**AN EXPLORATION OF THE PREPARATION OF
NEW ZEALAND NURSE EDUCATORS
FOR
THEIR ROLE IN TEACHING POSTGRADUATE
CLINICAL NURSING COURSES**

by

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ABSTRACT

Little is known about the preparation of New Zealand nurse educators teaching clinically focused postgraduate programmes. This research gives an insight into their world and the preparation they had in order to fulfil their roles. A review of the literature on nurse educator preparation revealed a dichotomy of preparation nationally and internationally. This study was carried out to inform the New Zealand nursing profession on the preparedness of its educators teaching clinical nursing postgraduate programmes. It was my assumption that nurse educator preparation lacked strategic direction and was not nationally uniform. The research expected to answer how and to what extent New Zealand nurse educators teaching clinical nursing postgraduate courses at NQF Level 8 are prepared and supported for their teaching role.

This research used an exploratory descriptive survey methodology and was underpinned by a conceptual framework. The conceptual framework, referred to as the critical elements of nurse educator preparation (CENEP), contained four key concepts, support, educational preparation, personal attitudes and experience. These concepts informed the design and construct of a questionnaire to determine the level of preparation of New Zealand nurse educators teaching clinical postgraduate programmes. A total of 89 postal questionnaires were administered resulting in a response rate of 46% (N=41), however, four questionnaires were excluded leaving a sample size of 37. The Statistical Package for Social Sciences (SPSS Version 12) was used to analyse the data, and descriptive statistics along with non-parametric testing was undertaken. There were three open-ended questions included in the questionnaire and these were analysed thematically.

Results of this research reveal a culture where nurse educator preparation lacks uniformity and consistency. Individually, New Zealand nurse educators were found to be highly qualified for their positions and motivated and enthusiastic about their roles. However, 40% of respondents did not hold a teaching qualification. Results from this research revealed a pattern of clinical training for postgraduate nurses that was immersed in the world of the academic institution.

This research study is limited and cannot be generalised to the entire population of nurse educators teaching clinical postgraduate programmes. However, some valuable insights have been gained into a previously unexplored area, and recommendations have been made for the future direction of preparation for nurse educators teaching clinical postgraduate programmes in New Zealand.

Keywords: Nursing as a profession, faculty nursing, education nursing, exploratory descriptive study.

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CHAPTER 1: INTRODUCTION TO THE STUDY

I have always been interested in education, the development of nurses and the advancement of the profession. For these reasons I steered my professional career towards nurse education. I began my teaching journey 18 months prior to the commencement of this research study in the capacity of a nurse educator teaching a postgraduate programme with an intensive care specialisation.

My first year of teaching was extraordinarily challenging. I can remember feeling both energised and motivated, yet periodically deflated. Many times during my first year I felt internally torn between clinical practice and teaching and how to integrate them both. I questioned my nursing identity and skill, was I a nurse or a teacher, or could I be both? Did I have the necessary preparation and knowledge to do both? During this time I reflected on Dubins (1974) four-stage model of conscious competence. The stages described by Dubin are unconscious incompetent, conscious incompetent, conscious competent and unconscious competent. I felt I was at stage two of Dubins model, conscious incompetent; I had expert clinical knowledge but knew I needed further development in certain teaching aspects of my role. In order to enhance quality student learning I thought the best thing to do was talk to and learn from other nurse educators teaching clinical programmes. I was hoping to learn and develop from them. It soon became apparent however that a large number of nurse educators, some of whom had been in their positions for a number of years, appeared to be in the same situation as me. That is, they were clinically expert but had no formal qualifications or training specifically in nurse education. This raised questions for me; were all nurse educators teaching clinical programmes in New Zealand in a similar situation? and what was the profession doing nationally to prepare nurse educators for their roles?

It was my experience that expert clinical nurses appeared to 'land' into nurse education opportunistically rather than being developed as nurse educators and strategically placed, and that succession planning was simply non-existent. My experiences led me to believe that just because a nurse has expert clinical knowledge it does not necessarily mean they can teach – after all, knowing how to do something yourself doesn't necessarily mean that you can automatically teach someone else

how to do the same thing. I wondered what the significance this lack of role preparation had on New Zealand nurses, their educators and most importantly their patients. This led to two questions, do nurses teaching clinical programmes need to be educationally prepared in education? and are there any benefits of having educated educators?

Job satisfaction, retention and recruitment are as important for nurse educators as they are for nurses. Yet, from my personal experience I felt that although the industry dedicates a large amount of financial and other resources to some areas of nursing, an investment in educating nurses to teach had yet to be made. A direct consequence of this investment void is likely to be a lack of job satisfaction, low retention rates, poor recruitment and an inevitable decline in the quality of the profession. The opening paragraphs give an impression of my first year of practice as a nurse educator and identify some specific questions that I had during that time. In an attempt to answer some of these queries I embarked on my research journey. The background to the research along with the definition of key terms will now be outlined.

BACKGROUND

Little is known about the preparation of New Zealand nurse educators teaching clinically focused postgraduate programmes. Nurse educator preparation has been a concern of the international fraternity for a number of years (Bachman, Kitchens, Halley & Ellison, 1992; Choudhry, 1992; Diekelmann & Gunn, 2004). More than 25 years ago Fitzpatrick and Heller (1980) made the statement that there was an urgent need for nurse educator preparation. Billings (2003, p. 99) concurred and states, “Being a nurse educator takes preparation. Excellence in teaching is not intuitive, and a career as a nurse educator does not simply ‘happen’”. Johnson-Crowley (2004) states that although nurse educator preparation has been on the agenda for years, many of the strategies for nurse teacher preparation utilise outdated models that are not successful in producing the requisite teaching skills needed for the future.

In the context of this research project it is important to review what the term *nurse educator* means. There are a number of role titles both within New Zealand and internationally for nurses who interface between nursing education and clinical practice. Some other examples include Clinical Teachers and Clinical Instructors

(Fairbrother & Ford, 1998), Clinical Nurse Teacher, Clinical Educator (Howie, 1988; Sellick & Katinsaki, 1992) and Nurse Educator (Bachman, et al, 1992; McDonald, 2004; Naughton & Strobel, 1996).

Generally speaking, nurse educators are employed by polytechnics or universities to teach both undergraduate and postgraduate nursing programmes. There are also joint appointments between academic institutions and health service providers (usually hospitals), with nurse educators dedicating a small percentage of their time to clinical instruction or practice within a clinical institution/environment. These individuals are essentially academics with clinical responsibilities. Within this rubric there are also nurse educators working as clinicians with some academic responsibilities. The latter are employed by the clinical institution and provide expert clinical instruction. The literature often describes these positions as adjunct, conjoint or honorary appointments (Holmes, 2005). Finally there are Practice Educators (UKCC, 2000). A practice educator contributes “to education in the practice setting, co-ordination student experiences and assessment of learning” (English National Board & Department of Health 2001, p. 6). It is clear to see that internationally there are a variety of job titles associated with nurses teaching students, and New Zealand is no different.

In March 2005 New Zealand nurses and midwives working in the public sector entered into a multi-employer collective agreement negotiating pay and conditions. As part of the campaign to standardise pay and conditions, all job titles underwent standardisation (NZNO, 2006). The scoping exercise aspired to have generic job titles and descriptions for all nurses, nurse educators, nurse managers, nurse specialists and so forth. The necessity to explain the context of the title Nurse Educator stems from the fact that the scoping exercise was not completed at the commencement of this research. My job title on commencement of the research was Clinical Nurse Educator, a position working within an Intensive Care Unit. My role was much like the adjunct, conjoint or honorary appointments. During the course of this research, and as a result of internal restructuring, my job title changed to Nurse Lecturer, although the scope of my duties remained materially unchanged. I made the decision to use the title *nurse educator* as it was a common title in New Zealand and makes an obvious referral to those who educate nurses. To avoid any ambiguity in

identifying the research population I specified the teaching activities that the nurse educators needed to be involved in. My theories and motivations for research were based on my own experiences, so I wanted the participants to be involved in teaching clinical postgraduate programme(s) similar to the one I was involved in. Principally, it was my assumption that postgraduate nursing education is a critical factor in providing quality patient care, and I was interested in the quality of those who provide that education.

I was employed by a District Health Board (DHB)¹ and was responsible for delivering a specialist postgraduate programme at national qualification Level 8. Since 1990 New Zealand has had a National Qualification Authority responsible for the development and implementation of a national qualifications framework (NQF) (New Zealand Qualifications Authority, 2005). The intention of the framework was to establish parameters for nationally recognised qualifications. The framework has ten levels, National Certificates at Levels 1-7, National Diplomas at Levels 5-7 and National Degrees and Postgraduate qualifications at Levels 7-10. Level 8 specifically accounts for postgraduate diplomas, certificates and bachelors with honours. There are numerous clinical postgraduate programmes at NQF Level 8 delivered throughout New Zealand. Examples include specialty programmes in Mental Health nursing, Primary Health nursing and Intensive Care nursing. There is a significant trend in New Zealand for clinical postgraduate programmes, and according to Watson (2006) this trend has no sign of abating. Funding for Post Entry Clinical Training, including postgraduate nursing training programmes is the responsibility of the Clinical Training Agency (CTA) - a business unit situated under the umbrella of the Ministry of Health. All postgraduate nursing programme(s) require NQF Level 8 and Level 9 accreditation to receive funding (Clinical Training Agency, 2002).

This funding is assigned to the DHBs to distribute to the particular education programmes that they feel meet and service their individual needs. In order to attract funding, clinical postgraduate programmes have to meet a number of considerations. In addition to the NQF Level 8 accreditation courses must be financially sound, clinically relevant, meet the needs of a diverse and aging population and have a

¹ There are 21 DHBs in New Zealand all of which are responsible for funding and providing health and disability services for a given geographic location.

positive impact on patient outcomes (Clinical Training Agency, 2002). Radzyninski (2005, p. 124) states “programmes in graduate education in nursing need to support the evolving needs of the complex health care system and the anticipated health-care dilemmas of the future”. Having examined the funding and qualification framework for postgraduate programmes it is worth considering firstly who teaches them, and secondly whether they have the necessary skills and preparation to do so? From my experience as a clinical nurse educator teaching a clinically focused postgraduate programme I noted that many expert clinical nurses working in the field of education felt comfortable with their clinical skills, but under prepared and under supported for the teaching aspect of their role. This activated my interest in exploring the level of preparation that these nurse educators received. There is a question that must be asked of the accountability of postgraduate programmes if those who teach them feel under prepared.

THE RESEARCH PROBLEM

This research examined the preparation of New Zealand nurse educators, teaching clinical nursing postgraduate courses at National Qualification Framework Level 8.

THE RESEARCH PURPOSE

This research was carried out to inform the New Zealand nursing profession on the preparedness of its educators teaching clinical nursing postgraduate programmes. In New Zealand there is a lack of strategic direction for nurse educator preparation. It is the researcher’s assumption that nurse educator preparation is not nationally uniform and lacks formal instruction. This perception is the major impetus for this research. Teaching is a paradoxical activity, on one hand it is something anyone can do and on the other it can be viewed as complex, involving intellectual and social interaction. It is well documented that participation in teacher education programmes, formal preparation and role socialisation make a difference in the teaching skills of teachers (Darling-Hammond, 2000; Wilson, Floden, & Ferrin-Mundy, 2001). If we accept this concept and accept that nurse educators teach, then naturally it is worth investigating if New Zealand nurse educators are adequately prepared to teach. This research will describe how nurse educators in New Zealand teaching clinical nursing postgraduate courses at NQF Level 8 are prepared for their roles. Recommendations will be made on role preparation based on the results of the research.

Overall Research Question: To what extent and how are New Zealand nurse educators, teaching clinical nursing postgraduate courses at NQF Level 8 prepared and supported for their teaching role?

The aim of the research was to determine the preparedness of New Zealand nurse educators for their role in teaching clinical postgraduate programmes. A sample of New Zealand nurse educators, identified as those teaching clinical nursing postgraduate courses/programmes at NQF Level 8, was selected to determine how they were prepared for their roles. This research expected to answer the following questions:

Is a New Zealand nurse educator, teaching clinical postgraduate courses at NQF Level 8

- Academically prepared to teach a clinical postgraduate course?
 - For example, do they have a teaching qualification and are they registered nurses?
- Supported into the role of Nurse Educator?
 - For example, are they mentored by a senior colleague and given supervision opportunities, supported by their peers, given orientation on assessment development, using audiovisual aids and so forth?
- Prepared with the necessary personal attributes?
 - For example, can they work independently and manage their time? Are they enthusiastic and motivated?
- Experientially prepared to teach a clinical postgraduate course?
 - For example, do they have teaching experience and do they have clinical experience?

In summary this chapter has introduced the research, the background, motivation and impetus of the research. Some key terms were explained, and the research problem, purpose and research questions were outlined. To give the reader an idea of how the thesis will unfold it is necessary to consider the structure of this thesis as a whole, and following is a delineation of each of the thesis chapters.

THESIS STRUCTURE

Chapter 2 will examine the historical and contemporary context of the preparation of New Zealand nurse educators teaching clinical programmes. The pattern of nurse education preparation in New Zealand will be examined against specific themes that emerged from the literature.

The conceptual framework for the research is explored in Chapter 3. The development of the framework is explained and each of the four concepts (support, qualifications, personal attributes and experience) that form the framework is examined in light of the literature.

Chapter 4 contains the methodological approach, method and design of the research. In particular the chapter focuses on the sample selection, instrumentation, data collection and data analysis methods and ethical and Treaty of Waitangi considerations.

The results of the research are presented in Chapter 5. Descriptive statistics are used to represent the initial results. The results of non-parametric tests on key variables are reported. Results from three open-ended questions are reported in thematic form and the responses of the participants are presented.

The results of the research are discussed in Chapter 6. The pattern of nurse educator preparation and postgraduate clinical nursing delivery in New Zealand will be discussed. The dialogue is informed by the literature. Limitations of the research are considered in this chapter also.

Chapter 7 makes a number of key recommendations based on the results of the research. Details with regard to the dissemination of the studies findings will be articulated.

CHAPTER 2: REVIEW OF THE NEW ZEALAND AND INTERNATIONAL LITERATURE

This research explored the preparation of nurse educators teaching clinical postgraduate programme at National Qualification Framework (NQF) Level 8. This concise description incorporates a job title (nurse educator) and role (clinical postgraduate programme at National Qualification Framework (NQF) Level 8) and was a deliberate attempt by the researcher to examine this particular group. This chapter will examine the historical and contemporary context of the preparation of New Zealand nurse educators teaching clinical programmes. Throughout the chapter the pattern of nurse educator preparation in New Zealand will become apparent. This pattern will then be examined against three specific themes that emerged from the international literature. The themes are educational preparation, nurse educator competencies and clinical credibility. Prior to examining nurse educator preparation in the New Zealand context, the search strategy will be described and the importance of nurse educator preparation outlined.

A literature search was undertaken to establish what, if anything, had been written about nurse educator preparation. The databases searched were, Medline, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Educational Resources Information Centre (ERIC), Cochrane, Proquest, Expanded Academic and Embase. Keyword searches were used, and where available these were complemented with subject heading searches as well. The value of subject heading searches is that a more guided search is given and misunderstandings in language are reduced. This was particularly beneficial when reviewing the international literature. Search terms included 'nurse educator and preparation', 'clinical nurse educator and preparation', 'nurse faculty and preparation', 'nurse tutor and preparation', 'nurse educator', 'nurse teacher', 'lecturer practitioner', 'nurse educator and faculty nursing', 'joint appointments and nursing' and 'teacher preparation'.

In order to narrow the field to key literature related to the research topic I focused on literature pertaining to the preparation of nurse educators regardless of their scope. By this I mean literature pertaining to all nurse educator preparation, be they nurse educators who teach undergraduate or postgraduate programmes and positioned in

clinical practice or an academic institution. The literature search revealed a paucity of New Zealand literature on the preparation of nurse educators teaching clinical postgraduate programmes. Spence (2004a, 2004b) appears to be the key writer in the area of postgraduate education in New Zealand. Her area of interest is the advancement of nursing practice through postgraduate education. The search also identified a number of unpublished but particularly relevant theses completed for masters and doctoral study which explore the experiences of nurse educators teaching students in clinical practice (Boot, 1997; Clare, 1991). Hardcastle (2004, 2006) has more recently begun to explore the meaning of effective clinical education for graduate nurses in New Zealand. In her 2004 research (N=88) she undertook to explore the meaning of effective education for critical care nurses. Whilst useful, this study was limited to both the speciality it explored and the geographical area it targeted, that is the South Island of New Zealand. The New Zealand literature contains a significant number of editorial commentary pieces about nursing education in general and the lack of research into educator preparation and educational preparation for undergraduate and graduate nurses (Hardcastle, 2006; Hetherington, 2006; Mockett, Horsfall, & O'Callaghan, 2006)

The pattern for nurse educator preparation in New Zealand was unclear and this led to the exploration of the international literature. The examination of the international literature led to the emergence of three major themes. The themes were specific to educational preparation (Burke, 1993; Lathlean, 1995; McNally, 1994; Stevens, 1994; Vaughan, 1987), nurse educator competencies (ANTS, 1997; Davis, Stullenburg, Dearman, & Kelly, 2005; National League for Nursing, 2007) and the clinical credibility of nurse educators (Fisher, 2005; Gillespie & McFetridge 2006; Holmes, 2005; Lynaugh, 2004; Webster, 1990). These themes will be examined further within the chapter, but prior to the consideration of these themes a discussion about the importance of nurse educator preparation will be presented. This will contextualise the argument for educator preparation in the first place.

THE IMPORTANCE OF NURSE EDUCATOR PREPARATION

Many nurse educators assume their positions with sound clinical expertise and an interest in education, but are often without master level qualifications or teaching experience (Krisman-Scott, Kershbaumer, & Thompson, 1998). Ramsden (2002)

suggests that to teach effectively the teacher must learn exactly how students learn. Ramsden proposes that higher education blindly relies on teachers who do not know how to teach, and suggests that a professional approach to teaching is necessary. Bachman, et al. (1992) supports this position, suggesting that nurse educators require programmes specific to their teaching needs as they often assume their position with little or no teaching preparation. As a consequence the skills that new nurse educators need to be successful are missing. Fitzpatrick and Heller (1980, p. 373) suggest that a sombre “question must be raised about the accountability of graduate programmes to the profession” if those who teach the students need to be taught themselves how to teach in the first place.

Choudhry (1992) concurs with this position by stating that experienced nurses are not sufficiently qualified to be educators. Choudhry carried out survey research in Canada to examine the core competencies of nurse educators. The competencies examined encompassed two levels; in the first level were those skills deemed essential, and in the second were those skills that are minimally required by novice nurse educators. Choudhry’s questionnaire was sent to full-time nursing faculty including department heads in community colleges and universities in Canada. There were 626 questionnaires distributed with a response rate of 48% (N=291). The participants were asked to indicate their desirability for 96 specific competencies such as personal and professional growth, acting as a student advocate, and facilitating students practice. The results of the survey suggest that all nurse educators need prior educational preparation in order to be successful in their roles. The research also lists a number of subordinate roles that nurse educators are expected to achieve. These include “theoretical and clinical teacher, curriculum developer, measurement expert, student advisor, clinical practitioner, professional mentor and leader, critical and informed research user, creative and meticulous research producer and publisher, self-aware and self developing educator, and nurse” (Ibid, p. 272). Developing competence in all of these roles is “mammoth” (Ibid, p. 272). Choudhry suggests targeted graduate education may assist in the socialisation into the role and its functions. According to Siler and Kleiner (2001, p. 397) nurse “clinicians are socialised differently to academics therefore creating the potential for culture shock when a clinician assumes a faculty role”.

There is a worldwide shortage of nurse educators (Berlin & Sechrist, 2002; DeYoung & Beshore-Bliss, 1995). These authors describe the nurse educator crisis in terms of those working in Universities, Polytechnics and other third level institutions ('nursing faculty'). DeYoung, Bliss, and Tracy (2002) suggest that the nursing faculty shortage is linked to the general nursing shortage. From my personal experience there may well be other causes of faculty shortage including, unfavourable conditions of employment for nurses becoming educators, disparities in salaries between practice and education and also the performance based research funding in education. These factors could all deter nurses from becoming educators. Berlin and Sechrist (2002) point to a continued shortage of nursing faculty in the coming years. This shortage emphasises the necessity for the limited supply of nurse educators to be competent and prepared to meet the needs of nursing students (Zungolo, 2004).

From the above discussion the importance of nurse educator preparation is clear. Firstly it is unacceptable to under-prepare nurse educators by not giving them adequate training. By withholding preparation the ability to provide the highest quality of nursing education must certainly be questioned. The literature suggests that working as a clinical nurse is not in any way comparable to working as a nurse educator, particularly in a university environment. The future shortage of nurse educators is another factor to consider in the case for professional role preparation. Having established the need for formal nurse educator preparation in a general context, the next section will explore the past and current preparation of New Zealand's nurse educators.

NURSE EDUCATOR PREPARATION IN THE CONTEXT OF THE NEW ZEALAND POLITICAL CLIMATE

Nurse educators are a group of individuals who are entrusted with the professional development and education of the future generation of senior clinical nurses. The evidence presented suggests not only a faculty shortage but further suggests that those who teach nurses need to be prepared and have a specific skill set.

For the purposes of this research it is necessary to gather base line data on New Zealand nurse educators teaching clinical nursing postgraduate courses at NQF Level 8. This data will establish what is currently known about the population. As part of the Nursing Council of New Zealand annual practicing certification process each nurse is asked to complete a questionnaire. The questionnaire seeks information on the nurse's place of employment, specialisation, educational qualifications and demographics. The 2004 survey data revealed that 776 nurses in New Zealand identified education as being their primary occupational role (personal communication, Nursing Council of New Zealand, 25/8/04). By 2006 this number had risen to 1,457 representing 2.7% of the nursing population (Clarke, 2006), but no further classification exists specifying the type of education in which these nurse educators are involved.

This research may help to identify the group of nurse educators engaged in the delivery of clinical postgraduate programmes at National Qualification Level 8 and highlight the need for more preparation for the role of nurse educator; possibly in the form of specialised teaching courses. Another possibility is the recognition from both clinical institutions and tertiary education institutions that they need to provide mentoring and support programmes for new nurse educators.

Because this research is specific to New Zealand it is necessary to put it into the context of the New Zealand nursing society and the culture of health service delivery in New Zealand.

New Zealanders take pride in the claim that in 1938 it was one of the first countries to introduce a universal health care system (Hornblow, 1997). Since this time nursing and the health service have undergone radical changes and a number of reforms. The first nursing education programme was offered by Wellington Hospital in 1883, well before the introduction of the universal health care system. Most of the learning in the early days of nurse education was done 'on the job' with the occasional lecture from a doctor (Burgess, 1984). Tutor sisters were not appointed until the 1900s. In 1901 the Nursing Registration Act was passed and brought some uniformity to nurse

education in the shape of a three year 'apprentice' style hospital training programme followed by a state exam (Burgess, 1984). Schools of nursing emerged at a similar time. In the 1970s the attrition rate in nursing was high, with 37% of student nurses withdrawing from training before completion (Ibid). Not only was student nurse enrolment a problem at the time, but the schools of nursing themselves were also reported to be having difficulty "recruiting and retaining adequately qualified tutors" (Ibid, p. 64). In light of these and other issues, the government identified that nursing education was in need of critical examination.

In an attempt to generate a distinct body of nursing knowledge the 1970s saw nursing education reposition itself out from the umbrella of medicine and hospitals (McEldowney, 1995). The Carpenter Report – *An improved System of Nursing Education for New Zealand* was to be the impetus for radical change in nursing education in New Zealand. Carpenter (1971) made a number of recommendations including firstly that nursing education be moved from hospitals into educational institutions, secondly that formal university nursing programmes be made available, and thirdly the development of a structured career progression for nurse tutors.

McEldowney (1995) suggests the ambition of gaining professional status for nursing began in earnest when diploma and degree level education programmes were established in polytechnics and at Massey and Victoria universities. The transition from hospital-based to polytechnic or university-based training continued for a number of years, and the last hospital school of nursing closed in 1992 (McEldowney, 1995).

The next major change in nursing education arose out of an amendment to the Education Act in 1990. This legislation led to the establishment of the New Zealand Qualifications Authority and enabled non-university educational institutions (such as polytechnics) to award degrees (Philips, 2003). As part of his role as Manager for research, monitoring and strategy for the New Zealand Qualifications Authority, Phillips has written a comprehensive overview of the development and implementation of the National Qualifications Framework (NQF). According to Phillips, the NQF attempted to unite the vocational and academic institutions by combining both within the same framework.

During the 1980s the health sector in general also had its difficulties. These difficulties included poor management practices, large budget overruns, large waiting lists, reduced public confidence and increased growth in the public sector (Devlin, Maynard, & Mays, 2001). In the late 1980s there were 14 elected health boards, and Thompson and Gauld (2001) note that a change of government at this time saw the New Zealand health care system completely reconfigured. The climate in New Zealand that led to the health reforms is summarised by Schick (1996, p. 11)

Economic conditions were not sustainable in New Zealand when the reform was initiated in 1984. The economy was in disrepair and conventional remedies - more fiscal stimulus and more government intervention - had not worked...Doing nothing - or a little as politicians could get away with - was not a viable option.

Changes were made quickly and thoroughly. The characteristics of the change were “radicalism, boldness, coherence, and innovate methods” (Bostan, 1999, p. 3). The health service was not excluded from the transformation and underwent reform in 1991 led by the then National Party government. At the heart of the “health reforms” according to Hornblow (1997) was the establishment of a “purchaser-provider split” (p. 1893). As a result, hospitals became publicly owned companies called Crown Health Enterprises (CHE) which were, according to Devlin, et al. (2001) subject to normal company law and expected to perform like a business.

The reforms were particularly radical at the time and were not universally accepted, and during the years 1993 - 1996 opposition from health professionals and the public gained momentum. Hornblow suggested that hospital waiting lists were lengthened rather than shortened and borrowing had increased necessitating cost-cutting measures. Nursing and nursing education bore the brunt of many of the cost cutting exercises. Harre (2003, p. 2) later reported “that from 1990-1994 nursing staffing levels dropped by 12.4% while inpatient numbers increased. Whole layers of nursing leadership were removed from hospitals and the numbers of general managers swelled”.

Historically, nurse educator preparation in New Zealand was carried out in the form of programmes run by the Department of Education. Hospital Schools of Nursing sent nurse educators to Teachers Colleges to learn teaching and learning practices. Nurse educators also had regional and national forums to explore issues, particularly during the transition of nursing education from hospitals to tertiary education institutes. As part of the Health Reforms during the 1990s these programmes were abolished as a cost cutting measure, and have never been re-established.

The pattern of nurse educator preparation in New Zealand is now unclear and lacks a co-ordinated national approach. However, The Nursing Council of New Zealand has a clear expectation for nurse educators teaching education programmes for the registered nurse scope of practice that they keep up-to-date in the area they teach, gain a qualification in teaching within their first two years and hold a qualification higher to what they teach years (Nursing Council of New Zealand, 2005a). There are examples of teaching support and role preparation within some tertiary education institutions, such as professional development units or teaching and development centres. Some institutions in complying with Nursing Council requirements require nurse educators to complete a certificate in adult teaching within their first two years of employment as part of a contractual agreement. Having explored the historical context of nursing and the preparation (both past and present) of nurse educators the next section will examine postgraduate nursing education in New Zealand.

POSTGRADUATE NURSING EDUCATION IN NEW ZEALAND

In a number of New Zealand universities and polytechnics lecturers are employed to teach undergraduate and postgraduate nursing programmes. Postgraduate clinical courses are generally but not exclusively run in partnership with clinical areas. Hospital-based programmes arose to address clinical and service needs. As times changed these programmes slowly linked into third level institutions as a means to satisfy the national and internationally accepted move of nursing from practice environment to tertiary education institutions. Since 2001, all nursing programmes leading to registration are at degree level (KPMG Consulting, 2001). One of the struggles polytechnics and schools of nursing faced during the transition from hospital training to degree programmes was ensuring their staff had the necessary qualifications to teach degree level programmes (KPMG Consulting).

Not only is the quality of the teaching important, so too is the strategic direction of post basic/postgraduate nursing education and the funding sources associated with it. The Report of the *National Taskforce on Nursing* (Ministry of Health, 1998, p. 56) states “Education for nursing at the postgraduate level is ad hoc, inconsistent and largely driven by initiatives from educational institutions, rather than from any analysis of the needs of the health sector”. The report also states that funding is a major barrier in the delivery of quality postgraduate education. The Clinical Training Agency (CTA) funds clinical postgraduate programmes that have a 30% and over clinical component. The programmes have to provide nationally recognised advanced clinical training in the health sector. As mentioned previously, the CTA is a business unit situated in the Ministry of Health, and the vision of the CTA is “to facilitate development of a health and disability workforce which can meet the future requirements of health and disability services in New Zealand” (CTA, 2002, p. 1). The training is vocational in nature, clinically based, post entry training occurring after entry into the profession. One of the problems noted by the Taskforce was associated with the distribution of CTA funding and the fact that 90% of the available funding was targeted for medical education. The Taskforce recognised this inequity and recommended that the CTA increase its funding for nursing education to 60% with this increase to occur incrementally over the next five years.

The nursing profession has a responsibility to deliver quality clinical training/education that is cognisant of funding realities as well as the impact on patient outcomes. Spence (2004a) using hermeneutic methodology carried out research to explore the impact of clinical postgraduate programmes on advancing nursing practice. This New Zealand research notes a high prevalence of clinical postgraduate programmes and suggests that these programmes have a significant contribution to make in terms of instilling nursing courage that in turn advances nursing practice (Spence, 2004b). Further research is necessary to explore the impact of these programmes and advanced nursing practice on patient outcomes.

The Nursing Council of New Zealand commissioned independent consultants KPMG Consulting (2001) to review undergraduate nursing education. Although outside the scope of the document, there was a section dedicated to nurse educator preparation

and a specific recommendation was made. The recommendation states that the “Nursing Council incorporate into standards the differing roles and expectations of educators as well as the greater emphasis on partnership arrangements with service providers” (KPMG Consulting, p. 94). The report notes that nurse educators have been required to “up skill and obtain masters qualifications” (Ibid, p. 94). There is recognition in the report of the disharmony between practice and education. The report suggests that notwithstanding the fact that for some educator roles clinical practice skills are not required, up to date knowledge is. The KPMG report recommends joint appointments such as those likened to the Lecturer Practitioner (LP) role in the United Kingdom. The LP role will be examined later in this chapter within the context of educational preparation and clinical credibility of nurse educators. Many of these concepts will need further analysis and exploration with the advent of the Health Practitioners Competence Assurance Act 2003 as can be seen in the following discussion.

In September 2003 the New Zealand Parliament passed the Health Practitioners Competence Assurance Act 2003 (HPCAA). The Ministry of Health (2003) states “The HPCAA is about public safety. Its purpose is to protect the health and safety of members of the public by providing mechanisms to ensure the life long competence of health practitioners”. Under the HPCAA the Nursing Council is required to audit and approve educational institutions and their programmes for the education of nurses. In 2004 the Nursing Council audited a tertiary education institution and the audit revealed that six nurse educators did not have appropriate postgraduate qualifications to teach theory-based aspects of the programme. The educators were restricted to clinical teaching until they obtained the academic qualifications (Nursing Council of New Zealand, 2005a). The HPCAA has also cemented the relationship between competence and practice; and as a result each registered nurse in New Zealand must provide evidence of clinical practice hours. The minimum requirement is 750 hours within the pervious five years or 450 hours within the last three years (Nursing Council of New Zealand, 2007).

The literature explored has given context to the development of professional nursing in New Zealand. Nurse Educator preparation is complex and the literature has failed to identify a single way that this can be achieved. There is a paucity of information

concerning the preparation of nurse educators delivering clinical postgraduate programmes. The literature described has identified a tumultuous political period in New Zealand where cost cutting measures and economies of scale deeply effected nursing and nurse education.

Historically all nurse educators in a nationally coordinated way were taught how to teach but this is no longer the case. Instead, there is the expectation from the Nursing Council of New Zealand and the HPCAA that nurse educators have a level of competence including educational and clinical preparation yet there are no nationally uniform formal programmes to facilitate the fulfilment of this expectation.

It is noteworthy that reports such as that from KPMG recommend New Zealand explore concepts drawn from other countries. On exploring the international literature the following three specific themes of educational preparation, nurse educator competencies and clinical credibility of nurse educators emerged. Each of these themes will now be discussed and linked back to the New Zealand situation.

EDUCATIONAL PREPARATION OF NURSE EDUCATORS

One of the roles identified in the United Kingdom literature similar to my role was that of the Lecturer Practitioner (LP). The role emerged in the 1980s from a perceived need in the United Kingdom to narrow the theory-practice gap. Woodrow (1994) noted that sister tutors were appointed as nursing education delivery changed. The sister tutors were replaced in time by nurse educators based in schools of nursing. The advent of such roles led to the ideology of a theory-practice gap (Gott, 1984). The responsibility of clinical teaching was viewed as the domain of all clinical staff (Myrick, 1988). French (1992) considered this approach to clinical teaching (i.e. shared professional responsibility) with a degree of scepticism and suggested it produced nurses who failed to think critically and who were mere mimics of practice. In an attempt to address these issues the new role of lecturer practitioner (LP) was created.

The qualifications required for the LP role have changed over time and reflect the changes in nursing education in the United Kingdom. Vaughan (1987) suggests that a diploma in nursing and a teaching qualification were the minimal qualifications

required. More recently the literature suggests that a degree qualification supersedes that of a diploma (Burke, 1993; McNally, 1994). Stevens (1994) and Lathlean (1995) are of the opinion that the minimum qualification of a masters degree, preferably a masters in nursing is vital for the successful functioning of the LP role. Jones (1996) carried out exploratory research (N=29) about the implementation aspects of the LP role. The results suggest that 72% of respondents felt that an educational qualification was necessary for those working as LPs, or at least be undertaken by the LP when in post. A degree was considered by 50% of participants to be the minimum prerequisite of a LP role.

Williamson (2004) undertook a systematic review of United Kingdom LP roles in both nursing and midwifery. The review examined 13 papers of which nine were qualitative, three were quantitative and one utilised a mixed method approach. Williamson's review highlighted that the LP role can make an important contribution to nursing education in terms of providing a link between education and practice. This systematic review demonstrated that there is an unclear picture of the purpose and achievement of the LP role. If there is a question about the purpose of the LP role then the next question is how exactly the profession is going to prepare an individual LP to best fulfil their role? Fairbrother and Ford (1998) caution that if the issue of LP role preparation is not addressed then any potential benefits of the role uniting practice and education will be lost. The literature overwhelmingly suggests that LPs need to be expert clinicians as well as expert teachers. Fitzgerald (1989) regards LPs as senior clinical nurses with expertise in the world of practice, education, research and management. Credibility in both worlds clinical and educational is essential (McGee, 1998).

The United Kingdom's neighbouring country Ireland has no evidence of a LP role or equivalent. It has however, a clear and well-established model of nurse educator preparation. As with the many other countries, the Irish historical system of nurse preparation was primarily a hospital based apprenticeship model. Fealy (2006) describes the schools of nursing as places of sanctuary from the clinical environment where the principle/head tutor ran the school and a team of nurse tutors delivered the teaching material. Historically "most nurse tutors had no special preparation but many of them were highly intelligent and creative women" (Robins, 2000, p.205).

Ireland has a long history of investing in nurse tutor education. In fact, a Nurse Tutor Diploma was awarded years before undergraduate education was assimilated into tertiary institutions (Fealy, 2006). The first university education programme for nurses in Ireland was the Nurse Tutor Diploma awarded by University College Dublin in 1960 (Robins). The Irish Nursing Board (An Board Altranais) has a registration division dedicated specifically to Nurse Tutors. In 2005 there were 661 registered Nurse Tutors in Ireland (An Board Altranais, 2005).

Educational preparation pathways for nurse educators are similarly apparent in the nursing literature from the United States of America, although their model too has its problems. Johnson-Crowley (2004) state that although nurse educator preparation has been on the agenda in the United States of America for years, many of the strategies for nurse teacher preparation utilise outdated models that are not successful in producing the kinds of teacher skills needed for the future. As in New Zealand, the preparation of nurse educators in the USA has heralded some debate however there is a lack of research in this area.

Johnson-Crowley noted that little research has been done to examine the effectiveness of nurse teacher preparation or the types of teacher preparation models. Bachman, Kitchens, Halley, and Ellison (1992) in their seminal American research on the assessment of the learning needs of nurse educators, suggested that there was a 'market' for education programmes designed specifically for nurse educators. Findings from Bachman et al's. (1992) descriptive survey (N=866) suggest that nurse educators have a number of learning needs (e.g. teaching strategies, evaluation of student learning and computer applications in nursing) specific to their roles, and that these needs were influenced by their academic preparation for the role. Mailloux (1998) carried out a smaller survey (N=163) to determine the learning needs assessment of hospital nurse educators. The results suggest that nurse educators need specific teaching about the tools used to predict areas in which there is educational need. Mailloux suggests that the role of the nurse educator is fragmented and in part ineffectual and recommends that nurse educators take responsibility to become more competent.

Young and Diekelmann (2002) used a Heideggerian hermeneutic analysis to elicit common experiences of new nurse educators. One of the revelations from this work was that the “science of nursing education” (p. 411) is not meeting the needs of those who teach nurses. These authors also suggest that educational preparation for nurse educators needs to change and become better; it should embrace a mix of traditional pedagogies like problem based learning and untraditional pedagogies such as postmodernism. In the United States of America preparation for the role of nurse educator is taken seriously and postgraduate courses are run nationally. However, some of these courses fail to meet the needs of their nurse educators as they do not include a mix “conventional pedagogies e.g. outcomes, competency-based education, critical thinking frameworks, problem-based learning as well as critical, feminist, post-modern, and phenomenological pedagogies” (Young & Diekelmann, p. 411).

In contrast to the United States of America it would appear that nurse educator preparation in Australia lacks a national coordinated approach. In a response to the Australian Government’s review on nursing education (Department of Education, Science and Training, 2002) the Australian Nurse Teacher’s Society (ANTS) (2001) stated “there is no consistency in definition, job description and qualification requirements for the role of clinical nurse educator and nurse educators”. McAllister and Moyle (2006) suggest that the role of the nurse educator necessitates specialist education knowledge. However, these authors note that there is reluctance from clinical nurse educators in Australia to undertake graduate education as there are few educational pathways and where they do exist they lack professional support. McAllister and Moyle conducted qualitative research to establish stakeholders’ views in relation to curriculum development approaches for Australian clinical educators (N=10). The participants in this small-scale research felt that access to a specific educational programme designed to meet their needs would not only benefit them and their students but the profession as a whole. The research did not identify the specific prerequisite qualifications for nurse educators. Ten years prior to McAllister and Moyle’s research Ferguson (1996) called for extensive preparation and on-going support for clinical educators. Ferguson’s qualitative research used a hermeneutic approach to explore the lived experience of clinical educators. No clear pathway of educational preparation for nurse educators is apparent from the Australian nursing literature.

The literature presented gives a sense of the educational preparation for nurse educators internationally. This literature is by no means meant to explore all countries and all patterns or ways in which to educationally prepare nurse educators, rather it is meant to show some of the various approaches that exist.

Formal structures of preparation in the United States of America and Ireland and the developing approaches in the United Kingdom and Australia have been described. All of the literature presented suggests that some form of educational preparation is necessary. However, it does not suggest one form of educational preparation over another. What is clear is that New Zealand is not alone in grappling with the issue of educational preparation for nurse educators. The second theme that emerged from the literature was the notion of specific competencies for nurse educators, and this will now be discussed.

NURSE EDUCATOR COMPETENCIES

As a means to address the national issues of faculty (nurse educator) preparation in the United States of America, the National League for Nursing (NLN) has made a number of recommendations and identified specific educator competencies. The NLN is committed to the development and quality of nursing education. They have developed a list of core competencies for nurse educators. The eight competencies that nurse educators should be able to attain are:

- To facilitate learning
- To facilitate learner development and socialisation
- To use assessment and evaluation strategies
- To participate in curriculum design and evaluation of program outcomes
- To function as a change agent and leader
- To pursue continuous quality improvement in the nurse educator role
- To engage in scholarship
- To function within the educational environment (National League for Nursing, 2005).

Along with these competencies the NLN has a certification process for nurse educators. To be certified the nurse educator must hold a masters or doctoral degree in nursing along with a masters in education or have carried out specified teaching hours (National League for Nursing, 2007). The NLN believes that having a certification process indicates to the profession and the public that nursing education is a speciality area of practice requiring specific expertise. Similar thinking about nurse educator competencies has emerged from the Australian literature. The same cannot be said of the New Zealand literature, in fact there are no identified competencies for nurse educators in New Zealand at this time.

In recent years the Australian Nurse Teacher's Society (ANTS) has been actively involved in generating competencies for nurse teachers in Australia. ANTS is committed to the promotion of the professionalism of nursing as well as fostering significant issues related to teaching the discipline of nursing (ANTS, 2000). ANTS state that it has "a commitment to the belief that the competence of teachers of nursing is a crucial issue, not only for the nursing profession but for employers, governments and the community" (p.1). The first draft of the ANTS competencies was published by the society in 1997. The ten competencies are:

- The integration of educational outcomes with the health needs of society
- The continued development of professional inquiry, relationships and environments
- The integration of professional nursing and educational knowledge and expertise to achieve learning
- The facilitation of curriculum development
- The effective implementation of curriculum
- The teaching of nursing to maximise student outcomes
- The demonstration of excellent communication and interpersonal skills
- The guarantee of currency and applicability of educational programmes
- The efficient management of resources
- The fostering of critical enquiry and seeks to develop, maintain and affirm and promote the discipline of nursing (ANTS, 1997).

Ten years later and these competencies are still under review. The society is currently seeking consultation from all Australian nurse educators on the competencies.

Davis, Stullenbarger, Dearman, and Kelley (2005, p. 206) from their North American perspective state

In this time of faculty shortage, clear statements of expected competencies for nurse educator preparation are critical to guide graduate programs in the development of a competency-based approach for the preparation of nurse educators for the recognition and credentialing of faculty.

It is the view of Davis, et al. that generating educator competencies along with a certification process instils a positive view of nurse educators. Having a given set of competencies not only conveys the purpose but also the practice of nurse educators. The competencies described by the NLN and ANTS have clear similarities but there is no international agreement on the competency requirements of nurse educators. In fact, a number of countries including the United Kingdom, Ireland and New Zealand have not yet embraced the notion of educator competencies.

The competency debate is complicated by the clinical credibility debate. Nursing is a practice-discipline therefore those who teach clinical nursing should “not only be academically rigorous but also clinically competent” (Good & Schubert, 2001, p. 389). The concept of clinical credibility for nurse educators was the final theme that emerged from the literature and will now be examined.

CLINICAL CREDIBILITY

Clinical credibility is a concept widely reported in the nursing literature (Fisher, 2005; Gillespie & McFetridge, 2006) and is in Cave’s opinion (2005) necessary to narrow the theory-practice gap. Clinical credibility is in Webster’s (1990) view equally as important as educational credibility.

The move of nursing education from hospitals to universities has had a cost. Lynaugh (2004) suggests the cost is the distance between nurse educators, students and nurses caring for patients. She aptly calls it the “practice-education gap” (Lynaugh, p. 28). Attempts have been made in the United States of America to synergise the relationship between academia and practice. One way of doing this is for schools of nursing to open their own care facility. This approach has led to the concept of academic nursing practice. Academic nursing practice is “the intentional integration of educational, research and clinical care in an academic setting for the purpose of advancing the science and shaping the structure and quality of health care” (Lang, Evans, & Swan, 2002, p. 63). Initiatives have arisen from the growing awareness that the one constant in the practice environment is change. Therefore, nursing knowledge has to be responsive. Conservative nursing teaching of standard procedures and requiring students to rigidly apply these procedures fails to acknowledge the changing climate in which the students are immersed. This climate creates academic nursing practice and has led to the establishment of faculty run care facilities or nursing centres.

One of the first centres established was the Loeb Centre for Nursing and Rehabilitation in New York. Nurses who offered nursing services as well as other rehabilitation services fully administered the Centre (Lynaugh 2004). Lynaugh intimates that a particular reason for schools of nursing undertaking this kind of measure was their need for clinical placements for students and also to institute exhibitions of particular research projects. American academics like Lynaugh fully accept that “clinical expertise is prerequisite for most nursing faculty in higher education...nursing practice must be effectively melded with education and research goals” (Ibid, p. 35). She accepts that this is a change in the self-image of nursing and one that nurse educators are only now beginning to internalise.

Dr Holmes, Professor of Nursing in James Cook University Australia was commissioned by the Australian Council of Deans of Nursing and Midwifery to write a report on faculty practice in Australia. The report presented a detailed literature review and made international comparisons. Holmes (2005) wrote that in the late 1980s Deakin University required all academic staff to work 20% of their

time in clinical practice, and this was written into their job contracts. Holmes suggests this was done with the intention of keeping academics “up-to-date” and “in touch” with clinical practice and to demonstrate to clinical staff that academics were not removed from clinical practice.

However, most Australian Schools of Nursing do not engage in faculty practice and whilst it may be encouraged it is not a job requirement and as such is not factored into the workload of the academic. Holmes (p. 29) refers to Lissan’s (1994) statement that “to believe one can teach what one cannot practice is logically inconsistent” and he makes the point that this assumes that nursing is a practice discipline, and all teaching is directed at skill development. But it might be argued that knowledge acquisition, the development of insight and understanding, and the refinement of attitudes and values, are as important as the acquisition of clinical skills. Within the United Kingdom nursing literature there is a call for nurse teachers to remain active in the clinical environment in order to demonstrate to students the relevance and application of theory (Andrews & Roberts, 2003; Neary, 2000). In a criticism of nurse educator’s immersion in the world of academia, Hoyles, Pollard, and Glossop (2000) contend that the swing away from clinical practice has gone too far.

The debate about the nurse educators’ clinical credibility is evident in the literature. However, there is no coherent and national recommendation on how exactly nurse educators should remain both clinically and academically credible. Suffice to say that this should happen. Gillespie and McFetridge (2005, p. 643) suggest that the nursing curriculum be revisited to “embrace a partnership between education and practice”. A universal model or recommendation of how educators maintain clinical credibility is not something that Maslin-Prothero and Owen (2001) would advocate. These authors suggest that each nurse educator needs to be individually accountable for their practice and create their own links to clinical sites. They do offer a number of suggestions on how this could be achieved; examples include, participating in clinical research, practice development and inviting clinical staff to teach. Cronenwett (2001) argues that nursing faculty must role model the type of professional behaviour that is expected of students in the clinical environment. If they don’t, Cronenwett asks, how else will students learn the behaviour and values

needed for their future? Internationally, nursing students recognize clinical competence as being an essential characteristic of successful nurse teachers (Nahas, Nour, & Al-Nobani, 1999; Tang, Chou, & Chiang, 2005).

There is evidence to suggest that many in the nursing profession believe that nurse educators must work in clinical practice in order to be clinically credible (Aston, Mallik, Day, & Fraser, 2000; Goorapah, 1997; Nahas, 2000). Calpin-Davies (2001) suggests that rather than saying nurse educators are totally removed from the practice or patient-centred world they should be considered as having a person-centred perspective where their area of specialisation and expertise is with student nurses.

Calpin-Davies calls for the removal of the lecture practitioner (LP) role as the concept is based on mistaken assumptions and is a defective model. Calpin-Davies asserts that the LP model negates education and bows to the requirements of the service. There is an assertion that lecturer practitioners are exploited by service (hospitals) as a direct result of economic constraints, which directly impacts on the quality of nurse education (Ibid). Therefore, Calpin-Davies believes that to accept the model of LP as the preferred and sole concept to narrow the theory practice gap would be naive.

The United Kingdom Central Council (UKCC) conducted a report on fitness to practice in the late 1990s and suggested that academic institutions have failed to support the role of the lecturer and treat classroom teaching as a priority (UKCC, 1999). The UKCC (1999) intimate that lecturers lack clinical credibility and need regular access to clinical practice. New Zealand authors Brasell-Brian and Vallance (2002) have made the case for clinical practice education exchanges, meaning a clinical educator situated in clinical practice should 'swap' with an educator situated in an academic institution for a period of time. These authors assert that this would narrow the theory practice gap. Pegram and Robinson (2002, p. 31) concur with the notion of practice based credibility and state that "in a very real sense it seems unimaginable to those outside nursing that teachers of a practice based discipline, are themselves, not engaged in practice in a coherent and meaningful way".

SUMMARY

The pattern of nurse educator preparation in New Zealand is far from clear. The literature has established that New Zealand is not alone in grappling with the issue of educator preparation. This chapter has outlined the turbulent political period in New Zealand, which saw the focus on financial efficiencies rather than development of the nursing profession.

There is an expectation from the New Zealand Nursing Council and the HPCAA that all nurse educators have a certain competence in clinical practice and teaching. The Nursing Council allows the nurse educator a time period in which to achieve a qualification in education. As yet there are no national competencies for New Zealand's nurse educators.

The international literature suggests that approaches to educator preparation vary. However, the literature explored expressed that a degree of preparation for the role is necessary, but failed to identify one method of preparation over another. Much of the literature presented was qualitative and descriptive in nature. No research has made causal links between the educational preparation of educators and student outcomes.

The three major themes that emerged from the literature were the concepts of educational preparation, educator competencies and clinical credibility. Some of these notions will be explored further in the context of the development of the conceptual framework for the research in the next chapter.

CHAPTER 3: CONCEPTUAL FRAMEWORK

This chapter will explore the development of the conceptual framework for this research. It was the intention that the foundations of this research would be embedded in a robust theoretical framework, “that would embody the beliefs traditions, goals and values of the [nursing] discipline” (Gills & Jackson, 2002, p. 47). The development of the conceptual framework is examined in the context of previously established work. Over 35 years ago Batey (1971) suggested that in order for nursing research to be meaningful it must be positioned within a theoretical framework. The call for theory-guided research is still apparent today (Meleis, 2005). McKenna (2002) intimates that although some researchers may be unaware of it, all questions asked by them arise from a theoretical framework. Moreover, Moody (1990) proposes that parameters for research can be established when a theory acts as a framework. In this research a framework was used to guide the data collection and interpretation processes. This approach gives the research greater meaning (Moody, 1990).

The framework for this research is comprised of four concepts:

1. support (peer, mentorship, organisational and administration),
2. qualifications (educational & clinical),
3. personal attributes, and
4. experience (teaching & clinical).

These concepts were devised and informed by the comparative literature review in chapter two as well as personal reflections. Each concept will be examined within this chapter.

CONCEPTUAL FRAMEWORK DEVELOPMENT

This research aimed to determine to what extent and how nurse educators, teaching clinical nursing postgraduate courses at NQF Level 8 were prepared and supported for their teaching role. The research arose from my own personal experience. As I commenced my new position of nurse educator I felt motivated and enthusiastic, but I was all too aware of not knowing what I did not know. Some of my colleagues

were feeling similarly in that they had a sense of being under-prepared for their role, or as one of my colleagues said “having to get on with it and ask questions later”.

An extensive examination of the literature was carried out to identify a theoretical framework for the research. This literature was informed by but separate to the comparative literature review in Chapter two. The data bases searched were Pubmed, CINAHL, ERIC, Cochrane, Proquest, Expanded Academic, Te Puna and Embase. As in the previous literature review, both key word searches and guided search strategies were utilised. These searches included the terms ‘nurse educator and preparation’, ‘nurse educator and socialisation’, ‘mentoring’, ‘peer support’, ‘organisational support’, ‘administration support’, ‘educational qualifications’, ‘clinical qualifications’, ‘time management’, ‘motivation and enthusiasm’, ‘experience’ and ‘prepared teachers’.

As was stated in the opening paragraph there is an argument in the literature that quality research uses an established theoretical framework (Robson, 2004; Rudestam & Newton, 1992). If links can be made to established theories as Robson suggests, the research would have greater credibility and align the thinking and exploration of others. In ‘real world’ research the linking of the topic with existing theory is not straightforward and theories may be elusive. Added to this is time pressure, which can hinder the in-depth exploration of often-difficult literature (Ibid).

In the exploration of the literature I could find no single theory, model or framework that accurately reflected the area under study. Initially I thought that the work of Dreyfus and Dreyfus (1986) on skill acquisition could be used as the theoretical framework. They suggested that skill acquisition is not innate, rather a skill is learned. Dreyfus and Dreyfus state that skill is acquired through a process of instruction and experience. To confirm their hypothesis they studied the skills acquisition process of pilots, drivers, chess players and adults learning a second language. In each of these groups they observed a common pattern which they call the “five stages of skill acquisition” (Dreyfus & Dreyfus, p. 20). The novice acquires new skill through instruction, and is generally guided by a set of instructions. These instructions are followed to the letter, to the extent that the novice cannot take extraneous factors and variables into account. While the work of Dreyfus and

Dreyfus has some relevance to this research such that preparation for a role requires the acquisition of new skills, I felt that their work would not help to identify the process involved in the preparation of nurse educators

Upon further reading I considered the work of Schumacher and Meleis (1994) on transitions as a central concept in nursing. Schumacher and Meleis carried out a concept analysis and reviewed 310 literature citations from 1986-1992. They identified universal properties of transitions that include process, direction and change in life patterns. Also in a follow-up to the original concept analysis, Meleis, Sawyer, Im, Hilfinger-Messias, and Schumacher, (2000) identify transition theory as an emerging middle range theory. Meleis, et al. (2000) expanded on the existing conceptual framework by examining five additional nursing studies that were based on a transition framework. Although this work does not fit seamlessly with this research it certainly has some noteworthy elements, particularly the link between preparation and transition. Meleis et al. (p. 20) state, “anticipatory preparation facilitates the transition experience, whereas lack of preparation is an inhibitor”. This concept fits when considering role preparation. However, this would be taking the work of Meleis, et al. out of context, as their work was concerned with the transitions of individuals to health and illness.

The work of Dreyfus and Dreyfus (1986), Schumacher and Meleis (1994) and Meleis et al. (2000) informed my thinking, but I was unable to rigidly apply their theories to this research. Therefore, I made the decision to frame this research within a conceptual rather than theoretical framework. A conceptual framework exists when no specific theory exists “to explain the expected relationship between variables but rather synthesizes relevant literature” (Gills & Jackson, 2002, p. 54). LoBiondo-Wood and Haber (1998) liken a theoretical framework to the blue prints of a house and as “a group of interrelated concepts that fit together because of their relevance to a common theme” (p. 140).

With this in mind and the fact that I had a clear mental image of what might be, I decided that the best way to comprehend the conceptual framework was in diagrammatic form. Meleis (2005, p. 225) states, “A theory is an articulation and communication of a mental image of a certain order that exists in the world, of the

important components of that order, and of the way in which those components are connected.” Initially the framework was rather flat as can be seen in Figure 1.

Figure 1: The flat structure of Nurse Educator Preparation

Upon further exploration of the literature and periods of reflection it was clear that this conceptual framework was lacking depth and scope. As a result this initial framework underwent eight different drafts. The revisions were made to the framework by asking a number of questions. Two of the key questions were as follows; having described three key areas is there anything else in my experience and from what I had read that could be considered necessary for nurse educator preparation? and, what is the relationship between the concepts when considering nurse educators who teach clinical postgraduate programme at NQF Level 8?

What I came to appreciate was that I had described a top down approach. Essentially the model implied that if you had expert clinical knowledge, classroom experience, worked along-side role models and had an understanding of education delivery and theory, then you were prepared for the role of nurse educator. Considering that the focus of the research was the preparation of nurse educators teaching clinical programmes, the framework failed to adequately reflect on personal attributes and the multifaceted concepts involved in teaching and clinical experience, educational and clinical qualifications and the range of necessary supports.

The framework had to evolve to incorporate all these aspects and the co-relationship of each to the other. Figure two represents the culmination of these ideas and the conceptual framework that formed the basis of this research. This framework with its four concepts was explored in light of the literature and led to the questionnaire design and development.

Figure 2: Critical Elements of Nurse Educator Preparation (CENEP)

To fully understand the critical elements of nurse educator preparation (CENEP) each aspect of the CENEP framework will be explained and relevant literature explored. To begin with, the central concept is Nurse Educator preparation, as this is the heart of the research project.

The introduction to McDonald's (2004) doctoral thesis on new nurse educators' transition from clinical practice to teaching is an entry from her personal journal. She describes her first teaching encounter as follows,

I am a nurse. I am not a teacher. It is March. I am standing at the front of a class of 50 nursing students. My heart is racing, I am pale and clammy, my hands shake enough that I have firmly planted them in my pockets. I am about to teach a theory class to this unsuspecting group. It will be my first formal classroom teaching experience. The topic is shock and I begin the class by offering words to this effect: "Today we are going to look at shock. Here I am – your case-study." (McDonald, 2004, p. 1)

When I read this account I could fully empathise with her position. I too am a nurse, I am not a teacher but as McDonald did, now I find myself teaching. McDonald

carried out what she called a “naturalistic qualitative study” (Ibid, p. 1) and interviewed eight beginning nurse teachers over the course of their first teaching semester. Her aim was to determine what it was like for them making the transition from practice to teaching. Some of her results revealed that novice teachers had difficulty making the transition to teaching if they were not “cared for as teachers” (Ibid, p. ii) or when they felt they did not have the practical knowledge or skills to do the job.

In its most simplistic form, nurse educators prepare the nursing profession to care for people. They go about this formally by teaching undergraduate and postgraduate courses and informally teaching in a clinical area. Nurse educator preparation is not unlike the preparation of educators for any other profession. In the world of journalism there has been a call for better teacher preparation. Barnes (2003) notes that if journalism teachers are not taught to teach, their ability to succeed as teachers and researchers is undermined. Kurdziel and Libarkin (2003) raise some interesting points about the preparation of graduate teaching assistants (GTAs) in geosciences. Kurdziel and Libarkin suggest that it is questionable if “GTAs can be effective teachers without significant background in pedagogy, science of teaching and learning, and advanced content skills” (p. 350). Wilson, Floden and Ferrini-Mundy (2001) examined 57 research studies concerning schoolteacher preparation in the United States of America. They found that there was a severe discrepancy between what constitutes a well-qualified teacher and what it takes to prepare teachers.

Neese (2003, p. 261) states, “that preparation for and socialization into the educator role is essential to the success of novice educators and their students”. Neese further suggests that following academic preparation a faculty member should mentor the novice nurse educator, to allow for the successful transition into the role of an educator. Ideas like these need to be contemplated, as there is a worldwide shortage of nurse educators (Berlin & Sechrist, 2002; DeYoung & Beshore-Bliss, 1995). Fitzpatrick and Heller (1980) highlight this very issue and trace the problem back to a shift in the emphasis of nursing graduate education from functional to clinical specialisation. Berlin and Sechrist point to a continued shortage of nursing faculty in the coming years. Therefore with the limited supply of educators it is necessary that

the educators are competent and prepared to meet the needs of nursing students (Zungolo, 2004). Having reviewed the central concept of nurse educator preparation within the CENEP framework, the other four concepts will now be explored starting with the concept of support.

SUPPORT

No matter what job is undertaken having some support makes the task a whole lot easier. This help can take the form of direction, instruction and/or supervision, and would typically involve having access to the necessary tools and the correct environment. One of the key elements underlining the concept of support is the idea of mentoring. Having received mentorship in previous roles I consider that formal mentor relationships would improve the transition into nurse education and enhance role preparation and effectiveness. Peer support is also essential to successful role preparation. Administration and organisational backing augment the effectiveness of individuals. My understanding of these supports led me to believe that they were key components to the preparation of nurse educators. Mentoring, peer support and organisational and administration support will be explored in the following subsections.

Mentoring - background and definition

There is much written in the literature about mentorship (Clutterbuch & Lane, 2004; Grossman, 2007) and according to the National League for Nursing (2006) it is deemed important for role socialisation. The concept is not exclusive to nursing – it is commonly referred to in education and business. Databases were searched by means of a keyword search using the term ‘mentor’ resulting in 40,170 results in Proquest, 618 in CINAHL, and 43,575 in Expanded Academic ASAP. Identifying specific date ranges condensed the literature, as did limiting results to scholarly peer reviewed journals as well as linking mentor to other keywords.

The information gathered can be grouped into the history of mentoring; mentoring in business; medicine and other professions; mentoring in nursing; and mentoring in faculty. In an attempt to illicit some understanding of mentoring, Stewart and Krueger (1996) carried out a concept analysis on the topic. The concept analysis examined a sample of 82 research abstracts and journal articles which corresponded

to 26% of the entire literature written on the subject. Their analysis led to the identification of six particular characteristics of the concept of mentoring, namely “a teaching and learning process, a reciprocal role, a career development relationship, a knowledge or competence differential between participants, a duration of several years, and a resonating phenomena” (p. 311). They suggest that mentoring “is a unique relationship that is spawned from mutual perception and experience of need for professional connection, interpersonal growth, scientific inquiry, and theory-based clinical practice” (p. 318).

The dictionary definition of mentor is a person who guides and advises, offers guidance and support, and can be an experienced and faithful counsellor (Oxford English Dictionary, 2006, p. 256). References to mentoring go back to ancient Greek mythology. Roberts (1999) suggests that Mentor was the trusted friend of Odysseus and was charged with caring for Odysseus’s son Telemachus. According to Roberts, this led to the assumption that Mentor was a wise trusted protector and role model and hence can be given as one of the explanations for the words use in modern day language.

Mentoring in business

In the world of business, mentoring is seen as essential to career mobility and the overall success of an organisation. In his seminal research about the relationship between business mentors and their protégés Roche (1979) suggested that executives who were mentored had more successful working lives, more earning power at a younger age and were more likely to act as mentors themselves. There is some difficulty interpreting Roche’s results, as the published research gave no detail about the studies aims, methodology or method. Even so, the results of the research are referred to time and time again (Darwin, 2000; Whitely, Dougherty, & Dreher, 1991).

Okurame and Balogun (2005) carried out a survey (N=510) to examine the role of formal mentoring in the career success of bank managers in Nigeria. The results suggest that informal mentoring was positively related to career success ($p < 0.01$).

Roche's survey as described earlier (N=1,250) suggested that nearly two-thirds of respondents had a mentor, and executives who had a mentor earned more money at a younger age, were better educated and were more likely to have a career plan. When a comparative analysis was carried out between non-mentored and mentored executives in this research, although both worked long hours, those who had a mentor reported feeling happier with their career progression. Correspondingly, in a survey (N=246) conducted by Fagenson (1989, p. 311) to examine "whether men versus women in higher versus lower level positions perceived equal benefits from being or not being mentored in their career/jobs" reported results suggesting that those mentored versus those non-mentored had greater career satisfactions.

The war for talent as described by Friday and Friday (2002) is escalating, and in order for businesses to have a competitive edge they need to have effective mentoring strategies ingrained in the corporate culture. Friday and Friday suggest that businesses need to integrate mentoring into their strategic plan, vision and overall corporate strategy. To this end they propose a strategic framework at corporate level, a standardization of mentoring processes, and optimising mentoring programmes. Coca-Cola Foods believes that mentoring gives them a realistic market advantage and as such invests in formal mentoring programmes throughout the company (Veale, 1996).

The mentor relationship as noted by Kram (1983) in her influential research could boost an individual's development. Kram's research examined 18 developmental relationships between pairs of younger and older managers, and interviewed the 'pairs' about their relationship with each other. The results led to Kram's concept of developmental phases within mentoring relationships. Joiner, Bartram, and Garreffa (2004) undertook a survey (N=25) in an attempt to explore the effects of mentoring on career success and turnover intentions of managers working in recruitment and advertising. Their research although small scale (and according to Joiner et al. (2004) lacking statistical rigour) suggests that mentoring is an economical means to not only proactively affect employee ways of thinking but also reduce turnover. Waters, McCabe, Kiellerup, and Kiellerup (2002) examined the role of formal mentoring on business and between employees. They suggest that formal mentoring programmes are useful when starting a new business. This research found that mentors provided

higher levels of psychosocial support rather than career support. According to Kram and Isabella (1985) peer relationships in the work environment can offer similar opportunities to formal mentoring for personal and professional growth.

A meta-analysis on the effectiveness of mentoring programs in business undertaken by Underhill (2006) revealed that there is a deficiency in experimental research on the topic of mentoring in business. Underhill examined a total of 106 articles published over a period of 16 years. The results of the meta-analysis suggest that those who were mentored had a small but significant advantage over those who were not mentored. However, there is a dearth of research on these comparison groups therefore it is difficult to say decisively if those not mentored have negative career success, if there is such a concept. Underhill therefore calls for more research to be carried out in order to provide a stronger link between mentoring and career success.

Mentoring in other professions

Business is by no means unique in researching the benefits of mentoring for the corporate good. Indeed some professional associations view mentoring as of such importance that they have dedicated a specific month in their association's calendar to promoting mentoring (Ridout, 2006). The physical therapy association as noted by Ridout suggests that mentoring enhances leadership, career, practice, research, education and professional development, boosts recruitment and retention and individual professionalism.

In an attempt to determine if all mentoring relationships are created equal, Ragins, Cotton, and Miller (2000) carried out a national survey of 1,162 employees working in the field of social work, engineering and journalism. The results of their survey were not any different to previous studies on mentoring. However, they found that non-mentored individuals expressed more positive attitudes than those in unsatisfactory mentor relationships. This suggests that the presence of a mentor alone does not automatically lead to positive outcomes; the outcomes actually depend on the quality of the mentoring relationship.

Mentoring in medicine

Lack of mentorship can cause serious harm. This was discovered in public inquiries in Canada and England examining the deaths of children as a result of cardiac surgery. Both Winnipeg and Bristol inquiry reports suggest that supportive, open work environments, with supervision are necessary to reduce harm (Davies, 2001). This certainly included the mentorship of junior surgeons. Murray Sinclair, author of the Winnipeg inquiry noted the lack of clear mentoring process whereby a young surgeon, new to practice and in a new environment, found himself 'alone' (McDonald, 2006).

Mentoring in nursing

In nursing there is a similar responsibility to support junior colleagues. Oermann (2001, p. 12) states that "mentoring is essential to provide new staff with a solid foundation for independent practice". The nursing literature has begun to define what mentoring is and what it means to the profession (Block, Claffey, Korrow, & McCaffrey, 2005; Stewart & Krueger, 1996; Thorpe & Kalischuk, 2003). A formal mentoring process is strongly advocated by Tourigny and Pulich (2005), as one that health service managers should embrace and fund. Their reasons for wanting such a process are clear; nurses are leaving nursing and health care organisations depend on nurses.

In New Zealand the problem with retention of nursing staff is significant. Research suggests that 30-40% of all nurses plan to leave their jobs within 12 months (Cobden-Grainge & Walker, 2002; Gower & Finlayson, 2002). It is difficult to validate these findings as a repeat study has not been undertaken. However, it is known that in 2003 the registration figures for nurses was 2,684 and in 2007 the figures were down to 2,484 (Nursing Council of New Zealand, 2007). Both sets of figures included registration of overseas nurses. Tourigny & Pulich (2005) suggest a formal mentoring programme can be effective in increasing retention of nurses otherwise destined to leave the profession.

Tourigny and Pulich (2005) are very specific about the requirements of a formal mentoring process. They suggest that a number of key components such as

remuneration, training, dedicated time (a minimum of 40 hours a month) and a contractual agreement between the mentor and the protégé are required.

Stewart and Kruger (1996) carried out a detailed concept analysis of mentoring in nursing. The research utilised an evolutionary concept analysis first described by Rodgers in 1989 and examined 26% of the total published population of literature on the subject. Stewart and Kruger found that even though debate exists there is evidence to suggest that nurses who underwent mentorship participated in more professional development activities, have greater job satisfaction, and were more likely to undertake advanced educational qualifications such as masters and doctoral degrees or indeed “develop the nursing gestalt” (p. 314). Hunt and Michael (1983) reviewed the literature on mentorship and stated “mentorship is recognized as a critical on-the-job training development tool for career success for both men and women” (p. 483).

Mentoring in faculty

There is a significant shortage of nurses worldwide, but even more significant is the shortage of nursing faculty (American Association of Colleges of Nursing, 2002; Berlin & Sechrist, 2002; Hinshaw, 2001). The National League for Nursing (2006) suggests mentoring is a key component to retaining faculty and should be part of the occupational continuum. Gibson (2004) undertook phenomenological research in an attempt to obtain an understanding of the experience of woman faculty being mentored. The experiences of the nine women who participated in the research were classified into five distinct themes; being cared about, connectivity, affirmation of worth, feeling accompanied, and accepting that culture and politics are part of the experience.

These themes guided Gibson to suggest that mentoring should be considered as a means to contribute to the career success of women faculty members. Gibson further postulated that having a specific definition of mentoring is not as important as having the existence of the specified themes in the environment.

Gibson states “Having a culture that was committed to their success made a considerable difference in the provision of mentoring and in what protégés felt was

possible to achieve within their academic environments” (p.182). Morin and Ashton (2004) carried out a literature review in an attempt to determine the quality of evidence regarding faculty orientation. Similar to Gibson, they found that faculty who were mentored made a better transition into the academic environment. Morin and Ashton identified strong levels of evidence to suggest that faculty orientation programmes should include the identification of a specific resource person such as a mentor.

It is safe to say that mentoring is considered by many to be important in career success and role preparation. The presence and usefulness of peer support will now be examined.

Peer support

It has been my experience that informal peer support can promote socialisation and collaboration. Peer support offers an opportunity to critically think, reflect and enhance professional development. Peer support is conceptualised within the idea of social relationships (Dennis, 2003). According to Lakey and Cohen (2000) the impact of peer support on health outcomes is reflected in the growing concern of health care industries with health promotion and disease prevention. Developing social relationships is a much a part of health promotion as encouraging exercise and healthy diet (Stewart & Tilden, 1995). The enhancement of social relationships has been found to reduce occupational stress (LaRocco, House, & French, 1980) and in 1984 the World Health Organisation identified strengthening social relationships as a health promotion strategy.

The establishment of formal processes like clinical supervision and mentoring can achieve the development of social relationships in the workplace. Bedward and Daniels (2005) undertook longitudinal mixed method research to evaluate the implementation of clinical supervision. The research reported a concept of professional isolation among the participants. Such isolation led to a feeling of being unsupported. Following the implementation of professional supervision and formal peer support, the participants in Bedward and Daniels’s research reported year on year reduction of feelings of isolation.

Bruce, Conaglen and Conaglen (2005) explored levels of burnout among New Zealand physicians. Bruce et al. administered 83 questionnaires to a confined geographical area and reported a response rate of 60%. Results of the questionnaire reported 28% of participants had high levels of burnout and emotional exhaustion. One of the recommendations from this research was the implementation on 1:1 peer support to enhance the well being of physicians.

When work environments are supportive, and foster learning and development they are empowering places to be and can influence mind-set and efficiency as well as organizational success (Beaulieu, Sharmian, Donner, & Pringle, 1997; Laschinger, Finegan & Sharmian, 2001a, 2001b; Laschinger & Wong, 1999). Support in the workplace creates an environment that empowers nurses (Laschinger et al., 2000a; Beaulieu, et al. 1997).

Organisational and administration support

In considering organisational and administration support the assumption can be made that without it no individual would be wholly successful. There is a lack of evidence in this area however, it appears to me to be an imperative aspect to success and therefore a necessary concept to consider in the context of overall support in the preparation of nurse educators.

Employees need to trust that the organisations they work for will support them to carry out their duties. Organisational trust as defined by Gilbert and Tang (1998) is the belief that the employer will adhere to its obligations such as pay, facilities, training and so forth. Gilbert and Tang suggest that commitment to an organisation comes from identification with corporate goals whereas organisational trust refers to employee faith that the organisation will achieve their goals. Ultimately the attainment of organisational goals should provide some benefits to the employee (Ibid). Kruger Wilson and Porter O'Grady (1999, p. 238) note, "the organisation depends more on the skills of its workers than the workers depend on the organisation".

The worker however can be promoted to a position where new skills are being learned, and in such instances they need to be supported and guided. If a newly promoted employee is left in a position where they must get on with it and seek out their own answers it is not going to be beneficial for them or the organisation. Administration support helps the employee to understand process. Kruger Wilson and Porter O'Grady (1999) advocate that it is the managers who are responsible and accountable to have all the necessary resources available to the employee. In work carried out on the characteristics of magnet hospitals, Upenieks (2003) noted administration support and structures were necessary to support nurses in their work. "Ensuring that the providers have what they need to perform their work is essential" (Kruger Wilson & Porter O'Grady, p. 238). Without a supportive culture where employees feel valued members of the team, they will leave for as little \$1 extra in their pay (Allen, 2006).

There are many support structures that help prepare nurse educators for their role. I have examined the literature to inform the conceptual framework of this research. The concept of support has been examined in relation to the many aspects of mentoring, drawing from a wide range of literature and experiences of other professions. Peer support has been explored in the context of improving social relationship. Finally organisational and administration supports were found to be necessary to support employees carry out their roles.

The next concept to be examined to inform the conceptual framework is the prerequisites of education qualifications and clinical qualifications.

QUALIFICATIONS – EDUCATIONAL AND CLINICAL

Educational qualifications

Ramsden (2002) suggests that to teach effectively the teacher must learn how exactly students learn. Ramsden also proposes that higher education relies on teachers who do not know how to teach, and suggests that a professional approach to teaching is necessary. Bachman et al. (1992) support this position suggesting that nurse educators require programmes specific to their teaching needs, as they often assume their position with little or no teaching preparation. Therefore, the skills that they need to be successful could be said to be missing.

Ramsden urges that a professional attitude to teaching is as necessary as a professional approach to any other discipline. Teaching in higher education is complex and requires expertise that takes years to develop (Ibid). Professional teachers of whatever discipline listen to and learn from their students (Ibid). These professional teachers evaluate their performance and have an astute awareness of the learning needs of their students. Choudhry (1992) concurs with this position by stating that experienced nurses are not sufficiently qualified to be educators. The results of the descriptive survey carried out by Choudhry on the core competencies required for new nurse educators role development (N=268) suggest that all nurse educators need prior educational preparation in order to be successful in their roles.

The role of the teaching assistant (TA) described by Marincovich, Prostko, and Stout (1998), can be likened to that of a nurse educator. One of the main emphases of developing such a role in universities is to have a clear developmental step to becoming a faculty member. How this role can be related to that of nurse educator specifically correlates to the roles developmental stages.

Marincovich et al. outlined the indicators of the developmental steps as follows. The process begins as a senior learner, develops to a colleague in training, and finishes as a junior colleague. As a senior learner the major concerns are for ultimate survival. Moving to a colleague in training the concerns are more about skills – how to lecture. A junior colleague is concerned about outcomes – are the students understanding the content. Having an understanding of the developmental stages of a nurse educator may go some way to directing the further development of the role both in terms of academia and socialisation.

Allen (2003) was charged with examining teacher preparation in the United States of America. It is suggested in his report that the effectiveness of teaching is influenced by the environment and students willingness to learn, but more importantly Allen purports that teaching effectiveness is more influenced by the skills and knowledge of the teacher. In an attempt to answer eight specific questions about teacher preparation Allen examined 92 research studies. One of the questions focused on the extent to which a teacher preparation enhances teacher effectiveness. The literature

review found two studies in particular that found a correlation between the academic success of the teacher and their teaching success. Cameron and Baker (2004) suggest that teacher preparation has implications for quality teaching and learning in New Zealand. Rice (2003) declares that when teachers understand the fundamentals of pedagogy and subject matter they are more successful teachers and encouragingly affect student outcomes.

Despite having teacher preparation some nurse educators still feel unprepared. Young and Diekelmann (2002) investigated the experiences of new nurse teachers. The phenomenological research investigation utilised a Heideggerian hermeneutic analysis. The lack of transferability of the findings of phenomenological research approaches is often given as a criticism of the approach. However, Young and Diekelmann present a rich and meaningful description of the new nurse teacher. This research suggests that new teachers need preparation to teach. Young and Diekelmann state, “teaching and learning like nursing are practices” (p. 406). Siler and Kleiner (2001) reiterate this concept of preparing nurses for faculty practice and suggest that by doing so the uncertainty and stress of the novice will be significantly reduced.

Clinical qualifications

The vocational nature of nursing has historically expected registered nurses to supervise, teach and assess student nurses (Nicklin & Kenworthy, 2000). Nicklin and Kenworthy state, “It is self-evident that a pre-registration education does not adequately prepare nurses for their teaching role and responsibilities, nor is it intended to do so” (p.19). Without formal and specific preparation, qualified nurses will be unable to adequately fulfil the role of teacher.

The findings of Benner’s (2001) descriptive research on nurses’ skill acquisition suggest that the clinical instruction of novice student nurses does not necessarily need to be taught by nurses with advanced levels of skill acquisition. However when nurses enter advanced specialisation they should be taught by “teachers who can themselves demonstrate advanced levels of clinical judgement” (Benner, p. 186). It could be extrapolated from this that those who teach clinical programmes to nurses should have a high level of clinical credibility.

Nursing is a vocational occupation. As such the best people to teach nurses nursing are in my opinion nurses. (This is not to say that nursing is everything the profession needs to know and understand). Many vocational professions approach teaching similarly, doctors teach doctors, accountants teach accountants, and teachers teach teachers. My thoughts around this concept were that to be a fully prepared nurse educator teaching postgraduate clinical courses one must first be a nurse and fulfil the professional requirements of the profession. This in my view is even more important when teaching clinically specific programmes of education.

Benner (2001) states that proficient and expert nurses gather archetype cases of patient care. Archetype cases, or as Benner refers to them – ‘paradigm cases’ (p. 8), are powerful experiences of patient care that stand-out in the nurse’s mind. This allows them to manage patient care using specific examples from their past experiences. Discriminating capability such as early recognition of changes in a patient’s condition originates from many hours of direct patient observation and care.

Expert clinical teachers also share their archetype cases and these cases bestow to the learner far more than can be communicated through theoretical principles or guidelines (Ibid). In order for a student to learn from another person’s cases they must immerse themselves in them. This is where simulation can be effective because it necessitates performance and decision making from the learner. Using patient simulation can also allow the student to develop archetype cases in a safe and guided environment. As nurses advance their practice and focus on speciality areas they require instruction from teachers who can exhibit advanced levels of clinical judgement. The ability to demonstrate and articulate clinical judgement by the nurse educator is important in imparting advanced practice competencies, as it is the cornerstone of clinical decision-making. In addition the nurse educator requires specific personal attributes to be prepared for their role.

PERSONAL ATTRIBUTES

Within the concept of personal attributes the focus centres on time management, motivation/enthusiasm, and the ability to work independently. These were skills and attributes that were key to my survival and success as a nurse educator. Each will be explored in light of the current literature, beginning with time management.

Time management

People's utilisation of their time is what makes some people more successful than others (Pettigrew, 2007). Pettigrew suggests that effective time management is a skill that can be taught, learned, and improved, and is important in achieving personal and professional goals. Time management is generally considered to be the guiding principles that control the time spent on lesser goals to ensure that time can be spent on specific activities that can lead to accomplishing primary aspirations (Pettigrew). Covey (1999) proposes that time management is a misnomer and the challenge is not to manage time but to manage our-selves.

Covey designed a time management matrix to help people determine where they spend their time and to enable them to be more effective. Within the matrix there are four quadrants; important urgent, non-urgent important, non-important urgent, and non-urgent non-important) and Covey suggests that most of a person's time should be spent on quadrant two. The concepts included in this quadrant deal with important but non-urgent issues. The quadrant focuses on building relationships, long range planning, exercising and preparation.

Covey bases some on his ideas on the work of Vilfredo Pareto. Pareto, in his early 19th century work about social cycle theory found that the greatest distribution of wealth went to a few families (Phillips-Donaldson, 2004). This concept of disproportion saw the development of the 80% and 20% principle (20% of the population have 80% of the wealth). Phillips-Donaldson states that Juran adapted this principle commonly referred to as the Pareto principle or the 80-20 rule. Juran applied this concept to quality stating that 80% of problems come from 20% of causes, and management should concentrate on the 20% (Phillips-Donaldson). Simply put the 80-20 rule states that the relationship between input and output is rarely, if ever balanced. When applied to work, Vaccaro (2000) maintains that approximately 20% of the efforts will produce 80% of the results.

Work independently

An ability to work independently is a quality admired in most professions. Lomo-David and Griffin (2001) carried out survey research to examine the perceptions of university business students entering the workforce (N=1,098). The results of the

research identify four specific traits necessary for all new graduates to be successful. The number one trait was the ability to work independently with little supervision. Secondary traits included resourcefulness, initiative, ethics, loyalty and flexibility. In my own journey into education I found that the ability to ‘get on with the job’ was a key to success. The irony is that the ability to do this is somewhat influenced by knowing what you need to do to begin with as initiative can only take you so far.

Motivation and enthusiasm

Motivation and enthusiasm are concepts that I felt were necessary for success in my role as a nurse educator. Without these attributes I feel I would surely have failed in the transition from practice to education. In education, teaching and learning motivational concepts are considered to be important factors in both the quality of the teaching and student learning (Quinn, 2001). There is much written about motivation, and one of the most well-known concepts was described by Maslow (1972).

American psychologist Abraham Maslow proposed that there is a hierarchy of needs. Once the most basic needs are gratified, like hunger, the next need emerges. The needs at one level must be satisfied at least partially before those at the next level become important determiners of action. The highest motive (self-actualisation) can only be fulfilled after the other needs have been fulfilled.

My thought process when I identified motivation was not specifically concerned with needs. Although how one becomes self-actualised is part of the process of success. My thinking was more in relation to self-motivation and success. Commonly referred to as achievement motivation, on exploring the literature about motivation and enthusiasm I came across a large body of research on the subject (Biggs, 2003; McClelland, Clarke, Roby, & Atkinson, 1949; Quinn)

McClelland and colleagues were the first to describe achievement motivation by means of the thematic appreciation test (TAT) (McClelland et al., 1949). A number of indistinct images were shown to the participants in McClelland, et al.’s research.

They were then asked to construct a story based on the picture. The researchers determined that this would assess the participant's need for achievement. McClelland et al. further hypothesised that the participants own feelings and thoughts would be reflected onto the picture and consequently gauge their motivation. Indeed that is exactly what they found. The participants when shown specific images wrote stories of success and achievement.

Achievement motivation can also be considered to be an opportunity for the enhancement of one's ego (Biggs, 2003). Biggs suggests that in student's achievement motivation can kill collaborative learning and requires a competitive environment in which to work. Quinn (2001, p. 21) states "there are at least two factors involved in achievement – the need for success and the fear of failure and both are present in everyone. The resultant motivation depends upon the relative strength of the two aspects". Rungapadiachy (2003) suggests that motivation is best expressed as the driving force of behaviour. Good behaviour can ultimately lead to success.

In contrast to achievement motivation, intrinsic motivation is the internal drive to succeed because you want to, not because you are forced to. This motivation is solely reliant on the individual. Intrinsic motivation is what keeps a person going and what drives the individual to succeed. It was an attribute that was essential to my job success. Goleman (2005) recommends using positive motivation and feelings like enthusiasm to enhance achievement and is well known for the popularisation of the concept of emotional intelligence.

Researchers Mayer and Salovey (1997) carried out the seminal work on emotional intelligence. Mayer, Salovey, and Caruso (2004, p. 197) define emotional intelligence as follows;

The capacity to reason about emotions, and of emotions to enhance thinking. It includes the abilities to accurately perceive emotions, to access and generate emotions so as to assist thought, to understand emotions and emotional knowledge, and to reflectively regulate emotions so as to promote emotional and intellectual growth.

When describing emotional intelligence, Goleman states that it is the ability to motivate one-self and to persist in the face of frustrations. But these are not the sole concepts described by Goleman, as there are a number of others including delayed gratification and controlling impulses. The degree to which a person is motivated by feelings of enthusiasm and pleasure in what they do propels them to accomplishment.

This chapter has now examined four of the five concepts within the conceptual framework. The final concept of experience (teaching and clinical) will now be discussed.

EXPERIENCE – TEACHING AND CLINICAL

Experience is gained over time, though practice and the accumulation of knowledge. Dreyfus and Dreyfus (1986, p. 19) state that people obtain a skill because of instruction and experience and do not abruptly plunge from rule guided “knowing that” to experienced-based “know how”. Benner (2001) similarly suggests that novice nurses are beginning nurses who have no experience of the circumstances in which they will work while the expert nurse has “...enormous background experience” and “...has an intuitive grasp of each situation” (p. 32). If we assume that nurse educators have all the necessary qualifications (both educational and clinical), are fully supported and have the key personal attributes, will the amount of experience they have as teachers and nurses impact on their preparedness?

Storch (1999) argues that having nursing experience is essential to fulfil the role of a nurse educator and this is because it is a practice discipline. To fully understand the phenomenon of nursing, grounding in clinical practice is necessary. The nurse educator must have lived the experience of practice and furthermore Storch says they must have a lived understanding of nursing’s moral foundations and the meaning of nursing. Without such understanding the nurse educator cannot translate the meaning into educational practice and the teaching of nursing is worthless. Storch suggests the nurse educator will struggle to reflect on practice and fail to implement or understand nursing praxis.

It is generally expected that those who teach or have oversight of nursing curricula must be registered nurses. The Nursing Council of New Zealand (2005a) explicitly

states that nurse lecturers teaching in undergraduate programmes should have a least three years full time clinical experience and hold a current practicing certificate. There is also the requirement for those teaching programmes for the registered nurse scope of practice that they keep up-to-date in the area they teach and undertake a teaching qualification (Nursing Council of New Zealand, 2005a)

Wilson, Floden and Ferrini-Mundy (2001) in their literature review about teacher preparation established that teachers required significant subject knowledge in order to be successful. Wilson et al. also found that the literature overwhelmingly recommends that practical experience is vital to learning the skills of teaching (Darling-Hammond, 2000; Goldhaber & Brewer, 2000; Guyton & Farokhi, 1987; Monk, 1994). However there is a void of literature in this area and the little amount of literature that does exist is mostly descriptive in nature. Siler and Kleiner (2001) carried out phenomenological research to reveal the significance of new faculty experiences. Siler and Kleiner's purposeful sample consisted of 12 faculty members – six experienced and six novices. All participants were interviewed and the material was analysed using a Hermeneutic approach. The findings of this research suggest that faculty members who joined the academic world with experience in teaching had an enhanced appreciation of the university culture and managed their workloads better. Beres (2006) wrote a reflection on her transition into faculty practice, and she clearly acknowledges that having experience in both teaching and clinical practice enhanced the transition process for her. Beres states “this [teaching] experience along with years of clinical practice provided a comfort level for me and made the transition to teaching in a school of nursing less intimidating” (p. 143).

SUMMARY

This chapter detailed the development and construction of the conceptual framework for this research. The necessity for a framework was outlined. There are advantages to a study if links can be made to established frameworks (Robson, 2004). However, in this instance this was not the case and the framework was drawn from tacit knowledge and informed by the literature on support (mentorship, peer support, organisational and administration support), clinical and educational qualifications, personal attributes, and clinical and teaching experience.

The culmination was the establishment of a conceptual framework of nurse educator preparation. A conceptual framework is described when there is no theory on which to pin the research. The conceptual framework informed and guided the questions asked in questionnaire. The next chapter will outline the methodological approach, method and design of the research.

CHAPTER 4: METHODOLOGY, METHOD AND DESIGN

The methodological approach, method and design of the research will be described in this chapter. This will include the process of sample selection; steps involved in the development of the data collection instrument, and ethical and cultural considerations. Data collection methods and data analysis will finally be described.

METHODOLOGY

The methodological approach for the research is an exploratory descriptive survey. It is difficult to define exactly what is meant by descriptive or even social survey. A definition would achieve little, as the term is associated with such a large number of diverse investigations. Such investigations range from the classical poverty surveys to modern day Gallup polls (Moser & Kalton, 1982). Generally speaking descriptive survey is used to investigate or describe how things are, and its birthplace can be traced back to ancient times. Descriptive survey has an ability to describe what exists and is the dominant reason it was considered as the methodology of choice for this research.

The roots of descriptive survey are deeply embedded in the history of civilisation. References to it can be found throughout the Old Testament where Egyptian rulers conducted census surveys for the purpose of managing their provinces. Notably, Jesus was born away from home because Joseph and Mary were journeying to Joseph's family home for a Roman census (Babbie, 1986). Looking at more modern day sources, descriptive, or social survey has its foundations in sociology. The work of German sociologist Max Weber is an example of this. Weber carried out a number of social investigations and surveys where he examined concepts like religion and work ethic. Aron (1976) said of Weber that he tried

To understand the meaning of all existences, individual or collective, endured or chosen, without concealing either the weight of social necessities pressing on us or the ineluctable obligation to make decisions which can never be scientifically demonstrated. (p. 259)

To understand the meaning of all existences is a difficult concept to grasp, much like trying to ascertain which came first – the chicken, or the egg. It is however, the journey to understanding that really reveals some answers.

Investigating social understanding is not solely the job of sociologists; any one who has an interest in society can study it. Bulmer (1984) supports this notion by stating that individuals who do not consider themselves as sociologists undertake the majority of descriptive social-survey research. Weber gained a significant amount of social understanding utilising descriptive survey and contested that money did not determine everything in society. Babbie (1986) gives a comprehensive description of Weber's work. Babbie notes that Weber studied the degree in which religious institutions are the foundation of social behaviour more exactly than a manifestation of economic conditions. Weber is recounted as being particularly influential in developing methodological approaches that emphasised the significance of the 'interpretation' individuals place on their actions and on the actions and reactions of others (Gillis & Jackson, 2002). This approach is referred to as 'interpretive perspective' and is associated with research designs such as grounded theory, phenomenology and studies that are rich in description. Karl Marx had a different opinion to that of Weber and contented that monetary considerations establish the nature of all other aspects of society. In 1880 he carried out a survey of 25,000 workers to determine if they were oppressed and mistreated by their employers (Ibid).

According to Bulmer (1984) in Western industrial society empirical social research is lead by social surveys. The social survey in its modern form is attributed to being a British invention. It was first developed in the classical poverty surveys undertaken by Booth and Rowntree (as cited in Moser & Kalton, 1982). The poverty surveys were designed to describe the characteristics of people, groups or situations. What they wanted to ascertain was the frequency particular behaviour is demonstrated in a sample under investigation (Bulmer 1984). Booth wanted to determine what the social conditions of the poor living in London were like and how the family income was generated, Moser and Kalton (1982) note that Booth's main concern was how to gather such information. The method he ultimately used was interviewing. Booth

states that “my object was to show the numerical relation which poverty, misery and depravity bear to regular earnings and comparative comfort, and so describe the general conditions under which each class lives” (Booth, 1889 cited in Moser & Kalton, 1982, p. 7). On the whole the work of Booth was descriptive and is not without its weaknesses; however it is landmark research on the extent of the poverty trap in London in the 1900s. Ultimately the survey fulfilled the purpose for which it was intended.

Moser and Kalton (1982, p. 2) state the “the purpose of many surveys is simply to provide someone with information”. The ‘someone’ can be anyone and the information ascertained can be either qualitative or quantitative or both. Moser and Kalton suggest that surveys can be purely descriptive in terms of describing social circumstances; this is reflected in Booth’s work. Surveys can also be used to explain phenomenon. According to Moser and Kalton the function of a survey can be theoretical, for example to test a hypothesis or it can be strictly practical such as to assess the weight of an assortment of factors. In either case, the key is to describe the association amid a number of variables (Ibid).

Pure descriptive research grapples with questions of what things are like not why they are that way (De Vaus, 1986). As was previously stated the approach includes a wide variety of styles such as public opinion polling, market research, and media rating surveys. No matter what approach is taken, De Vaus stresses the need for accuracy and good descriptions, as they are the foundation for sound theory. Unless there is accurate description attempts to explain it will be misplaced.

De Vaus makes a number of other points that descriptive research can act as the foundation for theory building and highlight issues that need to be explored. This thinking strongly supports the methodological choice of this research. If this research can describe the preparation of nurse educators then at least something will be known about it. DeVaus further states “Competent description makes it more difficult to deny the existence of problems” (p. 25). It would be naive to assume that all description is good. Bearing this in mind it is not really a surprise that there is some argument as to the ‘soundness’ of descriptive survey. In fact there are suggestions the

approach isn't even resting on a good epistemological footing. According to Marsh (1982) much of the debate is generated because of the assumption that survey research can inform and produce sociological theory. The reason for this is that much of the survey research being carried out is done so by market research and pollsters. These types of researchers are ultimately more concerned in the extrapolative information rather than explanations. Marsh suggests that we should not criticise the method because of the errors of the researchers.

The results of nursing and medical research can influence and guide practice, improve the health and quality of life of patients/clients. Clinical trials that were carried out on early goal directed therapy for example have pushed the boundaries of critical care and are reducing patient mortality rates by 16% ($p=0.009$) in patients with septic shock (Rivers, et al., 2001). The studies carried out on nursing sensitive patient outcomes and organisational climate impact nursing practice and ultimately patient care (Behrenbeck, Timm, Griebenow, & Demmer, 2005; Clarke, Rockett, Sloane, & Aiken, 2002). The strength of the research relies heavily on its validity and ability to be generalised. That is not to say that a small-scale qualitative project has no influence. Everything is relative and must be viewed with an informed eye.

On contemplation of this research my own understanding of descriptive survey research, as a methodology was limited. Like most people my understanding was focused on survey as a data collection tool rather than methodology. Extensive reading has made the value of the approach much clearer. Subsequently this approach can assist nurses to find out what people think/feel or do about an issue (Wood & Giddings, 2001).

Nurse researchers use descriptive survey extensively (Lehwaldt & Timmins, 2005; Vint, 2005). One of the many reasons is the ability of the approach to give the researcher an idea of what's going on in the real world. This is only useful if the approach is resting on a sound methodological footing. If we were to investigate why nurses leave nursing, the data obtained could provide information on what Robson (2004) calls 'people characteristics' and the relationship between these characteristics. There is an ability to take the description further and identify causal

links; that is moving beyond description to causal relationships. The approach has therefore a degree of flexibility. Often in nursing what is required is a scoping exercise, in terms of understanding what is happening. This is exactly what is called for when exploring nurse educators teaching postgraduate clinical programmes.

Descriptive survey design has both advantages and disadvantages. Beanland, Schneider, LoBiondo-Wood and Haber (1999) state a large amount of information can be gathered from a big population in a financially affordable way by surveys. However, LoBiondo-Wood and Haber (1999) focus much of their discussion on the methods disadvantages. They state that survey researchers need to have an in-depth knowledge of research design, in particular in sampling, construction of questionnaires and interviews, as well as data analysis procedures. Arguably this type of in-depth knowledge is not exclusive to survey; undeniably other research methods require similar levels of skill.

Gillis and Jackson (2002) observe that a survey researcher deals with a number of variables concurrently in an effort to describe the intricacy of human behaviour. The approach has difficulty with making causal inference and it is suggested that the view of the world represented is ideal, not real. The forte of surveys is their perceived ability to reflect the general population. However, it is difficult to say that respondents didn't behave in a particular way because they were being studied. It should never be assumed "the respondents claim is true only that it is their perception of reality" (Olsen, 1995).

METHOD

Moser and Kalton (1982) suggest that the first step in a survey is to define the population to be covered. Discussions on populations and sample generation abound. Suffice to say that in descriptive survey a substantial effort should be paid to the methods employed in selection. Moser and Kalton recommend that problems with population definition must be solved clearly and with due regard to what is realistic, or the search for typicality (Smith, 1975). Sampling is equated to the external soundness or generalisability of the findings – or the extent to which findings in a particular situation at a particular time apply more generally (Robson, 2004).

The process of sample selection was thought about extensively at the outset of the research and even when the research was underway, the reason being the group of interest to the researcher was difficult to access. Nothing is known about the population in this research apart from the fact that it exists. There is no national database of nurse educators. Even within the context of data held by the Nursing Council of New Zealand nurse educators teaching clinical postgraduate programme(s) are not captured. The Nursing Council records the numbers of those who self report as working in 'education', but this could be in-patient education, or as nurse educators at undergraduate or postgraduate level in tertiary education institution.

The National Association of Nurse Educators in the Tertiary Sector (NETS) has voluntary membership and consists mainly of "Heads of nursing from nursing education providers", although members can also be "registered nurses with a leadership role in education" (NETS, 2007). So while they may capture many nurse educators the list is not all-inclusive.

From conversations with my supervisor, communication with NETS as well as accessing university and polytechnic websites I was able to ascertain that there are 15² tertiary education providers who deliver postgraduate clinical nursing programmes in New Zealand. There are 21 District Health Boards (DHBs) who can facilitate students undertaking these programmes (Ministry of Health, 2006). From this knowledge my supervisor and I approximated that there were up to 150 nurse educators teaching clinical nursing postgraduate courses at Level 8 throughout New Zealand.

Some of the DHBs employ nurse educators to run programmes in collaboration with a tertiary education institution either a polytechnic, institute of technology or

² On completion of the research it was revealed that the actual number of tertiary education providers accredited to deliver postgraduate clinical nursing programmes is 11. Some institutions were counted when they in fact work under the umbrella of another

university. In an effort to capture a representative sample, tertiary education providers and DHBs were approached via their professional links. The approach to the tertiary institutions was made via NETS as one of the mandates of NETS is to promote and to participate in research related to nursing education. Directors of Nursing (DONs) were approached via the National Nurse Executives Forum. A DON represents each DHB at the Nurses Executives Forum. Initial contact was made to a representative from each group asking for the cooperation of the group. Each group agreed to facilitate the research. A detailed letter outlining the project was sent to each Head of School (HOS) and DON via their professional body on the 26th March 2006 (Appendix I). The letter outlined the aims of the project and asked for the number of nurse educators teaching clinical nursing postgraduate courses at Level 8 in their institution. Based on the information returned the desired number of questionnaires were sent. The questionnaire was mailed to the HOS or DON for distribution and included a pre-paid return-addressed envelope.

In essence I had no clear idea of the potential sample size. Prior to distribution of the questionnaire I calculated the response rate using Goyder's formula (cited in Gillis & Jackson, 2002). An estimated response rate of 65% was calculated. Response rate will be discussed further in the discussion chapter. Suffice to say that a response rate of 40% is not uncommon for postal questionnaires (May, 2001). The sample was gathered from the accessible population. The sample was essentially purposeful as the potential participants had to meet specific criteria. The specific criteria required the sample to comprise of nurse educators who deliver clinical postgraduate education programmes at National Qualifications Framework (NQF) Level 8 to registered nurses.

This category of sampling is a form of non-probability sampling where cases are determined as typical of some particular characteristic by the researcher (Gillis & Jackson, 2002; De Vaus, 1986) the result of which prevents a random sample being selected. Non-probability sampling is one broad form of sampling, the other is probability. A probability sample is one in which each person in the population has an equal chance of selection, while a non-probability sample as we have seen can allow for some people to have a greater chance of selection over others. This

sampling approach is desirable when the researcher is interested in a specific population. Gillis and Jackson recognise however that the notion of representativeness is a limitation of this type of sampling. As there is no data in the case of nurse educators teaching clinical postgraduate students, it is difficult to confer any representativeness of the sample. While there was no guarantee of representativeness, the information provided is still deemed useful. This technique of sampling according to De Vaus is appropriate when “sampling frames are unavailable” (p. 67). Sampling frames are present in probability sampling where all the members of the population are listed.

The generation of a sample was dependent on the participation of each DON and HOS. Reliance on a DON or HOS does not guarantee impartiality and “provides no external, objective methods for assign the typicalness of the selected subjects” (Polit & Hungler, 1991, p. 260). Polit and Hungler describe sampling bias as the over or under representation of a population. Certainly, because of the unknown nature of the population in this research it was open to sampling bias. Access to the sample was mediated by a number of gatekeepers, the first level being NETS and the Nurses Executive Forum and the second level the DONs and HOSs. Gatekeepers are generally concerned with the motives of the research and the cost to their organisation in time and reputation.

Bryman (2004, p. 518) suggests gaining access is a process of “negotiation and as such inevitably turns into a political process”. Within the concept of gate keeping is the risk of coercion in what is voluntary research. The researcher by the very virtue of having to go through so many people has no way of knowing if the participants were told to participate or told not to participate. In fact several of the HOSs and DONs did not ask for any questionnaires. This could mean a number of things:

- They had no nurse educators who met the inclusion criteria, or
- One institution covered the other – by that I mean a university with links to a DHB counted the educators who were employed by the DHB but facilitated their education programmes in their numbers, or

- They choose not to participate. Therefore making a unilateral decision for others.

Out of the 15 tertiary education providers nine asked for questionnaires. Out of the 21 DHBs two asked for questionnaires. Reminder notifications were emailed to the representative from NETS, the National Nurse Executives Forum and individual DON and HOS three weeks from the initial contact. This was done to enhance the response rate. The total sample size generated was 89 nurse educators.

INSTRUMENTATION

As has been previously stated survey research can utilise any number of data collection tools, including for example questionnaires or interviews. Each tool has both strengths and weaknesses. Postal surveys typically have a low response rate therefore it is difficult to assess if the sample is representative (Oppenheim, 2003; Robson, 2003). It can be said the postal surveys are often the simplest way of retrieving data about a population at a low cost. They also allow anonymity, which can encourage honesty (Robson). Response rates can be increased by face-to-face interviews. According to Polit and Beck (2008) a well-constructed interview can yield response rates of 80% to 90%. Interviews also allow the opportunity to reduce ambiguity that can be caused by some questions. However, the presence of an interviewer can occasionally influence participant responses (Polit & Beck).

The key to any research design is matching it to what the researcher wants to explore and the appropriateness of instrumentation. There are a number of data collection tools associated with descriptive survey including interviews, observation, content analysis and questionnaire. Oppenheim (2003) cautions researchers not to rush through survey design suggesting that “fact gathering can be an exciting and tempting activity to which a questionnaire opens a quick and seemingly easy avenue; the weakness in the design are frequently not recognised until the results have to be interpreted-if then!”(p. 7).

The long and onerous task of survey design is not always recognised. The process also requires a great deal of technical knowledge and skill. Oppenheim suggests that

the ‘process’ involves reflexive thought which gives the researcher greater clarity about the design and instrumentation. Oppenheim describes the function of each question is to try to elicit a particular response with the minimal of distortion. In an attempt to achieve this, each question in this research underwent extensive development and redevelopment. The final questionnaire (Appendix II) was reworked 20 times over a period of 13 months. The amount of time spent on the questionnaire design was necessary to ensure the validity of each question and the questionnaire as a whole and therefore the results of the research.

The questionnaire had to answer a list of specific questions listed in Table 1. Each question was related to a concept within the conceptual framework and are grouped as appropriate in Figure 3. These questions were used to keep the questionnaire on track and ensured only relevant questions were asked. It was difficult to get an even distribution of questions per concept as I grouped questions related to skill with the concept of experience and questions related to knowledge with the concept of qualifications. Also the central concept of preparation has only two specific questions as each question informs the concept of overall preparation.

Table 1: Questions on questions

Questions

What are their overall qualifications?
 What are their qualifications in teaching?
 What is their teaching experience?
 What is their clinical experience?
 Were their teaching skills acceptable?
 Were their clinical skills up to teaching the clinical?
 Were their technical teaching skills acceptable?
 Were their personal skills/attributes (motivation and enthusiasm) present?
 Did they receive peer support?
 Was the management support appropriate and helpful?
 Was their peer support helpful to them?
 Were they mentored?
 Was the mentoring useful?
 How formal was the mentoring?
 Current job satisfaction?
 To teach a clinical program do you need to work clinically in the specialty you teach?
 What helped to prepare them?
 What would have prepared them better?
 Demographics

Two non-participating nurse educator colleagues and an international academic (Dr Maureen Coombs) reviewed the first draft questionnaire to determine content validity. To enhance the validity of the questions I questioned my reviewers using cognitive questions. Examples of these include: are there statements that confused you? and what was your understanding of the meaning of each question? This questioning technique according to Oppenheim (2003) enhances the validity of a questionnaire. A statistician worked alongside me in the questionnaire development to ensure that the questions would not only answer the research questions but would also be statistically analysable. The statistician aided in the technical aspects of the questionnaire design.

The wisdom of designing a questionnaire could certainly be questioned as it raises a number of validity and reliability issues. Rudestam and Newton (1992) strongly advise against developing an instrument for a Masters level research project, as they can be created in haste, lack any form of pre-testing and consequently have little scientific value. It can be argued that even though Rudestam and Newton are fundamentally correct, instrument development is not without its merits and can give a greater contribution to the research project. The design of the questionnaire for this research consumed many hours of intellectual thought and is congruent with the conceptual underpinnings of the research.

Figure 3: Positioning of questions in relation to CENEP concepts

The self-report questionnaire has 43-items. The items are used to realise the dependent variables – support, educational preparation, clinical and teaching skills and experience. There are 36 closed questions, 29 of which used likert scales. The likert scale is an attitude scale where respondents place themselves on an attitude continuum for each statement running from strongly disagree, disagree, neutral, agree, strongly agree (Oppenheim, 2003). For scoring purposes these five positions were given a numerical weighting – 1, 2, 3, 4, and 5. A score of 5 indicated a favourable attitude and a score of 1 an unfavourable attitude. The questionnaire finished with three open-ended questions. The questionnaires were coded for tracking purposes only. Each questionnaire was coded consecutively – 001, 002, 003, etc.

In designing the questionnaire I was mindful of a number of key concepts. The questionnaire needed to look professional, be explicit in its direction and lack ambiguity. It was imperative that the participants knew how they were selected and that their participation was entirely voluntary. This was achieved by attaching a detailed cover letter with each questionnaire (Appendix III). The letter detailed the selection process the intent of the research and the eligibility criteria. The opening paragraph of the questionnaire repeated the eligibility criteria and gave instruction on how to complete the questionnaire. Each question required a response. To guide participants, each section within the questionnaire was introduced and instructions given on how to complete it. Questions were divided into subsections; namely respondent's attitudes when they first started their roles as nurse educators teaching clinical postgraduate programme(s) and their current attitudes to their role.

The questionnaire started by asking respondents what their completed tertiary qualifications were. This was done to engage the respondents early. Demographics, which are normally seen at the beginning of questionnaires, can often be viewed as off putting and irrelevant. This is because the participants are motivated to engage with the research and would like some pertinent questions about the topic rather than

who they are (Oppenheim, 2003). As a result a decision was made to put demographic details at the end of the questionnaire.

Annual practicing certificates are issued to all registered nurses by the New Zealand Nursing Council (NZNC). The NZNC utilise the re-certification process to survey each registered nurse and collect demographic data. The NZNC survey gives registered nurses 14 different ethnic choices. These 14 choices were employed in the questionnaire.

TREATY OF WAITANGI CONSIDERATIONS

One of New Zealand's founding documents is the Treaty of Waitangi and the principles of partnership, protection and participation were taken into account to ensure the researcher was culturally safe. Cultural safety as defined by the New Zealand Nursing Council (2005b, p. 7) is

The effective nursing practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability

Tolich (2002) suggests that this definition of cultural safety can be easily applied to and adopted by researchers. New Zealand has a diverse cultural context and when taking a purposeful sample of the population Maori as well as other cultural groups will be represented. I sent an overview of the research project to Te Kaunihera O Nga Neehi Maori O Aotearoa (National Council of Maori Nurses) and invited them to comment on the questionnaire. One of the aims of this group is to "lead and influence research, planning and implementation...for Maori" (National Council of Maori Nurses, 2004). The Council made no recommendation to change any aspect of the questionnaire. It was understood that if the analysis of the questionnaires identified any cultural differences these could be discussed and examined against relevant literature. Although this research was not specifically examining the preparation of Maori nurse educators, it has the potential to benefit nurse educators from all cultural backgrounds.

ETHICAL IMPLICATIONS

Ethical and moral imperatives have not been violated by this research. The research was strictly anonymous and a background information sheet was attached to each questionnaire outlining the motivation for and use of the data. Informed consent was implied by voluntary participation in filling out a questionnaire. Gilles and Jackson (2002) state that health care research is principally concerned with 'doing good', but immoral and over enthusiastic researchers can abuse it. No coercive strategies were employed to increase the response rate. All the completed questionnaires are kept in a locked filing cabinet and access is strictly limited to the researcher. All electronic information is password-protected and all questionnaires will be destroyed five years after the conclusion of the research.

Confidentiality of the participants and their responses has been maintained throughout as the names or contact details of the participants were never known as the HOS or DON distributed each questionnaire. Further, the results of the survey have been aggregated so no data has been attributed or is attributable to any specific DHB or tertiary education provider.

Ethical approval was sought and granted by Victoria University of Wellington Human Ethics Committee on the 21st March 2006 (Appendix IV). The Committee did not recommend any amendments to the research proposal or questionnaire.

DATA COLLECTION

After the research was granted ethical approval, contact was made with a representative from NETS and the National Nurse Executives Forum. A total of nine tertiary education providers and two DHBs contacted me directly and asked for questionnaires. The HOS or DON received questionnaires for distribution over a period of six weeks (from 10th April 2006 to 17th May 2006). As I was dependant on the HOS or DON to distribute the questionnaires there was no return date specified on the questionnaire. This allowed for a degree of flexibility for the HOS/DON and individual respondents. Two of the tertiary education providers were delayed in participating as they had to seek internal ethics approval to participate in the research although this did not materially affect the research.

Reminder e-mails were sent to NETS, the National Nurse Executives Forum and individual HOS and DONs. The reminders were e-mailed to individuals on the basis of the numbers of questionnaires sent and the numbers returned as each questionnaire had a tracking code so it was possible to ascertain how many questionnaires were returned from each provider. Generally speaking the follow up was made after a two-week period following the postal of the questionnaires. This was done in an attempt to increase the questionnaires response rate. Completed questionnaires were returned in pre-paid return-addressed envelopes. The responses came in over a period of 12 weeks (from 18th April 2006 to 21st July 2006).

DATA ANALYSIS

An excel spreadsheet was created to track the entire distribution of questionnaires, and as each was returned it was entered into the spreadsheet. Out of the tertiary education providers nine asked for questionnaires and questionnaires were returned from eight of these. Questionnaires were sent back from each of the two DHBs who sought them.

Each returned questionnaire was examined to ensure all the questions were answered. Before any data was recorded or analysed a codebook was created. The codebook proved a means of recording the conversion of information generated from each respondent into a form that could be entered into a statistical package for analysis. For example, in question two participants were asked “do you have any educational qualification(s) specifically in education?” and the answer choices were yes or no. In the codebook yes = 1 and no = 0.

The Statistical Package for Social Sciences (SPSS Version 12) was used to analyse the data. SPSS is one of the most widely used statistical packages. “SPSS provides excellent capabilities for labelling variables and includes all of the most commonly used parametric and non-parametric statistical procedures” (Polit & Hungler, 1991, p. 541). The data analysis process requires a number of steps. First the data file was examined for any missing data including running a missing value analysis. Once it was established that there was no missing data the descriptive phase of the data analysis took place. Descriptive statistics help to describe the characteristics of a

population. A number of graphs and tables were used to present the data. Total scores were calculated for teaching skills (TS), personal skills (PS), clinical skills (CS), management support (MS), peer and mentoring support (PMS), and job satisfaction (JS). When calculating total scores it was not necessary to reverse scores, as there were no negatively worded questions

The data was nominal and ordinal in nature. Nominal variables are where numbers are assigned randomly to variables, and examples include gender and ethnicity (Gillis & Jackson, 2002). Ordinal measurement requires a continuum in which numerical values are ordered, Likert scales are a good example of this kind of measurement (Gillis & Jackson). Ordinal measurement orders the values but does not guarantee the gap between each measurement point.

Means and medians were calculated for individual questions and are reported along with the standard deviation (SD). The mean is a measure of central tendency or average and is widely reported by researchers (Ibid; Clegg, 1990). The median is the midpoint of a distribution of numbers and is normally used for ordinal level measurement (ibid). Standard deviation is reported to indicate the spread within the distribution of scores (Ibid).

Likert scales were used to capture participant's responses, with scoring of 1 (strongly disagree), 2 (disagree), 3 (neutral), 4 (agree) and 5 (strongly agree). Likert scales are widely used in questionnaires and whilst they have many positive attributes they do have a number of disadvantages. Some of the disadvantages as described by Gillis and Jackson (2002) include response set bias, extreme response set bias and acquiescence response set bias. Response set bias is where participants respond in the context of social values or norms. Extreme response set bias as the name suggests is a propensity to select extreme attitudes. When participants always agree with statements regards of content the term acquiescence response set bias is used.

One of the main issues with scale measures is internal consistency. Internal consistency is the concept where all the items in the scale measure the same underlying construct (Pallant, 2005). The reliability of the scale and its internal consistency was checked using Cronbach's alpha. A Cronbach's alpha level greater

than .7 is recommended by Pallant (2005). In the results chapter questions will be presented according to the groupings of TS, PS, CS, MS, PMS and JS. Results of each question will be presented as percentage agreement or percentage disagreement. Percentage agreement is a combination of strongly agree and agree, and percentage disagreement a combination of strongly disagree and disagree.

Non-Parametric versus Parametric tests

Choosing the right statistical tests to address particular research questions is important. However, the most important part of the process is “clearly spelling out what you have, and what you want to do with it” (Pallant, 2005, p. 94)

There are two main classifications of statistical tests, parametric and non-parametric. Parametric tests (of which T-test is an example) make certain assumptions about the population from which the sample has been drawn and are based on certain assumptions, for example normalcy. Normalcy refers to the assumption that the variables are normally distributed within the population under study (Polit & Beck, 2008). For Parametric testing the measurement should use an interval scale and data distribution. An interval scale contains ordered numbers and the interval between each number is the same, an example is the temperature measurement Celsius (Clegg, 1990).

When certain assumptions about the underlying population are uncertain, non-parametric tests are often used in place of their parametric counterparts as they involve less controlled assumptions. Non-parametric tests are valuable when data is measured in nominal and ordinal scales and is not normally distributed. They are also considered to be useful when sample sizes are small (Pallant).

Spearman’s Rank Order Correlation (Rho) is a form of non-parametric test and is used to calculate the relationship between two continuous variables. Some statisticians advise that when N is less than 50 parametric tests are inappropriate as the central limit theorem is unreliable and probability values could be wrong (Polit & Beck). Central limit theorem occurs “when samples are large the theoretical distribution of the *means* tends to follow a normal distribution”. (Ibid, p.591)

A number of statistical tests were used in the analysis of the data. Spearman's Rank Order Correlation (Rho) was the first statistical test used. Rho is a form of non-parametric test; the parametric alternative is Pearson's product-moment correlation coefficient (Pallant, 2005). This test is used to explore the strength of the relationship between two continuous variables, for example the relationship between clinical experience and clinical skills. Rho is a measure of correlation association. A correlation is simply the relationship between variables. The number used to express the relationship is the correlation co-efficient. To calculate the precise correlation co-efficient the Spearman test gives a co-efficient known as Rho.

The second statistical test used in the analysis of the data was the Wilcoxon Signed Rank Test. This is a form of non-parametric testing and was used to explore repeated measures i.e. when participants are measured for the same thing but at two different times (time one and time two). For example how nurse educators felt about their clinical credibility on commencement of their role compared to their current feelings of clinical credibility. The output or result from a Wilcoxon Signed Rank Test is characterized as the Z values and the significance levels are presented as Asymp. Sig (2-tailed). Pallant (2005) suggests that when a significance level is less than .05 it can be concluded that the difference between the two scores is statistically significant. The parametric alternative to a Wilcoxon Signed Rank Test is a paired sample t-test.

The final statistical test used was the Mann-Whitney U. This test is used to explore the differences between dependent variables such as understanding educational theory or understating pedagogy and an independent variable like holding or not holding a teaching qualification. The Mann-Whitney U test is another form of non-parametric testing, and similarly it has a parametric alternative; in this case it is an independent-sample test. The test compares medians. Pallant describes how the test converts the scores into ranks and then compares the ranks to see if there is a significant difference. Because of the ranking structure, the distribution of the scores does not matter. When looking at the results the two values examined are the Z value and the Asymp. Sig (2-tailed) this will give the probability and in turn the significance of the relationship.

As I approached the data analysis I considered conducting a multivariate analysis of variance (MANOVA) to compare groups. MANOVA is the statistical examination of difference when there is more than one dependent variable (Pallant, 2005). These dependent variables should be related in some way. Like t-tests, MANOVA is a form of parametric testing and as such is considered to be more 'powerful' than a non-parametric test (Clegg, 1990). However, there are a number of assumptions underlying the use of parametric tests like the MANOVA. As discussed earlier normalcy is one of the assumptions, other examples are random sampling and homogeneity of variance. Due to the sample size a number of these assumptions were violated and as such MANOVA was not undertaken.

Qualitative data gathered from each free-response questions was transcribed to the letter into a word document. Each line of commentary was numbered. Each question was examined to identify any common themes. Themes were created from shared meaning and shared words. These were then colour coded and numbered to give an overall picture of the themes. The three free-response questions were analysed individually, so that the theme could be attributed to each question. SPSS was not used to analyse the qualitative data. There were instances where participants used abbreviations. In presenting the results all abbreviations were written in full for ease of understanding, this in no way changed the meaning of what was being said by the participants.

SUMMARY

This chapter outlined that methodological approach, the method and design of the research. A detailed description of the rather complex process of sample selection was given. The process of constructing a questionnaire congruent with the theoretical framework was outlined. Key issues of the validity and internal consistency of the scales were specified and methods of enhancing reliability explained. The chapter included the process of data analysis as well as a description of the statistical tests used. An overview of the ethical and cultural considerations was given. The preparation of New Zealand nurse educators teaching clinical postgraduate programme(s) will be presented in the next chapter where the results of the research will be described.

CHAPTER 5: RESULTS

The purpose of this chapter is to present the results of the research. The sample in terms of response rate, demographics, academic qualifications and experience will be described. Descriptive statistics will be used to explore the 29-Likert scale questions. These questions are grouped into teaching skills, personal skills, clinical skills, management support, peer support and mentoring support. Non-parametric tests are presented on key variables such as length of experience teaching and total teaching skills. Tables and figures will be utilised to present the data in meaningful ways. Qualitative data from each free-response question will be reported by means of participants' comments. Reflections on the results will take place in the discussion chapter, where results will be considered in relation to the conceptual framework and the literature.

RESPONSE RATE

In total 89 questionnaires were sent to Head of Schools (HOSs) and Directors of Nursing (DONs) for distribution and responses came in over a period of 12 weeks from 18th April 2006 to 21st July 2006. A total of 41 questionnaires were returned indicating a 46% (N=41) response rate. All returned questionnaires were fully completed and the open ended questions legible. Four questionnaires were excluded as the respondents did not teach clinical postgraduate programmes at NQF Level 8, a pre-requisite for inclusion in the study. Those excluded taught research methodologies and generic nursing papers. A total of 41.5% (N=37) questionnaires met the inclusion criteria (nurse educators teaching clinical postgraduate education programmes at NQF Level 8) and were used to generate a data set.

DEMOGRAPHIC DATA

The respondents' gender was mixed with 56.8% (n=21) being female and 43.2% being (n=16) male. Within the New Zealand nursing profession the reported ratio of males to females in the year 2000 was 1:14.9 (New Zealand Health Information Service, 2002). The predominant ethnicity reported was NZ European 73% (n=27) followed by other 13.5% (n=5), other European 10.8% (n=4) and NZ Maori 2.7% (n=1). Examples of 'other' ethnicity included American and Australian. Respondents were asked if their contract of employment was with a tertiary education provider,

District Health Board (DHB), both or other. The majority of respondents had an employment contract with a tertiary education provider 64.9% (n=24) and 18.9% (n=7) had a contract with a DHB while 13.5% (n=5) had a contract with both a tertiary education provider and DHB. One respondent (2.7%) had a tri-partite contract with a Tertiary education provider, DHB and a Non-Governmental Organisation (NGO).

Table 2: Demographic data of participants

	% (n)
Gender	
Male	43.2 (16)
Female	56.8 (21)
Ethnicity	
NZ European	73.0 (27)
Other e.g. Australian & American	13.5 (13)
Other European	10.8 (40)
NZ Maori	2.7 (1)
Employment contract	
Tertiary Education Provider (TEP)	64.9 (24)
District Health Board (DHB)	18.9 (7)
TEP & DHB	13.5 (5)
TEP, DHB & other	2.7 (1)

Ages ranged from 31 years to 66 years and the mean age was 48.19 years (SD= 8.05). This is illustrated in the histogram in Figure 4.

Figure 4: Age distribution of participants

QUALIFICATIONS AND EXPERIENCE

Respondents were asked what their completed tertiary qualifications were. This allowed respondents to report all their completed qualifications. Results revealed that 40.5% (n=15) had a Bachelors degree, 78.4% (n=29) of respondents had a Masters qualification and 10.8 % (n=4) had completed a Doctorate. A qualification specifically in education was held by 59.5 % (n=22) of respondents. Figure 5 displays the qualifications held by participants.

Figure 5: Qualifications held by participants

The range of experience was from zero months (n=1) to 192 months (n=1) and the mean length experience of respondents as nurse educators teaching postgraduate clinical programmes was 58.7 months.. The participant with zero experience was eligible to participate in the research as they met the inclusion criteria.

The mean experience in months that respondents spent in teaching when they first undertook their role as a nurse educator teaching postgraduate clinical programme was 100.38 (SD=92.22). Only 10.8% (n=4) of respondents had less than 12 months teaching experience when they first started in their roles as nurse educators teaching postgraduate clinical programme(s).

The respondents reported a mean length of experience as registered nurses of 259.97 months (SD=129.36). The registered nurse experience of the participants ranged

from 0 months (n=1) to 576 months (n=1). The mean length of experience of respondents working in the speciality they taught was 165.86 months (SD=112.37). Total mean experiences are presented in Figure 6 below.

Figure 6: Mean Experiences of participants in months

The breakdown of specialty teaching areas identified by the respondents can be seen in Table 3.

Table 3: Speciality teaching areas

	% (n)
Advanced assessment	13 (5)
Assessment Treatment & Rehabilitation	6 (2)
Burns/plastics	3 (1)
Cancer	8 (3)
Cardiac/Cardiothoracic	3 (1)
Cardiac Rehabilitation	3 (1)
Community	6 (2)
Intensive Care	11 (4)
Medical/Surgical	11 (4)
Mental Health	22 (8)
Orthopaedics	3 (1)
Paediatrics	8 (3)
Palliative Care	3 (1)
Primary Health	13 (5)
Trauma & Emergency	6 (2)
Other	13 (5)

Experience working in the specialist area for the participants ranged from 0 months (n=1) to 432 months (36 years) (n=1). Respondents were asked to identify the

specialty area(s) that they taught and a list of options was given based of the researcher's knowledge of the speciality programmes delivered throughout New Zealand. Respondents identified with all but two of the 16 options given, with none of the respondents identifying teaching renal or neonatal programmes. The most common specialty program was mental health nursing with 22% (n=8) of respondents. The next most reported programmes were advanced assessment 13.5 % (n=5), primary health 13.5% (n=5) and other 13.5% (n=5). Child and family health is an example of 'other' programmes.

The next section of the questionnaire progressed to the use of Likert scale questions. The scales used in the questionnaire had good internal consistency with a Cronbach's alpha coefficient of .81. There were 29 questions in this section (Appendix II).

Total scores were calculated for teaching skills (TS), personal skills (PS), clinical skills (CS), management support (MS), peer and mentoring support (PMS), and job satisfaction (JS). Each of these totals will now be presented. Along with the total scores the percentage agreement and percentage disagreement will be presented for each question. Tables 4-9 will present the percentage agreement and percentage disagreement for each question. As an example, question eight asked respondents whether they understood how educational theory informed their teaching when they first started as a nurse educator teaching a postgraduate clinical programme. The percentage agreement was 71% (n=26) and percentage disagreement was 22% (n=8). Each question has been positioned under the heading TS, PS, CS, MS, PMS and JS

TEACHING SKILLS

Respondent's attitudes about their teaching skills (TS) were generated from questions 8, 11, 14, 16, 18, 19, 20 and 21. For TS there was a potential minimum score of 8 (negative attitude) and a maximum score of 40 (positive attitude). Within TS no respondent scored less than 16, and one respondent scored the maximum of 40. The mean score for TS was 29.48 and median 30 indicating that respondents had a positive attitude toward TS. The majority of respondents (59%, n=22) indicated that their understanding of pedagogical principles prepared their teaching strategy, however despite this confidence there was a 32% (n=12) percentage disagreement

about the participants ability to develop a curriculum. The mean score for this question was 3.46 and median 4.00 (SD=1.36).

A majority of respondents (81%, n=30) felt that they could give the students quality feedback (Mdn=4.00, M=4.05, SD=.66). Confidence in classroom teaching and the use and development of audio visual aids was high, with a mean and median score of 4.00 (SD=1.02) for classroom teaching and a mean score of 3.84 with a median of 4.00 (SD=1.14) for use and development of audio visual aids. The respondents were not as positive about marking student assignments (Mdn 4.00, M=3.43, SD=1.25) or developing student assessments (Mdn=3.00, M=3.43, SD=1.16).

Table 4: Percentage Disagreement and Percentage Agreement for each TS question

<i>Question No:</i>	<i>Question</i>	<i>Percentage Disagreement</i>	<i>Neutral</i>	<i>Percentage Agreement</i>
8	Understanding of how educational theory informed teaching	22	7	71
11	My understanding of pedagogy helped me prepare my teaching strategy	19	22	59
14	I was able to give the students quality feedback	0	19	81
16	I knew how to develop a curriculum	32	11	57
18	I felt confident in my classroom teaching skills	8	19	73
19	I felt confident in developing and using audio visual aids	18	15	67
20	I felt confident in developing student assessment	27	24	49
21	I felt confident marking student assessments	27	21	52

PERSONAL SKILLS

Personal skills (PS), which examined motivation, enthusiasm, time management and ability to work independently, were collated from questions 9,10,12,13, and 15. The minimum score possible was 5 (no skills) and the maximum 25 (highly skilled). The minimum score for PS reported by respondents was 16 and the mean score was 21. The median score was 20. Overall, respondent's reported a positive attitude toward personal skills. When respondents first started in their roles as nurse educators they were motivated enthusiastic and enjoyed their role as the percentage agreement was 100% (Mdn=5.00, M=4.59, SD=.49). The respondents were generally able to manage their time effectively indicated by a mean and median of 4.00 (SD=.78) to

this line of questioning, however their ability to work independently was reported slightly less with a mean of 3.73 and median of 4.00 (SD=1.26). Confidence in teaching was reported favourably with a mean and median 4.00 (SD=.91).

Table 5: Percentage Disagreement and Percentage Agreement for each PS question

<i>Question No.</i>	<i>Question</i>	<i>Percentage Disagreement</i>	<i>Neutral</i>	<i>Percentage Agreement</i>
9	I was able to manage my time effectively	5	14	81
10	I was motivated and enthusiastic	0	0	100
12	I was confident in my role as a nurse educator	25	13	62
13	I enjoyed my role as a nurse educator	0	0	100
15	I was confident teaching	8	17	75

CLINICAL SKILLS

Clinical skills (CS) were totalled from questions 17, 22, 23 and 24. The minimum score possible was 4 (no skills) and maximum 20 (highly skilled), and the actual reported scores were 13 – 20. The mean score was 17.18 and median score was 17. Again respondent's attitudes to their CS were reported as mostly positive. Respondents were very confident engaging with clinical issues raised by the students resulting in a mean score of 4.41 and median score of 4.00 (SD=.55). Similarly, respondents felt clinically credible with a mean score of 4.30 and median score of 4.0 (SD=.77). Confidence in developing clinical practice and clinical teaching skills was high, with mean scores of 4.24 (SD=.64) and 4.16 (SD=.64) respectively; median scores were both 4.00.

Table 6: Percentage Disagreement and Percentage Agreement for each CS question

<i>Question No.</i>	<i>Question</i>	<i>Percentage Disagreement</i>	<i>Neutral</i>	<i>Percentage Agreement</i>
17	I was confident in my clinical teaching skills	0	13	87
22	I felt confident dealing with clinical issues that the students raised	0	3	97
23	I felt clinically credible	0	19	81
24	I felt confident engaging students in implementing and developing best practice	0	11	89

MANAGEMENT SUPPORT

Management support (MS) was analysed using questions 25, 26 and 27 and generated a mean score of 10.08 and median of 10. The minimum score possible was 3 (no support) and maximum score of 15 (high level of support), and the actual range of scores reported was from 6 to 14. Respondents conveyed good support from management indicated by a mean score of 4.16 and median score of 4.00 (SD=.86). Having sufficient orientation was communicated unfavourably however with a mean score of 3.05 and median score of 3.00 (SD=1.05). Respondents did not indicate that they had good secretarial support either with a mean score of 2.86 and a median score of 3.00 (SD=1.22).

Table 7: Percentage Disagreement and Percentage Agreement for each MS question

<i>Question No.</i>	<i>Question</i>	<i>Percentage Disagreement</i>	<i>Neutral</i>	<i>Percentage Agreement</i>
25	The management of my department supported me in my work	5	13	82
26	I felt I had a sufficient orientation period	27	41	32
27	I received good secretarial support	38	25	37

PEER AND MENTORING SUPPORT

Peer and mentoring support (PMS) was analysed using questions 28, 29, 30, 31 and 32. The minimum score possible was 5 (no PMS support) and the maximum 25 (high levels of PMS support). The reported range of scores was 5 –to 25 with a mean of 16.6 and a median of 16. Peer support availability had a mean score of 3.89 and median score of 4.00 (SD=.99). Percentage agreement was 76% (n=28) and percentage disagreement 11% (n=4). Those who had peer support reported it being useful with a mean score 3.92 and median score of 4.00 (SD=1.06). Respondents were asked to categorize their mentoring experience from none to working alongside a senior colleague in partnership, and mean and median scores of 3.00 (SD=1.52) were reported. There was a 44% disagreement (n=16) to this question. Respondents were asked to further describe the mentoring they received and were given the options of chats over coffee to a formal process with goals and outcomes. Results revealed that 60% (n=22) of respondents indicated chats over coffee (Mdn=2.00, M=2.41, SD=1.34). The usefulness of the mentoring respondents received had a

mean score of 3.46 and a median score of 4.00 (SD=1.21) which combined with the previous answers indicate that participants deemed chats over coffee useful.

Table 8: Percentage Disagreement and Percentage Agreement for each PMS question

<i>Question No.</i>	<i>Question</i>	<i>Percentage Disagreement</i>	<i>Neutral</i>	<i>Percentage Agreement</i>
28	There was peer support available to me	11	13	76
29	The peer support I received was helpful to me	14	11	75
30	When I started my job my mentoring experience involved working alongside a senior colleague in partnership	44	18	38
31	The mentoring I received can be described as a formal process with goals and outcomes	59	19	22
32	The mentoring I received was useful	22	24	54

CURRENT ROLE JOB SATISFACTION

After the exploration of TS, PS, CS and PMS respondents were asked to consider their position as a nurse educator teaching a postgraduate clinical programme and answer the remaining questions as they apply to their current position. Satisfaction with their current role was totalled from questions 33, 34, 35 and 36. The minimum score possible was 4 (not satisfied) and maximum 20 (highly satisfied). The actual range of scores was 8-20. Mean satisfaction was 15.91 and median was 16. Percentage agreement for motivation and enthusiasm for the teaching aspects of their current role was 81% (n=30, Mdn=5.00 M=4.38, SD=7.94). Equally the motivation and enthusiasm toward the clinical aspects of their role was high (Mdn= 4.00, M=4.24, SD=.86). Clinical credibility had a mean score of 3.38 and a median score of 3.00 (SD=1.25). Being currently clinical credible had a 54% disagreement (n=20). The mean score of current job satisfaction was high at 3.92 and median score was 4.00 (SD=0.95).

Table 9: Percentage Disagreement and Percentage Agreement for each JS question

<i>Question No.</i>	<i>Question</i>	<i>Percentage Disagreement</i>	<i>Neutral</i>	<i>Percentage Agreement</i>
33	I am highly motivated and enthusiastic about my current role	3	11	86
34	I am highly motivated and enthusiastic about the clinical aspects of my work	5	11	84
35	I feel clinically credible now	24	30	46
36	I am extremely satisfied with my role	11	16	73

RELATIONSHIP BETWEEN CLINICAL EXPERIENCE AND CLINICAL SKILLS

The relationship between the number of years respondents spent working as registered nurses and the number of years they worked in the speciality was highly related ($r=.538$, $p=.001$). On average, people spent 65% of the time they had been working as registered nurses working in their specialty area. Spearman's rank order correlation was calculated to examine if the length of time participants worked in speciality practice correlated to their clinical confidence. There was a positive relationship between number of months working in the specialty and clinical skills see Figure 7 ($r=.43$, $p=.007$). The longer the participant worked in speciality practice the more confident they were dealing with clinical issues raised by the students and engaging with students to implement and develop best practice. The scatter plot in Figure 6 shows this relationship.

Figure 7: Relationship between number of months in speciality area and CS

RELATIONSHIP BETWEEN TEACHING EXPERIENCE AND TEACHING SKILLS

The relationship between length of experience teaching when nurse educators first started in their roles and TS was explored using Spearman's rank order correlation. There was a strong positive relationship between length of teaching experience and

TS ($r=.70$, $p=0.01$). This relationship can be seen in the scatter plot in Figure 7. The more teaching experience the more confident the participants were.

Figure 8: Relationship between number of months teaching experience and TTS

REPEATED MEASURE OF CLINICAL CREDIBILITY

A Wilcoxon Signed Rank Test was carried out to examine the difference in clinical credibility when respondents first started as nurse educators and their current feeling of clinical credibility. The Z value was 4.09 ($p=.001$) identifying that there was a statistically significant difference in clinical credibility over that period. A paired sample t-test resulted in a probability value of .000, which means the actual probability value, was less than .0005. Therefore it can be concluded that there was a significant difference in clinical credibility from when respondents first started as nurse educators and their current feeling of clinical credibility. Having established that there was a significant difference it was necessary to determine which set of scores was higher, current credibility or credibility on commencement of role. The mean for clinical credibility on commencement of nurse educator role was 4.30 (Mdn=4.00) and the mean for current clinical credibility 3.38 (Mdn=3.00) therefore, it can be concluded that current clinical credibility significantly decreased from that felt on commencement of nurse educator role. Even though there was a significant

difference in the scores the cause of the drop in clinical credibility cannot be solely related to time.

REPEATED MEASURE OF MOTIVATION AND ENTHUSIASM

Current motivation and enthusiasm were examined in relation to motivation and enthusiasm when participants first started in their role. Wilcoxon Signed Rank test revealed a statistically significant difference between scores ($Z = 2.695$, $p = .007$). Participants were slightly more motivated and enthusiastic when they first started in their role ($M = 4.98$, $Mdn = 5.00$) than current levels of motivation and enthusiasm ($M = 4.38$, $Mdn = 5.00$). This was statistically significant ($p = .05$).

RELATIONSHIP BETWEEN HOLDING A TEACHING QUALIFICATION AND TEACHING SKILLS

Mann-Whitney U was used to investigate differences between holding a teaching qualification and teaching knowledge. Three dependent variables were used, understanding of educational theory, understanding of pedagogy, and development of curriculum. The independent variable was teaching qualification (holding or not holding a teaching qualification). The results indicated that those holding a teaching qualification had a higher level of knowledge on all areas. Conversely, those without a teaching qualification had a lower level of knowledge. This was statistically significant in the area of pedagogical influences on teaching strategy ($u = 87.5$, $p = .01$) but not for understanding educational theory ($u = 121.5$, $p = .18$) or knowledge of curriculum development ($u = 119.5$, $p = .16$).

The next section of the questionnaire gave participants the opportunity to write what they considered were key aspects in their role preparation and what additional preparation would have been useful. The final question in the questionnaire invited the participant to add any further comments they wished to make. All of the participants ($N = 37$) supplied information on what they considered prepared them for their role, and 95% ($n = 36$) of respondents answered the question on what additional preparation would have been useful and 48.6% ($n = 18$) wrote additional comments.

WHAT HELPED PREPARE NURSE EDUCATORS

Table 10 gives an overview of comments made by respondents when asked to describe the things (course, clinical experience, life experience etc) that prepared them to teach a postgraduate clinical programme. This is the opinion of one participant about preparation:

I had little preparation apart from being involved “helping” with “the course” on previous year. I undertook the ENB (English Nation Board) teaching course in the UK, but feel this held little relevance to teaching here in New Zealand (17).

There were two major themes that emerged from what prepared participants, personal education experiences (62.2%, n=23) and clinical experience (59.5%, n=22). An additional five minor themes were identified, teaching experience (32.4%, n=12), colleague support (27%, n=10), research /conference/ publications (21.6%, n=8), mentoring (8.1%, n=3), and interest/life experiences (16.2%, n=6).

Having personal experience of education was strongly identified as a factor in role preparation. One respondent stated that:

Participation as a student in a Masters programme provided on going knowledge and development of academic writing requirements (11).

Another respondent stated:

I had obtained my BN. The experience of doing my own academic study assisted me (162).

A period of time in clinical practice was the next most reported factor in role preparation. The following is an example of a comment from one respondent on what prepared them for their roles:

Years of clinical work and continuing part time clinical with part time teaching (150).

A number of respondent linked clinical experiences in a specialty area as important:

My years of clinical experience in my speciality area (159).

Teaching experience was mentioned by 32.4% (n=12) of respondents. As noted earlier in the chapter only 10.8% (n=4) of respondents had less than 12 months teaching experience when they first started in their roles. It would appear from the comments made by respondents that a number of nurse educators taught undergraduate programme(s) before progressing to teach postgraduate clinical programme(s). The following are examples of comments from two respondents about their teaching experiences and the confidence they gained from having undergraduate teaching experiences:

Teaching undergraduate gave me some confidence to direct this energy to colleagues who came to masters papers (86).

I was already teaching undergraduate students (year 3) so was confident in my teaching practice (209).

Reference to collegial support was made by 27% (n=10) of respondents while 8.1% (n=3) specifically mentioned mentorship support. One respondent stated that having a mentor and a supportive team of peers impacted on role preparation:

I had excellent mentors, role models to aspire to, constructive critique of observed teaching sessions and a team of peers with whom to discuss issues (48).

Twenty one percent (n=8) of respondents suggested that participation activities like research, conference attendance/presentation and writing for publication prepared them teach postgraduate clinical programme(s). This is captured by the following respondent's comment:

Undertaking research projects related to clinical – present at conferences – national & international which assist in keeping up to date – also constantly reading and writing – also very helpful (239).

Having interest in education as well as life experience was mentioned by 16.2% (n=6) of respondents. One respondent stated that:

Passion for subject, love teaching, enjoy people, makes a difference ultimately to the patient (129).

Table 10: Considerations about what prepared respondents to teach PG clinical programme(s)

Emergent Theme % (n)	Participant Quotations (code number)
Personal education experiences (62.2%, n=23)	<ul style="list-style-type: none"> • Participated in the course the year prior to teaching (61) • Completing my masters thesis and undertaking Postgraduate studies in education (79) • Working as a nurse while a student myself (94) • I have achieved a high level of academic achievement in my undergraduate and postgraduate studies (137) • Having a masters degree and doing doctoral study (256)
Clinical experience (59.5%, n= 22)	<ul style="list-style-type: none"> • Extensive clinical experience as a senior nurse (9) • Clinical experience and a great desire to ensure that we provided “something” for paediatric nurses were my greatest motivation (21) • Confidence in clinical skills and knowledge (52) • Clinical experience which allowed me to link: nursing to physiology/pathophysiology (84) • A period of time in clinical practice working as a registered nurse (97)
Teaching experience (32.4%, n=12)	<ul style="list-style-type: none"> • Previous teaching experience (201) • Teaching in clinical setting to undergraduate students (95) • I had been involved in teaching numerous short courses over the years so viewed my step into full-time teaching an opportunity to progress my skills (247)
Colleague support (27%, n=10)	<ul style="list-style-type: none"> • Colleague support (185) • Discussions with colleagues (222) • Keeping in touch with the team (257)
Research/conference/publications (21.6%, n=8)	<ul style="list-style-type: none"> • Involved in research in specialty field (6) • Attending conferences – research projects – writing for publication (115)
Mentoring (8.1%, n=3)	<ul style="list-style-type: none"> • I had excellent mentors, role models to aspire to, constructive critique of observed teaching sessions (47) • I superb mentor who at times “helped me” and at other times “carried me” (164)
Interest/life experience (16.2%, n=6)	<ul style="list-style-type: none"> • A keen interest in how nurses learn their clinical work (13) • Life experience (112) • Involvement in a range of nursing and “outside life” activities (65)

ADDITIONAL PREPARATION THAT WOULD HAVE BEEN USEFUL

As stated earlier 95% (n=36) of respondents wrote comments about the additional preparation they would have found useful. There were two major emergent themes, educational theory (36.1%, n=13) and support (27.8%, n=10). Five smaller themes also came to light. These included educational qualification (16.7%, n=6), mentoring (16.7%, n=6), E-learning (8.35%, n=3), peer networking (8.35%, n=3) and clinical practice (5.6%, n=2). Table 11 gives a breakdown of participants' comments for each theme.

Additional preparation in education theory was a theme that emerged strongly. One respondent stated additional preparation should include:

Having a better understanding of pedagogy and curriculum development. More education theory (232).

Another stated that:

I previously taught undergraduates – adult-learning styles was taught to me in a brief teaching course further training in this would be beneficial (56).

Support was the next emergent theme. There were a number of concepts covered by support. These included aspects of orientation, being aware of policies and procedures and knowledge of available university services. One respondent wanted:

A better understanding of tertiary education per se. More information and experience with marking and feedback know about major difference teaching in higher education centre; know a little what I would feel like, to be aware of the very steep learning curve for me (14).

Another respondent wanted to access the universities teaching services:

I would love to have been able to tap into the university teaching service (23).

Earlier in the chapter it was noted that 40.5% (n=15) of participants did not hold a qualification in education. Having an educational qualification was considered by

16.7% (n=6) of respondents to be important for additional preparation. One participant made the suggestion that an educational qualification should be a role requirement.

Postgraduate diploma in education – maybe this should be a role requirement and if I were to stay in education, I would actively pursue this qualification (50).

Table 11: Additional preparation participants would have found useful

Emergent Theme % (n)	Participant Quotations (code number)
Educational Theory (36.1%, n=13)	<ul style="list-style-type: none"> • Education theory (7) • A course in teaching strategies (45) • Know how to mark correctly (131)
Support (27.8%, n=10)	<ul style="list-style-type: none"> • A few days at least to overview the processes of post graduate education (66) • Being orientated to policies and procedures, and accessing resources (111) • More targeted seminars/workshops for post graduate educators (145) • Learning the administrative aspects of student management (post moderation process etc) (151) • Doing orientation to tertiary Ed provider sooner rather than later (232)
Educational qualification (16.7%, n=6)	<ul style="list-style-type: none"> • A formal teaching qualification (75) • Teaching qualification – especially in adult learning (140)
Mentoring (16.7%, n=6)	<ul style="list-style-type: none"> • Good mentoring (101) • Formal mentoring from an experienced nurse educator /lecturer (141)
E-Learning (8.35%, n=3)	<ul style="list-style-type: none"> • Intro to local online support services (blackboard) (153)
Peer networking (8.35%, n=3)	<ul style="list-style-type: none"> • Networking with others in similar roles (90)
Clinical Practice (5.6%, n=2)	<ul style="list-style-type: none"> • A period of time in clinical practice working as a registered nurse (97)

The next theme that became apparent was that of mentoring, which was mentioned by 16.7% (n=6) of respondents. We know from previously in the chapter that out of the 37 respondents 22% (n=8) had no mentoring. One respondent stated that it would have been useful preparation to have:

Mentorship in my early days of teaching as it was very much a trial and error situation (223).

Another recommended:

Having an academic mentor appointed – some formal process (83).

Support with e-learning was considered by 8.35% (n=3) as a skill that would have been useful to them. One respondent specifically stated that having additional time to understand teaching strategies would have been useful:

Time to get my head around on line learning strategies (116).

Peer networking was viewed by 8.35% (n=3) of respondents as additional preparation they would have found beneficial. Results discussed previously reported that 10.8% (n=4) of the total responses disagreed that peer support was available to them. One participant highlighted this social isolation and would have found contact with peers useful:

Some contact with other people in the same position as me – i.e. just moved from a clinician in the DHB to educator at a tertiary institute (167).

The final theme to emerge was clinical practice, two respondents identified this as an aspect of preparation that would have useful to prepare them for their teaching. One of the comments suggested linking clinical practice with teaching:

Ability to work in both clinical practice and teach(187).

ADDITIONAL COMMENTS FROM PARTICIPANTS

The final open-ended question gave participants the chance to write additional comments. Table 12 has examples of participants' comments. Eighteen respondents availed of the opportunity to make additional comments. Responses were clustered into three thematic groups, positive research comments (36%, n=13), stress (22%, n=4) and clinical credibility (22%, n=4). Under the theme positive research comments one participant stated:

Research like this might have prepared me for my journey ahead! (169).

Stress was another thematic area identified by four respondents one of whom stated:

I never imagined how difficult and stressful the move from clinician to educator was going to be. I only ‘survived’ it because of the incredible support I got from management and other staff (193).

The final theme identified was clinical credibility one respondent recommended the concept of joint appointments but acknowledged the financial implications in resourcing same:

I think for nurse educators to be clinically competent as well as educators is a huge load – joint appointments are ideal – but resourcing this is difficult! – An ideal though (244).

Table 12: Additional participant comments

Emergent Theme % (n)	Participant Quotations (code number)
Positive research comments (36%, n=13)	<ul style="list-style-type: none"> • Thank you for taking the time to complete this research: the outcomes will benefit all NZ nurse educators (121)
Stress (22%, n=4)	<ul style="list-style-type: none"> • Working in a postgraduate programme within a <i>academic institution</i>³ has been a hard struggle – a really great programme but under resourced, taught by overstretched staff (259) • Pressure of multiple roles, particularly having to travel regularly and stay away from home. The remuneration was not particularly good and at times the ‘business ethic’ of a tertiary provider seemed to be in conflict with my clinical values.
Clinical credibility (22%, n=4)	<ul style="list-style-type: none"> • Part time teaching and part time clinical position is a wonderful way to stay enthused, up to date, and credible (210) • Important clinical educators have appropriate practice experience and credibility but also designated education / preparation hours to develop role and programmes (35)

³ For reasons of confidentiality the name of the university has been removed.

SUMMARY

This chapter presented the results of the research. Response rate and demographic data were described, followed by educational qualifications and experience. Speciality teaching area was presented with the majority of respondents identifying with mental health. There was an examination of the 29 attitude questions as well as the three open ended questions. Each Likert scale was presented. Total scores for teaching skills, personal skills, clinical skills, management support, peer and mentoring support and job satisfaction were expressed.

Teaching skills were generally well reported. Respondents had a good understanding of pedagogical principles. The majority of participants felt they could give students quality feedback and were confident in their classroom teaching skills. However, respondents were not as positive about marking and developing assessments. Overall the attitude toward personal skill was positive. When the respondents first started in their roles they were motivated and enthusiastic however, current levels of motivation and enthusiasm were not as high. Respondents' attitude to clinical skills was mostly positive. Current clinical credibility significantly decreased from that felt on commencement of a nurse educator role. Support from management was good but respondents reported that they did not have sufficient orientation. Peer and mentoring were generally positively reported and the majority of participants had access to both. High levels of motivation and enthusiasm were reported for the teaching aspects of participants' current role.

Results from non-parametric tests were presented. Spearman's rank order correlation reported a relationship between the time participants had been working as an RN and the time they spent in their speciality area. The relationship between total clinical skills and months working in the specialty were similarly explored using Spearman's rank order correlation. There was also a strong relationship between length of teaching experience and teaching skills. Scatter plots were used to present some salient results. Wilcoxon Signed Rank test investigated the difference in clinical credibility and returned a significant difference in levels at time 1 (when participants started in their roles) and time 2 (current feelings). Motivation and enthusiasm also reported statistically significant differences from when participants first started to their current feelings. Participants holding a teaching qualification had higher levels

of teaching knowledge, those without had lower levels of knowledge and this was statistically significant in the area of pedagogical influences on teaching strategy.

Respondents reported a number of things that helped prepare them for their role. These included the two principle themes of personal education experiences and clinical experience. Other themes that emerged were teaching experience, colleague support, research/conference/publications, mentoring, and interest/life experiences. Key suggestions for additional role preparation included having more of an understanding of educational theory (including e-learning) and greater access to support services. Holding an educational qualification, having access to peers and mentors, as well as continued clinical practice experience were all suggestions for additional role preparation. Some respondents wrote additional comments, which reported significant levels of stress making the transition from clinical practice to teaching as well as recommendations for joint appointments.

These results from a sample population of New Zealand nurse educators teaching clinical postgraduate programmes raise some interesting points. It can be said that something is now known about the population. The results will be discussed in the next chapter within the context of the conceptual framework and current literature. Limitations to the research will also be addressed.

CHAPTER 6: DISSUSSION

The aim of this research was to determine the preparedness of New Zealand nurse educators for their role in teaching clinical postgraduate programmes. The concept of preparedness is complex and as such the conceptual framework was designed to guide the research. The participants were a sample of New Zealand nurse educators, teaching clinical nursing postgraduate courses/programmes at NQF Level 8. A questionnaire was sent to the participants to capture their feelings of preparedness. The questions posed by the research attempted to explore if a New Zealand nurse educator, teaching clinical postgraduate courses at NQF Level 8 is:

- Supported into the role of Nurse Educator?
- Academically prepared to teach a clinical postgraduate course?
- Prepared with the necessary personal attributes?
- Experientially prepared to teach a clinical postgraduate course?

The main research question answered within the discussion is:

To what extent and how are New Zealand nurse educators, teaching clinical nursing postgraduate courses at NQF Level 8 prepared and supported for their teaching role?

Participants in this research were not asked specifically if they felt prepared for their roles. The reason being, this is a closed question and ultimately does not take into account the complexities and multifaceted nature of preparation. Instead I asked specific questions in relation to each concept that arose from the conceptual framework. Participants were then given the opportunity to add free text comments of what they felt prepared them and what additional preparation they would have found useful. This chapter will discuss the results of the research in the context of the conceptual framework.

IMPLICATIONS OF DEMOGRAPHICAL FINDINGS

Prior to this research little was known about the population of nurse educators teaching clinically focused postgraduate programmes in New Zealand. As a result of this research we now know a great deal about the population and about the model of

preparation that exists and the model of postgraduate clinical nursing delivery in New Zealand. To begin with it appears that there is a good gender mix in this group. The ratio of males to females in this research is 1:1.3. This is a substantially higher ratio from that within the New Zealand nursing profession, which is 1:14.9 (New Zealand Information Service, 2002). Sherrod, Sherrod and Rasch (2005) suggest that it is important that the nursing profession reflect the diversity of the population it serves and with that in mind the proportion of men needs to increase. Sherrod, et al. further suggest that the profession needs to integrate gender and cultural differences so that the profession can meet the needs of patients and clients. Having a gender mix “increases creative ideas and thoughts and improves problem-solving” (Ibid., p 47). Yang, Gau, Shiao Hu and Shih (2004) conducted a descriptive survey to explore the professional career development for male nurses. Their research suggested that male nurses often pay special attention to their career development. This is an interesting concept but cannot be linked to this research, as the reasons for becoming a nurse educator were not explored. All that can be said is that the population who participated in this research reported an excellent gender mix and that this was not a reflection of New Zealand nurses generally

Ethnicity trends in the respondents are similar but not wholly representative of the New Zealand Nursing population. New Zealand European is the biggest ethnic group for both. The biggest variance seen was in ‘other’ which the Nursing Council of New Zealand (2007) reports as 5.5% of the total nursing population and yet it accounts for 13.5% in the population in this research. New Zealand Maori also has a variance, with 6.6% of the total nursing population identifying with New Zealand Maori (NCNZ, 2007) yet only one participant in this research identified with New Zealand Maori – a representative response would have been 2 to 3.

The reported mean age of the participants was 48.19 years. This is higher than the national average age of New Zealanders which is 35.9 years (Statistics New Zealand, 2006) and slightly higher than the RN workforce which has an average age of 45 years (NZNC, 2006). This has implications as both the population and nursing workforce is aging as well as those who teach nurses. Statistics from the United

Kingdom show that almost two thirds of nurses are over the age of 40 and more than a quarter are in their 50s or older (Duffin, 2005). According to the American Association of Colleges of Nursing (2001) “one of the most critical problems facing nursing and the nursing workforce is the aging of nurses and nursing faculty” (p. 7). There are multiple problems with an aging nursing workforce and I believe that there are tremendous implications when an experienced workforce retires as they take their vast experience and knowledge with them. As to the reasons why the population in this research were older than the national average for nurses one can only assume as this research cannot make specific claims. However, it may well be because these nurse educators had a long career in clinical practice before turning to education therefore coming into education later in life but with a vast amount of clinical nursing experience. The evidence gained from this research allows me to present the pattern of nurse educator preparation in New Zealand. This cannot be generalised to the entire nurse educator population and because of the small sample size must be viewed with caution.

CENEP AND THE PATTERN OF NURSE EDUCATOR PREPARATION IN NEW ZEALAND

The central concept with the CENEP framework is nurse educator preparation. This research suggests that there is no consistent approach to nurse educator preparation in New Zealand. There are some requirements as outlined by the Nursing Council of New Zealand but in particular no national competency requirements. If it is accepted that role preparation for nurse educators is necessary then the question that remains is how to best to achieve this. One of the easiest ways of having consistent approach to preparation is via educational training and specific structured career pathways for nurse educators. In clinical practice there are well-structured career pathways for registered nurses. These pathways in nursing have multiple functions to ensure ongoing competence (Ministry of Health, 2003) and to meet the professional development hours required by the Nursing Council of New Zealand (2005a). As a clinical nurse working in intensive care I participated in a professional development recognition programme (PDRP) and it gave me a set of goals to progress my clinical career. I knew where I was going and what I had to do to get there. This was not the same for my nurse educator career which required much more self direction. The

New Zealand nursing profession did not formally expect me to achieve specific competencies in nursing education. There are minimal requirements for educational qualifications and this is reflected in the population explored in this research.

The concept of qualifications (educational and clinical) is inherent within the CENEP framework. Overall the population in this research were highly qualified when compared with national qualifications held by nurses, 0.2% of whom have doctoral preparation, and 2.8% have a masters qualification (NCNZ, 2006). The majority of respondents held a masters qualification 78% (n=29) and 11% (n=4) hold a doctorate. When respondents were asked what prepared them for their role 62% (n=23) said their personal experience of education. It is difficult to determine if the participants were talking about their personal experience of education in terms of the content they learned, or the experience of being a student or both.

A compelling argument was made by Ramsden (2002) that professional teachers are necessary for students to have positive learning outcomes. Fitzpatrick and Heller (1980) suggested that the nursing profession needs to ask itself about the accountability of graduate programmes if those who teach them need to be taught themselves how to teach. The results of this research report that 40% (n=15) of the participants who teach clinical postgraduate programmes do not hold a qualification specifically in education. If we accept Fitzpatrick and Heller's argument then the credibility of some clinical postgraduate programmes could be questioned. Sixty percent (n=22) of participants in this research said they understood how pedagogical principles helped to prepare a teaching strategy. However, 43% (n=16) of respondents did not feel confident in curriculum development. Similarly, confidence in designing and marking assignments was low. Qualitative data supports the notion that participants felt they would have been more prepared had they a greater understanding of educational theory. Choudhry (1992) stated that understanding education theory is one of the core competencies for nurse educators in order for them to be successful in their roles. Respondents did indicate a positive attitude to their teaching skills (TS) particularly in the areas of giving student feedback, classroom teaching using audio visual aids.

As I embarked on this research I felt strongly that nurses educators should at the very least be able to teach and the results suggest that many do in fact have a qualification in teaching. Respondents taught in 15 various clinical specialisations with a mean length of teaching experience of five years. All of the participants had teaching experience prior to teaching a clinical postgraduate programme. Experience (teaching and clinical) was imbedded in the CENEP framework and resonated with participants. There was a strong correlation between the length of teaching experience and TS. This finding compares with that of Wilson, Floden and Ferrini-Mundy (2001) who found the literature overwhelmingly recommends that practical experience is vital to learning the skills of teaching. Qualitative data similarly supported this notion, as 32% (n=12) of respondents felt that having such experience prepared them.

Because there are no national training programmes for nurse educators (unlike Ireland for example) it is safe to assume that many of the participants were self-motivated to seek out an educational qualification or had a contractual obligation to obtain one. Either way there was a sense that holding a teaching qualification would be of some benefit to them in their careers as nurse educators. I would challenge the profession to set out clearly the expectations of its educators and how best to prepare them to meet these expectations. The next section of discussion focuses on the supports that are in place to assist nurse educators in their roles teaching clinical postgraduate programme(s). The concept of support was clearly highlighted in the CENEP framework.

Without organisational and administrative supports no individual would be wholly successful. Respondents reported good support from management. Within the realm of management support is the concept of having an orientation period. Having a sufficient orientation period and good secretarial support were both reported unfavourably. This may be why 28% (n=10) of respondents when asked what would have prepared them better said support. The support they asked for included orientation, understanding the administrative aspects of the role as well as knowing what services were available to them. Kruger Wilson and Porter O'Grady (1999) propose that organisations rely on the skills and knowledge and aptitude of their employees. In order for organisations to reap the benefits from their employees they

need to support and guide them. Employers and indeed employees will not benefit if an employee is left in a position where they must seek out their own answers and resources rather than being guided and orientated. It is up to the employer to ensure that sufficient orientation takes place.

I remember the first day I started as a nurse educator I didn't know where to start. I sat looking through files of teaching material, I felt completely out of my depth. At that time I shared an office space and my colleague could see the distress on my face. She closed the door and advised me how to proceed. Her support helped and sustained me during my first day, week, month and year. I can not imagine how the 11% (n=4) of participants in this research felt having no peer support. It must have been very difficult for them to have no one to turn to and to discuss the highs and lows of a very demanding job. Even though some participants had no peer support, 27% (n=11) suggested that they would have been better prepared if they had peer or colleague support. This correlates to the usefulness of peer support. A total of 24% (n=9) of respondents felt that peer support was not particularly useful. Even with relatively small numbers participants reported no support and/or ineffective support this is hardly conducive to a positive work environment. Developing social relationships are of benefit in reducing occupational stress and improving health and well-being of employees (LaRocco, House, & French, 1980). It would therefore benefit organisational outcomes to foster a supportive environment.

Seventy eight percent (n=25) of respondents stated that they had a mentoring experience when they first started in their role teaching clinical postgraduate programme(s). The value of the experience can certainly be questioned when 60% (n=22) of respondents said that the experience could be described as 'chats over coffee'. Despite this, respondents said that the mentoring they received was helpful leaving one to wonder whether any form of mentoring is better than none at all, regardless of the quality or quantity. This research examined respondents mentoring experience and the usefulness of the mentoring they received. Results show the usefulness of the mentoring was higher than the mentoring experience ($p=.000$). Eight percent of participants (n=4) viewed mentoring as important in role preparation and 17% (n=6) suggested that access to mentoring would have been helpful in

preparing them for their teaching role. There have been numerous reports in the literature about formal mentoring arrangements and the benefits these arrangements hold for the individual and the organisation (Gibson, 2004; Stewart & Kruger, 1996; Tourigny & Pulich, 2005). Morin and Ashton (2004) report that faculty who were mentored made a better transition into the academic environment. It can only be supposed that with a structured mentoring programme participants may have reported even more positive outcomes. I had an informal mentoring arrangement and I found it extremely useful. I can not imagine how much better my move into education would have been had the mentoring been formalised and sustained beyond a few months.

The final concept in the CENEP framework was that of personal attitudes. Overall respondents reported positive attitudes toward personal skills. Pettigrew (2007) suggested that people's utilisation of their time is what makes some people more successful than others. Participants reported a good ability to manage their time effectively. Participants were not asked if this ability to manage time helped to prepare them in their role, therefore no additional inferences can be made. Many of the participants lacked confidence in managing their time when they first started in their teaching role. This may have hindered participants' success but again minimal inferences can be made. We know that for graduate success the ability to work independently is a key factor (Griffin, 2001) and that positive motivation and feelings like enthusiasm can enhance achievement (Goleman, 2005). The participants in this research were highly motivated and enthusiastic when they first started in their roles, however this significantly ($p=.007$) dropped over time. Goleman articulates that the degree to which a person is motivated by feelings of enthusiasm and pleasure in what they do propels them to accomplishment. This is a key consideration in the retention of nurse educators

Participation in research and academic activities like publications and conference presentations, was useful preparation for 22% ($n=8$) of respondents. This is important as many nurse educators are expected to participate in research, in fact in New Zealand increasingly individual performance is in some instances measured by research outcomes more than excellence in teaching (Tertiary Education Commission, 2007). The pattern of educator preparation presented clearly lacks

uniformity and standards. There are no structured pathways, and organisational support is inconsistent. It is essential that the profession consider the implications of this deficit for nurse educators, their students, and in turn the patients they care for.

THE PATTERN OF POSTGRADUATE CLINICAL NURSING DELIVERY IN NEW ZEALAND

One of the key findings in this research is the description of the pattern of clinical training for postgraduate nurses in New Zealand. Clinical training for postgraduate nurses is immersed in the world of the academic institution which Hoyles, Pollard and Glossop (2000) caution against. The majority of respondents 65% (n=24) were employed by tertiary education providers. Despite them being removed from clinical practice the respondent's attitudes to their clinical skills (CS) were good, particularly engaging with the students when they raised clinical issues. Ninety seven percent (n=34) of participants felt confident dealing with clinical issues raised by their students. Qualitative data from this research suggest that 59% (n=22) of respondents felt their clinical experience prepared them for their role. One of the more notable results from the research was a statistically significant ($p=.000$) difference in initial clinical credibility to current clinical credibility of participants. It is significant that many participants felt reduced levels of clinical credibility, yet they were actively teaching clinical programmes.

As a profession, nursing struggles with the complexities of merging practice, research and teaching requirements (Evans & Lang, 2004). There is an old adage that you can't be all things to all people. In my opinion nurses can't be expert clinicians, expert researchers and expert teachers. From my experience nurse educators are frequently challenged about their clinical credibility. As noted earlier participants felt reduced levels of clinical credibility. Is there therefore a question waiting to be asked about the sustainability of nurse educators embedded in the world of academia teaching clinical nursing programmes. There is only one constant in nursing practice and that is change. How can we as a profession expect our educators to be up-to-date, dynamic and challenging if they feel less than that? It is only a matter of time before questions are raised about the professions approach to clinical education for postgraduate nurses. Respondents had an average of over 21 years experience as registered nurses (RNs) when they first started in their teaching roles. Years working

in a speciality area were lower (average 14 years). Non-parametric testing revealed that on average people had spent 65% of the time they had been working as a RN, working in their specialty area. This is a positive correlation as Benner (2001, p.186) recommended that those teaching graduate specialisation programmes should be able to “demonstrate advanced levels of clinical judgement”. However, having worked in a speciality for 14 years does not mean high levels of clinical judgement as the individual may very well be out of speciality practice for 20 years.

Quantitative research (N=1612) carried out by Dean, Congdon, and Sellers (2003) attempted to explore what the expectations of nursing academics were for the future. Their results predicted that into the future nurse educators would be spending more time on research and publication and that nursing curriculums will be driven by service need and workforce priorities. In an editorial, Whitehead (2005, p. 253) made a brave prediction “that nursing specific programmes will be delivered in the clinical setting... by those who are the most clinically credible – active clinical practitioners”. I agree with Whitehead, radical change is imminent in nursing education and it is only a matter of time before questions are asked of clinical postgraduate programmes and the impact they have on clinical practice and the cost of these programmes on health service budget. In my review of the New Zealand literature, I found no papers that explored the ‘value for money’ of post registration and postgraduate education programmes.

In Ireland, the Health Service Executive established the Post-Registration Nursing and Midwifery Education Review Group in January 2007. The aim of this review is to identify a framework for the development of future post-registration education programmes including a preferred model for procuring and financing the development and delivery and evaluation of these programmes (HSE, 2007). Undergraduate nursing education had already been evaluated in New Zealand (KPMG Consulting, 2001), postgraduate education will not go unnoticed and we need to be ready. Do we accept that nurse educators situated in universities are in the best position to provide clinical postgraduate programmes? I think we have to be honest about how we answer this. Do we want to be jack-of-all-trades and master of none? Do we want to embrace faculty practice like the United States or the lecturer practitioner route like the United Kingdom? Whatever we decide, I believe we

cannot continue providing clinical education and yet not feel clinically credible. This research has for the first time described a population of nurse educators teaching clinical postgraduate programmes in New Zealand. However has the research question been answered within this discussion? *To what extent and how are New Zealand nurse educators, teaching clinical nursing postgraduate courses at NQF Level 8 prepared and supported for their teaching role?*

To answer the research question definitively cannot be done, as many participants felt prepared and supported in some areas and not in others. In an attempt to answer the research question a variety of new information has arisen which has led to the description of nurse educator preparation as well as the pattern of clinical training for postgraduate nurses. Many nurse educators in this research felt prepared for their role and the majority gave suggestions on how their preparation could have been improved. The concepts within the CENEP framework resonated with the participants. No research is without its limitations and this research is no exception. The limitations to this research will now be discussed.

LIMITATIONS

I think that I have made the best attempt possible to carry out rigorous research and have learned a great deal during the process. There are a number of limitations to this research, some of which are a natural consequence of the exploratory nature of the research. Accessing the population of interest was challenging and there were a number of barriers to overcome, and gate keeping was a particular challenge. There were at times three layers of bureaucracy to navigate before getting to the population of nurse educators, the professional body, the head of school, as well as internal ethics approval. This allowed for the introduction of sampling bias.

Despite the issues of access to the questionnaire, there was an initial response rate of 46%. Significantly the response rate and sample size are too small for the results to be considered meaningful. May (2001) suggests that a response rate of 40% is not uncommon for postal questionnaires. Methods of data collection have some bearing on response rates, with rates for questionnaires generally lower than other forms of self-report data collection (Murphy-Black, 2000). Miller (1991) postulates that the potential for non-response is a major disadvantage to survey research resulting in the

collected data to be unrepresentative. This in turn threatens the external validity of the research and suitable conclusions cannot be drawn (Williamson, 1981, Denzin, 1989). External validity is concerned with the extent to which inferences or conclusions about the results of research can be related to other groups (Gillis & Jackson, 2002). A sample size of 37 was very small and therefore results cannot be generalised to the entire nurse educator population. On reflection I think the only thing that would have increased the response rate would have been a face-to-face meeting with each university, polytechnic and DHB.

The construction of the questionnaire took a considerable period of time but returned analysable results. The scales used in the questionnaire had good internal consistency with a Cronbach's alpha coefficient of .81. The Likert scale questions posed were all positively positioned and therefore could have led participants to automatically agreeing with all statements. In the future this could be managed by using a variety of both positive and negatively worded statements. The questions were assigned to the concepts in the conceptual framework, but these were not evenly distributed. This should be addressed for future research.

The inclusion criteria for this research were New Zealand nurse educators teaching clinical postgraduate courses at NQF Level 8. These criteria may have been too narrow to allow full investigation of nurse educator preparation. Are the needs of nurse educators teaching undergraduate programmes any different from those teaching at masters' level? Further research is warranted to explore the entire nurse educator population in New Zealand.

SUMMARY

This exploration of the preparation of nurse educators teaching clinical postgraduate programmes suggests that concepts identified in the CENEP framework resonated with the participants. In relation to support participants clearly identified the need for additional supports in formal mentoring, administration support or planned orientation. Results suggest that some form of mentoring is better than none and participants find something as simple as a chat over coffee helpful.

Educational and clinical qualifications prepared participants for their roles. Nurse educators were confident in their teaching skill, yet 40% of them did not hold any educational qualification. The integrity of graduate programmes could potentially be questioned if those who teach them do not know or understand the theoretical bases of teaching. Evidence suggests that self reported clinical credibility was low. This in turn raises a number of questions for the nursing profession. The profession must explore if nursing education is a specialisation in itself or do its educators need to be able to demonstrate up to date clinical skills.

Nurse educators are a motivated, enthusiastic, independent group with good time management skills. This is a positive outcome for employers. Despite wanting more support, the educators in this research appeared to 'get on with it' and were generally positive about most aspects of their preparation. Something to be aware of is the level of stress reported by some participants. The more clinical and teaching experience participants had the more prepared they felt to undertake the role of clinical nurse educator teaching clinical postgraduate programmes. Not surprisingly, those with less experience did not feel as prepared.

One of the biggest concerns I have when examining the results of this research is the pattern of educator preparation and the pattern of clinical skills education. These are two separate but connected concepts worthy of further exploration. The pattern of nurse educator preparation lacked a national approach and relied on the individual's intrinsic motivation to develop professionally. The pattern of clinical skills education is removed from clinical practice and immersed in the worlds of academia. Recommendations on how best to move nurse educator preparation into the future and how to refocus the profession to deliver clinically credible specialty training for postgraduate nurses will be discussed in the next chapter.

CHAPTER 7: RECOMMENDATIONS

The premise for this thesis was that nurse educators are a fundamental requirement for a successful profession. Indeed if there is not an investment made into the preparation of nurse educators the quality of nursing education may be compromised. Are New Zealand nurse educators prepared for their roles? There is some way to go before this question can be answered because of the uncoordinated approach to nurse educator preparation in New Zealand. This chapter will make some recommendations on how this can be achieved; also aspects of the research's dissemination will be discussed.

FUTURE RESEARCH

It would be naive to base the future direction of nurse educator preparation on a single small-scale study. Therefore, the first recommendation from this research is for larger more inclusive research to be undertaken. Although links have been found between some of the variables in this research, this in itself does not prove that they are in fact connected. If larger scale research were to be undertaken I recommend that it include a replication of the questionnaire in this research. This would further validate the CENEP framework of the current research. I recommend a reconfiguration of the questions to include both positive and negative questions as well as an equal balance of question pre CENEP concept. In relation to larger research it would also be recommended that inclusion criteria be opened to include all nurse educators teaching postgraduate nursing programmes regardless of NQF level. Qualitative interviews and focus groups in which the voices and experiences of nurse educators were heard would also add to the richness of the data yielded by larger research.

DEVELOPMENT OF NURSE EDUCATORS

The literature suggests that there is a worldwide shortage of nurse educators (Berlin & Sechrist, 2002; DeYoung & Beshore-Bliss, 1995). In this research it was found that the nurse educator population is older than the nursing population in general. Therefore recruitment of new educators is an important consideration for the future of the profession. To recruit new nurse educators, the positions need to be attractive

and the profession possibly needs to be more creative in its recruiting strategies. Of all participants 60% (n=22) hold a qualification in education. I feel that a formal teaching qualification course would benefit the remaining 40% (n=15) of participants. Several participants in this research without a teaching qualification would clearly like to pursue one as we can see from the comments of one participant:

Postgraduate diploma in education – maybe this should be a role requirement and if I were to stay in education, I would actively pursue this qualification (50).

Therefore I recommend that a national teaching qualification for the preparation of nurse educators should be developed. In addition, only 11% of the nurse educators teaching clinical postgraduate programme(s) in this research held a doctorate. I suggested that a fast-track doctoral degree programmes and doctoral education programmes be developed at the very least in order to meet the demands of educating the educators. These recommendations would need further development and discussions with key stakeholders such as NETS, HOS and nurse educators.

MENTORING AND ORGANISATIONAL SUPPORTS

Formal mentoring relationships should be established for nurse educators immediately, and should also be part of any new national teaching qualification for the preparation of nurse educators. It is clear from this research that mentoring has a positive effect on nurse educator preparation. Even minimally structured mentoring was shown to be of benefit. Therefore a more structured approach will only improve the experiences of nurse educators. Formal mentoring expects mentors to act as role models, to instil a sense of confidence and competence in protégés, to share information and to provide feedback (Tourigny & Pulich, 2005). The initiation of a mentoring programme requires careful planning and buy-in from stakeholders, including management, potential mentors and protégés. There is also the financial benefit to organisations when they are able to retain nurse educators.

Along with mentoring all new nurse educators should be orientated to their role and their organisation. Evidence from this research suggests that nurse educators felt they were unaware of the supports available to them. Organisations have a responsibility to their employees to ensure they have an understanding of its processes and the

services available that may help the employee to fulfil their role to its full potential as nurse educators.

THE FUTURE DIRECTION OF CLINICAL NURSING POSTGRADUATE PROGRAMMES

Nursing education is a process of lifelong learning that meets the needs of patients, delivers the outcomes of the health services and enables professionals to expand and fulfil their potential. This may be a bold statement but I think that it is time that the delivery of clinical postgraduate nursing programmes in New Zealand is re-evaluated. I find it worrying that the majority of participants in this research are positioned away from the clinical environment and do not feel clinically credible. It is too much to expect nurse educators to be expert teachers, researchers and clinicians. Therefore I recommend that there be a full review of the delivery of clinical postgraduate programmes in New Zealand. This type of a review would need to be driven by the profession and either the Nursing Council of New Zealand, or the National Association of Nurse Educators could commission the review. The review could be like the one commissioned in 2001 to review undergraduate nursing education (KPMG, 2001). The purpose of the review would be to guide and direct the future development of postgraduate nursing education thus enabling excellence in professional practice and service delivery.

DISSEMINATION OF FINDINGS

A formal report of this research will be sent to the National Association of Nurse Educators in the Tertiary Sector and National Nurse Executives Forum highlighting aggregated findings and recommendations of the research. This report will then be distributed to individual Heads of School and Directors of Nursing. The participants in the research were informed that the results would be distributed in this way. Articles emerging out of this research will be presented for publication in appropriate nursing education journals and at academic conferences.

CONCLUSION

This research journey has been significant for me personally and professional. I began my journey to explore how nurses similar to myself were prepared for their education roles. I felt at the time that there was no acknowledgement by the

profession about how to prepare expert clinical nurses new to education. This research has identified that I was not alone. Feelings articulated by the participants resonated with me. Prior to this research, there were no reported studies about this population in New Zealand. While I acknowledge the small scale of the research, we now know some things about this group and this at least is a starting point. When I began to consider this thesis I tried to identify a theoretical framework, instead a conceptual framework derived from my personal experiences and informed by the literature guided the research.

The conceptual framework that has guided this research had four specific concepts leading to educator preparation. The first of these, support, is crucial to the professional preparation of nurse educators. The comments from the participants support this notion and commented favourably on the usefulness of the various forms of support peer, mentoring, administration and management. Even when the support is not formalised participants found it useful. The concept of clinical and educational qualifications was also central to educator preparation and emerged as an important element in the results, particularly a qualification in education. This has implications for the future preparation of nurse educators. I believed that certain personal attributes are essential for successful preparation. From my experience it took a certain amount of intrinsic motivation and enthusiasm to succeed. This concept resonated with the studies participants who were highly motivated and enthusiastic. The final concept was experience in teaching and clinical practice. The nurse educators in this research had varying degrees of experience which assisted their role preparation.

It is clear that nurse educator preparation has many elements. As such the New Zealand nursing profession should embrace all elements of nurse educator preparation to include issues of clinical credibility and core competencies. Successful role preparation to date relies heavily on individuals and the organisations they work for. The pattern of delivery of clinical nursing is immersed in the world of academia. The foundations of these findings are the perceptions of the 37 nurse educators who agreed to participate in the research. Because of their willingness to participate, there

are now a number of things known about the nurse educator population in New Zealand.

The research is not without its limitations but there is now something known about this important group within the New Zealand nursing profession. As a group they nurture and develop staff, help narrow the theory practice gap and in doing so improve the outcomes of patients. This research challenges the nursing profession to consider nurturing and preparing new nurse educators to ensure a healthy profession for tomorrow.

APPENDIX I: Head of school and director of nursing information letter

26th March 2006

Researcher: Helen Skally, Graduate School of Nursing and Midwifery, Victoria University of Wellington.

Dear Head of School / Postgraduate Co-ordinator,

I am a Master of Nursing student at Victoria University of Wellington. As part of this degree I am undertaking a research thesis. The project I am embarking on is exploring the preparation of nurse educators in New Zealand. Nurse Educators in New Zealand do a fantastic job delivering excellent clinical courses to the registered nurse population. However there has been little research exploring who they are and what do. With your help I would like to change that.

The sample required for this study will comprise of nurse educators who deliver clinical postgraduate education programmes at National Qualifications Framework (NQF) Level 8 to registered nurses. As you know the NQF has 10 levels of qualification. Level 8 is postgraduate standard equivalent to a master's level qualification.

There are 15 tertiary education providers who deliver postgraduate clinical nursing programmes in New Zealand and 21 District Health Boards (DHBs) who facilitate students undertaking these programmes. Some of the DHBs employ nurse educators to run programmes in collaboration with a tertiary education institution. In an effort to capture a representative sample, each of the 15 tertiary education providers and 21 DHBs has been approached and asked to provide the number of nurse educators teaching postgraduate courses at Level 8.

I need your help to make sure that the questionnaire is distributed to the nurse educators in your area.

Could you please provide me with the number of nurse educators (who fit the criteria as outlined above) in your institution. I will then forward the correct number of questionnaires to you for distribution.

The results of this survey will be aggregated – no data will be attributed to any specific DHB or tertiary education provider.

The study results will be sent to you on completion. If you have any questions about this study please contact my supervisor or me. You will find both our contact details below. Ethical approval for this study was sought and granted by Victoria University of Wellington Human Ethics Committee on the 21st March 2006.

The success of this research is dependent on your participation.

Kind Regards,

Helen Skally

Researcher Contact Details

Helen Skally, Nurse Lecturer,
Intensive Care Services,
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Supervisor Contact Details

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APPENDIX II: Questionnaire

The preparation of New Zealand nurse educators, teaching clinical nursing postgraduate courses at NQF Level 8.

Only complete this questionnaire if you are a nurse educator teaching clinical nursing postgraduate courses at NQF Level 8.

Thank you for taking the time to complete this questionnaire. Each question requires a response. Please tick the appropriate box for each question.

1. What are your completed tertiary qualifications?

Diploma	☐
Non-Nursing Bachelors Degree	☐
Nursing Bachelors Degree	☐
Graduate Certificate	☐
Graduate Diploma	☐
Postgraduate Certificate	☐
Postgraduate Diploma	☐
Masters	☐
Doctorate	☐
Other(s)_____	

2. Do you have any educational qualification(s) specifically in education? Yes ☐
No ☐

If yes please specify what qualification(s) you hold

3. How many years/months experience do you have as a nurse educator teaching a postgraduate clinical programme?

Years _____ Months _____

4. How many years/months experience of teaching did you have when you first started as a nurse educator teaching a postgraduate clinical programme?

Years _____ Months _____

5. How many years/months work experience have you as a registered nurse?

Years _____ Months _____

6. As postgraduate clinical programmes are speciality specific – how many years/months have you worked in the specialty you teach?

Years _____ Months _____

7. In what specialty area(s) do you teach?

Assessment Treatment & Rehabilitation ☐	Primary Health ☐	Orthopaedics ☐
Cancer ☐	Burns/Plastics ☐	Paediatrics ☐
Cardiac/Cardiothoracic ☐	Intensive Care ☐	Palliative Care ☐
Cardiac Rehabilitation ☐	Medical/Surgical ☐	Renal ☐
Community ☐	Mental Health ☐	Theatre/Preoperative ☐
	Neonatal ☐	Trauma & Emergency ☐

Other _____

Thinking back to when you first started your position as a nurse educator teaching a postgraduate clinical programme, please answer the following questions. Tick the box that is most closely aligned to what you think.

8. When I first started as a nurse educator teaching a postgraduate clinical programme:

I had an understanding of how educational theory informed my teaching

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
☐	☐	☐	☐	☐

9. I was able to manage my time effectively

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
☐	☐	☐	☐	☐

10. I was motivated and enthusiastic about teaching

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
☐	☐	☐	☐	☐

11. My understanding of pedagogy helped me prepare my teaching strategy

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
☐	☐	☐	☐	☐

12. I was confident in my role as a nurse educator to work independently

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
☐	☐	☐	☐	☐

13. I enjoyed my role as a nurse educator

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
☐	☐	☐	☐	☐

14. I was able to give students quality feedback

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
☐	☐	☐	☐	☐

15. I felt confident teaching

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
☐	☐	☐	☐	☐

16. I knew how to develop a curriculum

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
☐	☐	☐	☐	☐

17. When I first started as a nurse educator teaching a postgraduate clinical programme:

I felt confident in my clinical teaching skills

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
☐	☐	☐	☐	☐

18. I felt confident in my classroom teaching skills

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
☐	☐	☐	☐	☐

19. I felt confident in developing and using audio visual aids

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
☐	☐	☐	☐	☐

20. I felt confident in developing student assessments

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
☐	☐	☐	☐	☐

21. I felt confident marking student assessments

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
☐	☐	☐	☐	☐

Continuing to think about when you first started your position as a nurse educator teaching a postgraduate clinical programme, please answer the following questions.

22. I felt confident dealing with clinical issues that the students raised

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
☐	☐	☐	☐	☐

23. I felt clinically credible

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
☐	☐	☐	☐	☐

24. I felt confident engaging students in implementing and developing best practices

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
☐	☐	☐	☐	☐

25. The management of my department supported me in my work

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
☐	☐	☐	☐	☐

26. I felt I had a sufficient orientation period to my new role

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
☐	☐	☐	☐	☐

27. I received good secretarial support

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
☐	☐	☐	☐	☐

28. There was peer support available to me

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
☐	☐	☐	☐	☐

29. The peer support I received was helpful to me

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
☐	☐	☐	☐	☐

30. When I started my job my mentoring experience can be categorized as

1	2	3	4	5
None			Working alongside a senior colleague in partnership	

31. The mentoring I received can be described as

1	2	3	4	5
Chats over coffee			Formal process with goals and outcomes	

32. The mentoring I received was useful

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
☐	☐	☐	☐	☐

Considering your **current position** as a nurse educator teaching a postgraduate clinical programme, please answer the following questions as they apply **today**:

33. Thinking about your current position, are you enthusiastic and motivated about the **teaching** aspects of your work

1	2	3	4	5
Unmotivated and unenthusiastic			Highly motivated and enthusiastic	

34. Thinking about your current position, are you enthusiastic and motivated about **clinical** aspects of your work

1	2	3	4	5
Unmotivated and unenthusiastic			Highly motivated and enthusiastic	

35. I feel clinically credible now

1	2	3	4	5
My clinical skills are rusty			I am an expert in clinical practice	

36. How satisfied are you in your role?

1	2	3	4	5
Not satisfied				Extremely satisfied

37. Describe what things (courses, clinical experience, life experience etc) prepared you to teach a postgraduate clinical programme

38. What additional preparation would you have found useful to prepare you for your teaching role?

Finally some demographic details

39. Are you? Male ☐ Female ☐

40. What age are you?

41. Which ethnic group do you identify with? (You can tick more than one)

NZ Maori	☐	NZ European	☐	Other European	☐
Samoan	☐	Cook Island Maori	☐	Tongan	☐
Niuean	☐	Tokelauan	☐	Other Pacific	☐
South East Asian	☐	Chinese	☐	Indian	☐
Other Asian	☐	Other please specify: _____			

42. Is your contract of employment with a

District Health Board ☐

Tertiary education provider ☐

Both ☐

Other _____

43. Please add any further comments that you wish to make.

Thank you for taking the time to fill in this questionnaire your input is appreciated.

This questionnaire should be returned to Helen Skally by post in the pre-paid envelope provided.

APPENDIX III: Participant information letter

Researcher: Helen Skally, Graduate School of Nursing and Midwifery, Victoria University of Wellington.

Dear Colleague,

Nurse Educators in New Zealand do a fantastic job delivering excellent clinical courses to the registered nurse population. As a group we nurture and develop staff, narrow the theory practice gap and in doing so improve the outcomes of our patients. However there has been little research carried out exploring who we are and what we do. With your help I would like to change that. I am a Master of Nursing student at Victoria University of Wellington. As part of this degree I am undertaking a research thesis. The project I am embarking on is exploring the preparation of nurse educators in New Zealand. Ethical approval for this study was sought and granted by Victoria University of Wellington Human Ethics Committee.

For the purpose of this research study, nurse educators are defined as those who deliver clinical postgraduate education programmes at National Qualifications Framework (NQF) Level 8 to registered nurses. As you know the NQF has 10 levels of qualification. Level 8 is postgraduate standard equivalent to a master's level qualification.

How have you been chosen?

There are 15 tertiary education providers who deliver postgraduate clinical nursing programmes in New Zealand. There are 21 District Health Boards (DHBs) who facilitate students undertaking these programmes. Some of the DHBs employ nurse educators to run programmes in collaboration with a tertiary education institution. In an effort to capture a representative sample each tertiary education provider and DHB has been approached. This approach was made via the Heads of School (HOS) and Directors of Nursing (DON). Your HOS or DON has forwarded this questionnaire to you on my behalf. If for any reason you receive two questionnaires please return both to me one completed and the other blank.

Your participation in this research is entirely voluntary and you will not be identified in anyway. Your consent to participate is implied by the return of a completed questionnaire. Each questionnaire has a code on the top right hand corner this code is purely for tracking purposes.

I need your help to make this research meaningful to the profession and the patients we care for.

If for some reason you feel you do not meet the criteria as outlined above please disregard this questionnaire. As a reminder you need to be a nurse educator delivering a clinical postgraduate course at Level 8 to registered nurses. The questionnaire, may take you 15 minutes to complete.

All of the results of this research will be aggregated therefore your institution will not be identified. The quantitative data will be statistically analysed. The open ended question will undergo thematic analysis. A copy of the studies results will be sent to your HOS or DON.

Thank for your participation the success of this research is dependent upon it.

Kind Regards,

Helen Skally

Researcher Contact Details

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Supervisor Contact Details

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APPENDIX IV: Ethics approval

TE WHARE WĀNANGA O TE ŪPOKO O TE IKA A MĀUI

VICTORIA
UNIVERSITY OF WELLINGTON

Phone 0-4-463 5676
Fax 0-4-463 5209
Email Allison.kirkman@vuw.ac.nz

MEMORANDUM

TO	Helen Skally
COPY TO	Dr Rose McEldowney
FROM	Dr Allison Kirkman, Convener, Human Ethics Committee
DATE	March 21, 2006
PAGES	1
SUBJECT	Ethics Application: No 14/2006, The preparation of New Zealand Nurse Educators, teaching clinical postgraduate courses at NQF Level 8.

Thank you for your application for ethical approval, which has now been considered by the Standing Committee of the Human Ethics Committee.

Your application has been approved and this approval continues until 30 November 2006. If your data collection is not completed by this date you should apply to the Human Ethics Committee for an extension to this approval.

Best wishes with the research.

Allison Kirkman
Convener

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