are they getting evaluations? Like 'you are on the right track, or this is what you can work on.' Her charting was great from day one, so I had her showing other students. The one that wasn't exceeding I had to say, 'remember, there is going to be competition out there, you need to show and tell somebody how much you're loving this! You're passing, you're safe, you're prepared, all those things, but you're not shining.'

Regarding final evaluations Beth alleged, "Final evaluations were not much different from the midterms. I didn't know anything more then about the process.

Concerning a student who did not seem to be quite up to the standards Beth thought appropriate for a student nurse, Beth lamented, "And I guess at mid-semester, there was a fear of 'God, am I going to have to flunk her, am I going to have to?' I always wonder if I overstep my boundaries. 'Can I say that?' I wondered, 'if I don't tell her now, who is going to tell her?'"

Another area that Beth felt inadequately prepared for was grading of care plans.

Beth admitted,

And, I had no idea how to criticize the care plans! That was another thing. There was no instruction to me about that. It has been about 7 years since I've done one, when I was in nursing school. We don't use care plans in the hospital, it is a school thing. Nobody gets it the first time around, I try to explain it, but it is hard. "The other instructor had such a way of doing it from last semester", they would say, "she didn't do it like this". It was always different. I would say, "But this is the reality, think of what the problem is" you know. The care plans are by far the hardest thing that you don't see improve. Mid semester is about when you see them start to improve, as long as it improves by the end of the semester I was ok with it.

Of the end of the semester paperwork Beth claimed, “I didn’t know anything about that. I finally asked the faculty in charge of the junior year, but he was vague about it. I ended up giving it to the secretary, I didn’t know!”

Asked if she utilized the mentor assigned to her at the beginning of the semester Beth responded that she did but very little during the first semester. Most of her questions she directed to the junior year director and she seemed satisfied with the responses most of the time. It was the second semester that the mentor was fully engaged by Beth. While the first semester was clearly a learning experience for Beth and normal challenges were fairly easily rectified, the second semester posed problems that tested Beth’s ability to stick with the new position.

Beth’s First-Year Critical Incidents

As descriptive accounts of significant events the first year of teaching, Beth had no difficulty articulating the critical incidents that occurred. In discussing the transition to the second semester of teaching Beth stated,

“The difference between the first semester and the second semester is that the first semester was all BSN students. The second semester, 5 out of the 7 were the masters level entry students. Oh, my God, it is torture! These students have a very different maturity level. So, I had two of the students at the BSN level so they are 19-20 age range, and they were acting like 19-20 year olds. Basically, they are all taking the same classes, it’s just that the BSN students had 2 ½ years working their way into it where the masters students have been working on it for only 5 months. The masters level students are a little bit older, which I thought would be helpful..... It did make a lot of sense, the problem was that they wanted to challenge ...”

Having the mixed levels of students in the second semester was difficult for Beth throughout the semester. She was challenged on much of what she asked the students to do and became engaged in a power struggle with a student that tested her instructor

authority. Of the semester there were high points, low points and a surprising point that identified critical incidents for Beth.

High Point. Beth claimed that one of her students was not doing well. The high point of the semester for her was explained, “He had an ‘ah ha’ moment in the last two weeks, and I thought that I must have done something right, finally!” Beth stated that this was a student in the second semester who was struggling with producing a reasonable care plan.

Low Point. While Beth assured me that having students succeed was what she measured her teaching success by, she was very clear that there was an incident that she did not know how to address appropriately and she did not have support during the incident. Beth explained, “that no matter how I explained it, she was just not getting it. I don’t know how many other ways I can explain it, I can give 5 different ways and she still was not getting it.” She went on to state,

By the end of the semester she was in the OR all day and I didn’t even have to see her. It was starting to get too personal, I was tired from it. The thing is she started calling me at home. At one point, she called me over spring break and told me that she didn’t take confrontations well, which was completely obvious. But, she said she had emotional issues, that her mother died in a car crash, and her father had a stroke very soon after that, and she had been sexually abused right before going to college.

Beth had problems with this student from the very beginning of the second semester.

While initially the student was confrontational and manipulative of the other students,

Beth took the confrontations on and was firm in her responses to the student. She “wrote her up” with advisories numerous times and still the student persisted. After hearing the emotional issues the student posed, Beth stated she was “sympathetic”, but cautions. She explained,

...but I am not going to buy in to all this because I also realize that this is completely, that this is extremely interesting that all this is happening after she had gotten all the advisories and we had to work on all this stuff. I gave her all the numbers for counseling, I thought, you know, “I’m going to be a good person about this stuff”. I gave it all to her and she didn’t want to do it, which was fine. Complete lies! At one point she was going home to a wedding and her Mom is picking her up. I’m like, “she doesn’t even realize that she’s caught herself up in this!”

Beth admitted that she was not equipped to handle the situation and it required more than her level of novice instructor. Beth made the first call to her “mentor” who admitted that the student was problematic in her course the prior semester with a similar problem. Direction from the junior year director was discouraging to Beth. Of that she noted, “I think he is a little too soft because he kept saying ‘we’re here to nurture them, we’re here to do this, don’t feed into what she said, correct it’.” Beth commented, “If I had another student like that next semester, it would be over, I wouldn’t do this anymore, that would be that!” This situation had been ongoing the whole semester and Beth found herself ill-equipped to handle it due to lack of experience or training.

Surprising point. Still referring to the student issue discussed in the low point, Beth claimed,

I think I was surprised that I took it to the point where I was insulted, how do I say this? I wanted a certain degree of respect, because, I thought, I’m in that kind of position. I was really surprised that a student would so unabashedly say those things! I don’t want to say that I was surprised that I was really enjoying it [teaching], that wasn’t so much a surprise because I thought I would. I think having a student like that never really occurred to me. I thought that I could handle a student that wasn’t doing well and would have to repeat a semester or something like that. Things like that happened in my nursing school, not all people pass every time. But, this kind of communication completely took me off guard, completely. I think part of it is, I’m a nice person, like part of it is, like ‘people don’t say things like this to me, like, everybody loves me’ like, there are very few people that don’t like me. It definitely took it to another level, really.

Discussion of Beth’s Learning the Role of Nursing Instructor

Beth's learning in the first year reflected "learning on the job" and "learning on the fly". Beth had no prior knowledge of clinical instructor teaching, her experience was precepting an occasional student in her workplace or a new hire. Beth started the semester with a very positive attitude and felt supported in her new role by the faculty and her mentors within the program. As school started the first semester, Beth claimed, "This is the next step in the process of my life. This is where I'm meant to be, this feels right, however crazy it is going to be!"

The learning experiences are categorized as either transformative or informative. Table 1 summarizes Beth's first year learning followed by a discussion of that learning.

Informative Learning. While Beth had a little knowledge of teaching from her few precepting experiences, she did have a frame of reference about clinical teaching from her own student days. She remembered what the role of the clinical instructor was and had to reconfigure that notion based on her new experience. Whereas in her student days, the instructor was with the students all day and they were together on the unit, the fact that Beth had 8 students and they were on three different floors challenged her former schema and required adding to her existing frame of reference. The next eight examples of Beth's learning all were creating a new frame of reference where no schema existed. All experiences involved acclimation to the course, to the clinical site that was not her place of work, to the management of students, to the program itself. Beth was supported in her learning some of the time by her mentor and her faculty program contact. Nevertheless, Beth still struggled with many aspects of the position due to lack of knowledge. Being a novice instructor, Beth lacked the background knowledge for management of student problems. She was faced with what turned out to be critical

Table 1
Overview of Beth's Learning

What was Learned	Descriptive Quotes	Informative		Transformative	
		Add to existing frame of reference	Gain new frame of ref.	Point of view	Habit of mind
A clinical instructor is not the same as a preceptor, or role of former instructors.	"I can't be eight places at once and I had students on 3 different floors. When I was in nursing school, we went from floor to floor and you stayed with your instructor. The instructor picked out your patients, they were the ones doing the meds with you, they did everything."	▼			
As clinical instructor in a non-staff role, you do not have access to all patient information and have to rely on the staff nurses.	"I don't have a code to any of the pyxis information and I can't get into their computers. I didn't know about any of their charting, they do paper charting but the medications are all in the computers. I now have to rely on the nurses on the floor for things."		▲		
Teacher authority must be established to be confident in the teacher role	"I had to tell them 'you have to understand this stuff, in your own words'. Your patients need to understand you, so you have to say it in your own words. You are going to get more out of this if you are able to explain it to your patients in your own words. They said 'our other instructors don't do it that way.' I said 'I don't care, in this clinical you need to do it that way and I think you will get a lot more out of it.' The text book stuff you learn in other classes, you need to transfer that to clinical."		▲		
Partnership with staff nurses creates trust	"But now I know the hospital, the nurses know me there, they like me..that trust is a big deal. They know they can always find me. Trust is a big thing. But, I think they have learned that I am serious with them and that I take them seriously so if they have an issue with a student I listen."		▲		
Support from a mentor is a God-send in tough times, lack of support would force quitting.	"I had issues this last semester, a very difficult student and I didn't know what to do. I came really close to really walking out, quitting. This was taking over my life. I said to the faculty of record, 'I don't know what to do, I've gotten these insulting emails, having her telling me how to criticize, you know, I don't know how to		▲		

	answer her.' I don't want to take this too personally, I go, 'I need to vent to you because this is going on.' It was the help between him and my mentor that really helped me....I have learned huge amounts from both of them."	
She recognized lack of confidence in ability to teach	"I was trying to figure out all the things that have to be done, I can tell they are all bored stiff. I'm trying like: 'tell me why you all want to be here.' Again, nobody has told me what to do or how to do things for this clinical. I thought, 'I am tortured now! I don't know if I can do this.' This was going bad, I was trying to guide it, they looked to me for the answers."	▲
Students can be fierce accusers	"She proceeded to almost call me racist, and then also brought in her own being female and being Filipino and how it was hard for her to speak up."	▲
Without concrete evidence, students cannot be given an advisory	"She wanted to prove me wrong. She wanted to get herself out of an advisory. In her mind I had made a point of correcting her and she did not like it and she thought she was right and I was wrong... But, he [FOR] said because it was a phone conversation, it was a 'he said, she said' kind of thing and he can't write her up on it. There is not proof that it actually happened. He goes, 'this is the kind of student that is going to pull that crap, you have to make sure you have solid grounds and evidence.'"	▲
She had no knowledge about how to handle a challenging student	"I wanted a certain degree of respect, because, I thought, I'm in that kind of position. I was really surprised that a student would so unabashedly say those things! I think having a student like that never really occurred to me. I thought that I could handle a student that wasn't doing well and would have to repeat a semester or something like that. Things like that happened in my nursing school, not all people pass every time. But, this kind of communication completely took me off guard, completely."	●

student issues in the second semester and finally did ask for help with it. However, that wasn't before she agonized over what was happening between she and the student. Beth had no schema to work from in this situation. Beth shared the experiences she was having

with her co-workers and supervisor at her place of work and although it made no difference in the actual situation, she had someplace to vent.

Transformative Learning. To be transformative learning as described by Mezirow (2000), certain steps must occur and not necessarily in a specific order. Beth, when describing her most surprising point of the semester explained that “I thought that I could handle a student that wasn’t doing well and would have to repeat a semester or something like that. Things like that happened in my nursing school, not all people pass every time.” Beth’s point of view and schema maintained that students sometimes fail in nursing courses and she had already pondered that issue and felt confident that she could manage the situation if it came up. The critical incident or trigger event that occurred in the second semester with a single student challenging her word, showing clear lack of clinical knowledge, lying, pitting the students against her, sending her insulting emails, and calling her on the phone over the break with continued challenge regarding clinical lack of demonstrated competency, completely challenged the frame of reference that Beth maintained about what it would be like if a student was not “doing well”. Beth stated that this issue “consumed her” and she reflected on it in great detail. Beth validated her contested beliefs through discourse with her peers at work and her mentors at the school. Clearly, a new frame of reference about management of difficult student situations evolved. Learning from her mentors about how to handle various aspects of the ongoing issue and implementing a new plan of action based on critical reflection, discussion, adoption of a new point of view fit the transformative learning steps as Mezirow (2000) described.

Influencing Factors in the First Year. It was a very difficult year for the novice instructor who had no orientation to the program and very little contact initially with the program director. Forging new relationships both in the nursing program but also in the new clinical setting during the first few weeks of the semester, while not always smooth, happened without incident. There were initial communication problems with the clinical site and arrangements for her clinical group. Beth claimed that she was lucky and had a “very easy group” the first semester. There were no real student challenges and all students seemed to excel in the clinical site. This factor made it easy for Beth to establish good working relationships with the nurses in the various units who seemed to enjoy taking the students each day. The mixture of types of students, ages of students, backgrounds of students the second semester, and an especially challenging student tested Beth constantly during that period. It was during this time that Beth employed the assistance of her mentors in the program and peers from work. The support rendered was sufficient to carry Beth from one week to the next although she expressed exasperation with the situation and tension that leaked over into her private life, “it was taking over my life, it was taking over my life!” The learning during the first year was informal and experiential. Without the benefit of prior education about teaching as a clinical instructor in a university program and being placed in an unfamiliar clinical setting made learning in the first year of clinical teaching a challenge. Beth appeared to be positive and clearly upbeat about the total experience when recalling the details. Beth is a person who enjoys a challenge and this experience was no exception. When asked if she would consider teaching next semester, Beth enthusiastically declared, “Yes, I can’t wait to go back this

next semester, from the pure fact that I now know what I need to do, how I need to address things!”