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Understanding the Preparation and Support Needed for Undergraduate Clinical Faculty

Sara Mcpherson
University of Nevada, Las Vegas, miless1@unlv.nevada.edu

UNDERSTANDING THE PREPARATION AND SUPPORT NEEDED FOR UNDERGRADUATE CLINICAL FACULTY

By

Sara Miles McPherson

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Illinois State University
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Master of Science in Nursing
Millikin University
2009

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Sara McPherson

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Lori Candela, Ed.D.
Examination Committee Chair

Kathryn Hausbeck Korgan, Ph.D.
Graduate College Interim Dean

Reimund Serfica, Ph.D.
Examination Committee Member

Alona Angosta, Ph.D.
Examination Committee Member

Joseph Morgan, Ph.D.
Graduate College Faculty Representative

ABSTRACT

Even as nursing programs attempt to meet public demands for more registered nurses in the workforce, they are challenged with finding qualified clinical faculty to teach them. Many programs have had to turn away otherwise qualified applicants due to lack of faculty. One solution to the shortage of nursing faculty has been to increase the number of part-time clinical faculty. Many clinical faculty hired for part-time positions hold degrees outside of nursing education. Additionally, new, full-time faculty are frequently expected to immediately begin teaching one or more clinical groups. While those new full-time and part-time faculty enter their role as expert clinicians, many lack knowledge or formal instruction in working with students in clinical settings.

A review of the literature revealed a small amount of information available on the issue of clinical faculty preparation for the role. What is known is that there has been a lack of guidance and support for clinical faculty. Clinical faculty have admitted to passing underperforming students for several reasons in the clinical setting. Among the reasons that underperforming students pass in the clinical setting are unclear evaluation criteria/processes and grading processes. Clinical faculty have indicated that they receive little or no helpful orientations prior to beginning their role as clinical faculty. Nursing programs that have orientations were described as beneficial, but the information received was general. Passing underperforming students can compromise patient safety.

Malcolm Knowles's adult learning theory and Kolb's experiential learning theory were used as the framework for the study. The adult learning theory and experiential learning theory focused on how adults learn. Nurses who have taken on the role of clinical faculty have brought a vast amount of knowledge and expertise. Understanding how adults learn and transfer

knowledge into their new role provided a base for understanding what preparation new clinical faculty need to fulfill their role.

A Delphi study was used to explore the preparation and support needs of undergraduate clinical faculty. Three rounds were used in the Delphi study. Round 1 included the use of an open-ended questionnaire to obtain the opinions of a panel of 15 experts on what preparation they believed was needed for new clinical faculty. Round 2 used a Likert scale completed by 77 clinical nursing faculty, developed from information obtained in Round 1. Round 1 data was analyzed using content analysis and frequency counts. Round 2 data was analyzed with inferential statistics, specifically an independent *t*-test.

Results of the study indicated that faculty with a nursing education background were more likely to use a colleague as a resource person, $t(74) = 2.35$, $p = .022$. They also indicated that they had received more relevant content in their original training $t(74) = 4.09$, $p = .000$, that they had received more verbal instruction $t(74) = 2.11$, $p = .038$, and that they had received a brief overview of the clinical faculty role $t(42) = 2.38$, $p = .022$, than nurses with other educational backgrounds. Participants were asked to rank topics that were identified by the experts in Round 1, participants ranked expectations on their role as clinical nursing faculty highest (36.4%). Significant differences were also found between part-time and full-time faculty. Part-time faculty reported that they received less support, $t(75) = -2.96$, $p = .004$, were less likely to have a mentor, $t(75) = -4.28$, $p = .000$, received no formal training, $t(75) = 2.09$, $p = .04$, and less content presented in their educational preparation, $t(51) = -2.32$, $p = .024$, than full-time faculty. Results of the study indicated that faculty who had received a degree in nursing education and full-time faculty had a better understanding of their role and expectations as clinical nursing faculty.

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CHAPTER 1: INTRODUCTION

The United States (U.S.) is in the midst of a workforce shortage in the health field that receives little attention. The widely publicized registered nursing shortage has overshadowed the disturbing trend that has become an acute nursing faculty shortage. While the nursing shortage has received a significant amount of publicity, the shortage of nursing faculty has been emphasized less (Roberts, Chrisman, & Flowers, 2013). The American Association of Colleges of Nursing (AACN) conducted national surveys in 2013 and found that responding nursing schools identified 1,358 faculty vacancies as well as the need to create nearly 100 new positions to meet demand (AACN Nursing Faculty Shortage, 2014b). The shortage of nursing faculty was the main reason that 78,089 qualified students were turned away from nursing programs during the 2013-2014 academic year (AACN, 2014b). In addition to the shortage of classroom course instructors the lack of faculty has been greatly felt in the area of clinical instruction, which requires a much lower faculty-to-student ratio than that of the classroom settings.

The faculty shortage has paralleled the shortage of registered nurses (RNs). RNs comprised the largest segment of the healthcare workforce (Institute Of Medicine [IOM], 2011), but the need for more RNs has been apparent since 1998 (Buerhaus, Auerbach, & Staiger, 2009). Population growth and demographic shifts in the U. S. along with an aging nursing workforce have been correlated with the nursing shortage (Sigma Theta Tau, n.d.). The economic recession tended to temporarily diminish the impact of the nursing shortage. Despite an easing of the shortage in recent years, projections indicate that a major shortfall of needed RNs will occur at approximately 2018 and the trend will continue, creating a shortfall of 260,000 nurses by 2025 (Buerhaus et al., 2009).

In March 2010, the Patient Protection and Affordable Care Act was signed into law (IOM, 2011). The Patient Protection and Affordable Care Act allowed for higher quality, more affordable, and more accessible care than previously available, and more people than ever before were expected to access it. If the expectations proved to be accurate there would be more patients seeking healthcare than ever before and the nursing shortage would become even more pronounced. Shortages in the nurse labor market would be unavoidable until institutions that provide nursing education could increase their capacity to enroll more students (Buerhaus et al., 2009).

The need to hire adequate numbers of qualified faculty to teach students has prompted nursing programs to turn to a large number of part-time and adjunct faculty. The National League for Nursing (NLN) faculty census (2006) indicated that part-time faculty numbers grew by 72.5% in four years (NLN Nurse Educator Shortage Fact Sheet, 2010). The majority of the part-time and adjunct faculty have been RNs who were clinical experts in their own practices. Many nursing program have been utilizing those part-time clinical faculty to fill urgent needs in the management of students in clinical groups. While those new clinical faculty have been expert clinicians, many lacked formal knowledge about the academic setting (Heaslip & Scammell, 2012; Peters & Boylston, 2006; Pierangeli, 2006; West et al., 2009).

Nursing program commonly use both part-time and full-time faculty to teach students in the clinical setting. Full-time faculty assigned to teach clinical help to free up those faculty engaging in scholarship activities. Experienced faculty and those with tenure generally do not teach in the clinical setting (Wong & Wong, 1987). Therefore, Wong and Wong (1987) noted that often the job of teaching students in clinical setting is given to more novice, inexperienced faculty.

This chapter contains three sections. The first identifies the problem statement. The second discusses the background and significance of the study. The third describes the purpose and the fourth sections describes the theoretical and operational definitions.

Problem Statement

Effective clinical instruction has been critical if students were to be able to apply what they learned in classrooms in new and complex patient situations. In a structured literature review Dahlke, Baumbusch, Affleck, and Kwon (2012) found that clinical faculty believed they needed to role model and be able to communicate clearly, exercise clinical skill and judgment, use higher-order questioning, and be supportive of students. While some information does exist on the role of clinical faculty, Dahlke et al. (2012) noted a lack of literature on this important role, which the authors believed suggested that the role of clinical faculty was complex, misunderstood, and undervalued. Understanding the preparation and support needs applied to both full-time faculty and part-time faculty because nursing programs may have been using both groups to teach in the clinical settings.

The literature contained reports of qualitative studies on the use of preceptors and clinical faculty roles (Gazza, 2009; Gazza & Shellenbarger, 2010) and issues with failing students (Black, Curzio, & Terry, 2014; Brown, Douglas, Garrity, & Shepherd, 2012; Heaslip & Scammel, 2012). Literature was also available on ways to transition into the role of clinical faculty (Duffy, Stuart, & Smith, 2008; Forbes, Hickey, & White, 2010; Hewitt & Lewallen, 2010). However, with nursing programs using part-time faculty to fill up to 80% of clinical faculty positions (Duffy et al., 2008) there was a lack of literature on what clinical faculty, both full-time and part-time, believed they needed to adequately perform their jobs.

The focus of this research was to understand what preparation and support undergraduate clinical faculty have had prior to entering the clinical setting and what they believed was needed to adequately perform their job. A Delphi study was used to explore the preparation and support needs of undergraduate clinical faculty and help determine what can be done to better prepare clinical faculty for this role.

Background and Significance

The nursing faculty shortage has contributed to nursing programs enrollment issues. Finding qualified faculty has been a challenge. Faculty have had eight to 10 students in the clinical setting and have had to balance their learning needs with the safety of patients (Ironside, McNelis, & Ebright, 2014; Benner, Sutphen, Leonard, & Day, 2013). The public has expected that student nurses as well as new graduate nurses were prepared to provide safe efficient care in the clinical setting.

Nursing Faculty Shortage

While the nursing shortage has been a major concern for healthcare the impact of the shortage on educating future nurses was also significant. Nursing schools were having difficulty increasing enrollment to meet the future demands of the nursing shortage (AACN, 2014a). The Patient Protection and Affordable Care Act, passed in 2010, provided access to healthcare for more than 32 million American's who previously had no healthcare (AACN, 2014a). Many of those new patients would be served by RNs and advanced-practice registered nurses (APRN) which would require an increase in this workforce. AACN (2014a) reported that nursing programs increased their enrollment by 2.6% for entry-level baccalaureate programs in 2013. While that increase was a move in the right direction, nursing programs needed to significantly increase their enrollments if they were to address the nursing shortage.

One challenge to increasing enrollment has been the demand for more qualified nursing faculty. Even with the increase in enrollment, there has been a lack of nursing faculty to educate students (AACN, 2014a; Oermann, 2004). While, faculty vacancies may not have appeared alarming to the public eye this has been a critical issue for nursing programs and the future of the nursing workforce; for every two vacant nursing faculty positions, 20 students may have been turned away from nursing programs (Oermann, 2004).

Faculty Issues

Nursing programs have had two main goals: ensuring that students have the knowledge to pass the National Council Licensure Examination for Registered Nurses (NCLEX-RN) as well as deliver safe care in the clinical setting. The National Council of State Boards of Nursing (NCSBN, 2005) recommended that pre-licensure programs have qualified faculty who were able to provide feedback to students within this environment. Finding clinical faculty has been very challenging for nursing programs, and ensuring that those faculty are qualified has proven to be an ongoing quest.

The biggest challenge to ensuring that nursing programs are graduating safe and clinically capable students has been the lack of clinical faculty. Nursing education can be challenging to teach. Faculty have the responsibility of graduating safe and clinically capable students (Spector, 2012).

Nursing programs have not been able to fill all their full-time faculty positions. According to AACN (2014b), the vacancy rate of faculty positions was 8.3% in 2013. The qualifications for a high percentage of the open positions (86.9%) include a preference or requirement that the successful job applicant have a doctoral degree. Since many nursing faculty do not, that educational criterion keeps many potential candidates from applying for the jobs.

The need to fill faculty positions has caused an overdependence on part-time/adjunct faculty (Hewitt & Lewallen, 2010; Peters & Boylston, 2006; Reinhard & Hassmiller, 2009; Roberts et al., 2013; Yucha, Smyer, & Strano-Perry, 2014). Duffy et al. (2008) found that 80% of their undergraduate clinical faculty were part-time faculty. Part-time and adjunct clinical faculty filled the need for a significant portion of undergraduate clinical teaching, especially in large universities (Forbes et al., 2010).

AACN (2015) reported an increase of 3.2% in research-focused and 26.2% in practice-focused doctoral programs. Kelly (2010) described that in the 1970s most nurses seeking graduate degrees accepted teaching positions after completion of their degree. "Today this paradigm has shifted dramatically" (Kelly, 2010, p. 267). Graduate programs have been offering focuses in advanced practice roles, nursing administration, or nursing education (Kelly, 2010). Having research focused (PhD, DNS) and practice-focused (DNP) degrees had been a priority for nursing programs to help nurses achieve "the highest level of scientific knowledge and practice expertise to ensure high quality patient outcomes" (AACN, 2015, para. 8). However, nurses with graduate degrees have had numerous opportunities upon graduation and they have been seeking positions outside of universities (Kowalski & Kelley, 2013; Kelly, 2010). Kowalski et al. (2007) stated that "wage rates, workload, academic preparation, and attrition rates are acknowledge barriers to an adequate supply of qualified nursing faculty" (p. 69).

Many of the part-time faculty hired to help fill the shortage of clinical faculty positions have been expert clinicians but lacked knowledge about the clinical faculty role (Heaslip & Scammell, 2012; Peters & Boylston, 2006; Pierangeli, 2006; West et al., 2009). In many situations, newly hired clinical faculty must take on their position without experience or formal training (Crocetti, 2014, Scanlan, Care, & Gessler, 2001). New clinical faculty have been often

surprised by the lack of formal orientation processes within higher education (Gies, 2013; Peters & Boylston, 2006). Their lack of knowledge about program and course outcomes can compromise the quality of clinical education a student receives. Those nurses often struggled with the differences "between the real world of nursing practice and the idealistic scenarios presented in nursing education" (Bell-Scriber & Morton, 2009, p. 85). After beginning their positions as clinical faculty they realized the vast difference in skills needed for instructing students in clinical practice versus the skills they needed in their clinical positions. With their limited knowledge and experience in educating students, "these underprepared clinical instructors, armed with a list of students and course objectives, tend to teach as they were taught and learn on the job by trial and error" (Bell-Scriber & Morton, 2009, p. 85). Those clinical faculty made decisions on whether or not students pass the clinical component of a course; and that was being done in many instances with a lack of knowledge and guidance. While part-time and adjunct clinical faculty have been filling a much needed void in nursing education, it has been crucial that they were meeting the standards required.

Safety

James (2013) estimated between 2008 and 2011 that 210,000 to 400,000 patients died yearly in hospitals from preventable-harm incidents. Ever since the landmark study by the IOM (1999) indicated that 44,000 to 98,000 people died in hospitals annually from preventable errors; patient safety has been on the forefront of healthcare. Those numbers did not account for the near misses that have occurred in hospitals but did not result in patient deaths (James, 2013). James (2013) stated that there needs to be "vigilance in medical care to address the problem of harm to patients who come to a hospital seeking only to be healed" (p. 127).

To ensure patient safety, graduates of nursing programs must be competent and safe. However, as many as 50% of clinical faculty have assigned a passing grade to an underperforming nursing student in the clinical setting (Brown et al., 2012; Gainsbury, 2010, Mead, 2011). Clinical faculty have been obligated to maintain patient safety while ensuring that student learning has been occurring. Therefore, clinical faculty have been required to use their knowledge and confidence to balance the learning needs of students with the safety of patients.

Expectations of the Public

Nursing has been rated as the most honest and ethical profession on the Gallup poll every year except one, from 1999 to 2014 (Gallup Poll, 2014). The public has had high expectations of nurses and has assumed nurses were prepared to deliver safe care. The public expected that nursing faculty would ensure safe and competent new nurses were entering the workforce. Students entering the clinical setting have always been obligated to provide safe care. The quality of healthcare would be compromised by unsafe students in that high-stakes environment. However, that problem has been exacerbated by the challenge of finding and retaining high quality clinical faculty (Forbes et al., 2010).

Purpose of the Study

The purpose of this research study was to determine (a) what preparation and support a sample of part-time and full-time undergraduate clinical faculty received prior to assuming their clinical teaching responsibilities, (b) what the study participants believed they needed to adequately perform their jobs, and (c) if differences in perceptions of clinical faculty existed between full-time and part-time clinical faculty. However, the literature is limited in the needs of full-time and part-time clinical faculty's preparation to adequately perform their job.

A Delphi study was performed to understand what preparation and support was needed for undergraduate clinical instruction. The Delphi method was chosen because it allowed for anonymous communication to build consensus on what clinical nursing faculty believed was needed for the preparation of clinical instruction.

Malcolm Knowles's adult learning theory and Kolb's experiential learning theory were the frameworks used to guide this study. Knowles's adult learning theory emphasized that adults are self-directed and expected to take responsibility for their decision making (Merriam & Caffarella, 1999). With formal orientation and guidance, new clinical faculty would be expected to move from dependency to self-directed learners in their new role. The experiential learning theory described translating knowledge into experience (Kolb, 2015).

Many clinical faculty started their academic careers as experienced clinicians; however, novices in the educational arena. Their knowledge of nursing needs to be transformed to meet the needs of students in the academic setting. Understanding those needs may help nursing program administrators begin to address the inconsistencies in theory and clinical courses and begin to bridge this gap. The results may also be beneficial to address the issues faced by all clinical faculty. Understanding the needs of one crucial population in nursing education is essential to maintaining high quality clinical faculty within nursing programs. Patient safety has been addressed by the IOM and Quality Safety Education for Nurses (QSEN) and the data from this study will add to the literature.

Research Questions

Three formal research questions were developed to address the research problem. The questions were inclusive of both full-time and part-time faculty. They were:

1. What preparation and support do part-time and full-time undergraduate clinical nursing faculty receive prior to assuming their clinical teaching responsibilities?
2. What preparation and support do part-time and full-time undergraduate clinical faculty believe they need in order to adequately prepare students for clinical practice?
3. Are there differences between the perceived preparation and support needs of part-time and full-time undergraduate clinical faculty prior to assuming their clinical teaching responsibilities?

Theoretical and Operational Definitions

Clinical Faculty

Theoretical definition. "Clinical instructors include preceptors, staff nurses (who also teach students clinically), and clinical faculty employed by the schools of nursing to teach students in the clinical area" (Dahlke et al., 2012, p. 693).

Operational definition. Clinical faculty will be defined as any nurse who teaches students in the clinical setting.

Full-time Faculty

Theoretical definition. Faculty whose "regular assignment (at least 50 percent) is instruction, including release time for research" (American Association of University Professors, n.d.).

Operational definition. Full-time faculty will be defined as faculty whose primary job responsibility is teaching undergraduate students, and specifically students in the clinical setting.

Part-time/Adjunct Faculty

Theoretical definition. "Temporary faculty who may teach 1 or more courses and are generally awarded a 1-semester contract. They are usually clinical experts who bring current up-to-date knowledge of clinical practice to the academic setting" (Peters & Boylston, 2006, p. 61).

Operational definition. Part-time faculty will be defined as faculty who teach one clinical course for a nursing program.

Patient Safety

Theoretical definition. "First, do no harm," keeping patient free from injury or harm in the patient care environment (IOM, 1999, p. 2).

Operational definition. Patient safety will be defined as causing no harm or injury to patients in the clinical setting, specifically by students in this study.

Safe Clinical Practice

Theoretical definition. Scanlan et al. (2001) defined safe clinical practice as:

> Students are expected to demonstrate growth in clinical practice through application of knowledge and skills from previous and concurrent courses. Students are expected to demonstrate growth in clinical practice as they progress through courses and to meet clinical expectations outlined in the clinical evaluation tool. Students are expected to prepare for clinical practice in order to provide safe, competent care. Preparation expectations are detailed in clinical course syllabi. (p. 25)

Operational definition. Safe clinical practice in this study will be defined as students arriving to clinical following the policies and procedures within their nursing program to maintain an environment where patients receive quality care and have no harm or injury.

Unsafe Clinical Practice

Theoretical definition. Scanlan et al. defined unsafe clinical practice as:

> Behavior that places the client or staff in either physical or emotional jeopardy. Physical jeopardy is the risk of causing physical harm. Emotional jeopardy means that the student creates an environment of anxiety or distress which puts the client or family at risk for emotional or psychological harm. Unsafe clinical practice is an occurrence, or pattern of behavior involving unaccepted risk. (p. 25)

Operational definition. Unsafe clinical practice will be defined as students demonstrating behaviors, such as arriving late, being unprepared, and participating in high-risk behaviors that jeopardize the quality of care patients receive and may cause harm or injury to patients.

Summary

Patients have been suffering from preventable harm incidents in the clinical setting at an alarming rate (James, 2013). The nursing shortage has been impacting the quality of care patients receive at the bedside and it has had a direct impact on the number of clinical faculty to prepare future nurses (Roberts et al., 2013). Nursing programs have been turning to a large number of part-time and adjunct clinical faculty to fill those voids (Hewitt & Lewallen, 2010; Peters & Boylston, 2006; Reinhard & Hassmiller, 2009; Roberts et al., 2013; Yucha et al., 2014). While many of those new clinical faculty have been expert clinicians they often lacked formal knowledge on educational theory (Heaslip & Scammell, 2012; Peters & Boylston, 2006; Pierangeli, 2006; West et al., 2009). Vacancies in clinical faculty positions have been placing a

significant burden on nursing programs: for every two vacant positions there are 20 students being turned away from nursing programs (Oermann, 2004).

The public expected to receive high quality care when entering the clinical setting and with the Patient Protection and Affordable Care Act an increase in patients seeking healthcare has been expected (AACN, 2014a). Nursing programs have been preparing students to be safe effective new nurses. However, a large number of clinical faculty do not possess the knowledge needed to facilitate learning and the literature reveals that those new clinical faculty were often left to figure things out on their own (Gies, 2013; Peters & Boylston, 2006).

Understanding what preparation and support undergraduate clinical faculty need would allow nursing programs to better prepare new clinical faculty for the high-stakes crucial role they play in preparing nurses of the future. QSEN has emphasized the importance of adding patient safety to nursing education to "improve the quality and safety of the healthcare system" (QSEN, 2014, para. 1) by ensuring safety conscious new nurses enter the workforce. This study will help continue the work by QSEN and contribute knowledge to identify the needs of clinical faculty to help ensure that students are receiving a quality education and nursing programs are able to retain high quality clinical faculty.

CHAPTER 2: REVIEW OF THE LITERATURE

The purpose of this chapter was to review the literature on the shortage of nursing faculty, the providers of clinical instruction, and clinical nursing faculty expectations and responsibilities. Issues related to the nursing faculty shortage, the need to prepare safe new graduates for their role as nurses, and the difficulty in finding qualified clinical faculty were identified in the literature. However, there was a limited amount of research suggesting solutions to the problem of finding qualified nursing faculty to facilitate learning in the clinical setting. This chapter includes three sections: shortage of nursing faculty, providers of clinical instruction, and clinical nursing faculty expectations and responsibilities.

Shortage of Nursing Faculty

Nursing programs throughout the U.S. have had specific positions in their faculty that went unfilled year after year (Evans, 2013; Nardi & Gyurko, 2013). The AACN special survey on vacant faculty positions for the academic year 2014-2015 indicated that there were 1,235 (6.9%) vacancies in full-time faculty nursing positions (Li & Fang, 2014). Li and Fang (2014) indicated that 403 (56.4%) of the schools responding to the survey revealed that they had full-time faculty vacancies. The faculty vacancies in the West were 11.1%, Midwest 9.1%, South 8.8%, and North Atlantic 8.8% (Li & Fang, 2014). Kelly (2010) indicated that the shortage of nursing faculty was further complicated by the shortage of nurses which continues to slow the process of reversing the problem.

Nursing Shortage

Nursing faculty must become nurses before they can teach students to be nurses, but a shortage of nurses was a documented problem (Robeznieks, 2015). Shortages in the nurse labor market would be unavoidable until institutions that provided nursing education could increase

their capacity to enroll more students (Buerhaus et al., 2009). "A key driver of the nurse supply in the future is the nation's capacity to produce new nurses through our education system" (HRSA, 2013, p. 35). The RN workforce was among the top occupations for job growth (Bureau of Labor, 2013). According to the AACN (2014a) the shortage of RNs has been growing as healthcare demands have increased and the population ages. In December 2013, the Bureau of Labor Statistics' Employment Projections indicated that the RN workforce would grow from 2.71 million in 2012 to 3.24 million by 2022. The number of RN jobs would increase by 19%, meaning that 526,500 RN jobs would be available (Bureau of Labor, 2013). By 2022, the Bureau of Labor Statistics (2013) projected that 525,000 new nurses would be needed as replacements in the nursing workforce.

The number of students taking the NCLEX-RN more than doubled between 2001 and 2014 (NCSBN, 2015). Figure 1 represents the number of students who took the NCLEX-RN for the first time and the percentage of students who passed the NCLEX-RN on their first attempt from 2001 to 2014.

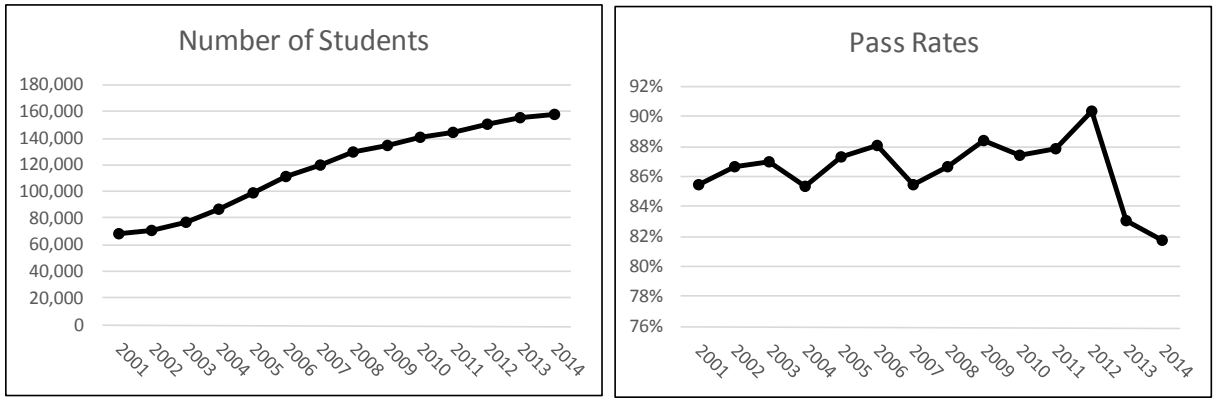

Figure 1 Number of Students Taking the NCLEX-RN and Percentage of Pass Rates for 2001-2014
The line graph on the left represents the number of students who took the NCLEX-RN during the time period of 2001-2014. The line graph on the right represents the percentage of students who passed the NCLEX-RN on their first attempt. Adapted from the National Council of State Boards of Nursing (NCSBN, 2015).

In the decade following his study Evans (2013) suggested that nursing programs would need to increase the number of new graduate by 30% to meet the demand for nurses. Juraschek, Zhang, Ranganathan, and Lin (2012) projected that by 2030, the national deficit for RNs would be 918,232.

Enrollment issues. The nursing faculty shortage has compromised the number of students who have been able to enroll each year in nursing programs. Nursing programs have attempted to increase enrollment to meet the demands of the nursing workforce (Gazza & Shellenbarger, 2010), but the AACN (2007) reported that the "the rate at which nursing schools have been able to increase student capacity has declined sharply since 2003 when enrollment was up by 16.6 percent" (para. 1). New data reported by the AACN (2015) revealed that entry into baccalaureate degree nursing programs increased by 4.2% and for RN-BSN programs by 10.4%. The primary reason nursing programs were not able to increase enrollment at rates high enough to meet the need was the lack of qualified nursing faculty (AACN, 2014b, McNeal, 2012; Nardi & Gyurko, 2013).

The shortage of RNs was projected to have the biggest impact on the West and South, with a shortage of 389 RN jobs per 100,000 in the West and 295 RN jobs per 100,000 in the South by 2030 (Juraschek et al., 2012). The shortage in the Midwest and Northeast will also have an impact with 108 RN shortages per 100,000 and 118 RN shortages per 100,000, respectively (Juraschek et al., 2012).

Causative Factors

Budden, Zhong, Moulton, and Cimiotti (2013) identified sociological factors that contributed to the nursing shortage. The increasing average age of professional nurses and of the nursing faculty reflected the increasing average age of the population in general, and the federal

government has become increasingly involved in healthcare, which has impacted healthcare workers as well as their patients.

Age of population. Juraschek et al. (2012) indicated that a supply-versus-demand issue would be faced by nursing with the increasing aging population as well as the aging RN workforce. According to the Administration on Aging (AOA), in 2013, 44.7 million Americans were 65 years of age and older (2014). The AOA (2014) projected that by 2040, the number of Americans 65 years of age and older would increase by approximately 82.3 million, which was a change of 21.7%. The results of the Juraschek et al. (2012) study showed that New Mexico and Wyoming had the top two highest increases for mean age, 5.62 and 5.93 years, respectively, which indicated that the nursing shortage could be projected to have a significant impact on those states. The demand for nurses would continue to increase due to the aging population (HRSA, 2013; Juraschek et al., 2012).

Age of RN workforce. Another significant factor contributing to the nursing shortage was the age of RNs (Budden et al, 2013; Juraschek et al., 2012). According to the Health Resources and Services Administration (HRSA, 2013) the average age of RNs was 44.6 years in 2013. RNs over the age of 50 accounted for one-third of the workforce (HRSA, 2013). It is estimated that nearly one million RNs over the age of 50 would retire in the next 10 to 15 years (HRSA, 2013).

Age of faculty. McNeal (2012) indicated that of the 32,000 nursing faculty the average age was 55 years or older. Fang, Li, Arietta, and Trautman (2015) indicated that the average age of doctoral-prepared nursing faculty was 61.8, and the mean age of master's-prepared nursing faculty was 56.8. The average age of retirement for nursing faculty was 62.5 (AACN, 2014b). According to the NLN (2010) more than half of nursing faculty were expected to retire by 2020.

Nardi and Gyurko (2013) indicated that nurses who pursued a career in academia often did so later in life. The NCSBN and The Forum of State Nursing Workforce Centers (2013) stated that faculty under the age of 40 represented only 14% of full-time faculty, indicating that younger nurses were choosing different career paths.

Healthcare access. In March 2010, the Patient Protection and Affordable Care Act was signed into law (IOM, 2011). The Patient Protection and Affordable Care Act allowed for higher quality, more affordable and more accessible care. The Patient Protection and Affordable Care Act data indicated that more than 30 million Americans would have access to healthcare (Budden et al., 2013). With more patients seeking healthcare than ever before, the nursing shortage would become even more pronounced.

Compensation. McNeal (2012) stated that nursing faculty earned 76% of the salary that other academic disciplines earned and that many nursing faculty held positions outside of the academic setting to make up for the financial shortfall. McNeal (2012) found that nursing faculty were estimated to work about 56 hours per week. That study indicated that 62% of nursing faculty members held additional jobs outside their academic roles that added another seven-to-ten hours of work to their weeks. According to the AACN (2010) faculty salaries must become more competitive in order to attract graduate prepared nurses. The AACN's Special Survey on Vacant Faculty Positions indicated that 32.1% of schools responded that noncompetitive salaries were their biggest deterrent to retaining faculty (Li & Fang, 2014).

The AACN (Fang et al., 2015) reported that faculty salaries for master's-prepared assistant professors was $76,035; but nurse practitioner salaries were $98,817 (Advanced Health Network, 2014). According to the healthcare economist for the American Nurses Association (ANA), Peter McMenamin, nursing faculty salaries were approximately $70,000, nurse

practitioners' and nurse midwives' salaries were approximately $90,000, and certified registered nurse anesthetists' salaries were approximately $160,000 (Robeznieks, 2015). While the mean salaries for nursing faculty increased by .01% to 4% from the 2013-2014 academic year to the 2014-2015 academic year; the disparity in nursing faculty salaries has continued to contribute to the issue of faculty retention and recruitment (Fang et al., 2015; Robeznieks, 2015).

Roughton (2013) conducted a survey to identify faculty's intention to leave their current position that included 7,193 nursing faculty participants. The average salary for the participants in the survey was $55,000. Almost 30% of the faculty indicated that salary/compensation represented the area in which they were most dissatisfied with their job. Of the reasons listed for leaving their current position, more compensation (46%) was rated after retirement (56%). Nursing faculty who received tuition reimbursement were more likely to stay in their current position. According to Roughton (2013), nursing faculty salaries needed to be more competitive with clinical nursing positions and non-nursing colleagues. Yucha and Witt (2009) indicated that having competitive salaries had allowed their nursing program to be selective in the recruitment process and retain high quality faculty.

Compensation was also an issue for part-time faculty. Clinical faculty who held part-time positions were paid by the semester with no guarantee of future employment. Faculty expressed a need to understand when and how they would be compensated for work (Hewitt & Lewallen, 2010). In many instances, part-time clinical faculty believed that their free time was imposed on with clinical grading and evaluations because they were hired for a specific number of clinical hours which did not account for the pre- and post-clinical work that was needed to complete the job (Hewitt & Lewallen, 2010).

Responses to the Problem

According to the AACN's Special Survey on Vacant Faculty Positions for the Academic Year 2014-2015, 17.4% of schools responded that they needed additional faculty but had no vacancies for full-time faculty (Li & Fang, 2014). Hiring additional full-time, tenure-track faculty was suggested by Nardi and Gyurko (2013) as one means to help alleviate the nursing faculty shortage. Hiring faculty who would fill full-time positions and paying those faculty competitive salaries, benefits, and allowing opportunities for professional development would help to emphasize the value that full-time nursing faculty bring to the profession (Nardi & Gyurko, 2013).

Reasons why nursing programs were not hiring included lack of funding to hire faculty (61.3%), unwilling administration to add additional faculty (39.5%), competition for nursing jobs in other markets (31.5%), and inability to attract qualified faculty due to geographic reasons (25%) (Li & Fang, 2014). Yordy (2006) indicated that institutional funding was a major reason for not hiring additional faculty, even when qualified faculty were available. Nursing program's inability to hire additional full-time faculty has had an impact on the shortage of nurses. Every one full-time nursing faculty member accounted for approximately six new graduate nurses (Colorado Center for Nursing Excellence, 2012).

Nursing programs have shifted to increasing numbers of part-time clinical faculty to augment the numbers of full-time faculty with clinical teaching assignments (Gazza & Shellenbarger, 2010; Nardi & Gyurko, 2013; Roberts et al., 2013). The availability of nursing faculty directly related to nursing program's ability to increase enrollment (Roberts et al., 2013). With the increase in part-time and adjunct clinical faculty, Roberts et al. (2013) suggested that

the education and preparation of those faculty need to be evaluated to ensure high quality education is occurring.

Clinical Instruction

Teaching students at the bedside is an essential component of nursing education (Hsu, 2006; Parsall & Bligh, 2001; Wong & Wong, 1987). Clinical instruction has moved from a focus of doing to a focus of knowing (Wong & Wong, 1987). Hsu (2006) indicated that nursing education has become more complex as the population has evolved and the setting has become technology based. The role of clinical faculty has been to help students acquire the knowledge needed to care for patients with different and complex needs (Herrmann, 1997). Effective clinical faculty help students become clinically competent (Hsu, 2006).

Hsu and Sandford (2007) explored clinical teaching behaviors of 10 nursing faculty in the clinical setting. Each participant was observed on the clinical unit for two days. The results of the study indicated that the clinical faculty observed were more task-oriented than learner-centered. The clinical faculty were viewed as placing too much emphasis on treatment and pathophysiology than focusing on nursing care questions.

Teaching competence was indicated by the themes of "teacher knowledge, instructional skills, planning the learning experience, teaching priorities, monitoring student progress, and teaching manner" (Hsu, 2006, p. 623). Knowledgeable clinical faculty were viewed as those who had a broad knowledge base and were able to guide students in the clinical setting (Hsu, 2006; Parsell & Bligh, 2001). Questioning students about client conditions was viewed as the theme instructional strategies (Hsu, 2006). Selecting a variety of patients to facilitate learning among students can help students develop a wider knowledge base (Hewitt & Lewallen, 2010; Hsu, 2006; Parsell & Bligh, 2001). In Hsu (2006) study teaching priorities were given primarily

to medication administrations. This was observed when clinical faculty only focused on medication administration and not additional concerns voiced by patients.

Monitoring student progress remains a critical part of nursing education so that students are able to meet the objectives and outcomes of the course and program. Hsu (2006) observed two of the 10 faculty allowing self-evaluation opportunities for their students.

Caring has remained an important aspect of nursing. Hsu (2006) indicated that clinical faculty need to demonstrate and emphasize "empathetic, caring and psychosocial elements of nursing" to students in the clinical setting (p. 625). A commitment to teaching was viewed as the final theme in Hsu (2006) study. Hsu (2006) indicated that clinical faculty need to emphasize all aspects of nursing in the clinical setting not just the cognitive and psychomotor skills needed.

Hsu (2006) indicated that excellent clinical faculty has been an important aspect of clinical teaching. Clinical faculty have been required to guide students in applying knowledge in the clinical setting. A lack of qualified knowledgeable clinical faculty compromise the quality of education students receive. Limitations of the study included the small sample size, the limited amount of observation in the clinical setting, and all participants being Taiwanese.

Recruitment/Retention

Faculty recruitment and retention, in general, has often been an issue. Emphasizing the need for more full-time faculty has been needed and "recruitment and retention is critical to increasing the global capacity of the nursing professions' education infrastructure" (Nardi & Gyurko, 2013, p. 324). Faculty have described the academic setting to be overwhelming and for this reason many return to work in clinical practice, retire early, or reduce their productivity (Bell-Scriber & Morton, 2009).

Proposed Solutions

Several studies were designed to determine more precisely what issues had the most impact on success in the role of clinical nursing faculty (Bell-Scriber & Morton, 2009; Kowalski et al., 2007). Others evaluated the success of various approaches to the need for acquiring and retaining more and better clinical faculty (Candela, Gutierrez, & Keating, 2013; Candela, Gutierrez, & Keating, 2015; Crocetti, 2014).

Preparation. Kowalski et al. (2007) developed a plan to help provide a long-term solution to the nursing faculty shortage. One reason nursing programs have had difficulty retaining faculty has been the minimal or complete lack of preparation for their new role, leaving clinical faculty dissatisfied and frustrated. In order to prepare new nursing faculty for their role, an intense 40-hour course was developed to meet the outcomes of education and support for the 45 clinical faculty (Kowalski et al., 2007). Other goals included clinical faculty staffing 362 clinical rotations, decreasing attrition rates by 15%, decreasing the turnover rate of new clinical nursing faculty, and maintaining NCLEX-RN pass rates.

The Colorado Center for Nursing Excellence (The Center) assisted in funding the project and their goal was to help address "the issues of availability and quality of clinical instructions" (Kowalski et al., 2007, p. 70). The 40-hour course was designed by nine experts from nursing programs, clinical agencies, and The Center. The experts designed the study to answer the question, "What is the most important information needed to prepare a new clinical scholar?" (Kowalski et al., 2007, p. 71).

In that project, staff nurses would have assumed the role of clinical faculty. The researchers designed the training course to include many of the issues they knew had been troubling to clinical faculty. Carlson (2015) had identified motivation as a factor in faculty

complacency, and motivation was a factor in Kowalski et al. (2007) study. Several other studies had identified the lack of clarity in the roles and responsibilities of full-time and part-time faculty (Allison-Jones & Hirt, 2004; Creech, 2008; Gazza, 2009; Gazza & Shellenbarger, 2010). Role expectations and responsibilities were included as topics for discussion in the Kowalski's et al. (2007) study, with the goal of helping new clinical faculty identify what their role was in the clinical setting.

A pilot-study was developed by Crocetti (2014) and used simulation to orient new clinical faculty to their role. Kowalski et al. (2007) introduced new clinical faculty to simulation in their orientation. Bell-Scriber and Morton (2009) identified the topics of clinical learning assignments, facilitating learning in the clinical setting, and critical thinking as important topics to orient new clinical faculty on during their workshop. When clinical faculty understand learning theories, the learning needs of students in the clinical setting, and the importance of critical thinking students leave the clinical with more knowledge. Clinical decision making was believed to be a shared responsibility by students and clinical faculty in order to maintain patient safety in Killam et al.'s (2010) study. The learning needs of students, an understanding of learning theories, and critical thinking and decision making were topics in Kowalski et al. (2007) study.

A lack of communication and inadequate documentation were indicated by Duffy et al. (2008) as weaknesses of faculty. Kowalski et al. (2007) included information in their workshop regarding communication and student progress documentation to help new clinical faculty understand their responsibility with this process. Roberts et al. (2013) explored how faculty move from expert clinician to clinical faculty. The topics of learning theories, legal issues, how to conduct pre- and post- conference, clinical evaluation methods, dealing with difficult students,

and practical tips were used in their two-day workshop for new faculty. While faculty acknowledged the information was beneficial, they also believed it was too general (Roberts et al., 2013). Kowalski et al. (2007) also included information on students' roles within the clinical agency, legal/ethical issues, clinical rotation planning, tools and resources for clinical assignments and rotations, and pre- and post-clinical conference information.

Kowalski et al. (2007) included support for new clinical faculty as one of the topics in their workshop. Support was identified in several studies as essential to the success of retaining faculty (Bell-Scriber & Morton, 2009; Candela et al., 2013; Candela et al., 2015; Duffy, 2003; Duffy et al., 2008; Forbes et al., 2010; Gazza, 2009; Hewitt & Lewallen, 2010; Luhanga, Yonge, & Myrick, 2008b; Roberts et al., 2003). Additional topics discussed in Kowalski et al. (2007) study included technology, NLN Nurse Educators competencies, and determination of how clinical can help students be successful on the NCLEX-RN (Kowalski et al., 2007).

The grant by The Center originally funded 24 participants; however, due to the demand for the course, 33 clinical faculty participated. The evaluations were positive and clinical faculty believed that the information provided was "useful, timely, and relevant" to current practice (Kowalski et al., 2007, p. 73). The clinical faculty believed the course was beneficial because it helped them to learn a new role and prevented burnout in some cases. The course was also beneficial to the facility by having clinical faculty who better understood their role and were more qualified for the position. There were also benefits to the students because the clinical faculty were familiar with the agency that the clinical rotation was conducted, and benefitted the academic institution because this allowed nursing programs to have a larger pool of clinical faculty who were better prepared for their role.

Kowalski et al. (2007) indicated that one ongoing unresolved issue was the number of hour's clinical faculty spent before and after the student rotation to make assignments, grade clinical work, and evaluate students. The need continued for formal mentoring and structured classes for new clinical faculty. Experienced faculty continued to be available in those settings; however, they had multiple responsibilities which prevented them from providing adequate support or mentoring to those new clinical faculty (Kowalski et al., 2007).

Some of the challenges the faculty encountered when they taught the course included clinical faculty working for several nursing programs whose mission, values, and philosophies were all different, some of the trained clinical faculty had taken promotions or left their clinical faculty position, and formal mentoring was also needed in addition to the course. Follow-up data was not available on how many of the clinical faculty who participated in the course remained in their clinical faculty positions (Kowalski et al., 2007).

Retention. Candela et al. (2013) explored factors that influenced recruiting and retaining faculty. The participants in the study were 808 nursing faculty from institutions accredited by the National League of Nursing Accrediting Commission (NLNAC) and the Commission for Collegiate Nursing Education (CCNE). The Nurse Faculty Work-Life Survey (NFWLS) was used for the study and included a 45-item instrument and two open-ended questions. The NFWLS measured information on teaching experience, workload, the view of support received, opportunities faculty had to network, activities in which faculty participated, view of productivity, and what influenced faculty to leave or stay in their current positions. The Cronbach's α ranged from 0.60 to 0.87 indicating adequate reliability. A step-wise linear regression was used to determine faculty's intent to stay in their current position. The significant factors, $p \geq .10$, from the linear regression in the study indicated faculty's intent to stay or leave

included the faculty's view of support from administration (β = -.26, CI -.24,-.06), productivity (β = -.23, CI -.30,-.06), faculty's choice of pursuing a professional career (β = -.21, CI -.21.,-.04) and the perception of expertise in teaching (β = .15, CI .04,.22) (Candela et al., 2013). Faculty who reported high values in those areas were less likely to leave their position. Participation in the study was based on self-selection, and results may have been biased because of faculty's fear of reporting accurate information about their role as nursing faculty. Additional information was not collected on other factors that may have influenced a faculty member's choice to stay or leave in their current position.

Candela's et al. (2013) study and Candela's et al. (2015) study were closely related, with the first study providing a foundation for the second study. Candela stressed that the researchers compared group differences in the 2013 study, but used a different kind of statistical analysis to examine "latent dimensions of work life, which is more informative than comparing group differences" (personal communication, June 19, 2015) in the second study. The participants in the study included 808 nursing faculty from nursing programs accredited by the NLNAC and CCNE. The study included a cross-sectional descriptive survey using the NFWLS. The study was conducted as a non-experimental design and all variables that influenced faculty's intent to stay or leave their positions were not collected. Reliability was established with a Cronbach's α of 0.71-0.88. Structural equation modeling (SEM) was used to analyze the factors of nursing faculty's work life. The SEM "specified six latent factors: perceived teaching expertise, perceived equity and fairness of the promotion and tenure process, perceptions of administration's support for faculty, satisfaction with work, workload, and intent to stay" (Candela et al., 2015, p. 585). Perceived teaching expertise had a statistically significant, model structural coefficient for satisfaction with work (-.19, $p < .05$), and intent to stay (.22, $p < .05$).

Support received from administration by faculty influenced the intent to stay (.23, p <.01) in their current positions as well as their likelihood to apply for tenure and promotion (.26, p <.01). Faculty workload (.44, p <.01) also influenced the participants' intent to stay (.22, p < .05) and that directly related to teaching expertise. The study limitations included the sampling and design methods used which may not represent "the true magnitude of the actual effects among the latent variables" (p. 588).

Motivation. Carlson (2015) conducted a survey of part-time clinical faculty to determine the most influential reasons they continued working in their clinical faculty position, and 553 surveys were returned. A love for teaching was indicated by 29% of respondents, 16% indicated pay and benefits, and 16% indicated they were respected and valued for reasons to continue in their part-time clinical faculty position.

The most-cited reasons for not wanting to continue in their part-time position were life and family conflict (17%), 16% indicated a disparity between pay in clinical practice and teaching, and 13% indicated an increase in workload. One unexpected finding from Carlson's 2015 study was that almost one third of respondents held only a baccalaureate degree, when the NCSBN (2008), CCNE (2013), and the AACN (2013) recommended that nursing faculty hold a minimum of a master's degree. The results of Carlson's (2015) study could not be generalized because all part-time participants were teaching in baccalaureate degree nursing programs. The reliability and validity may have been compromised because the research questions were developed by the researcher. The study was subject to bias based on the survey method used.

Strategies. Evans (2013) conducted a descriptive study using a survey method to determine what strategies were effective for recruitment and retention of nursing faculty. The study included 804 nursing programs: 243 associate degree, 248 baccalaureate degree, 210

master's degree, and 103 doctoral degree programs. A total of 2,083 surveys were usable for the study. The results indicated that the two most frequently mentioned factors that attracted nursing faculty were the opportunities to work with students (94.5%), and the ability to help shape the future of nursing (90%). A much lower percentage of respondents (27.3%) indicated that the salary and benefits were good attractors but 98.5% indicated that salaries needed to be increased. Another issue that appeared to be extremely important to the respondents was work environment: 97.5% indicated that a positive work environment was needed. Due to the nature of survey design, bias may have been a limitation due to self-selection of participants.

Kinds of faculty roles. Recruiting and retaining high quality faculty was described by Feldman, Greenberg, Jaffe-Ruiz, Kaufman, and Cignarale (2015). Feldman et al. (2015) described how one nursing program created a plan for developing new faculty and then strategies to retain them. Hiring faculty was difficult but retaining them appeared to have been an even bigger challenge. With the lack of qualified faculty, Feldman et al. (2015) decided that their nursing program needed to reduce the large number of adjunct faculty to maintain consistency in their teaching/learning process. Reducing the number of adjunct faculty would allow full-time faculty to better manage adjunct faculty. Creating the Clinical Practice Educator (CPE) was considered as one possible solution. Each CPE would teach the equivalent hours of a full-time position within the clinical setting, exceeding the allowed number of credits an adjunct faculty member could teach. This model helped the university for two years before an adjunct union was formed and the CPE role had to be eliminated. Once that role was eliminated, the role of full-time clinical faculty was developed.

The components of the clinical faculty role were taught by a master's prepared nurse who was an expert in the clinical setting. Initially two faculty were hired for this position; however,

over time the need increased. In an effort to recruit faculty who were as diverse as the student population, a grant in 2005 allowed the university to develop a program called "Grow Our Own" (Feldman et al., 2015, p. 172). The school identified a need to have more diverse faculty who were able to serve as role models for students. The doctoral studies of those students were supported by the grant, and those doctoral students taught 50% in the undergraduate nursing program. That allowed those students to become more familiar with the teaching process and allowed faculty to mentor them into their new role.

The first year, no single candidate was found for the grant program; however, in the second year two qualified candidates began the program. Both candidates specified that unless they were offered full-time positions, they would be unable to participate in the program, for financial reasons. At the interview process, mentoring was immediately started. One of the candidates for the grant program had a master's degree in nursing education. The other candidate had no experience in teaching. The participants were reimbursed for their work in the program; however, tracking of their academic progress throughout the process was not kept. Both candidates exceeded the four year time originally allotted and a request for extension of the grant monies was made and accepted. Candidates were allowed to complete a fifth year in order to assure that they would complete their doctoral degrees. Tracking progress was indicated to be essential for future candidates in the program, and identifying potential candidates earlier in their careers may also benefit the program.

Developing new part-time/adjunct faculty. Forbes et al. (2010) suggested one way to retain faculty and increase retention was to integrate part-time and adjunct faculty into the faculty of the nursing program. Forbes et al. (2010) conducted a study at a mid-sized university and identified issues adjunct faculty had expressed related to their role as clinical nursing faculty.

Surveys were sent to 132 adjunct faculty with a response rate of 49% (n = 65). The school provided an orientation program for those faculty that included a one-hour program that was not mandatory. Adjunct clinical faculty were assigned to several different clinical sites. They had an orientation within the clinical sites that varied by institution and were specific to the agency rather than the role of teaching.

A survey was developed that included three sections: a profile of adjunct faculty and their background, a yes/no checklist to determine what orientation topics were covered by the clinical agency, and a nine-item open-ended questionnaire that provided the opportunity to disclose information about frustrations and problem-solving obstacles faculty faced. Frequency and means were presented for demographic data, and a content analysis was used for qualitative information.

Fifty-nine of the faculty who responded worked full-time in other settings, four worked part-time, and two only worked in their adjunct position. The average length of time worked as a RN was 23.8 years (range of 4-46 years) and the average teaching experience was 7.3 years (range of less than one year to 40 years). Regarding orientation, faculty believed they were adequately prepared except on the topics of policies that included grading, information about clinical evaluation, the use of audiovisual equipment, and the use of BlackBoard. When asked about areas in which they needed more information, all topics were checked. Most adjunct faculty who said they were oriented well gave credit to full-time faculty or clinical staff members in the clinical setting (Forbes et al., 2010).

Resources. Another issue adjunct faculty expressed about clinical instruction was lack of resources, both material and persons (Forbes et al., 2010). Adjunct faculty thought it would be beneficial to have more textbooks, example examinations, course materials, and more help

with technology (Forbes et al., 2010). The obstacles most frequently mentioned were limited contact with faculty and inconsistent messages (Forbes et al., 2010). Part-time and adjunct faculty were primarily concerned with difficulty in knowing the full-time faculty and receiving assistance from them (Forbes et al., 2010).

Expectations. The unclear guidelines, unexpressed expectations, and inconsistent messages received about students were additional problems for clinical faculty (Forbes et al., 2010). While clinical experts may have had experience working with new graduate nurses in the clinical setting it was important that in their role as clinical faculty they remained mindful of the differences between a new graduate nurse and a nursing student. Hewitt and Lewallen (2010) stated that new part-time clinical faculty with this experience may have had expectations that were unreasonably high for student nurses, like expecting them to work at the level of new graduate nurse or turn them into "little nurses" (p. 404). Limitations in Forbes et al. (2010) study included the survey method used to collect data and the study being limited to one institution. Approximately half of the adjunct faculty, 49%, completed the survey. Therefore, no results were collected from the other half of the adjunct faculty.

In order to maintain anonymity, the second mailing of the survey was sent to all adjunct faculty, regardless of whether they had submitted a survey in the first mailing. With that method, it was impossible to determine if some of the same faculty filled out the survey twice. The survey was first sent at the beginning of the semester to elicit information about the orientation process. However, faculty who chose to fill out the survey later in the semester may have included information that reflected frustrations or timing of the semester. Faculty were not asked why they chose to be adjunct clinical faculty which Forbes et al. (2010) indicated would have been beneficial information.

Guidance/Support. Requirements for part-time clinical faculty varied from state to state; however, many of the faculty were new to teaching and required support, guidance, and mentoring (Hewitt & Lewallen, 2010). Understanding the plan-of-study for student progression has been viewed as important because it allowed part-time clinical faculty to know what the student has already been taught. New clinical faculty have benefitted from guidance on making clinical assignments. Hewitt and Lewallen (2010) indicated that new clinical faculty needed to be aware that students needed patients with a variety of acuity. Clinical faculty have needed to rotate easier patients with more difficult patients to allow for balance in the clinical setting.

Faculty-and-Student Relationships

One issue that has been difficult for both part-time and full-time clinical faculty, included challenging students. It has been important for clinical faculty to know what to do if a student was unprepared or unsafe in the clinical environment. Hewitt and Lewallen (2010) indicated that some clinical faculty were not able to recognize that a student had a problem until near the end of the clinical rotation.

Evaluation. Hewitt and Lewallen (2010) indicated that evaluation is another area that can be challenging for part-time faculty. Depending on the institution, new clinical faculty may have needed assistance with how to appropriately grade a care plan, concept map, case study, or drug card. Faculty would also benefit from knowing what to do when students have inaccurate information; for example, whether it should be counted as wrong or should feedback be given to guide the student to correct information. When nursing programs require faculty to meet one-on-one with students for evaluations more than teaching time is required, and faculty should be aware of this prior to taking on their new position. While those suggestions may be well known by full-time faculty, part-time faculty may have a different perspective. Alfaro-Lefevre (2004)

indicated that many nursing programs use the pass/fail method of grading for clinical and Hewitt and Lewallen (2010) expressed that faculty might need extra assistance on how to evaluate students using this method.

Formal instruction. In Bell-Scriber and Morton's (2009) study, a seven-hour clinical faculty workshop was held for new faculty at the start of each semester in conjunction with a mentoring program. To improve the attendance at the workshop, a small stipend was given to all faculty who participated. The workshop focused on theories about teaching and learning; techniques to facilitate critical thinking; the knowledge, abilities, and functions of the clinical faculty; procedures for evaluating students effectively in this environment; and resources for continuing education and support. The workshop included all-day instruction on clinical teaching, an orientation to the course and teaching responsibilities, and a graduate course was offered for an entire semester that focused on clinical instruction (Bell-Scriber & Morton, 2009). The university received positive feedback regarding their orientation program; however, full-time faculty did not have the time to provide the ongoing support needed by new clinical faculty.

Benner et al. (2010) stated that approximately 50% of nursing students' time was spent in the practice setting. A thorough understanding of clinical objectives enables the clinical faculty to make student assignments based on them (Carlson, 2015).

Mentoring. The nursing faculty shortage has intensified by the scarcity of clinical faculty (Kowalski et al., 2007). To address the issue of insufficient faculty, Bell-Scriber and Morton (2009) developed a clinical instruction model that allowed full-time faculty to focus on teaching in the classroom and mentoring staff nurses into the role of clinical faculty. However, staff nurses often time had difficulty differentiating "between the real world of nursing practice and the idealistic scenarios presented in nursing education" (Bell-Scriber & Morton, 2009, p.

85). When working with students, they realized there were vast differences in skills required for their own practice and those required for educating students. Often those differences made staff nurses feel inadequate and embarrassed that they were not more prepared for their new role. In many instances, with the lack of instruction in teaching, those new clinical faculty tended to use the teaching methods by which they had been taught (Bell-Scriber & Morton, 2009, Hsu, 2006). Challenges to this seven-hour workshop included the adjunct and part-time faculty feeling like they should already know everything they were being taught, and being uncomfortable since they did not know it all; and participants acknowledged being inexperienced with technology.

Providers of Clinical Instruction

Clinical instruction has included a much wider array of roles, locations, and experiences than classroom instruction, and those factors must be successfully integrated by the faculty to ensure the students' learning. "Nursing education begins in the classroom, but perhaps the most meaningful learning happens at the patient's bedside" (Koharchik, 2014, p. 65).

Clinical instruction has been an important but challenging component of the program for faculty. One challenge has been that clinical experiences may not relate directly to the didactic content being taught at the time. Faculty are required to be able to adapt to an unpredictable clinical environment with little control over what students might encounter (Allison-Jones & Hirt, 2004).

Consistency

Clinical nursing faculty serve an invaluable role in assisting students to take the knowledge they have gained in theory and apply it to the clinical setting (Koharchik, 2014, Wong & Wong, 1987). Inconsistency between theory and clinical practice has complicated the education of future nurses. Benner (2013) indicated that students must be able to apply

knowledge gained in theory to the clinical setting in order to fulfill their role as a professional nurse. When entering practice, nurses have needed to be prepared to handle a variety of situations (Benner et al., 2010). Nursing faculty have been responsible for integrating the learning of theory into the clinical setting.

Clinical faculty have been expected to maintain a safe environment for patients and students, as well as preparing students to become RNs (Allison-Jones & Hirt, 2004). In many situations, newly hired clinical faculty must take on their position without experience or formal education on instruction (Crocetti, 2014). Developing into the role of a competent, confident, consistent clinical faculty member takes time.

Setting

The clinical setting has allowed students to work in a "real-life laboratory" (Allison-Jones & Hirt, 2004, p. 238) enabling them to apply concepts learned in the theory section of a course to the clinical component. Teaching in the clinical setting has encompassed many purposes; however, the care of the patient has always been primary. Faculty have been required to balance the responsibilities of preparing future nurses with maintaining the safety of patients (Allison-Jones & Hirt, 2004). Dealing with actual patients rather than practicing in a lab or simulated experiences has made the clinical setting a high-stakes environment.

Perceptions. In order for faculty to find a successful balance in the clinical setting, they must have the necessary teaching skills (Allison-Jones & Hirt, 2004). Allison-Jones and Hirt (2004) compared student and faculty perceptions of their teaching effectiveness. The study population consisted of 583 students and 44 faculty from seven associate degree nursing programs. The Nursing Clinical Teaching Effectiveness Inventory (NCTEI) was used to measure effective teaching and addressed five sections. Two different forms were developed for

the study: one allowed students to evaluate current clinical faculty and the other which gave faculty the opportunity to evaluate their own performances. The study specified that the tool had been used in several nursing programs and was demonstrated to be reliable and valid to measure the effective behavior of clinical nurse faculty, however, no reliability or validity data were included in the study. The results of the Allison-Jones and Hirt (2004) study indicated that students perceived differences between full-time and part-time faculty. Full-time faculty were ranked as more effective teachers than part-time faculty in all five categories.

Data from both the student perspectives and faculty perspective have violated the assumption of homogeneity of variance. Faculty and students rated their teaching effectiveness as being very similar. The study indicated that several factors could influence the ratings. Full-time faculty had more experience, which may have allowed them to better judge students' abilities, and they were able to provide more appropriate feedback. In many instances, full-time faculty had been teaching in the theory portions of courses, which allowed them to pull the material into the clinical setting, and students may have perceived them as experts. Also, full-time faculty worked more closely with students and interacted with them on a day-to-day basis, therefore building stronger relationships. Table 1 represents the differences in student perceptions and faculty perceptions of components of full-time and part-time faculty's teaching effectiveness in the Allison-Jones and Hirt (2004) study.

Table 1

Perceptions of Full-time and Part-time Faculty

Students' Perceptions of Full-time and Part-time Faculty								
	Full-time Faculty				Part-time Faculty			
Variable	*M (SD)*	*N*	*df*	α	*M(SD)*	*N*	*df*	α
Teaching ability	6.0449 (.9078)	317	1	.000*	5.4208 (1.3011)	205	1	.000*
Nursing competence	6.2618 (9.069)	307	1	.000*	5.6625 (1.3008)	201	1	.000*
Evaluation	6.1450 (1.0455)	318	1	.000*	5.6839 (1.2668)	209	1	.000*
Interpersonal relationships	6.1456 (1.0805)	322	1	.009*	5.8687 (1.3271)	210	1	.009*
Personality	6.2256 (.9796)	319	1	.000*	5.7042 (1.3872)	208	1	.000*
Overall rating	6.1734 (.8816)	293	1	.000*	5.5787 (.12660)	185	1	.000*
Faculty's Perceptions of Full-time and Part-Time Faculty								
	Full-time Faculty				Part-time Faculty			
Variable	*M (SD)*	*N*	*df*	α	*M (SD)*	*N*	*df*	α
Teaching ability	5.9584 (.4905)	30	1	.917	5.9399 (.6282)	13	1	.917
Nursing competence	6.1592 (.5853)	26	1	.774	6.1014 (.6325)	14	1	.774
Evaluation	6.0537 (.6446)	30	1	.480	6.1952 (.5390)	14	1	.480
Interpersonal relationships	6.1828 (.6433)	30	1	.270	6.5167 (.6529)	14	1	.270
Personality	6.1110 (.5806)	30	1	.879	6.0816 (.6131)	14	1	.879
Overall rating	6.0713 (.5009)	26	1	.583	6.1677 (.5358)	13	1	.583

Note. M = mean (*SD)* = standard deviation; *N* = sample; *df* = degrees of freedom; * = significant at the .05 level. (Allison-Jones & Hirt, 2004).

Allison-Jones and Hirt (2004) made several explanations regarding the differences of ranking in full-time and part-time faculty, including full-time faculty's commitment to their nursing programs. Full-time faculty took on several roles in the academic setting. Those roles included refining curriculum and making sure accreditation standards were upheld. Therefore, those faculty may have devoted more time and energy to the institution's success than the part-time faculty did. With the trend of hiring a significant number of part-time clinical faculty, nursing programs have been faced with the challenge of enhancing their skills in order to maintain high quality education (Allison-Jones & Hirt, 2004).

The generalizability of the study is limited due to the sample representing only associate degree nursing programs. The population is also limited to one geographic region.

Orientation

"Formalized new-faculty orientation programs are not a luxury but rather a crucial necessity to recruit and retain competent and qualified faculty" (Hand, 2008, p. 63). Nursing programs have been hiring a significant number of part-time or adjunct faculty to fill clinical faculty positions who have been expert clinicians but have little to no formal education on how the academic setting works (Heaslip & Scammell, 2012; Hewitt & Lewallen, 2010; Peters & Boylston, 2006; Pierangeli, 2006; West et al., 2009). Many of those new clinical faculty were surprised by the informal orientation processes used within higher education (Gies, 2013; Peters & Boylston, 2006). Ensuring that part-time faculty have an adequate orientation can help retain qualified faculty (Hewitt & Lewallen, 2010).

Effectiveness. Exploring new ways to provide orientation to clinical faculty who may not have access to the campus or full-time faculty teaching has been crucial. Crocetti (2014) conducted a pilot study to determine if simulation could be used for faculty orientation and

increase the self-efficacy of adjunct faculty. A convenience sample of six nursing faculty was recruited. A four-hour orientation program using simulation to help educate adjunct clinical faculty was used (Crocetti, 2014). The simulation included instructing students on fetal monitoring, female catheterization, and fundal checks. A 30-question survey, adapted from the Self-Efficacy Toward Teaching Inventory (SETTI), was used to measure self-efficacy. Reliability and validity of the tool were not discussed in the article.

Data was analyzed using a paired samples *t-test* comparing the pre-assessment with the post assessment scores. Pre-assessment scores on self-efficacy showed a mean score of 26.17 and post assessment scores showed a score of 31.17. Scores measuring confidence received a 52.33 in pre-assessment and 67.33 in post assessment. Crocetti (2014) indicated that mean values represented that faculty were confident or completely confident that the use of simulation was beneficial in preparing clinical faculty. However, limited statistical information, such as the standard deviation of the means was unavailable in the study. The study was also limited in sample size.

Needs. Davidson and Rourke (2012) conducted a study to survey the orientation learning needs of clinical faculty. An existing learning needs survey developed by Seal-Whitlock was used and adapted to meet the design of the study. The tool included 53-items and used a 5-point Likert-style scale that took participants approximately 30 minutes to complete. The tool had been subjected to expert content reviewers to establish content validity. Forty-four of the 265 part-time clinical nursing faculty contacted completed the survey. Of the respondents, 32% had 6-10 years of nursing experience, 27% had greater than 25 years of nursing experience, and 14% had less than five years of nursing experience. The part-time clinical nursing faculty included

80% who had a bachelor's degree and 20% who had a master's degree or higher. Half of the participants had taught for four or fewer clinical nursing courses.

Results indicated that 84% of participants believed that information such as pay scale, insurance and benefits, disbursement of paychecks, and important dates such as faculty meetings, holidays, and deadlines needed to be included in a new employee orientation. Additional orientation components they identified as essential were faculty tools and resources, faculty websites, university email, and instructional software. Being introduced to the dean or other faculty was specified as being important by 50% of the faculty.

All participants indicated that information about clinical policies was important, including policies about needle sticks, tardiness and absence, unprepared students, impaired students, and students demonstrating unsafe behavior or judgment errors. A description of the nursing courses was indicated as important by 80% of participants. All participants indicated evaluation practices as essential information. A plan for faculty development and a schedule for evaluations were indicated as important by 80% of participants. The survey had a small sample size and was limited to one university. Davidson and Rourke (2012) indicated that the online survey program limited them from performing subgroup analyses as well.

Preparation. Herrmann (1997) found that clinical faculty who had received educational preparation for their role as faculty felt more confidence in their ability to facilitate clinical learning. The trend in graduate degrees for nurses has moved away from preparing teaching faculty and has a greater focus on preparing clinical practitioners (Herrmann, 1997; Kelly, 2010). Herrmann's (1997) study purpose was to determine if there was a relationship between preparation to teach nursing and the use of clinical instruction methods. The study indicated that 67% had taken courses in learning theories; 69% had taken courses about teaching methods; and

46% had participated in actual student teaching in the clinical setting. The average length of time as a clinical faculty member in Herrmann's (1997) study was 11 years; with experience ranging from one to 39 years. The results indicated that as clinical faculty's level of educational preparation increased, they reported that they were more prepared for their role as clinical faculty. A limitation of the study was the experience level of faculty. The majority of faculty had several years of teaching experience regardless of their level of educational preparation, suggesting that experience in the educational setting may have improved their teaching skills (Herrmann, 1997).

Full-time Faculty

A qualitative study using a hermeneutic phenomenology approach was conducted by Gazza (2009) to understand the lived experience of full-time nursing faculty. Faculty in the study included full-time faculty members who taught 51%, of their workload in undergraduate nursing programs. Those faculty taught in both clinical and theory courses. Eight participants from the Eastern half of the U.S. were the participants for the study.

Five themes emerged from the study. The first was "making a difference in the student, profession, and the world" (Gazza, 2009, p. 221). This was described as the rewarding process of their job. Four of the participants indicated that attending graduation and seeing students' practice as professional nurses as making a difference. As their students changed the lives of others, faculty felt that they had been making a difference in the world.

The second theme was "being a gate keeper to the profession" (Gazza, 2009, p. 221). Nursing faculty indicated that they had high standards for student performance. They believed that they had to ensure that the students graduating were safe and qualified.

The third theme was "trying ways to balance multiple roles" (Gazza, 2009, p. 221). The participants indicated their work lives as being busy, time intensive, work intensive, or overwhelming due to the multiple roles they played. While participants acknowledged there was a lot of work required from teaching, committee work, and scholarship activities; five of the participants continued to maintain jobs in the clinical practice setting to retain their nursing skills.

The fourth theme was "support is vital; can't do it alone" (Gazza, 2009, p. 221). All of the participants identified needing support to fulfill their faculty role. Five participants identified colleagues who acted as mentors to them, three discussed how their mentors helped them with basic functions, and one mentioned a long-term relationship with a mentor. Not only did those faculty need support, they also felt that they needed to provide support to others as well.

The final theme identified was "workplace relationships: the good, the bad, and the ugly" (Gazza, 2009, p. 221). Relationships that participants had encountered were described and ranged from positive and supportive to negative and detrimental, with the negative and detrimental being the majority. Two of the eight participants described positive interactions and six participants described relationships and conflicts that were belittling, disrespectful, and rude. Limitations in this study included the small sample size and geographic area.

Part-time/Adjunct Faculty

Roberts et al. (2013) defined adjunct faculty as "a registered nurse who is a clinical expert and employed part-time by an educational institution to coach students in the clinical setting, helping them apply theory to clinical situations" (p. 295). Many times, new clinical faculty work at distant clinical settings limiting their contact with more experienced faculty which may hinder their success (Gies, 2013). Forbes et al. (2010) recommended that hiring

adjunct and part-time clinical faculty be centralized, that those faculty receive formal orientation and staff support, that full-time faculty receive work release time to serve as faculty course coordinators to allow for more assistance to adjunct faculty, integrating adjunct faculty into the school's total faculty, and allowing faculty to take tuition free courses on nursing education. Another recommendation included that institutions continually assess the needs of adjunct faculty.

Challenges. Part-time clinical faculty are an essential part of nursing programs throughout the U.S. (Duffy et al., 2008). Duffy et al. (2008) indicated that part-time faculty were a major resource; however, using part-time faculty also had created some challenges. Strategies were discussed by Duffy et al. (2008) on how to assure the success of part-time faculty. Part-time faculty

> often lack knowledge about educational theory, are hesitant to give students failing grades when warranted, and have varying levels of commitment to their teaching role, as evidenced by a lack of consistent attendance at course meetings, requests for time off during the semester, and full-time job responsibilities that sometimes interfere with the routine progress of the semester. Their clinical proficiency also does not always extend to their teaching effectiveness. (Duffy et al., 2008, p. 53)

Duffy et al. (2008) indicated the greatest challenge facing nursing programs with part-time faculty was when failures had to be overturned due to weakness and lack of documentation. The three areas that were most problematic were grading clinical paperwork, documentation of communication, and evaluations. Lack of documentation of communication was most apparent when students were not progressing adequately through a course and were given an academic warning which required that the student meet with both part-time faculty and the course

coordinator. Part-time faculty were hesitant to make such documentation because it became a part of the students' permanent record.

Faculty retirements and an increase in enrollment had led to a significant use of part-time clinical faculty (Duffy et al., 2008). To help improve the success of part-time faculty, a part-time clinical faculty meeting was held to provide support and offer information on standards of behavior, clinical documentation tools, and strategies for clinical instruction. Information for part-time faculty was posted on WebCT, which allowed faculty to have access to this information at any time. Part-time faculty also were evaluated by their course coordinators yearly to allow the college to maintain documentation of the part-time faculty's effectiveness and growth.

Part-time faculty were compensated for actual time spent in the classroom as well as the work they spent on written assignments and evaluating students. The use of part-time faculty needs to be carefully considered by nursing programs in light of the shortage of nursing faculty (Duffy et al., 2008).

Perceptions. Gazza and Shellenbarger (2010) performed a hermeneutic phenomenological study to fully understand the experiences of being a part-time faculty member. Nine part-time nursing faculty from northeastern baccalaureate programs were the participants in this study. All the participants were Caucasian females who taught clinical courses. The participants had worked in clinical nursing positions for an average of 13.2 years before taking on the role of part-time clinical faculty. More than half of the participants continued to work in clinical positions.

Four themes were identified in the study: "achieving the dream, a group divided" (Gazza & Shellenbarger, 2010, p. 355), "for the love of the students, and jump in and figure it out"

(Gazza & Shellenbarger, 2010, p. 356). The first theme revealed that taking on the role of part-time faculty was a way of helping transition into full-time faculty, or having the chance to work with patients and students. Also, being part-time faculty allowed participants to see what it would be like to be a full-time faculty in order to decide if that was the career path they would pursue.

The second theme revealed was that all participants felt that there were divisions between full-time and part-time faculty; faculty teaching theory and clinical; temporary and tenured faculty; master's prepared and doctoral prepared faculty; clinical and academic staff; and those who taught acute nursing courses content and community nursing courses content. The most common theme identified as differentiating between part-time and full-time faculty was the exclusion from faculty meetings, discussions, and decisions. Part-time faculty expressed feelings of unimportance and never really being accepted.

The third theme was "for the love of students" (Gazza & Shellenbarger, 2010, p. 356). All the participants spoke highly of students with whom they worked. They indicated a sense of gratification seeing students learn new things.

The final theme was "jump in and figure it out" (Gazza & Shellenbarger, 2010, p. 356). The participants indicated that they needed resources to do their job as a part-time faculty member. Eight of the participants said that they needed the course requirements and stated they were never provided any before beginning their teaching assignment.

The most common deficiency described by part-time faculty was a lack of information about the theory component. One participant described how she was required to grade assignments submitted in the lecture portion of the course, and was not involved in developing those assignments. The participant also acknowledged the amount of time required to perform

her job as part-time faculty well and indicated that it was difficult while working two additional jobs. Participants indicated they did not have the course textbook or schedule, which made it difficult to connect theory to clinical. Three participants turned to colleagues for assistance, and two were successful at getting information. One participant used the students to obtain information. The study was limited in generalizability due to small sample size and specific geographic location.

Comparison of Full-time and Part-time Faculty

Similarities and differences were apparent between full-time and part-time faculty. Both groups described the positive impact they have had on shaping future nurses, they also both indicated the need for resources and support, and the need to be involved with the entire faculty.

Differences in Gazza (2009) and Gazza and Shellenbarger (2010) included that part-time faculty felt isolated in the clinical environment. Many part-time faculty did not have offices and lacked the support needed to perform their jobs. One theme that emerged from the responses of part-time faculty was using their part-time faculty position to achieve the dream of being a full-time faculty member. Gazza and Shellenbarger (2010) questioned why qualified students were turned away from nursing programs due to faculty shortages when part-time faculty had shown an interest in being full-time faculty. One possibility was that the part-time faculty did not hold the appropriate credentials. In the Gazza and Shellenbarger (2010) study none of the part-time faculty held terminal degrees. Both studies indicated that the experiences of part-time and full-time faculty were different.

Role transitioning. A naturalistic inquiry method was used by Roberts et al. (2013) to learn about adjunct faculty's transition from clinical expert to clinical faculty. The study's participants were 21 attendees of a two-day workshop for new adjunct faculty. The participants

included six who had baccalaureate degrees in nursing, 13 who had master's degrees in nursing, one who had a master's in adult education, and one who had a master's degree in human resources. Semi-structured interviews were conducted by three researchers.

Four major themes were identified: (a) role, (b) orientation, (c) support, and (d) connection (Roberts et al., 2013). Adjunct faculty described their role as being part of an educational community and others felt like they were "agency staff" or "pinch hitting" to fill a void (p. 297). Role conflict was an issue for some participants who had students they worked with on their unit in their clinical course.

Orientation was another theme. Faculty attended a two-day formal orientation. Many faculty indicated that the orientation was beneficial to their new role. Topics included learning theory, legal issues, how to conduct a pre- and post- conference, clinical evaluation methods, dealing with difficult students, and practical tips. Participants indicated that while the information was helpful, it was also very general.

Participants indicated support as another theme. Support was needed from the institution, work site, and staff. Many course coordinators were identified as mentors who had made themselves available by phone or email. Several faculty indicated that they did not have a mentor and felt that they were "just out there" (Roberts et al., 2013, p. 299).

The feeling of being connected to the university was the last theme. Many of the adjunct faculty stated they felt a disconnection between themselves and the university. They indicated a connection between students, but not the academic setting. Adjunct faculty felt disconnected due to the demands of their schedules and not being asked to participate in activities on campus. Clinical faculty who felt included indicated this by being asked to attend faculty meetings and being invited to social events.

The limitations of the study included a small sample size and generalizability. All adjunct-faculty included in the study had attended the same 2-day workshop. Roberts et al. (2013) recommended having a structured orientation program for new part-time faculty to help with the transition into their new role.

Contributions and Concerns of Part-time/Adjunct Faculty

While part time/adjunct faculty's role in higher education has differed slightly from full-time faculty's role and responsibility, Creech (2008) indicated that part-time faculty made significant contributions in teaching and service. An instrument adapted from the AACN was used in Creech's (2008) study with reliability indicated by a Cronbach α of .83 for the 21-item survey. Participants in the study included 250 nursing faculty and administrators from 25 nursing programs in the Midwest. Part-time faculty in the survey indicated that they performed research, teaching, service, and integration/synthesis to some extent within the university setting; with teaching and service reported as the highest (Creech, 2008). Without part time/adjunct clinical faculty, nursing schools would have turned away an even larger number of qualified students. However, many of these positions were filled by clinical experts who have had no formal education in how to teach students (Heaslip & Scammell, 2012; Peters & Boylston, 2006; Pierangeli, 2006; West et al., 2009). Limitations from Creech's (2008) study included a small sample size and one geographic location.

Role stress. A descriptive and multivariate correlational design study was used to determine the perceived role stress on part-time clinical affiliate nursing faculty and the relationship between selected background factors (Whalen, 2009). The participants included 91 out of 461 part-time clinical faculty in a western state. To meet the inclusion criteria participants must have been part-time clinical faculty and worked in that role for at least one semester in the

past twelve months. The part-time clinical faculty must have been RNs without full-time faculty status who taught in clinical courses in baccalaureate programs.

The Potential Work-Related Stressors Survey (PSS) was a 30-item survey that assessed potential situations that could cause role stress as well as one open-ended question to identify a stressor not listed in the survey. A pilot study revealed a Cronbach α of .932 and face and content validity were established by a panel of three part-time clinical faculty who had experience with clinical teaching, three expert nursing faculty who worked full-time and closely with part-time clinical faculty, a mental health nursing faculty member who was a stress expert, and a skilled designer of survey tools. In Whalen's (2009) study the Cronbach's α was greater than .8 and a factor analysis indicated that the PSS measured only role stress.

Job satisfaction. Another instrument used in the study was the Part-time Clinical Teaching Job in General Index (aJIG), which measured job satisfaction. Reliability of this tool was an α coefficient of .773 for the study. Data from the study indicated that 56% of part-time faculty had taught for less than two years and 81.3% had taught for less than four years; therefore, the findings revealed that nursing students are often taught by "somewhat inexperienced clinical teachers" (Whalen, 2009, p. 11). More than 60% of the part-time clinical faculty were older than 40 and almost 28% were older than 50. The AACN (2007) required that clinical faculty have a minimum of a master's degree (as cited in Whalen, 2009). However, in the study, 49.5% of faculty held only a Bachelor of Science degree. About 85% of the participants had some educational training for clinical instruction. Participants' level of education did not influence role stress or job satisfaction.

Two jobs. Participants' data showed that 69.2% held a second job while teaching students during a clinical rotation. While the part-time clinical faculty did not perceive any

additional stress related to their second job, it was important to consider how they balance their time between the two jobs.

A regression analysis was used to determine the relationship between role stress and job satisfaction. Role stress accounted for only 3.9% of the variance with teaching experience, teacher education, and part-time clinical faculty holding a second job. In regard to job satisfaction, teaching experience, teacher education, and holding a second job accounted for 12.2% of the variance. The amount of stress had an inverse relationship with job satisfaction ($\beta = .296$, $p < 0.05$). A positive correlation existed between holding a second job and job satisfaction ($\beta = .218$, $p < 0.05$).

The study indicated that those part-time clinical faculty had a low level of role stress and a high level of job satisfaction. The most dissatisfying aspect of their job was the poor monetary support they were given in the part-time role. Generalizability was limited due to the small sample size, specific geographic location, and the sample only including baccalaureate programs (Whalen, 2009).

Clinical Nursing Faculty Expectations and Responsibilities

The nursing shortage has increased the pressure to move students through nursing programs; however, faculty have been charged with ensuring that future nurses meet the minimum requirements for safe care when entering practice (Oermann, Yarbrough, Saewert, Ard, & Charasika, 2009b). Patients have had the right to safe and effective healthcare, and students required opportunities to learn.

The clinical setting has long been a high-stakes environment for both patients and students. Failing a student in the clinical setting has long been a difficult process (Larocque & Luhanga, 2013; Luhanga, Yonge, & Myrick, 2008a; Scanlan et al., 2001). Pushing an

underperforming student through the clinical setting can jeopardize patient lives as well as the reputation of the nursing program. To ensure that patient safety has been maintained and program outcomes are met, nursing faculty have been obligated to make certain that students have been meeting the clinical learning outcomes of their courses (Oermann, 2004).

Safety

Faculty in the clinical setting have been entrusted with making certain that students practice safely. Knowledge, confidence, and support are essential for faculty to maintain a safe environment. Regardless of the clinical faculty member's amount of preparation made for the clinical day, every student experience will be different and the number of students faculty have in the clinical setting as well as the unpredictability of the environment have made assuring safe practice a challenging assignment for faculty. Faculty have been required to manage, in many cases, eight to 10 students in the clinical setting (Ironside et al., 2014; Benner et al., 2010).

Nursing schools have been challenged with moving from a culture of blame to a culture of safety (Benner et al., 2010; Tanicala, Scheffer, & Roberts, 2011). Defining safety and determining what constitutes a clinical failure has been difficult. Students' behavior that compromised patient safety may warrant a student failing the clinical course. However, identifying those behaviors has been challenging for faculty (Tanicala et al., 2011), which in turn, creates additional stress on the clinical faculty member.

The nursing profession has the ability to improve patient safety while receiving nursing care (Vaismoradi, Salsali, & Marck, 2011). Seventeen baccalaureate degree nursing students from various semesters were participants in a qualitative study to determine the role that nursing education played in providing safe care. Three themes emerged from this study: viewing "safety as patient comfort, not being knowledgeable or experienced enough" (Vaismoradi et al., 2011, p.

437), and "being helped to internalise the principles and values of patient safety" (Vaismoradi et al., 2011, p. 438). Students described safety as patient comfort relative to physical and psychological comfort and specifically stated that they wanted patients to be protected from harm or injury. Students believed that they needed to be knowledgeable in regard to nursing care and patient safety issues but believed that most of their classroom education was comprised of learning pathophysiology of diseases, prognoses, and treatments. Students thought that the program should have given them opportunities to learn patient safety and use those principles in their daily practice. The study participants were one group of Iranian students which limits the generalizability (Vaismoradi et al., 2011).

Responsibility. Faculty and clinical preceptors have had the professional responsibility of protecting the public from incompetent practitioners by preventing underperforming students from becoming registered practitioners (Luhanga et al., 2008a). Luhanga et al. (2008a) performed a grounded theory study to understand the process of precepting an unsafe student. The definition of unsafe student in the study was taken from the work of Hrobsky and Kersbergen (2002) and Scanlan et al. (2001), whose definition was "students whose level of clinical practice is questionable regarding safety, and who exhibit marked deficits in knowledge and psychomotor skills, motivation, or interpersonal skills" (Luhanga et al., 2008a, p. 1).

The sample for the study included 22 nurse preceptors who were teaching in the final-year clinical practicum. Twenty of the participants were female and two were male. The ages of participants ranged from 26.5 to 62 years. The average years of teaching experience was 5.9. The participants had precepted from one to 20 students in their careers; seven indicated they had never received any training and two indicated their training had been years in the past.

Theoretical sampling was used to reach theoretical saturation. Constant comparative analysis was used to analyze the data.

The results showed that some clinical faculty passed underperforming students. Clinical preceptors acknowledged that failing a student was one of the most difficult responsibilities of their job; indicating that failing a student was a difficult decision because faculty did not want a student to experience disappointment or to repeat a specific course. The lack of experience, the amount of time, the possibility of feeling guilt or shame, lack of appropriate clinical evaluation tools, time to evaluate students, and pressure due to the nursing shortage to get more students into the workforce were identified as making the process of failing a student even more difficult. In the study, the majority of preceptors acknowledge that students passed the practicum gaining insufficient knowledge. Limitations in the study include generalizability related to the small sample size and all participants were from the acute care setting and worked with one nursing program (Luhanga et al., 2008a).

Grading clinical performance. Grading practices throughout clinical courses remains an issue among nursing programs. Students have indicated that the quality of work they put forth in the academic environment has directly related to the grading process, pass/fail or letter grade (Alfaro-LeFevre, 2004; O'Mara, McDonald, Gillespie, Brown, & Miles, 2014). Alfaro-LeFevre (2004) conducted a random survey of 79 schools and found that 59 (75%) of the schools used pass/fail as the grading method, 15 (19%) used letter grades, and 5 (6%) used combined grades. Alfaro-LeFevre stated that the way clinical was graded could impact the emphasis students' place on their performance. If the pass/fail method was used for evaluating clinical, students could work as hard or as little as they chose to in clinical and still receive a grade of pass. In theory courses, students working hard would be more likely to earn a better grade. The

method of grading clinical may have some impact on nursing program's ability to graduate students who can succeed in the clinical environment. Alfaro-LeFevre indicated their own bias in the pass/fail grading system. The study also has a small sample size which is a limitation.

The Evaluation of Learning Advisory Council (ELAC) conducted a study in the fall of 2007 to determine what assessment and evaluation strategies were used among nursing programs. The participants included 1,573 faculty from prelicensure nursing programs throughout the U.S. The majority of the participants were educated at the master's degree level, 1,132 (72%), and 361 (23%) had doctoral degrees. Eighty-four percent of faculty indicated that they had completed continuing education and 75% indicated that they had completed graduate level courses in assessment and evaluation (Oermann, Saewert, Charasika, and Yarbrough, 2009a).

A national survey was conducted by the ELAC of the NLN to better understand how nursing faculty evaluate and grade students in the clinical setting (Oermann, Yarbrough, Saewert, Ard, & Charasika, 2009b). The survey was conducted because there was little knowledge about how clinical faculty assess students in the clinical setting. The 29-item survey included information about demographics and evaluation strategies. Fifteen faculty members participated in a pilot-test of the survey. Members of the NLN database were surveyed and 1,573 faculty participated in the study. Clinical evaluation tools were used by 1,534 (98%) of faculty. The clinical evaluations tools were modified for specific courses according to 1,095 (70%) faculty. The pass/fail method of grading was the most common method used by nursing programs in the clinical setting according to 1,116 (83%) of participants.

Part-time and full-time faculty have found assigning grades for clinical performance to be one of the most difficult of their teaching responsibilities. Heaslip and Scammell (2012)

surveyed 112 nurse mentors about their confidence in grading practices and the results showed that 64.3% were confident in assigning a letter grade to students in the clinical setting and that 75.9% expressed their belief that letter grades allowed for better assessment of the students. One person grading another person's performance inherently includes some subjectivity; however, a letter grade can be more differentiating than a pass/fail system (Heaslip & Scammell, 2012). The population in the study was selected from an annual mentor and tutor conference. The sample size and population were limitations of the study.

Passing an Underperforming Student

In spite of the high stakes present when an underperforming student has been allowed to pass a clinical course, the literature indicated the practice is widespread in other countries as well as the U.S (Black et al., 2014; Brown et al., 2012; Duffy, 2003; Gainsbury, 2010; Jervis & Tilki, 2011).

Brown et al. (2012) conducted a study that explored mentorship practices in relation to nursing students at the University of the West of Scotland. The survey was distributed to 4,431 mentors with a response rate of 1,790 (41.2%). Findings from the study revealed that 82% of respondents stated they had not passed a failing student. Eighteen percent of the respondents acknowledged that they had passed a failing student (Brown et al., 2012).

Considerations. In Brown's et al. (2012) study, 8% of participants believed that the university would overturn a failing grade. Sixty percent of the participants indicated that they would initiate contact with the university if they perceived a problem with a student, and 25% revealed that they made contact as soon as a problem was identified. The results of the study showed that 90% of the mentors believed that they had received at least satisfactory support from their university. Limitations of the study included bias from the nature of the survey design.

Duffy (2003) explored the reason why mentors failed to fail students when their competence was questioned. The participants in the study included 14 lecturers and 26 mentors from Scottish institutions. Findings of the study indicated that in some cases, mentors and lecturers were passing students who were underperforming. Another finding was that mentors were identifying problems with students and coming to lecturers; however, those concerns were not acted upon and the mentors passed the student regardless of the issue.

Inadequate measures. Another problem encountered in Duffy's (2003) study was the lack of validity and reliability of the clinical evaluations being used. Failing a student required mentors to identify the student early on and required support and guidance from the university. Mentors who had failed students described the process as very emotional. Reasons the mentors provided that underperforming students passed clinical courses included: late identification of the problem, mentors not following proper procedures to fail a student, the university appeal process pressuring the faculty to pass the student, and thoughts that the student might improve in subsequent semesters. In many instances, participants identified that students were making it to their third year before they received a failure. The late first failure was compounded into more problems because mentors did not want to fail a student so close to graduation (Duffy, 2003).

Subjective factors. Mentors indicated that students' personal circumstances had influenced whether or not they had passed or failed a student. The clinical faculty also indicated that a lack of confidence and limited experience contributed to their decision to pass an underperforming student. Duffy (2003) described a very important issue that emerged from the study: the concern for borderline students. Mentors did not believe that they could fail a student unless the problems were significant; even though they were "adamant that they would recognise and act upon unsafe practice" (Duffy, 2003, p. 80). Often, borderline students passed clinical

courses because they were given the benefit of the doubt. Another problem identified in the study was the lack of validity and reliability of the clinical evaluations being used. Limitations of the study included a small sample size.

Insecurity. Gainsbury (2010) confirmed that failing to fail nursing students remained a significant problem in England even years after Duffy's (2003) Scottish study revealed the problem. A survey of 2000 mentors revealed that 37% had passed a student they believed had issues with competencies or attitudes and they thought should have failed the clinical. Reasons identified for passing those underperforming students included that they did not feel they had evidence to support their concerns. Of the participants in the study, 69% had struggled with the paperwork related to failing a student, 17% had had their decision to fail a student overturned, and 17% passed students because they did not have adequate time to evaluate them (Gainsbury, 2010). Information on the specifics of this study were not included in the article. The sample size and location limited the generalizability of the study.

Difficulty of decisions. Students have been more likely to fail for academic reasons than for inadequate clinical performance (Jervis & Tilki, 2011). Jervis and Tilki (2011) explored why mentors were "failing to fail poorly performing students" in England (p. 583). The mentorship role was defined as two different stages in the study. Stage one was the level that all RNs function at; and stage two was the level where mentors have full responsibility for students (Jervis & Tilki, 2011). Participants in the study included stage two mentors who had mentored at least three students in the previous two years. A total of 14 mentors participated in the study. The themes that emerged from the qualitative study included "the complexity of assessing students, the difficulty of assessing students", and the "confidence about assessment decisions" (Jervis & Tilki, 2011, p. 584).

One difficulty with evaluating students in the clinical setting has been making the pass/fail decision about a student whose performance was borderline between passing or failing. When mentors made a decision to fail a student they indicated that they did a great deal of soul searching and experienced a significant amount of stress. Mentors indicated that there was pressure from students to pass them. Students sometimes cried. Mentors were also concerned with the consequences they anticipated facing if they chose to fail a student, having grievances filed against them, dealing with blame, and feeling pressure from faculty to pass the student. "Failing a student can be emotionally demanding, stressful and possibly threatening for the mentor" (Jervis & Tilki, 2011, p. 586). A small sample size and limited geographic location were limitations in the study.

Failure to fail. Larocque and Luhanga (2013) conducted a study using 13 university faculty members, preceptors, and faculty advisors to explore the issues of "failure to fail" (p. 1) in a nursing program. Participants were interviewed for one hour with open-ended questions in which faculty described how they would communicate to a student that did not meet the objectives of their clinical course. Five themes emerged from this study.

The first theme identified was "It's a difficult process" (Larocque & Luhanga, 2013, p. 4). The guiding interview question was "Imagine having to communicate to a student that he or she has not met the clinical course objective in the final placement" (Larocque & Luhanga, 2013, p. 4). The participants indicated that this would have been one of the most challenging aspects of their role.

The second theme identified was "academic and emotional support" (Larocque & Luhanga, 2013, p. 4). Participants identified that support was essential. Some participants revealed that there was a lack of support from their academic institution.

The third theme was "consequences of failing a student" (Larocque & Luhanga, 2013, p. 4). Failing a student has also been identified as a time consuming process. Participants stated that failing a student was difficult. A preceptor stated, "I don't think any of us want to see somebody throw four years of their life out the window" (Larocque & Luhanga, 2013, p. 4). Concern was also expressed that issuing a failing grade may have influenced faculty evaluations.

The fourth theme was "reasons for failing to fail a student" (Larocque & Luhanga, 2013, p. 4). Underperforming and unsafe were identified as characteristics of students who failed. To avoid the inconvenience and possible embarrassment that could result from going through an appeal process, some faculty have given students the benefit of the doubt. Participants indicated that the perspectives of clinical faculty and the university sometimes differed, making failing a student even more difficult.

The fifth theme identified was "consequences of failure to fail" (Larocque & Luhanga, 2013, p. 4). Participants had indicated that failing to fail a student not only had implications for students but also for the nursing program and the public. Participants believed that the university should stand by their decision to fail a student and not overturn it, because of the perception that the institution was devaluing clinical faculty when that occurred. Limitations of this study included the use of convenience sampling and the small sample size.

Failing a Student

Failing a student was seen as a mechanism for protecting the public from incompetent students who would progress to become nurses (Black et al., 2014), but faculty sometimes found it so difficult to execute the process that they hesitated or chose not to follow through with it. Many factors have been cited as reasons that prevented mentors and faculty from failing students in clinical practice.

Black et al. (2014), explored mentors' experiences with failing nursing students in their final clinical assignment. The participants in this study included 19 mentors from seven different organizations in the United Kingdom, so one limitation of the study relative to generalizability in the U.S. was the British research site.

Personal moral questions. Three themes emerged from the study: " (a) experiencing moral stress (the personal price), (b) demonstrating moral integrity (professional responsibility and accountability), and (c) ensuing moral residue (having the strength to fail final placement students but feeling powerless to do little to address a prevailing culture of failing to fail)" (Black et al., 2014, p. 229).

Mentors were faced with difficult decisions, especially when needing to fail a student in the last clinical in their degree program. The mentors voiced their concerns about experiencing guilt that made them question their own competence, ability, and quality of mentorship they provided to students. Many mentors voiced concern with students; suggesting that previous mentors had passed students who had problems instead of dealing with them. The issue of passing those underperforming students in previous semesters left a sense of moral stress for the mentors. Mentors indicated that they believed they had not been a good enough mentor. Black et al. (2014) concluded that mentors believed they were not prepared to fail a student and they had a difficult time dealing with the emotions that experience would create for them.

Ambiguous definitions of *unsafe*. Student learning in the clinical setting is an important part of undergraduate education (Killam, Montgomery, Luhanga, Adamic, & Carter, 2010). Researchers who have published their studies in the literature defined and described unsafe practice and unsafe students in similar but slightly different ways in the literature. Hrobsky and Kersbergen (2002) defined unsafe students as those who have insufficient or inadequate

knowledge, psychomotor skills, and interpersonal skills. Unsafe practice was described by Scanlan et al. (2001) as "an occurrence or a pattern of behavior involving unacceptable risk" (p. 25).

In a study conducted by Killam et al. (2010), 57 students and 14 clinical nursing faculty were the participants. Faculty participants in Killam's et al. (2010) study were asked to express whether they agreed, disagreed, or were neutral when shown 39 cards and given the preface, "In a clinical setting, practicing safely is at risk when an undergraduate student…" (p. 5). Participants were asked to select a statement from the agree pile that represented the most risk for clinical safety, then they were asked to select a statement and place it in the disagree pile, and then the neutral pile.

Factor analysis was used to determine meaning of the *Q* sort, based on a 69 by 69 correlation matrix. Three factors accounted for 53% of the data. Of the participants in the study, 51 (74%) significantly loaded on one of the three factors. Suggesting that there was a degree of agreement on what constitutes unsafe practice. Selections were placed in a *Q* template and this continued for about 30 to 45 minutes (Killam et al., 2010).

Students' Perceptions

Failure in clinical performance involves at least two subjects—the faculty and the student. Researchers have addressed the student perspective on failure in the clinical nursing course as well as the faculty perspective.

Too much too soon. Factor one in Killam's et al. (2010) study was "compromised professional accountability" (p. 7), 19 students from Year III and 17 students from Year IV, and four faculty indicated that violating standards relative to recording, reporting, and performing skills was considered most unsafe (16/+4, 14/+3; 10/+3). The participants also agreed that safety

was highly compromised when repetitive errors were made (27/+3) or students were underprepared to care for their patient (36/+2; 20/+2). Subjects expressed the opinion that safety was somewhat compromised when there was a lack of respect for client needs (31/+1), an inability to critically think (2/+1), or documentation was incomplete (9/+1).

Factor two was "incomplete praxis" (Killam et al., 2010, p. 8). Five student subjects in the Killam et al. study (2010) perceived premature autonomy as a cause of unsafe practice and believed that clinical-decision making should be shared with the clinical nursing faculty to ensure patient safety (39/+4; 4/+4). Students stated that their lack of confidence in performing basic skills (6/+3) and incomplete reporting of patient information (9/+2, 14/+2) were perceived performance weaknesses. Participants viewed the "lack of enforcement of program expectations as contributors to the gap between clinical expectations and actual student practice" (33/+2) (Killam et al. 2010, p. 8).

Factor 3 was "clinical disengagement" (Killam et al., 2010, p. 10). Six participants, three students and three faculty, indicated that the inability to follow the directions of clinical faculty (3/+4) and respect the wishes of their clients (31/+3) contributed to unsafe behavior in the clinical setting. Killam et al. (2010) stated the one viewpoint with strong agreement for creating unsafe student practice was covering up mistakes. The limitations of this study included the fact that all participants were from one institution.

Too little knowledge. Killam, Montgomery, Raymond, Mossey, Timmermans, and Binette (2012) conducted a study to determine students' perceptions of unsafe behavior. The participants were recruited through an in class activity and 59 fourth-year baccalaureate students participated. Students were given a template with 43 spaces arranged as a pyramid and were

asked to place 43 cards in place following the prompt "in a clinical setting, it is most unsafe when…" (p. 5).

Factor analysis and varimax rotation were used to identify the shared viewpoints. Site A had three discrete viewpoints and one consensus viewpoint. Student's perceived care to be most unsafe when there was limited application of knowledge. The assertions were articulated by students who had been taught to do enough to meet only the minimum standards (40/+3), did not have adequate knowledge to change a plan of care to meet their patients' changing needs (17/+2), were unable to communicate essential information about their patients (7/+2), yet still received passing grades for their inadequate performance (24/+2), and transferring knowledge to clinical practice was jeopardized when clinical role models were not present (38/+2).

Too little connection. The second viewpoint was "non-student centered program" (Killam et al., 2012, p. 6). Students perceived a gap between theory and practice and felt it was most unsafe when students were overwhelmed by the expectations of the program (25/+3), felt their educators were not competent (22/+3), and could not facilitate learning (36/+2; 43/+2). Viewpoint three was "overt patterns of unsatisfactory clinical performance" (Killam et al., 2012, p. 7) and students indicated that deficits in knowledge and clinical skills were most unsafe (8/+3; 11/+3; 5/+2). "Contravening practices" (Killam et al., 2012, p. 7) was a consensus viewpoint. Actions related to expectations of professional practice were addressed by students. The viewpoints ranked from +5 to +2 and addressed the issues of failure to work within scope of practice (1), patient protections (18), and integrity (6).

Beyond scope of practice. Site B had three discrete viewpoints and one consensus viewpoint. The first viewpoint for Site B was "premature and inappropriate clinical progression" (Killam et al., 2012, p. 7). Students indicated that safety was most compromised when students

were making decisions beyond their scope of practice (2/+4), clinical faculty encouraged students to make decisions beyond their scope of practice (27/+3), and underperforming students successfully completing the clinical course when they performed unsatisfactorily (24/+1; 13/+1). Viewpoint two was "non-patient centered practice" (Killam et al., 2012, p. 8). Characteristics of viewpoint two included clinical faculty failing to adhere to boundaries (27/+2), enforce policies (31/+1), students failing to document care (13/+2), and protecting patients from harm (18/+4). Viewpoint three was "negating purposeful interactions for experiential learning" (Killam et al., 2012, p. 9). The clinical faculty competence was described as the most indicative for unsafe practice. The perspectives of this viewpoint were compromised relationships between students, clinical faculty, and patients (22/+3; 20/+2; 2/+2). The consensus viewpoint was "eroding conventions" (Killam et al., 2012, p. 9). The students indicated that the characteristics of eroding conventions were students who lacked honesty (6), knowledge (5), and demonstrated unsatisfactory performance (11, 7, 8, 9). The study was limited to a small sample size and two program sites.

Perception of being unsafe. Ninety-four first-year students in a baccalaureate program who had completed 122 hours of clinical learning were the participants in Killam, Mossey, Montgomery, and Timmermans' (2013) study. The *Q*-sort was used as an in class activity. Students were given 43 concourse statements, a blank *Q*-template, and a consent form. The purpose of the study was to identify first-year students' viewpoints of safety within the clinical setting. Study participants were asked "In a clinical setting, it is most unsafe when…" (Killam et al., 2013). Participants in the study identified four viewpoints: "(a) overwhelming sense of inner discomfort, (b) practicing contrary to conventions, (c) lacking in professional integrity, and (d) disharmonizing relations" (Killam et al., 2013, p. 477).

Centroid factor analysis and varimax rotation were used to analyze the data. Viewpoints from the study, or factors, were based on statistically significant patterns of rankings on clinical safety. The first viewpoint, "overwhelming sense of inner discomfort" (Killam et al., 2013, p. 477), loaded five participants with 24 statements. External expectations such as overwhelming course requirements (25/+5) and an unclear evaluation process (37/+4) were believed by participants to compromise safety within the clinical setting. Discomfort was recognized as nervousness (12/+3) and inexperience in working with other healthcare professionals (14/+3; 16/+3).

The second viewpoint, "practicing contrary to convention" (Killam et al., 2013, p. 478), had 26 students loaded with 11 statements. Violating practice standards (1/+5) was viewed as unsafe behavior. Students who made independent decisions (2/+4), chose to disregard patient rights (10/+2), and made errors were viewed as unsafe (11/+2).

The third viewpoint, "lacking in professional integrity" (Killam et al., 2013, p. 478), had 20 students loaded with 10 statements. Having a lack of patient centeredness (18/+4), being dishonest (6/+4), and having impaired cognition were viewed as lacking professional integrity (19/+5).

The final viewpoint, "disharmonizing relations" (Killam et al., 2013, p. 478), was loaded by five students. This included the lack of a role model (38/+5), incompetent educator (22/+4), a threatening educator (43/+3), and making risky behaviors (2/+2). Limitations of the study were that the sample was from only one baccalaureate degree program and all participants were first-year students.

Perception of being under-prepared. Montgomery, Mossey, and Killam (2013) conducted a study using 72 second-year nursing students to determine their view of impediments

to safety in the clinical setting. Q-methodology was used and a Q-sort activity was conducted with each student having 43 cards and a blank template. Participants were asked the extent in which they agreed with the statements based on the question, "It is most unsafe in the clinical setting when…" (Montgomery et al., 2013, p. 5). An introverted pyramid with 43 spaces was used and participants placed their cards with a single typed statement in the order in which they agreed with the statement from most agree (+5) to most disagree (-5). Three discrete viewpoints and one consensus viewpoint were identified.

The first viewpoint, "unprepared for role enactment" (Montgomery et al. 2013, p. 5), had 11 second year students share the viewpoint. Participants viewed it was most unsafe when students had knowledge deficits (5/+3), were unable to report a change in client condition (7/+4), and the student was unable to meet the standard of care (8/+3).

The second viewpoint, "unsupported learning" " (Montgomery et al. 2013, p. 6), was supported by nine students. Educators inability to guide learning in the clinical environment were highly ranked in the second viewpoint (22/+4), 27/+2, 38/+2).

Viewpoint three was "breached standards" " (Montgomery et al. 2013, p. 7). When students and educators failed to adhere to professional standards safety was most compromised according to 29 students. Working beyond a student's scope of practice (1/+5), and the educator encouraging students to work outside of their scope of practice (27/+5) were viewed as the highest risk of compromising safety in the clinical setting.

Perception of lack of standards. The consensus viewpoint was "patient protection" (Montgomery et al. 2013, p. 8). Several statements ranked similarly across all three viewpoints. Participants perceived it to be most unsafe when students could not protect a patient from harm

(18/+4 to +3), made repeated errors (11/+2 to +1), and the students inability to adapt care to a patient's needs (17/+1) were viewed as the most unsafe in clinical practice.

The findings of the Montgomery et al. (2013) study suggested that safety be a focus for students and that faculty have appropriate development and engagement in the clinical setting. Unprepared students and unprepared clinical faculty were viewed to compromise clinical safety. The findings further suggested that inexperienced students required more support and assistance from clinical faculty in order to maintain safety. Limitations of the study were that only one baccalaureate program was included in the sample and the sample was limited to second-year nursing students.

Student perception of students. Mossey, Montgomery, Raymond, and Killam (2012) conducted a study using 59 fourth-year baccalaureate nursing students to identify unsafe clinical practices. Q-methodology was used to make a Q-sort. Centroid factor analysis and varimax rotation were used to analyze the data.

Five student viewpoints about unsafe practice were identified in this study: "displaced student", "vulnerable student", "unprepared student", "unknowing student", and "distanced student" " (Mossey et al., 2012, p. 249). Displaced students were those who demonstrated dishonesty (6/+1), had repeated patterns of errors (3/+1), and those who have not been protective of their patients (18/+2). Those students were viewed as the most unsafe in clinical practice.

Vulnerable students were identified as those who were overwhelmed in the clinical setting (25/+2) and felt that they were taught by faculty who lacked competence (22/+4). Underprepared students were viewed as those who did not follow clinical guidelines (8/+3), lacked knowledge (5/+2), and avoided interacting with faculty (16/+1). Unknowing students were viewed as those who were unable to adjust care based on client needs (17/+4), a knowledge

deficit (5/+3), those who avoided faculty on the clinical unit (16/+0), and the uncertainty of the evaluation process (37+0/). Viewpoint four had similar rankings with other viewpoints and this was identified by the negative ranks. Distanced students were perceived as those who did not use evidenced-based practice (40/+3) and students who rushed through care (9/+2). Limitations of the study were that only one baccalaureate program was included in the sample and the sample was limited to fourth-year nursing students.

Preceptors' Perceptions

Clinical preceptors were used in the clinical setting to supervise undergraduate nursing students in their clinical experience. Luhanga et al., (2008a) indicated that preceptors provided feedback to nursing faculty on whether they believed a student "meets the standards delineated by the school or profession" (p. 1). In many situations, preceptors were used as students' progress to the end of their clinical rotation education. They were used to supervise students on a specific clinical unit when a faculty member is likely supervising students on several units and therefore is not in direct observance of each student at all times. Clinical preceptors differ from clinical faculty in that they are generally staff nurses who may or may not have advanced degrees. They are generally selected by nurse managers and given guidelines for what outcomes should be met within the clinical setting.

Emotional responses. A grounded theory study was conducted by Luhanga et al. (2008b) to explain how preceptors manage unsafe students. Participants in the study included 22 preceptors in the acute-care setting. The preceptors were working with final year students and included 20 females and two males, and two-thirds were prepared at the diploma level. When working with unsafe students preceptors reported their feelings as "relief, fear, anxiety, self-doubt, anger, and frustration" (Luhanga et al., 2008b, p. 229). Five preceptors reported that they

had failed a student. The results indicated that faculty had an easier time making decisions when they received support and guidance from full-time faculty and the university. While some preceptors felt guilt or self-doubt when making a decision to fail a student, some preceptors in the study indicated a sense of relief and assurance when failing an underperforming student. The findings indicated that faculty support was essential for preceptors when they were faced with making decisions about underperforming students (Luhanga et al., 2008b). Limitations of the study included a small sample size, and the fact that the sample was selected from an acute-care facility utilized during the students' final clinical placement.

Preparation and communication. Luhanga, Yonge, and Myrick (2008c) performed a grounded theory study about how preceptors teach or manage nursing students who exhibited unsafe practices. The participants were 22 preceptors in the acute-care setting. Participants were asked "How do you think students with unsafe practices should be dealt with? Having experienced precepting such a student, what recommendations would you make to other preceptors?" (Luhanga et al., 2008c, p. 215). The study results showed that all preceptors attempted to prevent unsafe practice from occurring. The preceptors familiarized themselves with the course, had clear expectations for students, and found it beneficial to review the expectations of students. Unsafe practice was identified through observations, and students observed to be practicing unsafely were watched more closely. Strategies recommended by those preceptors to help maintain a safe environment included "communicate the problem to the learner, develop a plan of action, communicate the problem to the faculty instructor" (Luhanga et al., 2008c, p. 216),

> if a major mistake occurs, interrupt and explain the correct approach, constant observation and allowance for gradual clinical independence, encourage students to

practice skills, question and give reading assignments, create an environment conducive to learning, give timely, specific, honest, ongoing, and constructive feedback in private, importance of self-evaluation, maintain a high standard of practice, seek external help (Luhanga et al., 2008c, p. 217),

and "remedial interventions and decision to fail" (Luhanga et al., 2008c, p. 218).

Limitations of the study included a small sample size, the fact that the sample selection was limited to one baccalaureate program, and that all participants were preceptors in the final clinical placement.

Summary

The shortage of nursing faculty has contributed to the nursing shortage (Kelly, 2010). The age of the population, the age of the RN workforce, and the Patient Protection and Affordable Care Act have been increasing the demand for nursing programs to produce larger numbers of new nurses (AOA, 2014; Budden et al., 2013; HRSA 2013; IOM, 2011; Juraschek et al., 2012). As faculty age, the number of younger nursing faculty has not been increasing to help replenish this population (Nardi & Gyurko, 2013). Noncompetitive salaries and budget cuts have made recruiting and retaining qualified faculty difficult for nursing programs (Bell-Scriber & Morton, 2009; McNeal, 2012)

Ensuring that patients remain safe and that student learning occurs has been a challenge within the clinical setting. Clinical faculty manage eight to 10 students in this environment, in many instances with little guidance and support (Benner et al., 2010; Tanicala et al., 2011). Clinical faculty have also been challenged by the grading and evaluation systems within this environment (Heaslip & Scammell, 2012). Clinical faculty have acknowledged that they have passed students who have performed inadequately within this setting (Black et al. 2014; Duffy,

2003; Gainsbury, 2010; Jervis & Tilki, 2011; Larocque & Luhanga, 2013). Student learning in the clinical setting has been influenced by competency and qualifications of their clinical faculty (Wong & Wong, 1987).

Clinical learning has been an important aspect of nursing practice with approximately half of students time spent in the clinical setting (Benner et al., 2010; Ironside et al., 2014). Clinical faculty have many expectations and responsibilities in the clinical setting. Faculty have been challenged with maintaining a safe environment while ensuring that student learning is occurring. Unclear expectations and uncertainty about grading procedures and evaluation processes have led faculty to pass, in some cases, underperforming students (Black et al, 2014; Brown et al., 2012; Duffy, 2003; Gainsbury, 2010, Jervis & Tilki, 2011). Underprepared clinical faculty have faced many challenges in the clinical environment.

CHAPTER 3: THEORETICAL FRAMEWORK

This chapter provides an overview of the two theoretical frameworks used to guide the study. Clinical nursing faculty have not only been teachers, they are also learners. As new faculty responsible for teaching student clinical groups, they must learn how to move students along toward meeting course learning objectives; managing multiple situations simultaneously, working within fast-paced, dynamic healthcare facilities; communicating with multiple healthcare team members; and keeping patients safe.

What and how clinical faculty have learned and what they believed was needed to learn about being a clinical faculty member would allow programs to make effective programs to prepare and develop faculty. Using the Delphi method helped to establish consensus on what clinical faculty have gained from preparation and support they received, and what they believed was needed for new clinical faculty regarding preparation and support. Two learning theories have been utilized to better understand how learners learn: Malcolm Knowles's adult learning theory and David Kolb's experiential learning theory.

Adult Learning Theories

The adult learner brings a vast amount of experience that creates a different teaching/learning process than that required by the child learner (Knowles, Holton, & Swanson, 2005). Knowles et al. (2005) described that throughout history there have been many great teachers of adults such as "Confucius and Lao Tse of China; the Hebrew prophets and Jesus in Biblical times; Aristotle, Socrates, and Plato in ancient Greece; and Cicero, Evelid, and Quintillian in ancient Rome" (p. 35).

Adult Learning Theory

Malcolm Knowles's adult learning theory focused on the learning processes of adults. Knowles defined adult learning as "the process of adults gaining knowledge and expertise" (Knowles, Holton, & Swanson, 2005, p. 174) and believed that there were differences between adult learners and learners under the age of eighteen (Knowles, 1975). The primary differences between adult learners and younger learners included that adult learners (a) were more self-directed, (b) have had a larger repertoire of experience, and (c) were more internally motivated to learn subject matter that can be applied immediately. Adult learners readily learned subject matter that was related to the developmental tasks of their job (Knowles, 1980). As adults grow within their life and profession, they continue to have learning needs. Each developmental milestone throughout one's career leads to a moment where the adult learner has become ready to learn. Knowles's theory emphasized that adults are self-directed and expected to take responsibility for their decision making (Merriam & Caffarella, 1999).

Knowles frequently used the term, *andragogy*, in his work. Andragogy was defined as "the art and science of helping adults learn" (Knowles, 1980, p. 43). Educators in the field of andragogy assume that adult learners have the need to know why they are learning something. Adults learn through doing. Adults are problem-solvers. Adults learn best when the subject is of immediate use (Merriam & Caffarella, 1999). Adult learners want to have control over the information they are learning and this allows an increase in the knowledge gained (Knowles et al., 2005). Knowles's work on the adult learner was based on six assumptions:

- Adults learn based on a need to gain new information;
- As a person matures, he or she moves from dependency to self-directness;
- The adult learner draws upon past experiences to aid in the learning process;

- The learning readiness of adults is closely related to the assumption of new social roles;
- As a person learns new knowledge, he or she wants to apply it immediately in problem solving; and
- As a person matures, he or she receives motivation to learn from internal factors (Knowles, 1984; Knowles et al., 2005).

New roles and environments. The transition from clinical expert to clinical faculty requires nurses to take on a new role. Knowles et al. (2005) stated "each boundary crossing thus creates a 'new' employee with unique learning needs that must be met in order for that employee to move to high performance" (p. 308). Knowles et al. stated that crossing into new roles required the employee to become familiar with a new culture. The two goals of new employees were (1) that they perform at a high level and (2) that they stay with the institution (Knowles et al., 2005).

Adult learning theory in nursing. The nursing faculty who teach in clinical settings are all adults and all with varying levels of experience in their own clinical practice. Nursing programs have identified needs of new clinical faculty and developed workshops and handbooks as a guide for new faculty (Bell-Scriber & Morton, 2009; Roberts et al., 2013; Pierangeli, 2006). However, understanding how the adult learner learns may influence the way new information is presented to clinical faculty.

As new clinical faculty enter the field of education there will be some degree of dependency on more experienced nursing faculty. With experience, novice faculty would gain independency in their new role. An ideal situation would include full-time faculty helping new clinical faculty learn their role. Unfortunately, many, full-time faculty have indicated that they

have workloads that prevent them from adequately mentoring new faculty (Bell-Scriber & Morton, 2009; Forbes et al., 2010).

The knowledge nurses bring into clinical education provides a foundation that enables them in the learning process. Knowles (1984) stated that adult learners were ready to learn when they identified a need to gain more information. Clinical faculty have drawn upon their past experiences in the clinical setting as expert clinicians (Heaslip & Scammell, 2012; Peters & Boylston, 2006; Pierangeli, 2006; West et al., 2009). Knowles's theory indicated that adult learners bring a vast amount of knowledge and experience into their new roles (Knowles, 1984).

Knowles (1984) indicated that when taking on a new role, adults have a readiness to learn because they need new information in order to perform. Knowles (1984) also indicated that in some cases, adults may need help in identifying the gaps in their knowledge and therefore, should be encouraged by having a good role model.

Full-time faculty who mentored new, part-time or adjunct clinical faculty were more effective in their supportive role if they understood the new faculty's motivations. Carlson (2015) identified several motivators, including a love for teaching, which is an internal motivator, and the income they received, which is an external motivator. Knowles (1984) considered internal motivators to be stronger than external ones.

Without formal education on clinical instruction, clinical faculty may only have their experiences to draw upon for guidance in decision making. This could include experiences from their education or from working with students in the clinical setting as staff nurses. Those experiences may be positive or negative.

In many ways, clinical faculty validated Knowles's adult learning theory in their role in the clinical setting. Many clinical faculty enter the clinical setting with little to no formal

instruction in how to educate students (Heaslip & Scammell, 2012; Peters & Boylston, 2006; Pierangeli, 2006; West et al., 2009). Crafting effective programs to educate clinical faculty would require an understanding of how adults learn and what they believe is most beneficial in helping them perform high quality work in their role as clinical faculty.

Experiential Learning Theory

The second theory framing this study is the experiential learning theory. David Kolb research has focused on learning styles and experiential learning. Kolb is a psychologist and educational theorist whose work with the experiential learning theory has been the focus of his 50-year academic career.

Kolb's theory was built on the work of Kurt Lewin, John Dewey, Jean Piaget and several others (Kolb, 2015). Kolb's definition of learning was "the process whereby knowledge is created through the transformation of experience" (Kolb, 2015, p. 49). According to the experiential learning theory, learning was a holistic experience operating at all levels.

Kolb's Six Propositions

Kolb's experiential learning theory was based on six propositions:

1. "Learning is best conceived as a process, not in terms of outcomes" (Kolb, 2015, p. 37);
2. "Learning is a continuous process grounded in experience" (Kolb, 2015, p. 38);
3. "The process of learning requires the resolution of conflicts between dialectically opposed modes of adaptation to the world" (Kolb, 2015, p. 40);
4. "Learning is a holistic process of adaptation to the world" (Kolb, 2015, p. 43);
5. "Learning involves transactions between the person and the environment" (Kolb, 2015, p. 45);

6. "Learning is the process of creating knowledge" (Kolb, 2015, p. 48).

The theory involves understanding the individuals learning styles and how this influences their perceptions. Clinical education is a form of experiential learning because it is based on real life experiences encountered in the clinical setting. Many clinical faculty come in as experienced clinicians; but are novices in the educational arena (Heaslip & Scammell, 2012; Peters & Boylston, 2006; Pierangeli, 2006; West et al., 2009). Therefore, their knowledge of nursing needs to be transformed from their use as an expert clinician to their role as clinical faculty, to meet the needs of students in the academic setting.

Experiential Learning Theory in Nursing

Nursing education takes a different approach from nursing practice. The experiential learning theory described learning as a process in which no two experiences will be interpreted the same way (Kolb, 2015). Clinical nursing faculty need the knowledge to help students translate their own personal experiences in the clinical setting into meaningful knowledge that can be applied throughout their education and career. Clinical nursing faculty need to help students apply information learned in natural and social sciences, humanities, and their nursing courses (Benner et al., 2010). Therefore, students leaving the clinical setting should be able to apply knowledge gained in past experiences to future encounters throughout their career.

Clinical faculty enter into their role with an idea of how education in the clinical setting should occur. With a lack of instruction in teaching, clinical faculty tended to use the teaching methods they were taught by (Bell-Scriber & Morton, 2009). This supports Kolb's assertion that "all learning is relearning" (2015, p. 39). Therefore, guiding clinical faculty through an orientation about learning theories may give clinical faculty a foundation on which to base new ideas about how to teach students.

In order for learning to occur, there must be resolution of conflict (Kolb, 2015). Killam et al. (2012) indicated that students perceived a disconnect between theory and practice. Benner et al. (2010) also noted that one major role of nursing faculty was to integrate theory and practice. However, "nursing education is fragmented" (Benner et al., 2010, p. 78). In many nursing programs, there have often been different faculty in the clinical setting, classroom, and skills lab. With that divide, students were required to adapt knowledge gained in the classroom to clinical practice (Benner et al., 2010). Roberts et al. (2013) indicated that clinical nursing faculty should be able to help students apply theory to clinical practice. One issue with the application of theory to practice has been that clinical nursing faculty with limited exposure on how to instruct students, often have a difficult time distinguishing from real world practice with student learning needs (Bell-Scriber & Morton, 2009).

Nursing is a profession that will require life-long learning (Laschinger 1990). Kolb (2015) indicated the process of learning was holistic and included "performance, learning, and development" (p. 45). Clinical nursing faculty will continue to learn in their role as clinical faculty.

Kolb's proposition that "learning involves transaction between the person and the environment" (2015, p. 45) is relevant to nursing education. Education in nursing occurs both in the classroom and clinical setting. Students learn through textbooks and nursing faculty in the classroom and then continue to learn in the "real-world" environment in the clinical setting (Kolb, 2015, p. 45).

Kolb's final proposition "learning is the process of creating knowledge" applies to the nature of education that must take place in nursing programs (Kolb, 2015, p. 49). The skills

needed to be a nurse differ from the skills needed to be nursing faculty. Clinical nursing faculty create a new body of knowledge to facilitate learning in the clinical environment.

Adaptive Learning Modes

"Students in the health professions share a common need to practice knowledge gained from classroom lectures and reading in actual concrete situation with clients" (Laschinger, 1990, p. 985). Throughout nursing education, learning is a process that is constantly changing based on personal experiences. Kolb (2015) described four steps in the cycle of adaptive learning modes: (a) *concrete experience*, (b) *reflective observation*, (c) *abstract conceptualization*, and (d) *active experimentation*.

Concrete experience and reflective observation allows the learner to comprehend or interpret the experience. In nursing education, understanding the student perspective and comprehending what the clinical experience is like for students will be necessary for novice clinical faculty to facilitate learning.

The abstract conceptualization stage is one in which the reflections are adapted into new concepts. In this stage the nursing faculty can generalize what is occurring in the clinical setting and reflect on the way situations are handled. Thus, allowing the clinical faculty to transfer knowledge.

Active experimentation represents the faculty's opportunity to apply the information they have learned as new situations arise. This is an ongoing process where faculty can continue to transfer their knowledge and adjust their actions based on the situations encountered.

Summary

Clinical nursing faculty have been challenged with working in a fast-paced, ever-changing clinical environment. When entering into their new role, clinical nursing faculty

become learners. Clinical faculty move students through the clinical, meeting course objectives, and maintaining patient safety. Through the use of a Delphi study, consensus was obtained on what type of preparation and support clinical faculty had when entering into their new role, and what they believed was needed to prepare and support new clinical faculty.

Malcolm Knowles's adult learning theory was based on six assumptions that the adult learner goes through when taking on a new role. Understanding the assumptions allows the adult learner to obtain new knowledge and apply it to their role. Allowing the adult learner, clinical faculty, to move from a state of dependency to being independent in their role. The support and preparation that clinical faculty had prior to entering the clinical setting and what they believed was needed for new clinical faculty would allow for programs to better meet the needs of this population.

According to Laschinger (1990) Kolb's experiential learning theory "appears to be a valid and useful model for instructional design in nursing education" (p. 991). The nursing profession requires lifelong learning (Laschinger 1990). The six propositions of the experiential learning theory help to understand how the theory takes a holistic approach and how learning is adapted throughout life experiences. Through the cycles of adaptive learning, clinical faculty have transformed their clinical expertise knowledge to meet the demands of nursing students in the clinical setting. Herrmann (1997) indicated that experience allowed clinical nursing faculty to feel more confident in their role.

CHAPTER 4: METHODOLOGY

In this chapter, the research methodology is described. The design was chosen to elicit information that would contribute to the literature about what preparation and support undergraduate clinical faculty have prior to entering the clinical setting and what they believed was needed to adequately perform their job. This chapter will address the following elements: (a) research design; (b) research questions; (c) sample (Round 1); (d) research instruments (Round 1); (e) data collection (Round 1) and data analysis (Round 1); (f) sample (Round 2); (g) research instruments (Round 2); (h) data collection (Round 2); (i) data analysis (Round 2); (j) study assumptions and limitations; and (k) ethical considerations.

Research Design

A Delphi method was used to conduct this study. The Delphi method allowed for anonymous communication to occur that achieved consensus on a real problem (Hsu & Sandford, 2007). The Delphi technique was chosen because it allowed for consensus building on what clinical nursing faculty believed was needed for preparation of clinical instruction (Barnette, Danielson, & Algozzine, 1978).

The Delphi method was appropriate when the problem could not be defined using logical techniques and the researcher believed gathering subjective information from experts and those working in the field was necessary (Stitt-Gohdes & Crews, 2004). This was the case regarding the issue of educational and developmental needs of clinical nursing faculty. In addition, the Delphi method has become more commonly used in nursing (Hasson, Keeney, & McKenna, 2000). McKenna (1994) described this research method as a successful survey method in nursing education.

The clinical setting has been an important learning environment for nursing practice (Benner et al., 2010; Ironside et al., 2014; Koharchik, 2014). Nursing programs have shifted to using ever greater numbers of part-time clinical faculty to augment the numbers of full-time faculty with clinical teaching assignments (Gazza & Shellenbarger, 2010; Nardi & Gyurko, 2013; Roberts et al., 2013). Little research has been published reporting studies that addressed the preparation needed for clinical instruction (Allison-Jones & Hirt, 2004; Gies, 2013; Hewitt & Lewallen, 2010; Peters & Boylston, 2006). Without evidence on which to base their practice, clinical faculty have been at a significant disadvantage when facilitating instruction and evaluating students in the clinical setting (Crocetti, 2014; Davidson & Rourke, 2012).

This study included a two-round Delphi process. In Round 1 of the process, clinical faculty experts answered a student investigator developed, nine question open-ended survey. Those questions were developed based on the current literature related to the education and preparation of clinical nursing faculty and their ability to provide targeted support and feedback. The responses were analyzed and used to develop a quantitative survey that was administered to clinical nursing faculty participants in Round 2 of the study (Hasson et al., 2000). Through this process, a consensus was developed regarding what preparation and support expert clinical faculty believed was needed to facilitate learning in the clinical setting.

Research Questions

Three research questions were developed that included the variables of the type of training clinical faculty received prior to becoming a faculty member in the clinical setting and part-time and full-time faculty's opinions about what they received and what they needed.

1. What preparation and support do part-time and full-time undergraduate clinical nursing faculty receive prior to assuming their clinical teaching responsibilities?

2. What preparation and support do part-time and full-time undergraduate clinical faculty believe they need in order to adequately prepare students for clinical practice?
3. Are there differences between the perceived preparation and support needs of part-time and full-time undergraduate clinical faculty prior to assuming their clinical teaching responsibilities?

Research Process

The Delphi method was used to gain consensus by obtaining the opinions of experts in the field (Loughlin and Moore, 1979). Barnette et al. (1978) described the most common technique for a Delphi study was the use of open-ended questions asked to a panel of experts to elicit their opinion on a topic. The panel of experts' opinions were used to help develop the survey which was then distributed to a group of participants. In the Delphi process, Barnette et al. (1978) indicated that the typical number of rounds is two or three.

Sampling for Round 1

Round 1 used purposive sampling of experts in the field of nursing. Purposive sampling was an appropriate sampling technique in this Delphi study because the participants chosen all met the criteria for expert in the study (Hasson et al., 2000). Hasson et al. (2000) stated that experts are chosen for a purpose and this allows for knowledge to be obtained based on the problem being addressed. For this study, the working definition of the term *expert* was operationally defined as (a) clinical practitioners, clinical faculty, and/or theory faculty working at an institution of higher education, and (b) have taught at least four clinical groups over the past five years, in any acute care setting, and (c) have been an RN for at least five years.

Since this design included surveying experts, purposive sampling was appropriate for the study. The quality of a Delphi study depends on the experts chosen (Hsu & Sandford, 2007),

because they provide keen insight into the specific needs of a particular field and the direction(s) that field is heading. The Delphi method does not include specific criteria for choosing experts; however, individuals who have experience and expertise in nursing education would yield the trends developing within that field.

Experts were recruited for the study using purposive sampling techniques. The number of participants for a Delphi study can vary significantly (Hsu & Sandford, 2007; Mangan, 2011). Powell (2003) stated that the success of a Delphi study results from the "panel size and the qualification of the experts" (p. 378). Reid (1988) explained that expert panels can range from 10 to 1685. Murphy et al. (1998) stated "there is very little actual empirical evidence on the effect of the number of participants on the reliability or validity of consensus processes" (p. 37). Ludwig (1997) indicated that most Delphi studies have used approximately 15-20 experts.

The experts in Round 1 were asked to participate in the study. A total of 21 surveys were sent to expert clinical nursing faculty throughout the United States using purposive sampling. Experts were chosen by the student investigator because they met the criteria of expert for this Delphi study. The surveys were sent using Qualtrics, a survey software. Experts received an email explaining the study with a link provided to begin the study if they chose to participate. Informed consent was provided by selecting next within the survey.

Research Instrument for Round 1

Round 1 of the Delphi used a student-investigator developed, nine-question open-ended survey based on information identified in the literature review. The questions were structured and unchanged throughout the process (Glesne, 2011). The focus of Round 1 was to generate a large amount of data on what was needed for the preparation and support of undergraduate

clinical faculty. The demographic survey and questions used in Round 1 are found in Appendix A and in Appendix B respectively.

Data Collection and Analysis for Round 1

Participants in Round 1 answered open-ended questions. Streubert and Carpenter (2011) described written survey responses as a good technique because it allows participants time to think about their responses. The advantages to this data collection method was lower costs because information would not need be transcribed by the researcher at the time of data collection (i.e., like an interview); however, the limitations would be the "lack of spontaneity in responses" (Streubert & Carpenter, 2011, p. 40).

During Round 1, data collection and data analysis occurred simultaneously. As responses were returned from experts, data was analyzed. Experts were asked to provide an email address if they were willing to review the results to confirm accuracy. Eleven experts (73%) provided email addresses. To confirm accuracy, statements from the open-ended questionnaire were compiled and returned to the eleven experts who chose to leave their email address. The panel of experts had the opportunity to provide feedback to ensure that the statements accurately reflected what preparation and support they believed clinical faculty needed in order to perform their job. Content analysis and frequency counts of particular words, phrases, or groups of words were identified and those items with a frequency count of four or more were used to develop the survey for Round 2.

Polit and Beck (2008) defined credibility as the "confidence in the truth of the data and interpretations of them" (p. 539). Credibility was established when findings were returned to the panel of experts and they confirmed the statements were the experiences and information they described. An audit trail was maintained (Streubert & Carpenter, 2011).

Sampling for Round 2

Round 2 participants were selected using convenience sampling of nursing faculty at accredited academic institutions in a Midwestern state in the U.S. No minimum number of participants was required for use of the Delphi method in a study design. If the group being studied was homogeneous, a smaller size may be adequate (Skulmoski, Hartman, & Krahn, 2007). Because a diverse sample of full-time and part-time clinical nursing faculty was sought, faculty from nursing programs accredited in the state were asked to participate. The academic institutions were accredited by the Commission on Collegiate Nursing Education (CCNE), the National League for Nursing (NLN), and/or and the National League for Nursing Commission for Nursing Education Accreditation (CNEA). Participants in Round 1 were able to participate in Round 2 because a different survey instrument was used, and this was acceptable for Delphi studies. In order to support the validity of the statistical analyses, 30 participants from both full-time and part-time clinical faculty were needed.

Round 2 participants were clinical faculty members who instructed clinical at an academic institution in a Midwestern State. Lists of academic institutions accredited by the CCNE, NLN, CNEA were obtained through their websites. Once the academic institutions were identified, a search was conducted for the deans/directors of the academic institutions being surveyed. An email was sent to the deans/directors of each nursing program explaining the study and asking them to forward the email to their faculty. A link within that email allowed faculty to access the survey. A follow-up email was sent weekly after the initial email was sent to the deans/directors of the nursing program reminding participants about the survey. The data collection period lasted for five weeks.

Obtaining an exact number of clinical nursing faculty that received the survey was not possible. The method was chosen so that both part-time and full-time faculty could be reached. After two weeks of data collection, only 20 surveys were returned. Due to the poor response rate after the first two weeks of data collection, a modification request was made to the Institutional Review Board (IRB) to contact faculty directly using their nursing programs website to obtain email addresses. More than 300 surveys were sent to deans/directors and faculty. A total of 86 surveys were returned. The original surveys collected included 49 full-time faculty, 35 part-time/adjunct faculty, and two faculty who did not indicate whether they were full-time or part-time/adjunct faculty. Data was reviewed for completeness and it was determined that surveys with missing data would remain as long as some portion of the Likert scale survey had been completed. After cleaning the data to meet this criterion, a total of 77 surveys were used for analysis. This included 45 (58.4%) full-time faculty and 32 (41.6%) part-time/adjunct faculty. Nine surveys were unable to be used because two did not identify with full-time or part-time/adjunct faculty, three indicated that they had not taught in a clinical in the last 12 months, and three did not answer any of the Likert scale questions on the survey.

Research Instrument for Round 2

In Round 2, participants received a forwarded email from the deans/directors of their nursing program. In the email, information about the study and a link to the survey were provided. The letter asked clinical nursing faculty who have taught in a clinical course within the last year to consider participating in the study (see Appendix J). If clinical nursing faculty chose to participate they selected the link within the email, participants reviewed the informed consent and if they chose to participate clicked the next button to continue to the survey. Opening the link to the survey implied informed consent. Faculty began by filling out a

demographic section and then completing the Likert scale survey. The surveys were designed specifically for this study. The demographic survey asked if faculty had taught in a clinical course within the last 12 months. If faculty answer "No" then their survey was excluded. Ensuring that faculty had taught in a clinical course within the past 12 months allowed for the most current information to be collected in the study.

Data Collection for Round 2

All the questions asked in Round 2 were based on data collected in Round 1. Independent variables included the demographic information obtained, including age, gender, race/ethnicity, educational background, focus of graduate education, employment status, number of years as clinical faculty, area of clinical instruction, grading system used in clinical course, the use of clinical evaluations, opportunities for professional development, and reasons for taking on the role as undergraduate clinical faculty. Dependent variables were the perceptions about the type of training faculty believed would be most helpful for clinical instruction and the differences in the training they received.

Qualtrics, a survey software, was used to create the survey, conduct the research, and store the data. The student investigator, principal investigator, and statistician were the only researchers who had access to the data. No identifiers were attached to the survey. All information submitted through the survey remained anonymous.

After the participants completed the demographic information a survey using a Likert scale was administered. The first part of the survey asked participants to rate their level of agreement with the variables identified by the expert panel in Round 1 of the survey. Participants were provided with a 5-point Likert scale that asked them to indicate their beliefs about the importance of each variable (5 = strongly agree, 4 = agree, 3 = neither agree nor

disagree, 2 = disagree, 1 = strongly disagree). The instructions for the second part of the survey asked participants to prioritize the variables they believed were the most important. This priority ranking would help inform nursing educators about the most important things to include in the preparation of clinical nursing faculty members by basing these decisions on the opinions of experts (Hsu & Sandford, 2007).

Data Analysis for Round 2

The quantitative data obtained in Round 2 was analyzed using descriptive and inferential statistics. Measure of central tendency were used for the descriptive statistics. This included means, medians, and modes (Hasson et al., 2000). Levels of dispersion were also analyzed, which included standard deviations (Hasson et al., 2000). The demographic data collected was analyzed using descriptive statistics.

The inferential statistics used was the independent *t*-test. An independent *t*-test provided information on whether group means differed from two independent samples in the study (Field, 2013). According to Field (2013) an independent *t*-test allows for the comparison of an overall mean between two independent samples.

Study Assumptions

Polit and Beck (2008) defined an assumption as "a principle that is accepted as being true based on logic or reason, without proof" (p. 748). The design of the study allowed for the following nine assumptions:

1. In many situations, newly hired clinical faculty, both full-time and part-time, have begun their positions without experience or knowledge about the academic setting (Crocetti, 2014).

2. Many new clinical faculty were expert clinicians, but have little knowledge of what students need to learn in the clinical setting (Peters & Boylston, 2006).
3. New clinical faculty, with lack of guidance, teach like they were taught (Bell-Scriber & Morton, 2009; Mossey et al., 2012).
4. There is a lack of adequate orientation programs and support for clinical faculty which has compromised nursing program's ability to develop and maintain clinical faculty (Dahlke et al., 2012).
5. The role of clinical faculty has been complex and misunderstood; therefore the role is undervalued (Dahlke et al., 2012).
6. Clinical faculty were failing to fail students who were underperforming in the clinical setting (Brown et al., 2012; Duffy, 2003; Gainsbury, 2010; Jervis & Tilki, 2011).
7. It has been difficult to find qualified clinical faculty (AACN, 2014; Oermann, 2004).
8. Failing a student in the clinical setting has been a difficult process (Larocque & Luhanga, 2013; Luhanga, Yonge, & Myrick, 2008a; Scanlan et al., 2001).
9. Nursing program's clinical evaluation methods were difficult for both full-time and part-time/adjunct clinical faculty to use, making the decision to fail a student even more difficult.

Due to all those factors and with the substantial use of part-time/adjunct clinical faculty, unsafe students have been passed through clinical courses due to the clinical faculty's lack of knowledge and guidance to support learning and evaluate students. Nursing programs have been hiring under-qualified clinical faculty to meet the demand, in turn, those clinical faculty may be

passing underperforming students (Heaslip & Scammell, 2012; Roberts et al., 2013; Whalen, 2009).

Limitations

Limitations are areas of weakness in the design or conduct of the study. Sampling limitations included a small population of research sites. Round 2 surveys were sent to accredited academic institutions in one Midwestern state. The limitation in the sample population affected the generalizability of the study. With participation being self-selected, faculty may choose not to participate for various reasons, which may skew the results.

The limitations of the study design included the use of electronic surveys. It would be impossible to assure that every dean/director of each nursing program forwarded the survey to his/her faculty or that all faculty received a survey based on the faculty listings on each nursing program website. With follow-up emails being sent to all deans/directors of accredited nursing programs, it would be difficult to discern if faculty completed the survey more than once.

The questionnaire in Round 1 was based on information obtained in the literature review and developed by the student investigator. The survey in Round 2 was developed based on the consensus of items obtained by the panel of experts in Round 1. Both instruments had a potential lack of reliability. Hasson et al. (2000) stated that it was difficult to establish the reliability of a study when using the Delphi method because sampling a different population may yield different results. The limitations were considered when interpreting the findings.

Ethical Considerations

Ethical considerations were maintained throughout the study. A university IRB approved the study, electronic informed consent was obtained from participants, and confidentiality was maintained for all participants involved.

Institutional Review Board

Prior to data collection, IRB approval was obtained through the University of Nevada, Las Vegas. The purpose of the IRB is to ensure the rights of participants were protected throughout the study (Polit & Beck, 2008). The responsibility of the IRB was to ensure that minimal risk would occur to participants, informed consent was obtained and appropriately documented, and privacy and confidentiality were maintained. Approval was obtained for both Round 1 and Round 2 of the Delphi study. Additional changes were made in Round 2 to contact faculty directly and extend the data collection period by three weeks and approval was obtained for all changes made.

Informed Consent

Informed consent was obtained from participants in both rounds of the study prior to beginning. Participants were given information regarding the study and chose to participate on their own free will. In Round 1, the panel of experts gave consent when they clicked next and started the open-ended questionnaire. In Round 2, participants gave consent when they began the survey. The participants received information about the study and were able to consent voluntarily to participation (Streubert & Carpenter, 2011). After participants read the letter regarding the study, informed consent was implied by clicking the next button and moving on to the survey.

Confidentiality

Confidentiality and privacy were maintained throughout the study. This was essential so that participants believed that they could provide insight and suggestions for improvement in clinical education without negative consequences. In Round 1, information was returned to the

panel of experts to confirm accuracy. No individual identifiers were used when statements were returned.

Qualtrics was used to create the survey, conduct the research, and store the data. This allowed for confidentiality to be maintained. The panel of experts in Round 1 and clinical nursing faculty in Round 2 completed surveys online which removed bias and allow for privacy when participants were completing the questionnaire and survey.

Summary

The Delphi method was used to address the research question: What preparation and support do undergraduate clinical faculty have prior to entering the clinical setting and what do they believe is needed to adequately perform their job? This method allowed for consensus building with a panel of expert clinical faculty. The study used two rounds to collect data. Round 1 included the administration of an open-ended questionnaire to a panel of experts. Round 2 included the administration of a Likert scale survey developed from the consensus reached by the panel of experts in Round 1. Round 1 data was analyzed using frequency counts and data analysis. Round 2 data was analyzed using descriptive and inferential statistics. The study assumptions and limitations have been identified. Ethical considerations were maintained throughout the study.

CHAPTER 5: RESULTS

In this chapter, the results of the study are described. A Delphi study was conducted using a total of three rounds (Round 1, 1.5, and 2) to elicit information that would contribute to the literature about what preparation and support undergraduate clinical faculty have prior to entering the clinical setting and what they believed was needed to adequately perform their job. This chapter will address the following elements: (a) Delphi Round 1, (b) Delphi Round 1.5, (c) Delphi Round 2, and the (d) research question results.

Delphi Round 1

The first round in the Delphi study included surveying a panel of clinical nursing faculty experts. Experts were recruited using purposive sampling. A total of 21 surveys were sent to potential clinical nursing faculty experts across the U. S.

Participant Descriptors

Clinical nursing faculty were considered experts if they were (a) clinical practitioners, clinical faculty, and/or theory faculty working at an institution of higher education, and (b) have taught at least four clinical groups over the past five years, in any acute care setting, and (c) have been an RN for at least five years. Round 1 used a survey with nine open-ended questions (see Appendix B).

A total of 21 surveys were sent to potential experts and 15 surveys were returned for a response rate of 71%. All participants were asked to provide demographic, educational, and employment information. The results are shown in Table 2.

Table 2

Round 1 Panel of Experts Demographic Descriptors

Descriptor Category	*n*	%	*M*
Nurse Educator Employment Status			
Full-time	12	80	
Part-time	2	13.3	
Adjunct	1	6.7	
Primary Clinical Instruction Area			
Medical/Surgical	13	86.6	
Maternal/Child	1	6.7	
Critical Care	1	6.7	
Experience as Nurse Educator			
Years as a Registered Nurse			10.87
Years with student clinical groups			12.73
Clinical groups taught within past 5 years			23.33

Note. *n* = raw number; *M* = median.

Aggregated Responses

Round 1 of the Delphi included 15 clinical nursing faculty experts in the U.S. The experts provided 315 unique responses. Nine open-ended questions were included in the survey (see Appendix B). Question 1 had 35 responses, Question 2 had 30 responses, Question 3 had 44 responses, Question 4 had 30 responses, Question 5 had 29 responses, Question 6 had 48 responses, Question 7 had 24 responses, Question 8 had 47 responses, and Question 9 had 28 responses.

The responses from the open-ended questions were compiled into comprehensive lists according to the question. Data was analyzed using frequency counts. The aggregated responses were assigned a value based on the number of responses that correlated. The items were placed in order and any item with a frequency count of four or more was used in the development of the

Round 2 survey. Table 3 represents the aggregated responses from the nine open-ended questions asked of the panel of clinical nursing faculty experts.

Table 3

Aggregated Responses with Frequency Counts of Four or More

Topic of Inquiry	Most Frequent Responses	*n*
Training and support received		
	From a colleague	7
	Received no training	4
	Met with course coordinator or course lead	4
Beneficial or needed resources (3)		
	Expectations	11
	Mentor	5
	Evaluation process	5
	Hospital orientation	5
	How to handle difficult students	4
Clinical setting concerns		
	Safety	15
	Clinical placements	15
	Communication	4
Supporting communication systems		
	Email, phone, text	12
	Course lead in charge of communication and available to faculty	6
Communication concerns (3)		
	Meetings on a regular basis	4
	Consistency	13
	Lack of knowledge and support	7
Suggested communications improvements		
	Communication	4
	Consistency/Communication	10
	Everyone's input	5
Method of constructive feedback to students		
	Clinical orientation	5
	Verbal	19
	Written	10
Resources needed for constructive feedback to students (3)		
	Evaluations	8
	Communication	13
	Clinical evaluations	12
Concerns re clinical evaluation process		
	Training/orientation	4
	Handbook	4
	Clinical evaluations too abstract	14
	Time	6
	Dilemmas	5
	Faculty knowledge	5

Note. *n* = raw number of responses.

The first question on the open-ended survey asked the experts to: "Describe the training and support you were given to teach in the clinical setting (e.g. types of training, length of education received)." A total of 35 unique responses were collected. Of the 16 aggregated responses, three had a frequency count of four or more. The three items included: received training and support from a colleague, received no training, and met with the course coordinator or course lead.

The nine questions used in the open-ended survey are listed and followed by the range of aggregated responses in Table 4. For example, question 1 had responses that were indicated by only one expert to responses that were indicated by seven experts. When reviewing the frequency counts, the low end range helped to establish a cut-off for items.

Table 4

Aggregated Responses with Frequency Count Ranges for Statements and Imperatives

Statements and Imperatives to Which Participants Responded	Frequency Count Ranges
Describe the training and support you were given to teach in the clinical setting	1-7
List three resources you believe you need, or would benefit other faculty, who are teaching in the clinical setting	1-11
Having a clear understanding of the clinical evaluation process is necessary for me to perform my job as clinical nursing faculty	1-15
Describe the communication systems in place between you and the nursing program you work for that support you in completing your job	1-12
List three concerns you have with the communication between the nursing program you work for and clinical faculty	2-13
List any suggestions you have for improving communication between the nursing program you work for and clinical faculty	1-10
How do you provide constructive feedback to students regarding their progress towards program objective mastery in the clinical setting	2-19
List three resources (e.g. trainings, tools) that you think you need to communicate constructive feedback to students in the clinical setting	1-13
List three concerns you have with the process of clinical evaluation of students	3-14

Note. Aggregation was based on qualitative analysis of responses.

Delphi Round 1.5

Round 1.5 began after completion of Round 1. The experts in Round 1 were asked at the end of the nine question open ended survey to provide an email address if they were willing to be contacted to confirm the accuracy of the statements compiled from the data in Round 1. After data analysis, experts who provided an email address were contacted through Qualtrics.

Participants

Eleven of the 15 clinical nursing faculty experts provided an email address to be contacted after the frequency counts and content analysis were completed for Round 1. Eight of the eleven (72.7%) experts that provided email addresses participated in Round 1.5. Participants were aware that the confirmation statements would be sent to their email addresses about two weeks after data collection ended for Round 1.

Determining Accuracy

Round 1.5 was used to determine the accuracy of the statements developed from the aggregated responses in Round 1. To confirm the accuracy of each statement, the eleven experts who included their email address were contacted through Qualtrics. Each open-ended question asked in Round 1 was listed and under the question were the responses that would be included in the Round 2 survey with a text box. The experts were asked to review each statement for relevance and accuracy. The text box under each statement allowed the experts to provide feedback on whether the statements accurately described the information they had provided in Round 1 of the survey. The experts were informed that the statements would be used for a Likert scale survey in Round 2 of the Delphi study.

Experts were asked whether they believed the statements were relevant and appropriate to the preparation and support needed for undergraduate clinical nursing faculty. Experts were also

encouraged to make any additional comments regarding the statements in the text box below each item. One expert thought that a wording change should be made and the word *ongoing* should be used instead of *continuous* in the statement, "New clinical faculty need continuous communication from the nursing program." That was the only suggestion for change. Seven of the eight (87.5%) experts who participated in Round 1.5 responded that they agreed with the accuracy of the statements and had no changes; therefore, no changes were made in the statements.

Delphi Round 2

Round 2 Likert scale surveys were developed from the data collected in Round 1. Participants in Round 2 were clinical nursing faculty from a Midwestern State. An email was sent to the dean/director of each nursing program explaining the study and asking them to forward the email to their faculty. A link within that email allowed faculty to access the survey. Because a diverse sample of full-time and part-time/adjunct clinical nursing faculty was sought, faculty from nursing programs within the Midwestern state accredited by the CCNE, NLN, and CNEA were asked to participate. Originally emails were sent to the deans/directors of their nursing programs to allow for contact with both full-time and part-time clinical nursing faculty. After only a small number of surveys were returned, modifications were made to IRB requesting to contact faculty directly from the email addresses listed on their nursing programs websites.

Participant Descriptors

Clinical nursing faculty were asked to participate in Round 2 if they had taught in at least one student clinical group within the past 12 months. All participants were asked to provide demographic, educational, and employment information. The results are shown in Table 5.

Table 5

Round 2 Clinical Nursing Faculty Descriptors

Demographic Descriptors								
Age Group	*n*	%	Gender	*n*	%	Race/ Ethnicity	*n*	%
25-34	6	7.8	Male	3	3.9	White	75	97.4
35-44	15	19.5	Female	74	96.1	Black/African American	2	2.6
45-54	23	29.9						
>55	33	42.9						

Professional Descriptors					
Educational Level Achieved	*n*	%	Educational Focus	*n*	%
Bachelor's	1	1.3	Nursing Education	49	63.6
Master's	58	75.3	Advanced Practice	11	14.3
Doctor of Nursing Practice	4	5.2	Other	16	20.8
Doctor of Philosophy	11	14.3	Missing	1	1.3
Other (Ed.D.)	3	3.9			

Note. *n* = raw number.

Survey Development

Round 2 of the Delphi study was developed based on the aggregated responses identified in Round 1 with four or more similar responses. The items were then organized into 11 prompts: support, training, resources, concerns, communication support, communication between faculty and program, improving communication, orientation, providing feedback, communicating constructive feedback, and clinical evaluations (See Appendix L).

Survey Distribution

Surveys were sent to deans/directors of 68 nursing programs accredited by the CCNE, NLN, and CNEA in a Midwestern state. Deans/directors of those programs were asked to forward the survey to their faculty. One school did not have an undergraduate nursing program and one school stated that the survey would not benefit their faculty and for this reason would

not forward it to their faculty. A total of 86 surveys were returned and 77 of those surveys were able to be used in the analysis.

Likert Scale

A Likert scale survey was used and clinical nursing faculty were asked to indicate their level of agreement or disagreement with each aggregated response (1-strongly disagree, 2-disagree, 3-neither agree nor disagree, 4-agree, 5-strongly agree). The Likert survey consisted of 76 items based on the aggregated responses from Round 1. After completing the Likert scale portion of the survey, clinical nursing faculty were asked to rank the seven variables that were described the most by the clinical nursing faculty experts in Round 1. The participants were instructed to rank the seven variables in order of highest to lowest priority on what they believed was most important for developing clinical nursing faculty. Those variables included support, training, resources, communication, the expectations on the role of clinical nursing faculty, clinical evaluations, and knowledge about maintaining safety.

Research Question Results

The data analysis was completed to assist in answering the three research questions of the study. Data from the 15 experts in Round 1 and the 77 participants in Round 2 were used to answer the research questions.

Question 1

The first research question addressed: What preparation and support do part-time and full-time undergraduate clinical nursing faculty receive prior to assuming their clinical teaching responsibilities?

This question was initially answered by the experts in Round 1. Round 1 experts described that they received training and support from colleagues, meeting with the course

coordinator or course lead, verbal/written instructions, shadowing other faculty, reading books and articles about the role of clinical faculty, receiving a brief overview of their role, education they received in their master's degree programs in nursing education, through informal orientations, formal clinical and hospital orientations, formal college orientations, and their previous experience as staff RNs.

The average summary scores for the eleven clinical nurse educator domains were examined, comparing those with an educational background in nursing education (63.6%) with those whose educational focus had been in advanced practice nursing (14.3%) or some other area of nursing (20.8%). Those groups did not differ significantly on any of the domains that were highlighted by the panel of expert clinical nursing faculty. *T* values ranged from -.09 to 1.93, *p*'s > .05 (see Appendix M). The means and standard deviations for those test can been seen in *Appendix M*.

Comparisons were made regarding the support given to clinical faculty between the clinical nursing faculty who had a nursing education background and the group with advanced practice or other educational focuses. There was a significant difference between the group that had a nursing education background and the group with advanced practice or other background, $t(74) = 2.35$, $p = .022$. Those with a nursing education background reported that they were more likely to use a colleague as a primary resource than those without a nursing education background (nursing education: $M = 4.57$, $SD = .82$; other nursing: $M = 4.07$, $SD = 1.0$). Table 6 represents the independent t-test comparing the variable support and descriptive statistics can be found in *Appendix N*.

Table 6

Support Source Variable: Independent t-tests by Nursing Education Background

Primary Source of Support	*t(74)*	Sig.
Colleague	2.35	.022*
Assigned mentor	1.56	.123
Course coordinator or faculty lead	-.253	.801

Note: t(df) = independent *t*-test and degrees of freedom for a comparison of educational background; Sig. = significance at the < .05 level.

The second summary variable focused on training clinical faculty received. Three significant differences emerged between those who studied nursing education and those who studied other nursing areas. The nurse educator group reported more relevant content in their original training $t(74) = 4.09$, $p = .000$, that they had received more verbal instruction $t(74) = 2.11$, $p = .038$, and that they had received a brief overview of the clinical faculty role $t(42) = 2.38$, $p = .022$, than those who studied other nursing areas. Table 7 represents the independent *t*-tests for training by nursing education background and descriptive statistics for training be found in *Appendix N*.

Table 7

Training Variable: Independent t-tests by Nursing Education Background

Training	*t(df)*	Sig.
Had no formal training.	.292(74)	.771
Had a formal orientation to my role and responsibilities.	-.908(74)	.367
Had content presented in my educational preparation	4.091(74)	.000*
Received verbal instruction.	2.107(74)	.038*
Received written instruction.	.539(74)	.592
Received a brief overview of clinical faculty role.	2.379(42)	.022*
Relied on experience from previous work as a staff nurse.	.468(74)	.642

Note: t(df) = independent *t*-test and degrees of freedom; Sig. = significance at the < .05 level.

The third summary variable indicated how beneficial resources would be to faculty in the clinical setting. Faculty with a nursing education background were compared to faculty with advanced practice backgrounds or some other area of nursing. Those groups did not differ significantly on any of the Likert scale items that were highlighted by the panel of expert clinical nursing faculty. *T* values ranged from -.496 to 1.336, *p*'s > .05 (see Appendix O). The means and standard deviations for those tests can be seen in *Appendix N*.

The fourth summary variable indicated faculty's agreement or disagreement with several concerns in the clinical setting. Faculty with a nursing education background were compared to faculty with advanced practice backgrounds or some other area of nursing. Those groups did not differ significantly on any of the Likert scale items that were highlighted by the panel of expert clinical nursing faculty. *T* values ranged from -1.391 to 1.356, *p*'s > .05 (see Appendix O). The means and standard deviations for those tests can be seen in *Appendix N*.

The fifth variable indicated how the communication systems in place between clinical nursing faculty and the nursing program they work for support them in completing their job. Faculty with a nursing education background were compared to faculty with advanced practice backgrounds or some other area of nursing. Those groups did not differ significantly on any of the Likert scale items that were highlighted by the panel of expert clinical nursing faculty. *T* values ranged from -.556 to 1.714, *p*'s > .05 (see Appendix O). The means and standard deviations for those tests can be seen in *Appendix N*.

The sixth variable indicated how clinical faculty felt about the communication with the nursing program. Faculty with a nursing education background were compared to faculty with advanced practice backgrounds or some other area of nursing. Those groups did not differ significantly on any of the Likert scale items that were highlighted by the panel of expert clinical

nursing faculty. *T* values ranged from -1.088 to 1.740, *p*'s > .05 (see Appendix O). The means and standard deviations for those tests can be seen in *Appendix N*.

The seventh variable indicated how clinical faculty believed communication could be improved. Faculty with a nursing education background were compared to faculty with advanced practice backgrounds or some other area of nursing. Those groups did not differ significantly on any of the Likert scale items that were highlighted by the panel of expert clinical nursing faculty. *T* values ranged from -.319 to .985, *p*'s > .05 (see Appendix O). The means and standard deviations for those tests can be seen in *Appendix N*.

The eighth variable indicated the usefulness of clinical orientation. Faculty with a nursing education background were compared to faculty with advanced practice backgrounds or some other area of nursing. Those groups did not differ significantly on any of the Likert scale items that were highlighted by the panel of expert clinical nursing faculty. *T* values ranged from -.665 to 1.319, *p*'s > .05 (see Appendix O). The means and standard deviations for those tests can be seen in *Appendix N*.

The ninth variable indicated how clinical faculty gave feedback to students regarding their progress towards program objective mastery in the clinical setting. Faculty with a nursing education background were compared to faculty with advanced practice backgrounds or some other area of nursing. There was a significant difference between the group that had a nursing education background and the group with advanced practice or other background, $t(36.49) = 2.04$, $p = .049$. Those with a nursing education background reported they were more likely to provide written clinical evaluations for each student than those without a nursing education background (nursing education: $M = 4.71$, $SD = .442$; other nursing: $M = 4.39$, $SD = .739$). The *t*-tests and descriptive statistics can be seen in Table 8.

Table 8

Providing Feedback Variable: Independent t-test and Descriptive Statistics by Educational Background

Providing Feedback	Educational Background	*N*	*M(SD)*	*t(df)*	Sig.
Constructive feedback is provided to students with the use of verbal communication.	Nursing Education	49	4.52(.604)	1.242*(74)*	.217
	Advanced Practice Nursing/Other	27	4.35(.476)		
Concerns regarding student performance are verbally communicated to students.	Nursing Education	49	4.47(.637)	.897*(74)*	.373
	Advanced Practice Nursing/Other	27	4.35(.476)		
Clinical faculty document written feedback on each student weekly.	Nursing Education	49	3.91(1.272)	.752*(74)*	.455
	Advanced Practice Nursing/Other	27	3.70(.952)		
Clinical faculty keep anecdotal notes of student clinical performance.	Nursing Education	49	4.10(.941)	1.283*(74)*	.204
	Advanced Practice Nursing/Other	27	3.81(.921)		
Students receive written feedback immediately in the clinical setting if a problem has been identified.	Nursing Education	49	3.95(1.04)	.57*(74)*	.57
	Advanced Practice Nursing/Other	27	3.81(1.04)		
Written clinical evaluations are completed on each student.	Nursing Education	49	4.71(.442)	2.04*(36.49)*	.049*
	Advanced Practice Nursing/Other	27	4.39(.739)		
Written clinical evaluations are done at midterm and final.	Nursing Education	49	4.49(.836)	1.342*(74)*	.184
	Advanced Practice Nursing/Other	27	4.2(1.039)		

Note: t(df) = independent t test and *df* for a comparison of nursing education background; Sig. = significance at the < .05 level.

The tenth variable indicated how items helped clinical faculty provide constructive feedback to students in the clinical setting. Faculty with a nursing education background were compared to faculty with advanced practice backgrounds or some other area of nursing. Those groups did not differ significantly on any of the items listed on the Likert scale. *T* values ranged from -.507 to 1.495, *p*'s > .05 (see Appendix O). The means and standard deviations for those tests can be seen in *Appendix N*.

The eleventh variable indicated how much of a concern clinical faculty have with the process of clinical evaluations of students. Faculty with a nursing education background were compared to faculty with advanced practice backgrounds or some other area of nursing. Those groups did not differ significantly on any of the items listed on the Likert scale. *T* values ranged from -.854 to 1.14, *p*'s > .05 (see Appendix O). The means and standard deviations for those tests can be seen in *Appendix N*.

Question 2

The second research question addressed: What preparation and support do part-time and full-time undergraduate clinical faculty believe they need in order to adequately prepare students for clinical practice?

The experts in Round 1 were asked to "List three resources you believe you need, or would benefit other faculty, who are teaching in the clinical setting." The responses included: clear expectations, a mentor, knowledge of the evaluation process, hospital orientation, how to handle difficult students, books regarding clinical teaching, written information such as a handbook, a clinical resource person, information on how to encourage clinical reasoning and make connections, checklist on things to do prior to starting the semester, smaller clinical groups, academic centers that facilitate learning, a simulation experience to facilitate

interventions commonly had in the clinical setting, ability to shadow another faculty member, examples of student paperwork, and a template for paperwork.

In Round 2, participants were asked to use a 5-point Likert scale to indicate their level of agreement with how important each of the topic was in preparing and supporting those faculty in their role teaching student clinical groups. Averages for the summary variables (support, training, resources that would be beneficial, concerns, communication systems in place, communication between clinical faculty and nursing program, possibilities for improving communication, usefulness of clinical orientation, providing student feedback, communicating constructive feedback, and process of clinical evaluations) are given in Table 9.

Table 9

Descriptive Statistics for Summary Variables

Summary Variables	*n*	Minimum	Maximum	*M(SD)*
Support	77	1.00	5.00	3.91(.86)
Training	77	2.43	5.00	3.68(.53)
Resources that would be useful	77	1.14	5.00	4.21(.79)
Concerns	77	2.55	5.00	4.10(.58)
Communication systems in place	77	1.50	5.00	4.21(.60)
Communication between clinical faculty and nursing program	77	1.86	5.00	3.16(.70)
Possibilities for improving communication	77	2.00	5.00	4.12(.54)
Usefulness of clinical orientation	77	3.33	5.00	4.53(.50)
Providing student feedback	77	2.86	5.00	4.23(.48)
Communicating constructive feedback	77	3.14	5.00	4.28(.48)
Process of clinical evaluations	77	1.00	5.00	3.18(.74)

Note: *n* = raw number of responses; *M(SD)* = mean and standard deviation.

Overall, it appeared that the clinical faculty who participated in the study strongly agreed with the usefulness of clinical orientation (*M*=4.53, *SD*=.50, *n*=77). The range of answers for those questions indicated that no one disagreed with suggestions related to clinical orientation. However, participants were less enthusiastic about the usefulness of clinical evaluation tools, with the answers, on average, representing a neutral attitude (*M*=3.18, *SD*=.74, *n*=77).

Participants in Round 2 were asked to indicate their level of agreement with how important the topics were in preparing and supporting those faculty in their role teaching student clinical groups. Participants ranked expectations on their role as clinical nursing faculty highest (36.4%), communication was ranked the second highest priority (16.9%), and clinical evaluations and resources were ranked as the lowest priority (1.3%). Table 10 presents the data.

Table 10

Clinical Faculty's Strongest Preferences for Developing New Clinical Faculty: Aggregation

Variables for Developing New Faculty	*n*	%
Support	6	7.8
Training	11	14.3
Resources	1	1.3
Communication	13	16.9
Expectations on the role	28	36.4
Clinical evaluations	1	1.3
Knowledge about maintaining safety	5	6.5
Missing data	12	15.5
Total	77	100

Note: *n* = raw number of responses included in aggregation.

Question 3

The third research question addressed: Are there differences between the perceived preparation and support needs of part-time and full-time undergraduate clinical faculty prior to assuming their clinical teaching responsibilities?

The first Likert scale question addressed the variable support. There were significant differences between the part-time and full-time faculty on the "used a colleague as a primary resource" as well as on composite variable termed "Support," which referred to the average of all three scores making up this area of the survey. Part-time clinical faculty reported significantly less support overall, $t(75) = -2.96$, $p = .004$, than full-time clinical faculty. Ratings on having been assigned a mentor were also significantly lower for part-time clinical faculty $t(75) = -4.28$, $p = .000$ (see Table 11). The means and standard deviations for all of the items related to support that faculty were given when starting their jobs are seen in Table 12.

Table 11

Support Source Variable: Independent t-tests by Employment Status

Support	*t(75)*	Sig.
For support: -used a colleague as a primary resource.	-1.143	.257
For support: -been assigned a mentor.	-4.28	.000*
For support: -used the course coordinator or faculty lead for support	-.644	.522
Support for clinical faculty composite variable	-2.96	.004*

Note: t(df) = independent t test and *df* for a comparison of employment status (part-time vs. full-time); Sig. = significance at the < .05 level.

Table 12

Support Source Variable: Descriptive Statistics by Employment Status

Support	Employment Status	*n*	*M(SD)*
For support: -used a colleague as a primary resource.	Part-time or Adjunct	32	4.25(.916)
	Full-time	45	4.49(.895)
For support: -been assigned a mentor.	Part-time or Adjunct	32	2.31(1.23)
	Full-time	45	3.60(1.354)
For support: -used the course coordinator or faculty lead for support	Part-time or Adjunct	32	4.19(1.061)
	Full-time	45	4.34(.999)
Support for clinical faculty composite variable	Part-time or Adjunct	32	3.58(.75)
	Full-time	45	4.14(.87)

Note: *n* = raw number of responses; *M(SD)*= mean and standard deviation.

The second Likert scale question addressed the variable training. There were significant differences between the part-time and full-time faculty on the "had no formal training" as well as on the question "content presented in educational preparation." Part-time clinical faculty reported significantly less training, $t(75) = 2.09$, $p = .04$, than full-time clinical faculty. Ratings on the question asking about having material presented in their original education were higher for full-time clinical faculty, $t(51) = -2.32$, $p = .024$ than for part-time faculty (see Table 14). The means and standard deviations for all of the items related to training that faculty were given when starting their jobs are seen in Table 13.

Table 13

Training Variable: Independent t-test and Descriptive Statistics by Employment Status

Training Received or Prior Experience Utilized	Employment Status	*n*	*M(SD)*	*t (df)*	Sig.
No formal training	Part-time or Adjunct	32	3.34(1.31)	2.09(75)	.04*
	Full-time	45	2.71(1.308)		
Formal orientation to role and responsibilities	Part-time or Adjunct	32	3.25(1.34)	.473(75)	.638
	Full-time	45	3.11(1.15)		
Content presented in educational preparation	Part-time or Adjunct	32	3.41(1.16)	-2.32(51)	.024*
	Full-time	45	3.96(.8)		
Verbal instruction.	Part-time or Adjunct	32	4.00(.84)	-.130(75)	.897
	Full-time	45	4.02(.66)		
Written instruction.	Part-time or Adjunct	32	3.47(1.05)	.283(75)	.778
	Full-time	45	3.40(1.05)		
Brief overview of clinical faculty role	Part-time or Adjunct	32	4.06(.801)	1.173(75)	.244
	Full-time	45	3.87(.661)		
Experience from previous work as a staff nurse	Part-time or Adjunct	32	4.50(.622)	1.013(75)	.315
	Full-time	45	4.33(.77)		
Training for clinical faculty composite variable	Part-time or Adjunct	32	3.62(.58)	-.735(75)	.464
	Full-time	45	3.71(.51)		

Note: t(df) = independent t test and *df* for a comparison of employment status (part-time vs. full-time); Sig. = significance at the < .05 level.

The third item on the Likert scale addressed the variable resources. None of the questions related to opinions about resources needed differed by the participant's status as full-time versus part-time status. All *t*-tests in this category were not significant, with *t*'s ranging from -.41 to -1.82, $p > .05$. Appendix P represents the t-tests and Appendix Q represents the descriptive statistics for resources.

The fourth item on the Likert scale addressed the variable concerns. Several differences were seen between part-time and full-time faculty on their concerns as clinical faculty. All the means and standard deviations for those tests are seen in Appendix Q. The quality and quantity of clinical placement sites was more of a concern to full-time faculty rather than to part-time faculty, $t(54) = -3.37$, $p = .001$, as was the number of students faculty members were expected to have in the clinical setting, $t(75) = -2.37$, $p = .02$. This pattern was also seen in the scores representing the average concerns across all 11 variables. Overall, full-time faculty had stronger concerns about a variety of aspects of their positions than part-time faculty, $t(75) = -1.99$, $p = .05$. Table 14 represents the independent *t*-test for concerns by employment status and the descriptive statistics can be found in Appendix Q.

Table 14

Concerns Variable: Independent t-tests by Employment Status

Concerns	*t(df)*	Sig.
Safety is a major concern for me in the clinical setting	-1.120(75)	.266
Being responsible for students and patients	-.790(75)	.432
Medication administration	-.306(75)	.761
Unsafe students	-1.66(75)	.102
Lack of confidential space for discussion	.592(74)	.555
How I communicate my role to the staff and managers so they know what to expect from me and my students	-.664(75)	.509
Unclear expectations which influence safety	-.579(75)	.565
Orientation to the clinical placement site	-1.735(75)	.087
Quality and quantity of clinical placements sites	-3.37(54)	.001*
Number of new Registered Nurses on clinical units with minimal experience	-1.39(75)	.185
The number of students I have in the clinical setting	-2.37(75)	.020*
Concerns of clinical faculty composite variable	-1.99(75)	.050*

Note: t(df) = independent *t*-test and degrees of freedom for a comparison of employment status (part-time compared to full-time); Sig. = significance at the < .05 level.

The fifth value on the Likert scale addressed communication systems in place between clinical faculty and the nursing program they work. Full-time faculty were compared to part-time faculty and the group did not differ significantly on any of the items listed in the Likert scale regarding communication systems. *T* values ranged from -1.74 to -.532, *p*'s > .05 (see Appendix P). The means and standard deviations for those tests can be seen in Appendix Q.

The sixth variable indicated how clinical faculty felt about the communication with the nursing program. There were significant differences between the part-time and full-time faculty on "different faculty have different expectations for students" as well as on the question regarding "new clinical faculty need continuous communication from the nursing program." Ratings on the question about different faculty having different expectations for students were higher for full-time clinical faculty, $t(50) = -2.17$, $p = .04$, than part-time faculty. Full-time faculty ratings on the question about new clinical faculty needing continuous communication from the nursing program were higher, $t(75), = -2.48$, $p = .02$, than part-time faculty. Table 15 represents the *t*-tests and the descriptive statistics can be found in Appendix Q.

Table 15

Communication between Faculty and Nursing Program Variable: Independent t-tests by Employment Status

Communication between Faculty and Nursing Program	*t(df)*	Sig.
Communication between the nursing program and clinical faculty is lacking in consistency.	-.96(75)	.34
Clinical faculty have no input on changes made affecting clinical courses.	1.69(75)	.1
Different faculty have different expectations for students.	-2.17(50)	.04*
Clinical faculty do not have the adequate resources to follow policies and procedures.	.370(75)	.71
Clinical faculty are not familiar with the curriculum of the nursing program.	.793(75)	.43
New clinical faculty need continuous communication from the nursing program.	-2.48(75)	.02*
Communication gaps exist between the faculty, dean, coordinators, and/or the hospital representatives.	.579(75)	.57
Communication Program composite variable	.237(75)	.81

Note: t(df) = independent *t*-test and degrees of freedom for a comparison of educational background; Sig. = significance at the < .05 level.

The seventh item on the Likert scale addressed the variable for communication improvement. Ratings on the item "have contact with nursing program daily" were significantly higher for full-time faculty, $t(75) = -2.1$, $p = .04$, than part-time faculty. Table 16 represents the independent *t*-test for Communication Improvement and the descriptive statistics can be found in Appendix Q.

Table 16

Communication Improvement Variable: Independent t-tests by Employment Status

Communication Improvement	*t(75)*	Sig.
Meet with all clinical faculty so there is consistency	-1.76	.08
Have a course coordinator who communicates well with clinical faculty	-1.51	.14
Have contact with the nursing program daily	-2.1	.04*
Have faculty from the nursing program meet with clinical faculty and student if there is a problem	-1.03	.31
Have faculty from the nursing program meet with clinical faculty and student if there is a problem	-1.34	.19
Have input from all faculty	-.09	.93
Have open and honest communication	-1.20	.23
Face to face meetings with all faculty (including clinical faculty)	-1.15	.25
Composite variable for communication improvement	-1.85	.07

Note: t(df) = independent *t*- test and degrees of freedom for a comparison of educational background; Sig = significance at the < .05 level.

The eighth variable on the Likert scale addressed clinical orientation. There were no significant differences between full-time and part-time faculty regarding clinical orientation.

The *t* values ranged from -.41 to -1.51, *p*'s > .05 (see Appendix P). The means and standard deviations for those tests can be seen in Appendix Q.

The ninth variable indicated how clinical faculty gave feedback to students regarding their progress towards program objective mastery in the clinical setting. Full-time faculty reported significantly higher use of keeping anecdotal notes of students clinical performance, $t(75) = -2.86$, $p = .006$, than part time faculty. The means and standard deviations for all of the items related to providing feedback are found in Table 17.

Table 17

Providing Feedback Variable: Independent t-tests by Employment Status

Providing Feedback	*t(df)*	Sig.
Constructive feedback is provided to students with the use of verbal communication	-.83*(75)*	.41
Concerns regarding student performance are verbally communicated to students	-.86*(75)*	.39
Clinical faculty document written feedback on each student weekly	-.58*(75)*	.57
Clinical faculty keep anecdotal notes of student clinical performance	-2.86*(75)*	.006*
Students receive written feedback immediately in the clinical setting if a problem has been identified	-1.77*(59)*	.08
Written clinical evaluations are completed on each student	-1.30*(75)*	.2
Written clinical evaluations are done at midterm and final	1.04*(75)*	.30
How clinical faculty provide feedback composite variable	-1.75(75)	.08

Note: t(df) = independent *t*- test and degrees of freedom for a comparison of educational background; Sig. = significance at the < .05 level.

The tenth variable addressed communicating constructive feedback to students in the clinical setting. There were significant differences between the part-time and full-time faculty on

the item “having communication training on how to have difficult conversations with students regarding their performance” and “having simulated experience on how to effectively communicate. Full-time faculty reported significantly higher importance on training to have difficult conversations, $t(75)$, -2.83, p = .006, than part-time faculty. Full-time faculty also reported significantly higher importance on having a simulated experience on how to effectively communicate, $t(75)$, -1.96, p = .05, than part-time faculty. The *t*-tests are in Table 18 and the means and standard deviations are found in Appendix Q.

Table 18

Constructive Feedback Variable: Independent t-tests by Employment Status

Elements Supportive of Constructive Feedback	*t(75)*	Sig.
Understanding of the clinical evaluations tool	-.33	.75
Comprehensive clinical evaluation tool to evaluate students	-.15	.88
Communication training on how to have difficult conversations with students regarding their performance	-2.83	.006*
Simulation experience on how to effectively communicate	-1.96	.05*
Examples of constructive feedback that has been used in the past	-1.21	.23
Orientation that includes training on correctly filling out documents	.83	.41
Handbook for clinical faculty	.87	.39
Composite variable for communication with program helps student feedback	-1.25	.22

Note: t(df) = independent *t*- test and degrees of freedom for a comparison of educational background; Sig. = significance at the < .05 level.

The eleventh variable addressed faculty concerns with the process of clinical evaluation of students. There were no significant differences between full-time and part-time clinical

nursing faculty. *T* values ranged from -1.25 to .97, $p > .05$. The *t*-test can be found in Appendix P and Appendix Q represents the descriptive statistics.

Summary

This chapter discussed Round 1, Round 1.5, Round 2, and the research questions in the Delphi study conducted. Participant descriptors were included for each round of the study. A panel of experts were purposefully sampled for Round 1 and answered demographic questions and a nine-question open ended survey. Round 1.5 included the experts who were willing to provide a follow-up email address and assist in confirming the accuracy of each statement compiled from Round 1. Round 2 included clinical nursing faculty throughout a Midwestern state from an accredited nursing program. Round 2 participants answered a demographic survey, followed by a 76 item Likert scale, and then a question asking them to prioritize clinical faculty needs.

The three research questions were explained based on the data analysis. Frequency counts and content analysis were used for Round 1 data; and descriptive and inferential statistics were used for Round 2 data. The Delphi study allowed for consensus building on what support and preparation clinical nursing faculty needed to adequately perform their job. Chapter 6 will discuss the findings of the study.

CHAPTER 6: DISCUSSION

The purpose of this research study was to determine (a) what preparation and support part-time and full-time undergraduate clinical faculty received prior to assuming their clinical teaching responsibilities, (b) what the study participants believed they needed to adequately perform their jobs, and (c) if differences in perceptions of clinical faculty existed between full-time and part-time clinical faculty. A Delphi study was conducted to understand the preparation and support needed for undergraduate clinical nursing faculty. This chapter will include (a) interpretation of the findings, (b) implications for nursing education and practice, (c) recommendations for future research, (d) relationship to theoretical framework (e) limitations, (f) summary and conclusion.

Relationship to Theoretical Framework

Two theoretical frameworks were used to guide the study. The two theories used were: Malcolm Knowles's adult learning theory and David Kolb's experiential learning theory. Those theories were utilized to better understand how learners learn and this related strongly to the study.

Adult Learning Theory

The adult learning theory was the first theory to frame the study. The focus of this theory was on the learning processes of adults. Knowles (1980) believed that adult learners were self-directed, had a large repertoire of experience, and were internally motivated to learn. Adults wanted to have control over information they were learning and this helped to increase the amount of knowledge gained (Knowles et al., 2005).

The Delphi study was used to understand what preparation and support undergraduate clinical faculty needed to adequately perform their job. The theory guided the study by

providing a better understanding of how adults learn. The literature revealed that many nursing faculty have entered the teaching role with little formal education on how to teach students; however, they were expert clinicians (Heaslip & Scammell, 2012; Peters & Boylston, 2006; Pierangeli, 2006; West et al., 2009). Those faculty were required to transition from the role of clinical expert to clinical nursing faculty. For this to occur, faculty needed to determine what learning needs they have in order to perform their job (Knowles et al., 2005).

Nursing programs have identified needs of new clinical faculty and developed workshops and handbooks to guide new faculty (Bell-Scriber & Morton, 2009; Roberts et al., 2013; Pierangeli, 2006). With an understanding of how the adult learner learns and what motivates him/her to learn can help provide beneficial information to new faculty. With experience, novice faculty will gain independence. An ideal situation would be for full-time faculty to help new clinical faculty learn their role. Many full-time faculty have indicated that they had workloads that prevent them from adequately mentoring new faculty (Bell-Scriber & Morton, 2009; Forbes et al., 2010). Results of the Delphi study revealed that faculty who had an educational background focus in nursing education were more likely to use a colleague as a primary resource than those without a nursing education background (nursing education: $M = 4.57$, $SD = .82$; other nursing: $M = 4.07$, $SD = 1.0$). Knowing and understanding the learning needs of new clinical faculty will help them better perform their role.

Experiential Learning Theory

The second framework guiding the study was David Kolb's experiential learning theory. Nursing education has taken a different approach from nursing practice. Clinical faculty help students transform their own personal experiences in the clinical setting into meaningful knowledge that can be applied throughout their education and career. Clinical faculty have

entered into their role with an idea of how education in the clinical setting should occur. With lack of instruction in teaching, clinical faculty tended to use the teaching methods with which they were taught by (Bell-Scriber & Morton, 2009). That supported Kolb's (2015) assertion that "all learning is relearning" (p. 39). The skills needed to be a nurse differed from the skills needed to be nursing faculty. Therefore, using a panel of clinical nursing faculty experts allowed for an understanding of what they believed was needed to prepare and support new clinical faculty.

Eleven themes from Round 1 helped to identify the needs of faculty. They included support, training, resources that would be useful, concerns, communication systems in place, communication between clinical faculty and nursing programs, possibilities for improving communication, usefulness of clinical orientation, providing student feedback, communicating constructive feedback, and the process of clinical evaluations. The panel of experts was able to describe what they believed were the most beneficial needs for new undergraduate clinical nursing faculty. Round 2 allowed for clinical nursing faculty with a wide variety of experience to indicate their level of agreement with how important the topics were in preparing and supporting new clinical nursing faculty in their role teaching student clinical groups.

Interpretation of the Findings

Clinical nursing faculty experts were recruited in Round 1 using purposive sampling. A total of 15 experts participated in Round 1. The experts met the criteria of (a) having been clinical practitioners, clinical faculty, and/or theory faculty working at an institution of higher education, and (b) having taught at least four clinical groups over the past five years, in any acute care setting, and (c) having been an RN for at least five years.

Clinical nursing faculty who had taught in at least one clinical course within the previous 12 months were recruited using convenience sampling from a Midwestern state for Round 2. Surveys were sent to the deans/directors and faculty listed on accredited nursing programs websites. A total of 77 surveys were used for the study. The participants in Round 2 of the study included 45 (58.4%) full-time faculty and 32 (41.6%) part-time/adjunct faculty.

Research Question 1

Research Question 1 addressed what preparation and support part-time and full-time undergraduate clinical nursing faculty received prior to assuming their clinical teaching responsibilities. Round 1 experts described the type of training they had received. Experts indicated that they received training from a colleague, received no training, or met with course coordinators. Results in Round 2 indicated that faculty with a nursing education background reported that they were more likely to use a colleague as a primary resource, that they received more relevant content in their original training, they received more verbal instruction, and a brief overview of the clinical faculty role than faculty with an educational focus other than nursing education. Faculty with a nursing education background also reported that they were more likely to provide written clinical evaluations for each student than faculty with other educational backgrounds.

The findings for Research Question 1 were consistent with the literature. Support has been identified as essential to the success of retaining faculty (Bell-Scriber & Morton, 2009; Candela et al., 2013; Candela et al., 2015; Duffy, 2003; Duffy et al., 2008; Forbes et al., 2010; Gazza, 2009; Hewitt & Lewallen, 2010; Luhanga, Yonge, & Myrick, 2008b; Roberts et al., 2003). Kowalski et al. (2007) included support for new clinical faculty as a topic in their orientation.

There was a statistically significant difference between the group that had a nursing education background and the group with advanced practice or other background, $t(74) = 2.35$, $p = .022$. Those with a nursing education background reported that they were more likely to use a colleague as a primary resource than those without a nursing education background (nursing education: $M = 4.57$, $SD = .82$; other nursing: $M = 4.07$, $SD = 1.0$). Nursing faculty who had been prepared through their master's degree or doctoral degree programs as nurse educators are more likely to seek assistance from experienced colleagues than faculty who enter the academic setting with other educational backgrounds.

In the study, 49 (63.6%) of faculty held a degree with a focus on nursing education and 26 (45.4%) held a degree as an advanced practice nurse or had another focus in their master's or doctoral programs. Faculty who received degrees with a focus on nursing education reported that they had received more relevant content in their original training $t(74) = 4.09$, $p = .000$, that they had received more verbal instruction $t(74) = 2.11$, $p = .038$, and that they had received a brief overview of the clinical faculty role $t(42) = 2.38$, $p = .022$ than faculty with other educational backgrounds. Forbes et al. (2010) indicated that unclear guidelines were problems for clinical faculty. Many clinical nursing faculty entered their academic role as expert clinicians but often lacked the experience and educational focus of their nursing faculty counterparts. Clinical faculty who received education as advanced practice nurses or in other nursing areas did not have courses on curriculum, pedagogy, and evaluations (Heaslip & Scammell, 2012; Peters & Boylston, 2006; Pierangeli, 2006; West et al., 2009). They were not likely, therefore, to receive any content regarding training, verbal instruction, or the role of clinical faculty. In order for clinical faculty to facilitate learning, they needed to have clear expectations of their role as clinical nursing faculty.

In the study, clinical nursing faculty with a nursing education background reported they were more likely to provide written clinical evaluations for each student than those without a nursing education background (nursing education: $M = 4.71$, $SD = .442$; other nursing: $M = 4.39$, $SD = .739$). All clinical faculty were required to evaluate students in the clinical setting. Duffy (2008) indicated that one of the greatest challenges nursing program face was the weakness and lack of documentation. Ensuring that safe competent students were graduating was a critical part of clinical nursing faculty responsibilities.

Providing written evaluations was one component that ensured that students were meeting the objectives and outcomes of their clinical courses; helping to ensure that safe competent students are graduating. Several studies have indicated that unclear expectations and uncertainty about grading procedures and evaluation processes led faculty to pass underperforming students in some cases (Black et al, 2014; Brown et al., 2012; Duffy, 2003; Gainsbury, 2010; Jervis & Tilki, 2011).

Research Question 2

Research Question 2 addressed what preparation and support part-time and full-time undergraduate clinical faculty believed they needed in order to adequately prepare students for clinical practice. The responses included clear expectations, knowledge of the evaluation process, a mentor, instruction in how to handle difficult students, and a simulation experience to facilitate interventions commonly had in the clinical setting.

A lack of clarity in the role of clinical nursing faculty had been identified in several studies (Allison-Jones & Hirt, 2004; Creech, 2008; Gazza, 2009; Gazza & Shellenbarger, 2010). Unclear expectations have led faculty to pass students in the clinical setting who were underperforming (Black et al., 2014; Brown et al., 2012; Duffy, 2003; Gainsbury, 2010; Jervis &

Tilki, 2011). Kowalski et al. (2007) indicated that formal mentoring was needed by new clinical nursing faculty; however, experienced faculty often had multiple responsibilities that prevented them from being available to provide support or mentoring to new faculty. Challenging students can be difficult to handle for both part-time and full-time clinical nursing faculty and it was often difficult to recognize problems until near the end of the clinical rotation (Hewitt and Lewallen, 2010). Crocetti (2014) conducted a pilot-study that utilized simulation to help orient new clinical faculty and found that the use of simulation increased the self-efficacy of part-time faculty.

Nursing faculty indicated that that they strongly agreed with the usefulness of clinical orientation (M=4.53, SD=.50, n=77). Orientations helped provide essential information needed for clinical nursing faculty to adequately perform their job. New clinical faculty have often been surprised by the lack of formal orientation processes within higher education (Gies, 2013; Peters & Boylston, 2006). The literature indicated that several nursing programs used orientations that ranged from one hour to an entire semester; however, many of those orientations were not mandatory for new clinical faculty (Forbes et al., 2010). Orientation was a logical place where explicit information regarding student clinical evaluation processes could occur.

Clinical faculty in Round 2 were asked to indicate their level of agreement with how important support, training, resources, communication, expectations on the role of clinical nursing faculty, clinical evaluations, and knowledge about maintaining safety were in preparing and supporting those faculty in their role teaching student clinical groups. Participants ranked expectations on their role as clinical nursing faculty highest (36.4%), communication was ranked the second highest priority (16.9%), and clinical evaluations and resources were ranked as the lowest priority (1.3%). Clinical faculty needed clear expectations and guidelines for their role to

be successful as clinical faculty. Faculty needed clear expectations in order to assure that competent and capable students are graduating. In some instances, unclear expectations have led clinical faculty to pass underperforming students (Black et al., 2014; Brown et al., 2012; Duffy, 2003; Gainsbury, 2010; Jervis & Tilki, 2011).

Research Question 3

Research Question 3 addressed the differences between the perceived preparation and support needs of part-time and full-time undergraduate clinical faculty prior to assuming their clinical teaching responsibilities. There were significant differences between part-time and full-time faculty. Part-time faculty reported that they received less support, $t(75) = -2.96$, $p = .004$, were less likely to have a mentor, $t(75) = -4.28$, $p = .000$, received no formal training, $t(75) = 2.09$, $p = .04$, and less content presented in their educational preparation, $t(51) = -2.32$, $p = .024$ than full-time faculty.

The literature supports those findings. Many clinical faculty positions were filled by clinical experts who had no formal education in how to teach students (Heaslip & Scammell, 2012; Peters & Boylston, 2006; Pierangeli, 2006; West et al., 2009). With the lack of beneficial orientations and the expressed needs for them indicated by clinical nursing faculty in this study, many new clinical nursing faculty do not understand the expectations of their role. This may result in a poor learning environment for students and the possibility that underperforming students may pass in the clinical setting. It could also jeopardize the safety of both patients and students in the clinical setting. Clinical faculty who have a lack of instruction in teaching, often teach as they were taught (Bell-Scriber & Morton, 2009). Clinical faculty are challenged with protecting the public from incompetent practitioners by preventing underperforming students from becoming nurses (Luhanga et al., 2008a). However, clinical faculty have indicated that

they have passed underperforming students because of the faculty's lack of experience, the amount of time, the possibility of feeling guilt or shame, lack of appropriate clinical evaluation tools, time to evaluate students, and pressure to get more student into the workforce (Luhanga et al., 2008a).

Full-time faculty had stronger concerns about a variety of aspects of their positions over part-time faculty, $t(75) = -1.99$, $p = .05$. Full-time faculty were more concerned with the quality and quantity of clinical placement sites, $t(54) = -3.37$, $p = .001$, as well as the number of students in the clinical setting, $t(75) = -2.37$, $p = .02$ than part-time faculty. Full time faculty reported more concern for the different expectations of faculty, $t(50) = -2.17$, $p = .04$, and the need for continuous communication between new clinical faculty and the nursing program, $t(75), = -2.48$, $p = .02$, than part-time faculty. Full-time faculty also indicated a stronger need for clinical faculty to have contact with the nursing program daily, $t(75) = -2.1$, $p = .04$, than part-time faculty. Part-time faculty, in many cases, have held other full-time positions (Whalen, 2009).

New clinical faculty often work at clinical institutions at a distance from the nursing program, which limits their contact with more experienced faculty (Gies, 2013). The distance between faculty and their nursing program and the amount of time spent working additional jobs would likely decrease the concern that part-time faculty have regarding issues faced by the nursing program. Allison-Jones and Hirt (2004) indicated that full-time faculty have devoted more time and energy to the institution's success than part-time faculty did. Part-time faculty were often hired to work a certain number of hours and that did not include pre- and post-clinical work. For this reason, in Hewitt and Lewallen's (2010) study, part-time clinical faculty believed their free time was imposed on with clinical grading and evaluations.

Full-time faculty also reported higher use of keeping anecdotal notes of student's clinical performance, $t(75) = -2.86$, $p = .006$, than part-time faculty. Full-time faculty indicated that having communication training on how to have difficult conversations with students regarding their performance, $t(75)$, -2.83, $p = .006$, and having simulated experience on how to effectively communicate, $t(75)$, -1.96, $p = .05$, were of higher importance than part-time faculty. Duffy et al. (2008) indicated that the most problematic issues with part-time faculty were grading clinical paperwork, documentation of communication, and evaluations. Lack of documentation of communication was most apparent when students were not progressing adequately through a course and were given an academic warning which required that the student meet with both part-time faculty and the course coordinator. Part-time faculty were hesitant to make such documentation because it became a part of the students' permanent record. That may be overcome with strategies such as simulation. Crocetti (2014) conducted a pilot study on the use of simulation to help orient new clinical faculty. Participants in the study did indicate that they were confident or completely confident that the use of simulation was beneficial in preparing clinical faculty.

Implications for Nursing Education and Practice

Due to the nursing faculty shortage, the use of part-time clinical faculty has been an essential part of nursing programs throughout the U.S. (Duffy et al., 2008; Gazza & Shellenbarger, 2010; Nardi & Gyurko, 2013; Roberts et al., 2013). Roberts et al. (2013) suggested that the education and preparation of part-time and adjunct faculty needed to be evaluated to ensure high quality education was occurring.

The findings of this study indicated that the academic administrators of nursing programs need to remain in close contact with their part-time and adjunct faculty. Having a mandatory

orientation would likely be beneficial for all new clinical nursing faculty and including simulation may have positive outcomes for new clinical faculty. Simulation can be used to assess student performance, communicate with students regarding their progression in the clinical course, and allow new clinical faculty the chance to communicate with a difficult student. During orientations, faculty can be introduced to the documentation system for student progress within the nursing program. They can be taught how to keep anecdotal notes and the importance of those notes in maintaining a safe environment and ensuring that future graduates are safe and competent as they enter practice. Those new faculty need a clear understanding of their roles and expectations. New faculty need assigned a specific mentor that will be available throughout the semester to answer questions and assist with other needs. The mentor needs to keep in close contact with the new faculty in order to assure that they understand their role and are performing at the level of expectation for the program of nursing.

One challenge, as identified in the literature, to having mandatory orientations is the distance clinical faculty may live from their academic institution and the lack of compensation. The literature and findings of this study indicated that administrators of nursing program may attract and retain better faculty if they were to address those issues. In order to hire and retain qualified clinical nursing faculty, nursing programs need to recognize those issues. The findings also indicate that paying clinical faculty for the time spent attending clinical orientations might increase employee satisfaction. This would require additional pay above and beyond the negotiated contract for the clinical hours they are required to teach. This would give clinical faculty incentive to attend those programs that would enhance their knowledge and understanding of their role as clinical nursing faculty. If nursing programs use distant clinical

sites, then holding those mandatory orientations at the clinical sites may prove more beneficial and be easier for part-time clinical faculty to attend.

Nursing programs may also consider providing release time or additional pay for full-time faculty who would be willing to mentor new clinical nursing faculty. Specific requirements could be made to meet with clinical faculty weekly in person or by phone to address any issues or concerns they may be having. They could assist new clinical faculty in documenting student performance and using the evaluation tools provided by the nursing program. While many studies indicated that full-time faculty did not have the time to mentor new clinical faculty, pay may prove to be an incentive for mentoring new faculty (Kowalski et al., 2007).

The use of part-time and adjunct faculty will likely continue to rise as the nursing faculty shortage increases. The nursing program administrators involved in hiring a large number of part-time and adjunct clinical faculty should be made aware of the challenges they would face. While those faculty are an essential part of educating future nurses, nursing programs' administrators need to make sure that they continue to uphold the expectations of the nursing program and the profession of the nursing.

Recommendations for Future Research

This Delphi study allowed for consensus building on what preparation and support clinical faculty believed they needed to adequately perform their jobs. Results of the study indicated that all participants who were clinical nursing faculty believed an orientation was an important part of preparing and supporting faculty. Clinical nursing faculty in the study also indicated that they needed clear expectations of their role.

The next step in future research would be to develop an orientation program that is beneficial to new clinical nursing faculty. This essential orientation program could be used

online or for face-to-face orientations that incorporate information on several topics. The first topic would be the expectation of their role as clinical nursing faculty. They would receive the outcomes and objectives for the clinical course they would teaching. The study's findings indicated that faculty would benefit from being made aware of the mission and vision of the nursing program.

Faculty would be instructed about what they need to do with students in the clinical setting, how to make assignments for students, and facilitate an environment that promotes critical thinking and clinical reasoning. Faculty would be exposed to the documentation used in the clinical setting, such as anecdotal notes and clinical evaluation tools. Simulation could be used to help new clinical nursing faculty interact with difficult students or underperforming students. Time would be dedicated to assuring that clinical faculty understood their responsibility in protecting patients and the public from incompetent underperforming students.

New clinical faculty would receive an experienced full-time faculty mentor to help guide them through the first semester of clinical teaching. Mentors would be required to make contact with the new faculty member once a week by phone, email, or in person, to assure that there were no issues that needed to be addressed.

The literature would be enhanced by the addition of studies that evaluated the roles and needs of clinical nursing faculty. If large numbers of clinical nursing faculty continue to be part-time and adjunct faculty with little to no formal education on teaching students, additional research could indicate how clinical faculty could be taught to best facilitate learning in the clinical setting. Allowing clinical nursing faculty to provide suggestions on what would be beneficial to know and what challenges they have faced would help nursing programs'

administrators provide a better quality orientation and prevent underperforming students from entering the workforce.

Limitations

The design of the study, sampling methods, procedure, and statistical analysis were all considered carefully for this study; however, limitations were present. A Delphi study was chosen as the best research design for the study. Polit and Beck (2008) described convenience sampling as "the weakest form of sampling" (p. 341). Convenience sampling was used for Round 2. That technique was chosen in order to elicit a large number of clinical nursing faculty and to reach part-time/adjunct faculty who were not routinely listed as faculty on nursing programs' websites.

Surveys were sent to the deans/directors of nursing programs and they were asked to forward the surveys on to part-time/adjunct and full-time faculty. A limitation to that sampling technique is that not all faculty may have received a forwarded email. Convenience sampling was used to obtain the most convenient sample for the study; however, this could include bias (Polit & Beck, 2008).

Another limitation was the generalizability of the findings for the study. The study was conducted in one Midwestern state, therefore, the findings may not be generalizable to clinical nursing faculty elsewhere.

The design of the study can also be a limitation. Participants self-selected whether they wanted to participate in the study, so faculty may have chosen not to participate for various reasons, which may have skewed the results. The design included using an electronic survey through Qualtrics. It is impossible to know how many faculty received the survey. Response and selection biases may also have been present in the study.

Summary and Conclusion

Clinical education is imperative in order to develop safe, competent nurses who are ready for the complexities of professional practice. Life and death issues are faced frequently. Stresses on both clinical nursing faculty and students are significant. The literature and this study indicated that nursing programs need very prepared and supported clinical nursing faculty.

As the nursing faculty shortage worsens, nursing programs will be dependent on clinical nursing faculty with a wide variety of nursing backgrounds. Approximately half of students' time in a nursing program is spent in the clinical setting (Benner et al., 2010; Ironside et al., 2014). A tremendous amount of knowledge and application is gained throughout a student's clinical experience. Untrained, unprepared faculty jeopardize patient and student safety and compromise the quality of the future nursing workforce. Continuing research, the interpreting finding, and intentionally applying strategies to address their implications may stimulate immediate and lasting improvement in the quality of clinical instruction.

APPENDIX A

Round 1 Demographic Survey

Directions: For each of the following, please provide the response that most accurately describes you.

1. Are you employed as a nurse educator: Full-time ___

   Part-time ___

   Adjunct ___

2. How many years have you taught a student clinical group? _____

3. How many student clinical groups have you taught in the last five years? _____

4. How many years have you been a Registered Nurse? _____

5. What is the clinical area in which you primarily instruct or have instructed student clinical groups in?
   ____Medical-surgical
   ____Pediatrics
   ____Maternal Child
   ____Psych
   ____Other (please describe)

APPENDIX B

Round 1 Questions

Directions: For each of the following, please provide the response that best reflects your experiences and views.

1. Describe the training and support you were given to teach in the clinical setting (e.g., types of training, length of training received).

2. List three resources you believe you need, or would benefit other faculty, who are teaching in the clinical setting.

3. List three concerns you have with teaching in the clinical setting.

4. Describe the communication systems in place between you and the nursing program you work for that support you in completing your job.

5. List three concerns you have with the communication between the nursing program you work for and clinical faculty.

6. List any suggestions you have for improving communication between the nursing program you work for and clinical faculty.

7. How do you provide constructive feedback to students regarding their progress towards program objective mastery in the clinical setting (e.g., how do you provide formative feedback, how do you communicate concerns)? Describe specific strategies or techniques you use.

8. List three resources (e.g., training, tools) that you think you need to communicate constructive feedback to students in the clinical setting.

9. List three concerns you have with the process of clinical evaluation of students.

Please provide an e-mail address if willing to review the results of the survey for accuracy and completeness. _____

APPENDIX C

UNLV Biomedical IRB - Exempt Review
Exempt Notice

DATE:	August 26, 2015
TO:	Lori Candela, EdD
FROM:	Office of Research Integrity - Human Subjects
PROTOCOL TITLE:	[792109-1] UNDERSTANDING THE PREPARATION AND SUPPORT NEEDS OF UNDERGRADUATE CLINICAL NURSING FACULTY
ACTION:	DETERMINATION OF EXEMPT STATUS
EXEMPT DATE:	August 26, 2015
REVIEW CATEGORY:	Exemption category # 2

Thank you for your submission of New Project materials for this protocol. This memorandum is notification that the protocol referenced above has been reviewed as indicated in Federal regulatory statutes 45CFR46.101(b) and deemed exempt.

We will retain a copy of this correspondence with our records.

PLEASE NOTE:
Upon final determination of exempt status, the research team is responsible for conducting the research as stated in the exempt application reviewed by the ORI - HS and/or the IRB which shall include using the most recently submitted Informed Consent/Assent Forms (Information Sheet) and recruitment materials. The official versions of these forms are indicated by footer which contains the date exempted.

Any changes to the application may cause this protocol to require a different level of IRB review. Should any changes need to be made, please submit a **Modification Form**. When the above-referenced protocol has been completed, please submit a **Continuing Review/Progress Completion report** to notify ORI HS of its closure.

If you have questions, please contact the Office of Research Integrity - Human Subjects at IRB@unlv.edu or call 702-895-2794. Please include your protocol title and IRBNet ID in all correspondence.

Office of Research Integrity - Human Subjects
4505 Maryland Parkway . Box 451047 . Las Vegas, Nevada 89154-1047
(702) 895-2794 . FAX: (702) 895-0805 . IRB@unlv.edu

APPENDIX D

INFORMED CONSENT

Department of Nursing

TITLE OF STUDY: Understanding the Preparation and Support Needs of Undergraduate Clinical Nursing Faculty INVESTIGATOR(S): Principal Investigator: Lori Candela, EdD, RN, APRN, FNP-BC, CNE Student Investigator: Sara Miles McPherson, MSN, RN, CCRN

For questions or concerns about the study, you may contact Lori Candela at 702-895-2443 or Sara Miles McPherson at 309-530-9465**.**

For questions regarding the rights of research subjects, any complaints or comments regarding the manner in which the study is being conducted, contact **the UNLV Office of Research Integrity – Human Subjects at 702-895-2794, toll free at 877-895-2794 or via email at IRB@unlv.edu.**

Purpose of the Study

You are invited to participate in a research study. The purpose of this study is (a) to determine what preparation and support part-time and full-time undergraduate clinical nursing faculty receive prior to assuming their clinical teaching responsibilities, (b) what they believe they need to adequately perform their jobs, and (c) if there are differences between the perceived preparation and support needs of fulltime and part-time undergraduate nursing faculty prior to assuming their clinical teaching responsibilities.

Participants

You are being asked to participate in the study because you fit this criteria: A clinical nursing faculty expert who is currently teaching or has previously taught student clinical groups four times in the last five years. An expert is defined as a registered nurse (RN) who has taught at least four nursing student clinical groups over the last five years, in any in-hospital setting, and has been an RN for at least five years.

Procedures

If you volunteer to participate in this study, you will be asked to do the following: complete a five question demographic survey and a nine question open-ended survey. You will also be asked if you would be willing to review the results of the survey. If you would be willing to review the results, you would also need to provide an e-mail address. You will have two weeks to complete the demographic questions and the open-ended survey. If you chose to provide your e-mail address, the analyzed data will be returned for confirmation of accuracy. Each expert will be asked to review and provide feedback to ensure that the statements accurately reflect what preparation and support they believe clinical nursing faculty need in order to perform their job.

TITLE OF STUDY: Understanding the Preparation and Support Needs of Undergraduate Clinical Nursing Faculty

Benefits of Participation

There may be no direct benefits to you as a participant in this study. However, some may feel positive about providing input on improving the preparation and support for faculty teaching in the clinical settings.

Risks of Participation

There are risks involved in all research studies. This study includes only minimal risks. Experts may feel some discomfort with answering one or more questions in the survey.

Cost /Compensation

There will be no financial cost to you to participate in this study. Answering the demographics and open-ended survey will take 30 minutes to one hour. Additionally, if you choose to review the results, it may take an additional 30 minutes to one hour. You will not be compensated for your time.

Confidentiality

All information gathered in this study will be kept as confidential as possible. No reference will be made in written or oral materials that could link you to this study. All records will be stored in a

locked facility at UNLV for 3 years after completion of the study. After the storage time the information gathered will be destroyed.

Voluntary Participation

Your participation in this study is voluntary. You may refuse to participate in this study or in any part of this study. You may skip any question you do not wish to answer. You may withdraw from the study at any time without prejudice to your relations with UNLV. You are encouraged to ask questions about this study at the beginning or any time during the research study.

Participant Consent:

I have read the above information and agree to participate in this study. I am at least 18 years of age. A copy of this form has been given to me. By clicking on the link at the bottom of this page, you indicate your consent to participate in this study.

APPENDIX E

Understanding the needs of clinical nursing faculty

My name is Sara Miles McPherson and I am a doctoral student at the University of Nevada, Las Vegas. I am conducting a two round Delphi study to understand the preparation and support needs of undergraduate clinical nursing faculty. As a nursing faculty member, I have worked with several clinical groups. My experience as a new clinical faculty member and working with new clinical faculty has led me to be very interested in how clinical faculty are prepared for their role and what support they receive and what they believe they need to adequately perform their job. That interest has led me to undertake this research project.

I know that taking on a new role as clinical nursing faculty can be challenging. I have discovered that many clinical nursing faculty feel disconnected to the schools of nursing and often lack adequate mentoring. Understanding what clinical nursing faculty believe they need to perform their job adequately will help schools of nursing prepare new clinical faculty. The only potential risk to you is the chance that you might feel uncomfortable answering a question. Please know that at any time you can choose to not answer a certain question, that all information will be handled with care and concern for your confidentiality and that you have the right to opt out of the study at any time. Without your help I will not be able to accomplish this goal of helping new clinical nursing faculty.

With the benefit of your help, I hope to be able to allow schools of nursing a better understanding of what clinical nursing faculty need to be better prepared for their role. If you would be willing to participate in this study there is a link below. There is a five question demographic survey, followed by nine open-ended questions. After you complete the surveys you will be asked if you would be willing to review the data analyzed from the surveys for accuracy. If so, you will be asked to leave your e-mail address. The study should take no more than 30 minutes to one hour of your time. Additionally, if you choose to review the results, it may take an additional 30 minutes to one hour. If you have questions please do not hesitate to contact me!

Please click on this link to participate in the survey.

Thank you for your consideration!

Sara Miles McPherson, MSN, RN, CCRN
Student Investigator
309-530-9465
Miless1@unlv.nevada.edu

Lori Candela, EdD, RN, APRN, FNP-BC, CNE
Principal Investigator
702-895-2443
lori.candela@unlv.edu

APPENDIX F

Understanding the needs of clinical nursing faculty

Several days have passed since I sent you a personal request for assistance in a research project on the preparation and support needs of undergraduate clinical nursing faculty. Thank you so much if you already responded. If you have not yet participated, I would be very grateful if you would read on and consider participating in the study now.

My name is Sara Miles McPherson and I am a doctoral student at the University of Nevada, Las Vegas. I am conducting a two round Delphi study to understand the preparation and support needs of undergraduate clinical nursing faculty. As a nursing faculty member, I have worked with several clinical groups. My experience as a new clinical faculty member and working with new clinical faculty has led me to be very interested in how clinical faculty are prepared for their role and what support they receive and what they believe they need to adequately perform their job. That interest has led me to undertake this research project.

I know that taking on a new role as clinical nursing faculty can be challenging. I have discovered that many clinical nursing faculty feel disconnected to the schools of nursing and often lack adequate mentoring. Understanding what clinical nursing faculty believe they need to perform their job adequately will help schools of nursing prepare new clinical faculty. The only potential risk to you is the chance that you might feel uncomfortable answering a question. Please know that at any time you can choose to not answer a certain question, that all information will be handled with care and concern for your confidentiality and that you have the right to opt out of the study at any time. Without your help I will not be able to accomplish this goal of helping new clinical nursing faculty.

With the benefit of your help, I hope to be able to allow schools of nursing a better understanding of what clinical nursing faculty need to be better prepared for their role. If you would be willing to participate in this study there is a link below. There is a five question demographic survey, followed by nine open-ended questions. After you complete the surveys you will be asked if you would be willing to review the data analyzed from the surveys for accuracy. If so, you will be asked to leave your e-mail address. The study should take no more than 30 minutes to one hour of your time. Additionally, if you choose to review the results, it may take an additional 30 minutes to one hour. If you have questions please do not hesitate to contact me!

Please click on this link to participate in the survey.

Thank you for your consideration!

Sara Miles McPherson, MSN, RN, CCRN
Student Investigator
309-530-9465
Miless1@unlv.nevada.edu

Lori Candela, EdD, RN, APRN, FNP-BC, CNE
Principal Investigator
702-895-2443
lori.candela@unlv.edu

APPENDIX G

Thank you for your participation in Round 1 of the Delphi study to understand the preparation and support needs of undergraduate clinical nursing faculty. A link is included at the bottom to review the statements compiled from the analysis of the surveys. Please review each statement for relevance and accuracy. There is a box under each statement where you can provide feedback on whether the statements accurately describe the information you provided in the survey. Please include whether you believe the statements are relevant to the preparation and support needed for undergraduate clinical nursing faculty and appropriate. Feel free to make any additional comments regarding the statement in the text box below each statement. I would appreciate it if you could complete this review within one week. You are encouraged to ask questions you have about this study at any time. You may contact Sara Miles McPherson at the contacts listed below.

Your participation in this review portion of the survey statements is appreciated. Thank you for your time.

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Student Investigator
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Miless1@unlv.nevada.edu

Lori Candela, EdD, RN, APRN, FNP-BC, CNE
Principal Investigator
702-895-2443
lori.candela@unlv.edu

APPENDIX H

UNLV Biomedical IRB - Exempt
Review Exempt Notice

DATE:	October 16, 2015
TO:	Lori Candela, EdD
FROM:	Office of Research Integrity - Human Subjects
PROTOCOL TITLE:	[820594-1] UNDERSTANDING THE PREPARATION AND SUPPORT NEEDS OF UNDERGRADUATE CLINICAL NURSING FACULTY
ACTION:	DETERMINATION OF EXEMPT STATUS
EXEMPT DATE:	October 16, 2015
REVIEW CATEGORY:	Exemption category # 2

Thank you for your submission of New Project materials for this protocol. This memorandum is notification that the protocol referenced above has been reviewed as indicated in Federal regulatory statutes 45CFR46.101(b) and deemed exempt.

We will retain a copy of this correspondence with our records.

PLEASE NOTE:

Upon final determination of exempt status, the research team is responsible for conducting the research as stated in the exempt application reviewed by the ORI - HS and/or the IRB which shall include using the most recently submitted Informed Consent/Assent Forms (Information Sheet) and recruitment materials. The official versions of these forms are indicated by footer which contains the date exempted.

Any changes to the application may cause this protocol to require a different level of IRB review. Should any changes need to be made, please submit a **Modification Form**. When the above-referenced protocol has been completed, please submit a **Continuing Review/Progress Completion report** to notify ORI - HS of its closure.

If you have questions, please contact the Office of Research Integrity - Human Subjects at IRB@unlv.edu or call 702-895-2794. Please include your protocol title and IRBNet ID in all correspondence.

Office of Research Integrity - Human Subjects

4505 Maryland Parkway . Box 451047 . Las Vegas, Nevada 89154-1047 (702) 895-2794 . FAX: (702) 895-0805 . IRB@unlv.edu

APPENDIX I

INFORMED CONSENT

Department of Nursing

TITLE OF STUDY: Understanding the Preparation and Support Needs of Undergraduate Clinical Nursing Faculty

INVESTIGATOR(S): Principal Investigator: Lori Candela, EdD, RN, APRN, FNP-BC, CNE Student Investigator: Sara Miles McPherson, MSN, RN, CCRN

For questions or concerns about the study, you may contact Lori Candela at 702-895-2443 or Sara Miles McPherson at 309-530-9465**.**

For questions regarding the rights of research subjects, any complaints or comments regarding the manner in which the study is being conducted, contact **the UNLV Office of Research Integrity – Human Subjects at 702-895-2794, toll free at 877-895-2794 or via email at IRB@unlv.edu.**

Purpose of the Study

You are invited to participate in a research study. The purpose of this study is (a) to determine what preparation and support part-time and full-time undergraduate clinical nursing faculty receive prior to assuming their clinical teaching responsibilities, (b) what they believe they need to adequately perform their jobs, and (c) if there are differences between the perceived preparation and support needs of full-time and part-time undergraduate nursing faculty prior to assuming their clinical teaching responsibilities.

Participants

You are being asked to participate in the study because you fit this criteria: A clinical nursing faculty member who has taught at least one student clinical course in the last twelve months.

Procedures

If you volunteer to participate in this study, you will be asked to do the following: complete a 20 question demographic survey and a 76 question Likert scale survey and one question prioritizing needs.

Benefits of Participation

There may be no direct benefits to you as a participant in this study. However, some may feel positive about providing input on improving the preparation and support for faculty teaching in the clinical settings.

Risks of Participation

There are risks involved in all research studies. This study includes only minimal risks. Nursing faculty may feel some discomfort with answering one or more questions in the survey.

Cost /Compensation

There will be no financial cost to you to participate in this study. Answering the demographics and Likert scale survey will take 30-45 minutes. You will not be compensated for your time.

Confidentiality

All information gathered in this study will be kept as confidential as possible. No reference will be made in written or oral materials that could link you to this study. All records will be stored in a locked facility at UNLV for 3 years after completion of the study. After the storage time the information gathered will be destroyed.

Voluntary Participation

Your participation in this study is voluntary. You may refuse to participate in this study or in any part of this study. You may skip any question you do not wish to answer. You may withdraw from the study at any time without prejudice to your relations with UNLV. You are encouraged to ask questions about this study at the beginning or any time during the research study.

Participant Consent:

I have read the above information and agree to participate in this study. I am at least 18 years of age. A copy of this form has been given to me. By clicking on the link at the bottom of this page, you indicate your consent to participate in this study.

APPENDIX J

Understanding the needs of clinical nursing faculty

My name is Sara Miles McPherson and I am a PhD in Nursing student at the University of Nevada, Las Vegas. I am conducting a two round Delphi study to understand the preparation and support needs of undergraduate clinical nursing faculty. The first round is completed and from that data, I have developed a survey. For this second round of the Delphi, I am hoping you will be willing to forward this e-mail to your full, part-time, and adjunct faculty so they may consider responding to my survey.

As a nursing faculty member who teaches clinical groups, I know that taking on a new role as clinical nursing can be challenging. Understanding what clinical nursing faculty believe they need to perform their job adequately will help schools of nursing prepare new clinical faculty.

With the benefit of your help, I hope to be able to allow schools of nursing a better understanding of what clinical nursing faculty need to be better prepared for their role. To participate in this study, I am looking for clinical nursing faculty who have taught at least one clinical student group in the last twelve months. If you would be willing to participate in this study there is a link below. There is a 20 question demographic survey, followed by a 76 item Likert scale survey and one question prioritizing needs. The study should take no more than 30-45 minutes of your time. If you have questions please do not hesitate to contact me!

Please click on the link below and read the informed consent. If you agree to participate, you will be automatically directed to the survey.

Thank you for your consideration!

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Student Investigator
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Miless1@unlv.nevada.edu

Lori Candela, EdD, RN, APRN, FNP-BC, CNE
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APPENDIX K

Understanding the needs of clinical nursing faculty

Several days have passed since I sent you a request for assistance in a research project on the preparation and support needs of undergraduate clinical nursing faculty. Thank you so much if you already responded. If you have not yet participated, I would be very grateful if you would read on and consider participating in the study now.

My name is Sara Miles McPherson and I am a PhD in Nursing student at the University of Nevada, Las Vegas. I am conducting a two round Delphi study to understand the preparation and support needs of undergraduate clinical nursing faculty. The first round is completed and from that data, I have developed a survey. For this second round of the Delphi, I am hoping you will be willing to forward this e-mail to your full, part-time, and adjunct faculty so they may consider responding to my survey.

As a nursing faculty member who teaches clinical groups, I know that taking on a new role as clinical nursing can be challenging. Understanding what clinical nursing faculty believe they need to perform their job adequately will help schools of nursing prepare new clinical faculty.

With the benefit of your help, I hope to be able to allow schools of nursing a better understanding of what clinical nursing faculty need to be better prepared for their role. To participate in this study, I am looking for clinical nursing faculty who have taught at least one clinical student group in the last twelve months. If you would be willing to participate in this study there is a link below. There is a 20 question demographic survey, followed by a 76 item Likert scale survey and one question prioritizing needs. The study should take no more than 15-30 minutes of your time. If you have questions please do not hesitate to contact me!

Please click on the link below and read the informed consent. If you agree to participate, you will be automatically directed to the survey.

Thank you for your consideration!

Sara Miles McPherson, MSN, RN, CCRN
Student Investigator
309-530-9465
Miless1@unlv.nevada.edu

Lori Candela, EdD, RN, APRN, FNP-BC, CNE
Principal Investigator
702-895-2443
lori.candela@unlv.edu

APPENDIX L

Round 2 Survey

Please answer the following demographic questions. To participate in the survey you must have taught at least one student clinical group within the last twelve months.

Q3 Please indicate your age:

- 25-34 years old (1)
- 35-44 years old (2)
- 45-54 years old (3)
- >55 years old (4)

Q4 Please indicate your gender:

- Male (1)
- Female (2)

Q5 Please indicate your race/ethnicity:

- White (1)
- Hispanic or Latino (2)
- Black or African American (3)
- Native American or American Indian (4)
- Asian/Pacific Islander (5)
- Other (6)

Q6 Please indicate your education background:

- Bachelor's Degree (1)
- Master's Degree (2)
- Doctorate of Nursing Practice (3)
- Ph. D. (4)
- Other (5) _____

Q7 What was your graduate education focused on:

- Nursing Education (1)
- Advanced Practice Nursing (2)
- Other (3) _____

Q8 Are you employed as a clinical instructor:

- ❍ Part-time or Adjunct (1)
- ❍ Full-time (2)

Q9 Have you taught in a clinical course within the past 12 months?

- ❍ Yes (1)
- ❍ No (2)

Q10 How many years have you been instructing students in the clinical setting?

- ❍ (1)
- ❍ 1-5 years (2)
- ❍ 6-10 years (3)
- ❍ 11-15 years (4)
- ❍ >16 years (5)

Q11 Is your employer for the clinical instruction of nursing students the hospital or the college/university?

- ❍ Hospital (1)
- ❍ College/University (2)

Q12 Do you teach clinical nursing students in the hospital you work in?

- ❍ Yes (1)
- ❍ No (2)

Answer If Do you teach clinical nursing students in the hospital you work in? Yes Is Selected

Q13 On days when you are teaching a student clinical group, are you asked by hospital staff to complete duties not related to clinical instruction of students?

- ❍ Yes (1)
- ❍ No (2)

Q14 Were you previously employed at the hospital where you teach a clinical?

- ❍ Yes (1)
- ❍ No (2)

Q15 What clinical area do you primarily instruct students in?

- ❑ Medical/Surgical (1)
- ❑ Obstetrics (2)
- ❑ Pediatrics (3)
- ❑ Psych/Mental Health (4)
- ❑ Critical Care (5)

Q16 Is the clinical you are teaching in given a letter-grade or given a Pass/Fail at the end of the semester?

- ❍ Graded (1)
- ❍ Pass/Fail (2)
- ❍ Other (3) _____

Q17 Do you use a clinical evaluation tool?

- ❍ Yes (1)
- ❍ No (2)

Q18 If you use clinical evaluation tools, how often do you use them?

- ❍ Midterm and Final (1)
- ❍ Final (2)
- ❍ Other (3) _____

Q19 Do you use clinical contracts in the clinical setting?

- ❍ Yes (1)
- ❍ No (2)

Q20 Are you provided professional development in your clinical faculty position?

- ❍ Yes (1)
- ❍ No (2)

Q21 Are you reimbursed for professional development?

- ❍ Yes (1)
- ❍ No (2)

Q22 Which of the following best describes the reason you decided to take on the role of undergraduate clinical faculty?

- ❍ Additional compensation (1)
- ❍ Enjoyment of teaching (2)
- ❍ Seeking a full-time faculty position (3)
- ❍ Other (4) _____

Q24 The items listed below were identified by a panel of experts in Round 1 of this Delphi study. Directions: Using a 5-point Likert-scale below, please indicate your level of agreement with how important each of the following is in preparing and supporting you in your role teaching student clinical groups. Scale: 1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree.

Q25 For support in my role as clinical faculty I have:

	Strongly Disagree (1)	Disagree (2)	Neither Agree nor Disagree (3)	Agree (4)	Strongly Agree (5)
used a colleague as a primary resource. (1)	❍	❍	❍	❍	❍
been assigned a mentor. (2)	❍	❍	❍	❍	❍
used the course coordinator or faculty lead for support or questions. (3)	❍	❍	❍	❍	❍

Q26 For training in my role as clinical faculty I have:

	Strongly Disagree (1)	Disagree (2)	Neither Agree nor Disagree (3)	Agree (4)	Strongly Agree (5)
had no formal training. (1)	❍	❍	❍	❍	❍
had a formal orientation to my role and responsibilities. (2)	❍	❍	❍	❍	❍
had content presented in my educational preparation (master's or PhD degree in nursing education or education courses). (3)	❍	❍	❍	❍	❍
received verbal instruction. (4)	❍	❍	❍	❍	❍
received written instruction. (5)	❍	❍	❍	❍	❍
received a brief overview of the clinical faculty role. (6)	❍	❍	❍	❍	❍
relied on experience from m y previous work as a staff nurse. (7)	❍	❍	❍	❍	❍

Q27 Please indicate how beneficial the resources below would be to you in the clinical setting.

	Strongly Disagree (1)	Disagree (2)	Neither Agree nor Disagree (3)	Agree (4)	Strongly Agree (5)
Information on the expectations of my role as clinical faculty. (1)	❍	❍	❍	❍	❍
Information on the expectations of student performance. (2)	❍	❍	❍	❍	❍
Information on the course and student outcomes. (3)	❍	❍	❍	❍	❍
A mentor for clinical nursing faculty. (4)	❍	❍	❍	❍	❍
A clear understanding of the clinical evaluation process. (5)	❍	❍	❍	❍	❍
An orientation to the clinical facility where my clinical course will be conducted. (6)	❍	❍	❍	❍	❍
An orientation on how to handle difficult students. (7)	❍	❍	❍	❍	❍

Q28 Please indicate with the Likert-scale how you agree or disagree with these concerns in the clinical setting.

	Strongly Disagree (1)	Disagree (2)	Neither Agree nor Disagree (3)	Agree (4)	Strongly Agree (5)
Safety is a major concern for me in the clinical setting. (1)	❍	❍	❍	❍	❍
Being responsible for students and patients. (2)	❍	❍	❍	❍	❍
Medication administration. (3)	❍	❍	❍	❍	❍
Unsafe students. (4)	❍	❍	❍	❍	❍
Lack of confidential space for discussion. (5)	❍	❍	❍	❍	❍
How I communicate my role to the staff and managers so they know what to expect from me and my students. (6)	❍	❍	❍	❍	❍
Unclear expectations which influence safety. (7)	❍	❍	❍	❍	❍
Orientation to the clinical placement site. (8)	❍	❍	❍	❍	❍
Quality and quantity of clinical placements sites. (9)	❍	❍	❍	❍	❍
Number of new Registered Nurses on clinical units with minimal experience. (10)	❍	❍	❍	❍	❍
The number of student I have in the clinical setting. (11)	❍	❍	❍	❍	❍

Q29 Please indicate using the Likert-scale how the communication systems in place between you and the nursing program you work for support you in completing your job.

	Strongly Disagree (1)	Disagree (2)	Neither Agree nor Disagree (3)	Agree (4)	Strongly Agree (5)
The communication systems in place between me and the nursing program I work for support me in completing my job. (1)	❍	❍	❍	❍	❍
The use of email, phone, and text allows for appropriate and effective communication with the nursing program. (2)	❍	❍	❍	❍	❍
Meeting with my program of nursing (clinical faculty, course leader, etc.) on a regular basis is important. (3)	❍	❍	❍	❍	❍
Good communication with the course leader is needed to effectively perform my job as clinical nursing faculty. (4)	❍	❍	❍	❍	❍

Q30 Using the Likert-scale indicate how you feel about the communication between the nursing program you work for and clinical faculty.

	Strongly Disagree (1)	Disagree (2)	Neither Agree nor Disagree (3)	Agree (4)	Strongly Agree (5)
Communication between the nursing program and clinical faculty is lacking in consistency. (1)	❍	❍	❍	❍	❍
Clinical faculty have no input on changes made affecting clinical courses. (2)	❍	❍	❍	❍	❍
Different faculty have different expectations for students. (3)	❍	❍	❍	❍	❍
Clinical faculty do not have the adequate resources to follow policies and procedures. (4)	❍	❍	❍	❍	❍
Clinical faculty are not familiar with the curriculum of the nursing program. (5)	❍	❍	❍	❍	❍
New clinical faculty need continuous communication from the nursing program. (6)	❍	❍	❍	❍	❍
Communication gaps exist between the faculty, dean, coordinators, and/or the hospital representatives. (7)	❍	❍	❍	❍	❍

Q31 Please indicate using the Likert-scale how well you believe the items would improve communication between the nursing program you work for and clinical faculty. To improve communication between the nursing program and clinical faculty it would be beneficial to:

	Strongly Disagree (1)	Disagree (2)	Neither Agree nor Disagree (3)	Agree (4)	Strongly Agree (5)
Meet with all clinical faculty so there is consistency. (1)	❍	❍	❍	❍	❍
Have a course coordinator who communicates well with clinical faculty. (2)	❍	❍	❍	❍	❍
Have contact with the nursing program daily. (3)	❍	❍	❍	❍	❍
Have faculty from the nursing program meet with clinical faculty and student if there is a problem. (4)	❍	❍	❍	❍	❍
Have faculty from the nursing program meet with clinical faculty and student if there is a problem. (5)	❍	❍	❍	❍	❍
Have input from all faculty. (6)	❍	❍	❍	❍	❍
Have open and honest communication. (7)	❍	❍	❍	❍	❍
Face to face meetings with all faculty (including clinical faculty). (8)	❍	❍	❍	❍	❍

Q32 A clinical orientation:

	Strongly Disagree (1)	Disagree (2)	Neither Agree nor Disagree (3)	Agree (4)	Strongly Agree (5)
Should be mandatory for all clinical faculty. (1)	❍	❍	❍	❍	❍
Should occur yearly to allow for clinical faculty to get the most up-to-date information. (2)	❍	❍	❍	❍	❍
Provide information on expectations. (3)	❍	❍	❍	❍	❍

Q33 Please indicate using the Likert-scale how you provide feedback to students regarding their progress towards program objective mastery in the clinical setting.

	Strongly Disagree (1)	Disagree (2)	Neither Agree nor Disagree (3)	Agree (4)	Strongly Agree (5)
Constructive feedback is provided to students with the use of verbal communication. (1)	❍	❍	❍	❍	❍
Concerns regarding student performance are verbally communicated to students. (2)	❍	❍	❍	❍	❍
Clinical faculty document written feedback on each student weekly. (3)	❍	❍	❍	❍	❍
Clinical faculty keep anecdotal notes of student clinical performance. (4)	❍	❍	❍	❍	❍
Students receive written feedback immediately in the clinical setting if a problem has been identified. (5)	❍	❍	❍	❍	❍
Written clinical evaluations are completed on each student. (6)	❍	❍	❍	❍	❍
Written clinical evaluations are done at midterm and final. (7)	❍	❍	❍	❍	❍

Q34 Please indicate on the Likert-scale how you think the items below would help you to communicate constructive feedback to students in the clinical setting.

	Strongly Disagree (1)	Disagree (2)	Neither Agree nor Disagree (3)	Agree (4)	Strongly Agree (5)
Having an understanding of the clinical evaluation tool. (1)	❍	❍	❍	❍	❍
Having a comprehensive clinical evaluation tools is needed to evaluate students. (2)	❍	❍	❍	❍	❍
Having communication training on how to have difficult conversations with students regarding their performance. (3)	❍	❍	❍	❍	❍
Having a simulated experience on how to effectively communicate. (4)	❍	❍	❍	❍	❍
Having examples of constructive feedback that has been used in the past. (5)	❍	❍	❍	❍	❍
Having an orientation that includes training on correctly filling out documents. (6)	❍	❍	❍	❍	❍
A handbook for clinical faculty. (7)	❍	❍	❍	❍	❍

Q35 Please indicate using the Likert-scale how much of a concern the items below are for you with the process of clinical evaluation of students.

	Strongly Disagree (1)	Disagree (2)	Neither Agree nor Disagree (3)	Agree (4)	Strongly Agree (5)
Clinical evaluation tools are too abstract. (1)	❍	❍	❍	❍	❍
Clinical evaluation tools do not provide a true reflection of student performance. (2)	❍	❍	❍	❍	❍
Clinical evaluation tools are poorly written. (3)	❍	❍	❍	❍	❍
Clinical evaluation tools are too subjective. (4)	❍	❍	❍	❍	❍
Clinical faculty do not have proper training on how to complete the clinical evaluation tool. (5)	❍	❍	❍	❍	❍
There is a lack of consistency in how clinical faculty fill out the clinical evaluation tool. (6)	❍	❍	❍	❍	❍
There is a lack of consistency about what defines an unsafe student. (7)	❍	❍	❍	❍	❍
Clinical evaluation tools are too long. (8)	❍	❍	❍	❍	❍
It is difficult to complete the clinical evaluation tool because clinical faculty do not spend enough time with students. (9)	❍	❍	❍	❍	❍
It is difficult to evaluate students when clinical faculty have large clinical groups. (10)	❍	❍	❍	❍	❍
Failing a student is difficult. (11)	❍	❍	❍	❍	❍
There is a lack of support in regards to clinical faculty's evaluation of student performance. (12)	❍	❍	❍	❍	❍

Q36 Please prioritize (1= highest priority; 7= lowest priority) the variables in order you believe are the most important for developing clinical faculty. Drag the variables to place them in order.

_____ Support (1)
_____ Training (2)
_____ Resources (3)
_____ Communication (4)
_____ Expectations on the role of clinical nursing faculty (5)
_____ Clinical Evaluations (6)
_____ Knowledge about maintaining safety (7)

Q37 At this time you may go back and review your answers or click the arrow to submit your survey. Thank you.

APPENDIX M

Independent t-tests for Educational Background

Summary Variables	*t(74)*	Sig.
Support	1.58	.118
Training	1.74	.09
Resources that would be useful	.755	.45
Concerns	-.66	.513
Communication systems in place	.43	.67
Communication between clinical faculty and nursing program	-.09	.93
Possibilities for improving communication	.51	.69
Usefulness of clinical orientation	.40	.69
Providing student feedback	1.93	.06
Communicating constructive feedback	.91	.37
Process of clinical evaluations	.45	.65

Note: t(df) = independent *t*-test and degrees of freedom for a comparison of educational background; Sig. = significance at the < .05 level.

Descriptive for Summary Variables for Educational Background

Summary Variables	Educational Background	*n*	*M(SD)*
Support	Nursing Education	49	4.02(.87)
	Advanced Practice Nursing/Other	27	3.70(.82)
Training	Nursing Education	49	3.75(.55)
	Advanced Practice Nursing/Other	27	3.53(.48)
Resources that would be useful	Nursing Education	49	4.27(.83)
	Advanced Practice Nursing/Other	27	4.12(.73)

Concerns	Nursing Education	49	4.06(.59)
	Advanced Practice Nursing/Other	27	4.15(.58)
Communication systems in place	Nursing Education	49	4.24(.64)
	Advanced Practice Nursing/Other	27	4.18(.54)
Communication between clinical faculty and nursing program	Nursing Education	49	3.14(.71)
	Advanced Practice Nursing/Other	27	3.16(.71)
Possibilities for improving communication	Nursing Education	49	4.14(.58)
	Advanced Practice Nursing/Other	27	4.07(.46)
Usefulness of clinical orientation	Nursing Education	49	4.55(.49)
	Advanced Practice Nursing/Other	27	4.50(.52)
Providing student feedback	Nursing Education	49	4.31(.48)
	Advanced Practice Nursing/Other	27	4.09(.46)
Communicating constructive feedback	Nursing Education	49	4.33(.47)
	Advanced Practice Nursing/Other	27	4.22(.48)
Process of clinical evaluations	Nursing Education	49	3.20(.74)
	Advanced Practice Nursing/Other	27	3.12(.75)

Note: *n* = raw number of responses; *M(SD)*= mean and standard deviation.

APPENDIX N

Support Source Variable: Descriptive Statistics by Educational Background

Support	Educational Background	*n*	*M(SD)*
Used a colleague as a primary resource.	Nursing Education	49	4.57(.82)
	Advanced Practice Nursing/Other	27	4.07(1.0)
Been assigned a mentor.	Nursing Education	49	3.24(1.42)
	Advanced Practice Nursing/Other	27	2.71(1.46)
Used the course coordinator or faculty lead for support	Nursing Education	49	4.24(1.15)
	Advanced Practice Nursing/Other	27	4.31(.77)

Note: *n* = raw number of responses; *M(SD)*= mean and standard deviation.

Training Variable: Descriptive Statistics by Educational Background

Training	Educational Background	*n*	*M(SD)*
Had no formal training	Nursing Education	49	3.02(1.4)
	Advanced Practice Nursing/Other	27	2.93(1.27)
Had a formal orientation to my role and responsibilities	Nursing Education	49	3.06(1.28)
	Advanced Practice Nursing/Other	27	3.33(1.14)
Had content presented in my educational preparation	Nursing Education	49	4.04(.87)
	Advanced Practice Nursing/Other	27	3.15(.99)
Received verbal instruction	Nursing Education	49	4.14(.71)
	Advanced Practice Nursing/Other	27	3.78(.75)
Received written instruction	Nursing Education	49	3.47(1.12)

	Advanced Practice Nursing/Other	27	3.33(.92)
For training: -received a brief overview of clinical faculty role	Nursing Education	49	4.10(.62)
	Advanced Practice Nursing/Other	27	3.67(.83)
For training: -received a brief overview of clinical faculty role	Nursing Education	49	4.45(.74)
	Advanced Practice Nursing/Other	27	4.37(.63)
For training: -relied on experience from previous work as a staff nurse	Nursing Education	49	3.75(.55)
	Advanced Practice Nursing/Other	27	3.53(.48)

Note: *n* = raw number of responses; *M(SD)*= mean and standard deviation.

Resources Variable: Descriptive Statistics by Educational Background

Resources	Educational Background	*n*	*M(SD)*
Information on the expectations of my role as clinical faculty	Nursing Education	49	4.27(.995)
	Advanced Practice Nursing/Other	27	4.37(.629)
Information on the expectations of student performance.	Nursing Education	49	4.41(.864)
	Advanced Practice Nursing/Other	27	4.33(.784)
Information on the course and student outcomes.	Nursing Education	49	4.45(.818)
	Advanced Practice Nursing/Other	27	4.19(.834)
A mentor for clinical nursing faculty.	Nursing Education	49	4.16(1.007)
	Advanced Practice Nursing/Other	27	3.85(1.167)
A clear understanding of the clinical evaluation process.	Nursing Education	49	4.24(1.071)
	Advanced Practice Nursing/Other	27	4.19(.962)
An orientation to the clinical facility where my clinical course will be conducted	Nursing Education	49	4.29(1.00)

	Advanced Practice Nursing/Other	27	4.00(.832)
An orientation on how to handle difficult students.	Nursing Education	49	4.04(1.207)
	Advanced Practice Nursing/Other	27	3.93(1.107)

Note: *n* = raw number of responses; *M(SD)*= mean and standard deviation.

Concerns Variable: Descriptive Statistics by Educational Background

Concerns	Educational Background	*n*	*M(SD)*
Safety is a major concern for me in the clinical setting.	Nursing Education	49	4.40(1.056)
	Advanced Practice Nursing/Other	27	4.45(.847)
Being responsible for students and patients.	Nursing Education	49	4.65(.661)
	Advanced Practice Nursing/Other	27	4.59(.636)
Medication administration.	Nursing Education	49	4.52(.79)
	Advanced Practice Nursing/Other	27	4.44(.698)
Unsafe students.	Nursing Education	49	4.33(.850)
	Advanced Practice Nursing/Other	27	4.37(1.006)
Lack of confidential space for discussion.	Nursing Education	49	3.42(1.32)
	Advanced Practice Nursing/Other	27	3.84(1.10)
How I communicate my role to the staff and managers so they know what to expect from me and my students.	Nursing Education	49	3.92(.976)
	Advanced Practice Nursing/Other	27	4.19(1.001)
Unclear expectations which influence safety.	Nursing Education	49	3.65(1.164)
	Advanced Practice Nursing/Other	27	4.00(1.074)
Orientation to the clinical placement site.	Nursing Education	49	3.86(.957)

	Advanced Practice Nursing/Other	27	4.15(.818)
Quality and quantity of clinical placement sites.	Nursing Education	49	3.94(.988)
	Advanced Practice Nursing/Other	27	3.93(1.174)
Number of new registered nurses on clinical units with minimal experience.	Nursing Education	49	3.94(.719)
	Advanced Practice Nursing/Other	27	3.36(1.043)
The number of students I have in the clinical setting.	Nursing Education	49	4.06(1.107)
	Advanced Practice Nursing/Other	27	4.00(.92)

Note: n = raw number of responses; *M(SD)*= mean and standard deviation.

Communication Systems Variable: Descriptive Statistics by Educational Background

Communication Systems	Educational Background	*n*	*M(SD)*
The communication systems in place between me and the nursing program I work for support me in completing my job.	Nursing Education	49	4.10(.895)
	Advanced Practice Nursing/Other	27	3.96(.898)
The use of email, phone, and text allows for appropriate and effective communication with the nursing program.	Nursing Education	49	4.37(.696)
	Advanced Practice Nursing/Other	27	4.07(.781)
Meeting with my program of nursing (clinical faculty, course leader, etc.) on a regular basis is important.	Nursing Education	49	4.06(.899)
	Advanced Practice Nursing/Other	27	4.15(.864)
Good communication with the course leader is needed to effectively perform my job as clinical nursing faculty.	Nursing Education	49	4.42(.812)
	Advanced Practice Nursing/Other	27	4.52(.643)

Note: n = raw number of responses; *M(SD)*= mean and standard deviation.

Communication between Faculty and Nursing Program Variable: Descriptive Statistics by Educational Background

Communication Between Faculty and Nursing Program	Educational Background	*n*	*M(SD)*
Communication between the nursing program and clinical faculty is lacking in consistency.	Nursing Education	49	2.98(1.164)
	Advanced Practice Nursing/Other	27	3.11(1.121)
Clinical faculty have no input on changes made affecting clinical courses.	Nursing Education	49	2.63(1.069)
	Advanced Practice Nursing/Other	27	2.37(1.006)
Different faculty have different expectations for students.	Nursing Education	49	4.14(.677)
	Advanced Practice Nursing/Other	27	3.76(1.03)
Clinical faculty do not have the adequate resources to follow policies and procedures.	Nursing Education	49	2.39(1.012)
	Advanced Practice Nursing/Other	27	2.59(1.085)
Clinical faculty are not familiar with the curriculum of the nursing program.	Nursing Education	49	2.62(1.217)
	Advanced Practice Nursing/Other	27	2.94(1.259)
New clinical faculty need continuous communication from the nursing program.	Nursing Education	49	4.27(.668)
	Advanced Practice Nursing/Other	27	4.10(.947)
Communication gaps exist between the faculty, dean, coordinators, and/or the hospital representatives.	Nursing Education	49	2.96(1.241)
	Advanced Practice Nursing/Other	27	3.23(1.128)

Note: n = raw number of responses; *M(SD)*= mean and standard deviation.

Communication Improvement Variable: Descriptive Statistics by Educational Background

Communication Improvement	Educational Background	*n*	*M(SD)*
Meet with all clinical faculty so there is consistency.	Nursing Education	49	4.41(.752)
	Advanced Practice Nursing/Other	27	4.23(.750)
Have a course coordinator who communicates well with clinical faculty.	Nursing Education	49	4.56(.697)
	Advanced Practice Nursing/Other	27	4.39(.789)
Have contact with the nursing program daily.	Nursing Education	49	2.96(1.06)
	Advanced Practice Nursing/Other	27	3.04(.94)
Have faculty from the nursing program meet with clinical faculty and student if there is a problem.	Nursing Education	49	4.24(.713)
	Advanced Practice Nursing/Other	27	4.12(.577)
Have faculty from the nursing program meet with clinical faculty and student if there is a problem.	Nursing Education	49	4.20(.78)
	Advanced Practice Nursing/Other	27	4.12(.577)
Have input from all faculty.	Nursing Education	49	3.85(.865)
	Advanced Practice Nursing/Other	27	3.85(.948)
Have open and honest communication.	Nursing Education	49	4.67(.502)
	Advanced Practice Nursing/Other	27	4.62(.684)
Face to face meetings with all faculty (including clinical faculty).	Nursing Education	49	4.24(.917)
	Advanced Practice Nursing/Other	27	4.23(.75)

Note: *n* = raw number of responses; *M(SD)*= mean and standard deviation.

Clinical Orientation Variable: Descriptive Statistics by Educational Background

Clinical Orientations	Educational Background	*n*	*M(SD)*
Should be mandatory for all clinical faculty	Nursing Education	49	4.63(.473)
	Advanced Practice Nursing/Other	27	4.47(.571)
Should occur yearly to allow for clinical faculty to get the most up-to-date information	Nursing Education	49	4.39(.692)
	Advanced Practice Nursing/Other	27	4.50(.572)
Provide information on expectations	Nursing Education	49	4.63(.473)
	Advanced Practice Nursing/Other	27	4.54(.499)

Note: *n* = raw number of responses; *M(SD)*= mean and standard deviation.

Constructive Feedback Variable: Descriptive Statistics by Educational Background.

Constructive Feedback	Educational Background	*n*	*M(SD)*
Having an understanding of the clinical evaluations tool.	Nursing Education	49	4.58(.482)
	Advanced Practice Nursing/Other	27	4.49(.49)
Having a comprehensive clinical evaluation tool is needed to evaluate students.	Nursing Education	49	4.46(.698)
	Advanced Practice Nursing/Other	27	4.4(.555)
Having communication training on how to have difficult conversations with students regarding their performance.	Nursing Education	49	4.31(.813)
	Advanced Practice Nursing/Other	27	4.40(.555)
Having a simulated experience on how to effectively communicate.	Nursing Education	49	3.82(1.105)
	Advanced Practice Nursing/Other	27	3.61(.833)

Having examples of constructive feedback that has been used in the past.	Nursing Education	49	4.21(.761)
	Advanced Practice Nursing/Other	27	4.09(.675)
Having an orientation that includes training on correctly filling out documents.	Nursing Education	49	4.37(.688)
	Advanced Practice Nursing/Other	27	4.25(.695)
A handbook for clinical faculty.	Nursing Education	49	4.54(.529)
	Advanced Practice Nursing/Other	27	4.33(.664)

Note: n = raw number of responses; *M(SD)*= mean and standard deviation.

Clinical Evaluation Variable: Descriptive Statistics by Educational Background.

Concerns with Clinical Evaluation Process	Educational Background	*n*	*M(SD)*
Clinical evaluation tools are too abstract.	Nursing Education	49	3.12(1.13)
	Advanced Practice Nursing/Other	27	2.82(1.111)
Clinical evaluation tools do not provide a true reflection of student performance.	Nursing Education	49	2.94(1.029)
	Advanced Practice Nursing/Other	27	3.03(1.091)
Clinical evaluations tools are poorly written.	Nursing Education	49	2.78(.911)
	Advanced Practice Nursing/Other	27	2.57(.924)
Clinical evaluation tools are too subjective.	Nursing Education	49	3.24(1.064)
	Advanced Practice Nursing/Other	27	3.05(1.056)
Clinical faculty do not have proper training on how to complete the clinical evaluation tool.	Nursing Education	49	3.30(1.17)
	Advanced Practice Nursing/Other	27	3.28(1.161)

There is a lack of consistency in how clinical faculty fill out the clinical evaluation tool.	Nursing Education	49	3.78(.956)
	Advanced Practice Nursing/Other	27	3.52(1.111)
There is a lack of consistency about what defines an unsafe student.	Nursing Education	49	3.13(1.201)
	Advanced Practice Nursing/Other	27	3.04(1.255)
Clinical evaluation tools are too long.	Nursing Education	49	3.16(1.136)
	Advanced Practice Nursing/Other	27	3.39(1.11)
It is difficult to complete the clinical evaluation tool because clinical faculty do not spend enough time with students.	Nursing Education	49	2.45(1.165)
	Advanced Practice Nursing/Other	27	2.55(1.003)
It is difficult to evaluate students when clinical faculty have large clinical groups.	Nursing Education	49	3.95(1.099)
	Advanced Practice Nursing/Other	27	3.77(1.085)
Failing a student is difficult.	Nursing Education	49	4.02(1.01)
	Advanced Practice Nursing/Other	27	3.73(1.058)
There is a lack of support in regards to clinical faculty's evaluation of student performance.	Nursing Education	49	2.55(.973)
	Advanced Practice Nursing/Other	27	2.67(1.134)

Note: *n* = raw number of responses; *M(SD)*= mean and standard deviation.

APPENDIX O

Resources Variable: Independent t-tests by Nursing Education Background

Resources	*t(74)*	Sig.
How beneficial: -information on the expectations of my role as clinical faculty.	-.496	.622
How beneficial: -information on the expectations of student performance.	.373	.710
How beneficial: -information on the course and student outcomes.	1.336	.186
How beneficial: -A mentor for clinical nursing faculty.	1.219	.227
How beneficial: -A clear understanding of the clinical evaluation process.	.241	.810
How beneficial: -An orientation to the clinical facility where my clinical course will be conducted.	1.262	.211
How beneficial: -An orientation on how to handle difficult students.	.409	.684

Note: t(df) = independent *t*-test and degrees of freedom for a comparison of educational background.; Sig. = significance at the < .05 level.

Concerns Variable: Independent t-tests by Nursing Education Background

Concerns	*t(df)*	Sig.
Safety is a major concern for me in the clinical setting.	-.669(74)	.505
Being responsible for students and patients.	.339(74)	.736
Medication administration.	.417(74)	.678
Unsafe students.	-.168(74)	.867
Lack of confidential space for discussion.	-1.391(74)	.168
How I communicate my role to the staff and managers so they know what to expect from me and my students.	-1.128(74)	.263
Unclear expectations which influence safety.	-1.294(74)	.200
Orientation to the clinical placement site.	-1.337(74)	.185
Quality and quantity of clinical placement sites.	.045(74)	.964

Number of new registered nurses on clinical units with minimal experience.	1.356(39.92)	.183
The number of students I have in the clinical setting.	.248(74)	.805

Note: t(df) = independent *t*-test and degrees of freedom for a comparison of educational background.; Sig. = significance at the < .05 level.

Communication Systems Variable: Independent t-tests Education Background

Communication Systems	*t(74)*	Sig.
The communication systems in place between me and the nursing program I work for support me in completing my job.	.652	.516
The use of email, phone, and text allows for appropriate and effective communication with the nursing program.	1.714	.091
Meeting with my program of nursing (clinical faculty, course leader, etc.) on a regular basis is important.	-.403	.688
Good communication with the course leader is needed to effectively perform my job as clinical nursing faculty.	-.556	.580

Note: t(df) = independent *t*-test and degrees of freedom for a comparison of educational background.; Sig. = significance at the < .05 level.

Communication between Faculty and Nursing Program Variable: Independent t-tests by Nursing Education Background

Communication between Faculty and Nursing Program	*t(df)*	Sig.
Communication between the nursing program and clinical faculty is lacking in consistency.	-.476*(74)*	.636
Clinical faculty have no input on changes made affecting clinical courses.	1.049*(74)*	.297
Different faculty have different expectations for students.	-1.740*(38.7)*	.09
Clinical faculty do not have the adequate resources to follow policies and procedures.	-.836*(74)*	.406
Clinical faculty are not familiar with the curriculum of the nursing program.	-1.088*(74)*	.280

New clinical faculty need continuous communication from the nursing program.	.931*(74)*	.355
Communication gaps exist between the faculty, dean, coordinators, and/or the hospital representatives.	-.935*(74)*	.353

Note: t(df) = independent *t*-test and degrees of freedom for a comparison of educational background.; Sig. = significance at the < .05 level.

Communication Improvement Variable: Independent t-tests by Nursing Education Background

Communication Improvement	*t(74)*	Sig.
Meet with all clinical faculty so there is consistency.	.965	.338
Have a course coordinator who communicates well with clinical faculty.	.985	.328
Have contact with the nursing program daily.	-.319	.751
Have faculty from the nursing program meet with clinical faculty and student if there is a problem.	.737	.463
Have faculty from the nursing program meet with clinical faculty and student if there is a problem.	.431	.668
Have input from all faculty.	.008	.994
Have open and honest communication.	.405	.686
Face to face meetings with all faculty (including clinical faculty).	.038	.97

Note: t(df) = independent *t*-test and degrees of freedom for a comparison of educational background.; Sig. = significance at the < .05 level.

Clinical Orientation Variable: Independent t-tests by Nursing Education Background

A Clinical Orientation	*t(74)*	Sig.
Should be mandatory for all clinical faculty.	1.319	.191
Should occur yearly to allow for clinical faculty to get the most up-to-date information.	-.665	.508
Provide information on expectations.	.758	.451

Note: t(df) = independent *t*-test and degrees of freedom for a comparison of educational background.; Sig. = significance at the < .05 level.

Constructive Feedback Variable: Independent t-tests by Nursing Education Background

Constructive Feedback	*t(74)*	Sig.
Having an understanding of the clinical evaluations tool.	.856	.395
Having a comprehensive clinical evaluation tool is needed to evaluate students.	.337	.737
Having communication training on how to have difficult conversations with students regarding their performance.	-.507	.614
Having a simulated experience on how to effectively communicate.	.862	.391
Having examples of constructive feedback that has been used in the past.	.686	.495
Having an orientation that includes training on correctly filling out documents.	.728	.469
A handbook for clinical faculty.	1.495	.139

Note: t(df) = independent *t*-test and degrees of freedom for a comparison of educational background.; Sig. = significance at the < .05 level.

Clinical Evaluation Variable: Independent t-tests by Nursing Education Background

Clinical Evaluations	*t(74)*	Sig.
Clinical evaluation tools are too abstract.	1.142	.257
Clinical evaluation tools do not provide a true reflection of student performance.	-.391	.697
Clinical evaluations tools are poorly written.	.944	.348
Clinical evaluation tools are too subjective.	.742	.46
Clinical faculty do not have proper training on how to complete the clinical evaluation tool.	.081	.936
There is a lack of consistency in how clinical faculty fill out the clinical evaluation tool.	1.055	.295
There is a lack of consistency about what defines an unsafe student.	.288	.774
Clinical evaluation tools are too long.	-.854	.396
It is difficult to complete the clinical evaluation tool because clinical faculty do not spend enough time with students.	-.401	.69
It is difficult to evaluate students when clinical faculty have large clinical groups.	.698	.488
Failing a student is difficult.	1.14	.258
There is a lack of support in regards to clinical faculty's evaluation of student performance.	-.513	.609

Note: t(df) = independent *t*-test and degrees of freedom for a comparison of educational background.; Sig. = significance at the < .05 level.

APPENDIX P

Resources Variable: Independent t-tests by Employment Status

	T(75)	Sig.
How beneficial: -information on the expectations of my role as clinical faculty.	-.410	.683
How beneficial: -information on the expectations of student performance.	-.851	.397
How beneficial: -information on the course and student outcomes.	-1.48	.144
How beneficial: -A mentor for clinical nursing faculty.	-1.69	.096
How beneficial: -A clear understanding of the clinical evaluation process.	-.92	.361
How beneficial: -An orientation to the clinical facility where my clinical course will be conducted.	-1.19	.239
How beneficial: -An orientation on how to handle difficult students.	-1.824	.072
Resources that would be useful for clinical faculty composite variable.	-1.495	.139

Note: t(df) = independent *t*-test and degrees of freedom for a comparison of educational background.; Sig. = significance at the < .05 level.

Communication Systems Variable: Independent t-tests by Employment Status

Communication Systems	*t(75)*	Sig.
The communication systems in place between me and the nursing program I work for support me in completing my job.	-1.23	.224
The use of email, phone, and text allows for appropriate and effective communication with the nursing program.	-1.74	.087
Meeting with my program of nursing (clinical faculty, course leader, etc.) on a regular basis is important.	-.79	.433
Good communication with the course leader is needed to effectively perform my job as clinical nursing faculty.	-.53	.596
Communication Systems composite variable	-1.44	.153

Note: t(df) = independent *t*-test and degrees of freedom for a comparison of educational background.; Sig. = significance at the < .05 level.

Clinical Orientation Variable: Independent t-tests by Employment Status

A Clinical Orientation	*t(df)*	Sig.
Should be mandatory for all clinical faculty.	-1.51(59)	.14
Should occur yearly to allow for clinical faculty to get the most up-to-date information.	-.414(75)	.68
Provide information on expectations.	-1.09(75)	.28

Note: t(df) = independent *t*-test and degrees of freedom for a comparison of educational background.; Sig. = significance at the < .05 level.

Clinical Evaluation Variable: Independent t-tests by Employment Status

Clinical Evaluations	*t(75)*	Sig.
Clinical evaluation tools are too abstract.	.31	.76
Clinical evaluation tools do not provide a true reflection of student performance.	-.06	.96
Clinical evaluations tools are poorly written.	.44	.66
Clinical evaluation tools are too subjective.	.38	.71
Clinical faculty do not have proper training on how to complete the clinical evaluation tool.	.97	.33
There is a lack of consistency in how clinical faculty fill out the clinical evaluation tool.	-.24	.81
There is a lack of consistency about what defines an unsafe student.	.69	.49
Clinical evaluation tools are too long.	.27	.79
It is difficult to complete the clinical evaluation tool because clinical faculty do not spend enough time with students.	-.65	.52
It is difficult to evaluate students when clinical faculty have large clinical groups.	-1.12	.25
Failing a student is difficult.	-1.25	.22
There is a lack of support in regards to clinical faculty's evaluation of student performance.	-.21	.84
Composite variable for usefulness of clinical evaluation tools.	.01	.99

Note: t(df) = independent *t*-test and degrees of freedom for a comparison of educational background.; Sig. = significance at the < .05 level.

APPENDIX Q

Resources Variable: Descriptive Statistics by Employment Status

Resources	Employment Status	*n*	*M(SD)*
Information on the expectations of my role as clinical faculty	Part-time or Adjunct	32	4.25 (.950)
	Full-time	45	4.33(.826)
Information on the expectations of student performance	Part-time or Adjunct	32	4.28(.888)
	Full-time	45	4.44(.785)
Information on the course and student outcomes	Part-time or Adjunct	32	4.19(.965)
	Full-time	45	4.47(.694)
A mentor for clinical nursing faculty	Part-time or Adjunct	32	3.81(1.203)
	Full-time	45	4.22(.927)
A clear understanding of the clinical evaluation process	Part-time or Adjunct	32	4.09(1.146)
	Full-time	45	4.31(.925)
An orientation to the clinical facility where my clinical course will be conducted	Part-time or Adjunct	32	4.03(.933)
	Full-time	45	4.29(.944)
An orientation on how to handle difficult students.	Part-time or Adjunct	32	3.72(1.143)
	Full-time	45	4.20(1.14)
Resources that would be useful for clinical faculty composite variable.	Part-time or Adjunct	32	4.05(.82)
	Full-time	45	4.32(.756)

Note: *n* = raw number of responses; *M(SD)*= mean and standard deviation.

Concerns Variable: Descriptive Statistics by Employment Status

Concerns	Employment Status	*n*	*M(SD)*
Safety is a major concern for me in the clinical setting	Part-time or Adjunct	32	4.31 (1.12)
	Full-time	45	4.57(.863)
Being responsible for students and patients	Part-time or Adjunct	32	4.56(.759)
	Full-time	45	4.68(.555)
Medication administration	Part-time or Adjunct	32	4.47(.803)
	Full-time	45	4.52(.723)
Unsafe students	Part-time or Adjunct	32	4.16(.987)
	Full-time	45	4.50(.812)
Lack of confidential space for discussion	Part-time or Adjunct	32	3.66(1.066)
	Full-time	45	3.49(1.371)
How I communicate my role to the staff and managers so they know what to expect from me and my students	Part-time or Adjunct	32	3.94(.982)
	Full-time	45	4.09(.996)
Unclear expectations which influence safety	Part-time or Adjunct	32	3.69(1.030)
	Full-time	45	3.84(1.205)
Orientation to the clinical placement site	Part-time or Adjunct	32	3.75(.95)
	Full-time	45	4.11(.859)
Quality and quantity of clinical placements sites	Part-time or Adjunct	32	3.47(1.135)
	Full-time	45	4.27(.837)
Number of new Registered Nurses on clinical units with minimal experience	Part-time or Adjunct	32	3.69(.78)

	Full-time	45	3.95(.904)
The number of students I have in the clinical setting	Part-time or Adjunct	32	3.72(.991)
	Full-time	45	4.27(1.009)
Concerns of clinical faculty composite variable	Part-time or Adjunct	32	3.946(.617)
	Full-time	45	4.21(.53)

Note: n = raw number of responses; *M(SD)*= mean and standard deviation.

Communication Systems Variable: Descriptive Statistics by Employment Status

Communication Systems	Employment Status	*n*	*M(SD)*
The communication systems in place between me and the nursing program I work for support me in completing my job	Part-time or Adjunct	32	3.91(.963)
	Full-time	45	4.16(.824)
The use of email, phone, and text allows for appropriate and effective communication with the nursing program	Part-time or Adjunct	32	4.09(.818)
	Full-time	45	4.38(.647)
Meeting with my program of nursing (clinical faculty, course leader, etc.) on a regular basis is important	Part-time or Adjunct	32	3.97(.933)
	Full-time	45	4.13(.894)
Good communication with the course leader is needed to effectively perform my job as clinical nursing faculty	Part-time or Adjunct	32	4.41(.837)
	Full-time	45	4.50(.691)

Note: n = raw number of responses; *M(SD)*= mean and standard deviation.

Communication between Faculty and Nursing Program Variable: Descriptive Statistics by Employment Status

Communication between Faculty and Nursing Program	Employment Status	*n*	*M(SD)*
Communication between the nursing program and clinical faculty is lacking in consistency.	Part-time or Adjunct	32	3.19(1.12)
	Full-time	45	2.93(1.16)
Clinical faculty have no input on changes made affecting clinical courses.	Part-time or Adjunct	32	2.78(1.1)
	Full-time	45	2.38(.98)
Different faculty have different expectations for students.	Part-time or Adjunct	32	3.77(.99)
	Full-time	45	4.2(.66)
Clinical faculty do not have the adequate resources to follow policies and procedures.	Part-time or Adjunct	32	2.53(.95)
	Full-time	45	2.44(1.1)
Clinical faculty are not familiar with the curriculum of the nursing program.	Part-time or Adjunct	32	2.86(1.3)
	Full-time	45	2.63(1.2)
New clinical faculty need continuous communication from the nursing program.	Part-time or Adjunct	32	3.96(.75)
	Full-time	45	4.39(.74)
Communication gaps exist between the faculty, dean, coordinators, and/or the hospital representatives.	Part-time or Adjunct	32	3.16(1.09)
	Full-time	45	3.00(1.28)

Note: *n* = raw number of responses; *M(SD)*= mean and standard deviation.

Communication Improvement Variable: Descriptive Statistics by Employment Status

Communication Improvement	Employment Status	*n*	*M(SD)*
Meet with all clinical faculty so there is consistency	Part-time or Adjunct	32	4.17(.95)
	Full-time	45	4.47(.53)
Have a course coordinator who communicates well with clinical faculty	Part-time or Adjunct	32	4.36(.83)
	Full-time	45	4.61(.64)
Have contact with the nursing program daily	Part-time or Adjunct	32	2.72(.92)
	Full-time	45	3.20(1.04)
Have faculty from the nursing program meet with clinical faculty and student if there is a problem	Part-time or Adjunct	32	4.10(.689)
	Full-time	45	4.26(.642)
Have faculty from the nursing program meet with clinical faculty and student if there is a problem	Part-time or Adjunct	32	4.04(.78)
	Full-time	45	4.26(.64)
Have input from all faculty	Part-time or Adjunct	32	3.84(.77)
	Full-time	45	3.86(.97)
Have open and honest communication	Part-time or Adjunct	32	4.55(.56)
	Full-time	45	4.71(.58)
Face to face meetings with all faculty (including clinical faculty)	Part-time or Adjunct	32	4.10(.89)
	Full-time	45	4.33(.82)

Note: *n* = raw number of responses; *M(SD)*= mean and standard deviation.

Clinical Orientation Variable: Descriptive Statistics by Employment Status

Clinical Orientation	Employment Status	*n*	*M(SD)*
Should be mandatory for all clinical faculty.	Part-time or Adjunct	32	4.46(.56)
	Full-time	45	4.64(.47)
Should occur yearly to allow for clinical faculty to get the most up-to-date information.	Part-time or Adjunct	32	4.39(.55)
	Full-time	45	4.45(.71)
Provide information on expectations.	Part-time or Adjunct	32	4.52(.5)
	Full-time	45	4.64(.47)

Note: *n* = raw number of responses; *M(SD)*= mean and standard deviation.

Providing Feedback Variable: Descriptive Statistics by Educational Background

Providing Feedback	Educational Background	*n*	*M(SD)*
Constructive feedback is provided to students with the use of verbal communication.	Nursing Education	49	4.39(.49)
	Advanced Practice Nursing/Other	27	4.5(.61)
Concerns regarding student performance are verbally communicated to students.	Nursing Education	49	4.36(.54)
	Advanced Practice Nursing/Other	27	4.47(.61)
Clinical faculty document written feedback on each student weekly.	Nursing Education	49	3.74(1.08)
	Advanced Practice Nursing/Other	27	3.90(1.22)
Clinical faculty keep anecdotal notes of student clinical performance.	Nursing Education	49	3.66(1.07)

	Advanced Practice Nursing/Other	27	4.24(.74)
Students receive written feedback immediately in the clinical setting if a problem has been identified.	Nursing Education	49	3.65(1.12)
	Advanced Practice Nursing/Other	27	4.08(.93)
Written clinical evaluations are completed on each student.	Nursing Education	49	4.49(.67)
	Advanced Practice Nursing/Other	27	4.66(.51)
Written clinical evaluations are done at midterm and final.	Nursing Education	49	4.51(.8)
	Advanced Practice Nursing/Other	27	4.29(.98)

Note: *n* = raw number of responses; *M(SD)*= mean and standard deviation.

Constructive Feedback Variable: Descriptive Statistics by Employment Status

Constructive Feedback	Employment Status	*n*	*M(SD)*
Having an understanding of the clinical evaluations tool	Part-time or Adjunct	32	4.52(.5)
	Full-time	45	4.55(.49)
Having a comprehensive clinical evaluation tool is needed to evaluate students	Part-time or Adjunct	32	4.42(.49)
	Full-time	45	4.44(.74)
Having communication training on how to have difficult conversations with students regarding their performance	Part-time or Adjunct	32	4.07(.84)
	Full-time	45	4.53(.57)

Having a simulated experience on how to effectively communicate	Part-time or Adjunct	32	3.49(1.08)
	Full-time	45	3.94(.93)
Having examples of constructive feedback that has been used in the past	Part-time or Adjunct	32	4.04(.82)
	Full-time	45	4.24(.67)
Having an orientation that includes training on correctly filling out documents	Part-time or Adjunct	32	4.39(.55)
	Full-time	45	4.25(.79)
A handbook for clinical faculty	Part-time or Adjunct	32	4.51(.5)
	Full-time	45	4.39(.69)

Note: *n* = raw number of responses; *M(SD)*= mean and standard deviation.

Clinical Evaluation Variable: Descriptive Statistics by Employment Status

Clinical Evaluation Process	Employment Status	*n*	*M(SD)*
Clinical evaluation tools are too abstract	Part-time or Adjunct	32	3.06(.98)
	Full-time	45	2.98(1.23)
Clinical evaluation tools do not provide a true reflection of student performance	Part-time or Adjunct	32	2.97(.9)
	Full-time	45	2.98(1.14)
Clinical evaluations tools are poorly written	Part-time or Adjunct	32	2.77(.94)
	Full-time	45	2.68(.91)
Clinical evaluation tools are too subjective	Part-time or Adjunct	32	3.22(.94)
	Full-time	45	3.13(1.13)
Clinical faculty do not have proper training on how to complete the clinical evaluation tool	Part-time or Adjunct	32	3.45(.98)

	Full-time	45	3.19(1.26)
There is a lack of consistency in how clinical faculty fill out the clinical evaluation tool	Part-time or Adjunct	32	3.64(1.06)
	Full-time	45	3.69(.99)
There is a lack of consistency about what defines an unsafe student.	Part-time or Adjunct	32	3.22(1.1)
	Full-time	45	3.03(1.29)
Clinical evaluation tools are too long	Part-time or Adjunct	32	3.29(.99)
	Full-time	45	3.22(1.22)
It is difficult to complete the clinical evaluation tool because clinical faculty do not spend enough time with students	Part-time or Adjunct	32	2.39(.94)
	Full-time	45	2.56(1.2)
It is difficult to evaluate students when clinical faculty have large clinical groups	Part-time or Adjunct	32	3.72(1.1)
	Full-time	45	4.01(1.1)
Failing a student is difficult	Part-time or Adjunct	32	3.75(1.02)
	Full-time	45	4.04(1.02)
There is a lack of support in regards to clinical faculty's evaluation of student performance	Part-time or Adjunct	32	2.64(.86)
	Full-time	45	2.59(1.16)

Note: n = raw number of responses; *M(SD)*= mean and standard deviation.

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CURRICULUM VITAE

Sara Miles McPherson, PhD(c), RN, CCRN

1 Pitner Place
Jacksonville, IL 62650
309-530-9465
Miless1@unlv.nevada.edu

EDUCATIONAL BACKGROUND

University of Nevada, Las Vegas Las Vegas, NV	PhD in Nursing May 2016
Millikin University Decatur, IL	MSN Nursing Education December 2009
Illinois State University Normal, IL	BSN Nursing May 2005

PROFESSIONAL EXPERIENCE

Assistant Professor of Nursing MacMurray College Jacksonville, IL	Full-time January 2010-May 2014 August 2015-current
Graduate Assistant University of Nevada, Las Vegas	Part-time August 2014-current
Instructional Assistant Professor of Nursing Illinois State University Normal, IL	Full-time August 2014-May 2015
Instructional Assistant Professor of Nursing Illinois State University Normal, IL	Part-time January 2012-May 2013

CLINICAL POSITIONS

Staff Nurse Medical-Surgical, Pre- and Post-Anesthesia Care Unit Passavant Hospital Jacksonville, IL	April 2007-current (per-diem) June 2005-April 2007 (full-time)
Intensive Care Unit	April 2007-June 2012

Memorial Medical Center

PROFESIONL LICENSES AND CERTIFICATIONS

Registered Nurse, State of Illinois	#041-346698
Certification in Acute and Critical Care Nursing Adult	June 2011

PROFESSIONAL ORIENTED PUBLIC SERVICE ACTIVITIES

Consultation

Labor Drive Community Center Jacksonville, IL	Health Fair March 2012-2014
Knollwood Retirement Village Jacksonville, IL	Investing in seniors January 2011-May 2014

COMMUNITY SERVICE

Girl Scouts of America Troop 663 Carrollton, IL	First Aide & Nursing February 2012
Flu Vaccination Clinic Jacksonville, IL	October 2010-2013
Time 2 Be a Nurse Passavant Area Hospital Jacksonville, IL	July 2010-2015
Teens Experiencing Nursing Memorial Medical Center Springfield, IL	July 2010-2011
Camp Care-A-Lot Pittsfield, IL	Summery 2009-2010

PROFESSIONAL ORGANIZATIONS

Sigma Theta Tau	Member